YALE NEW HAVEN HEALTH

October 7, 2015

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Yale New Haven Health Services Corporation and Lawrence + Memorial Corporation
Certificate of Need Application

Dear Ms. Martone:

Enclosed please find the original, four hard copies in 3-ring binders, and an electronic copy on CD of a Certificate of Need (CON) application for the affiliation of Yale New Haven Health Services Corporation and Lawrence + Memorial Corporation. Also enclosed is a check with the filing fee of $500.00.

Please do not hesitate to contact me with any questions or concerns.

Thank you for your time and support of this project.

Sincerely,

Nancy Rosenthal
Senior Vice President – Health Systems Development

Enclosures

789 Howard Avenue
New Haven, CT 06519

Yale New Haven Health Services Corporation
L + M Corporation

Certificate of Need

Affiliation of Lawrence + Memorial Corporation
with Yale New Haven Health Services Corporation

October 7, 2015

Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation
Certificate of Need Application
Table of Contents

State of Connecticut
Department of Public Health
Office of Health Care Access

Certificate of Need Application
Main Form
Required for all CON applications

Contents:

All Supplemental Forms

In addition to completing this Main Form and the appropriate financial worksheet, applicants must complete one of the following supplemental forms listed below. All CON forms can be found on the OHCA website at OHCA Forms.

Conn. Gen. Stat. Section 19a-638(a)	Supplemental Form
(1)	**Establishment of a new health care facility (mental health and/or substance abuse)** - *see note below**
(2)	**Transfer of ownership of a health care facility** (excludes transfer of ownership/sale of hospital – see "Other" below)
(3)	**Transfer of ownership of a group practice**
(4)	**Establishment of a freestanding emergency department**
(5) (7) (8) (15)	**Termination of a service:** termination of inpatient or outpatient services offered by a hospital termination of surgical services by an outpatient surgical facility termination of an emergency department by a short-term acute care general hospital termination of inpatient or outpatient services offered by a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended
(6)	**Establishment of an outpatient surgical facility**
(9)	**Establishment of cardiac services**
(10) (11)	**Acquisition of equipment:** acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners acquisition of nonhospital based linear accelerators
(12)	**Increase in licensed bed capacity** of a health care facility
(13)	**Acquisition of equipment utilizing [new] technology** that has not previously been used in the state
(14)	**Increase of two or more operating rooms** within any three-year period by an outpatient surgical facility or short-term acute care general hospital
Other	**Transfer of Ownership / Sale of Hospital**

*This supplemental form should be included with all applications requesting authorization for the establishment of a **mental health and/or substance abuse treatment facility.** For the establishment of other "health care facilities," as defined by Conn. Gen. Stat § 19a-630(11) - hospitals licensed by DPH under chapter 386v, specialty hospitals, or a central service facility - complete *the Main Form* only.

EXHIBIT I

GREENWICH TRUST
0901 0001397 0030

NTX

00-53-3364B 11-2010

Pay BANK OF AMERICA FIVE ZERO ZERO 00 CTSCTS

***$500.00

To The Order Of TREASURER STATE OF CONNECTICUT

Not-Negotiable
Customer Copy
Retain for your Records

Remitter (Purchased By): MATTHEW J MCKENNAN

001641005594

Bank of America, N.A.
SAN ANTONIO, TX

Bank of America

Cashier's Check

No. 1321105812

Notice to Purchaser - In the event that this check is lost, misplaced or stolen, a sworn statement and 90-day waiting period will be required prior to replacement. This check should be negotiated within 90 days.

Void After 90 Days

30-1/1140
NTX

Date 09/29/15 10:16:37 AM

GREENWICH TRUST
0901 0001397 0030

00-53-3364B 11-2010

Pay BANK OF AMERICA FIVE ZERO ZERO 00 CTSCTS

***$500.00

To The Order Of TREASURER STATE OF CONNECTICUT

Remitter (Purchased By): MATTHEW J MCKENNAN

Bank of America, N.A.
SAN ANTONIO, TX

AUTHORIZED SIGNATURE

THE ORIGINAL DOCUMENT HAS A REFLECTIVE WATERMARK ON THE BACK. HOLD AT AN ANGLE TO VIEW WHEN CHECKING THE ENDORSEMENTS.

EXHIBIT II

APARTMENTS FOR RENT (UNFURNISHED)

WEST HAVEN - Studios $600. 1BR $695-$895, 2BR $935-$1045. 3BR $1500. Many incl. ht/hw, balconies + pkg. No Pets. 203-937-6933

West Haven, 1 BR, 1st fl AND 1 BR, 2nd fl. Opposite green. Stove, refrigerator, coin laundry, on bus line. Utilities included, $1075/mo. References & security deposit. Call 203-996-6582

WEST HAVEN, Sunny 1 BR In immaculate bldg. w/elevator & laundry. W/W, appliances, pool. FREE HEAT/HW & COOKING GAS. Generous closet space. $800/mo. Other locations avail. 203-932-4707.

ROOMS FOR RENT

NEW HAVEN 1351 State St. 1 Room/Furn. Clean. Prkg., Bus Line. Cable. $150/wk. Ref. $500 dep. (203) 466-1996

HELP WANTED GENERAL

ELECTRICIANS CT Lic. E2 for immed. hire @ well-established company. Salary commensurate with experience. We offer health insurance, 401K, 40-hour work week, overtime, rate jobs at times. Signing bonus and vehicle available depending on experience. Call to hear what we have to offer. 203-798-6425 or fax 203-798-8670.

JOB DEVELOPER/ EMPLOYMENT SPECIALIST
F/T - 35hrs/wk + benefits. Req'd: Bachelor's degree in Marketing, Human Service discipline or related field; 2 yrs exp marketing, job development & placement; 2 yrs exp case management, career counseling & employment training. Strong communication/interpersonal skills. Resp. for participant recruitment, training & employment placements. Employer/community outreach & collaboration. Submit cover letter & resume to: info@womenfamilies.org or WFC – HR Office, 169 Colony St. Meriden CT 06451 AA/EOE

HELP WANTED FULL TIME

CIRCULATION MANAGER
NEWSPAPER
(New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a Circulation Manager to oversee 2 site warehouses, staff, and IC force for a new site launch in New Haven area...

Duties Include:

Distributing 255K weekly newspapers are timely and professionally

Recruit, contract, and administer Independent Contractor Delivery (IC) force

Understand warehouse operating procedures and staging

Ensure site staff are qualified, trained and QA product delivery

Possess excellent client and customer service skills

Experience with newspaper circulation and marketing/distribution industry must

Salary:$56-55k

Please email resumes to ATTN: HR at cwandrey@cipsmarketing.com

LUCK IS only part of it! A classified ad is the rest!

HELP WANTED FULL TIME

DISTRIBUTION CENTER FACILITATOR (DCF)
NEWSPAPER
(New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a Distribution Center Facilitator for a new site launch in New Haven area...

Duties Include:

Assisting the Manager in ensuring all client product is distributed timely and professionally

Responsible for quality assurance on routes checking Independent Contractor force.

Understand warehouse operating procedures

Ensure that site adheres to ethical business practices to the extent it depends on you.

Must communicate well

Be flexible and cooperative.

Experience with newspaper circulation and marketing/distribution industry preferred.

Salary: $13.50-$15.00/ hour, overtime paid at time +half.

Part-time & Full-time positions available

Must have own car and willing to use to QA distribution, mileage reimbursed at .51/mi driven.

Please email resumes to ATTN: HR at cwandrey@cipsmarketing.com

DISTRICT MANAGER
NEWSPAPER
(New Haven Area)

Growing company based in LA with multiple sites nationwide is looking for a District Manager for a new site launch in New Haven area...

Duties Include:

Distributing 100-125K weekly newspapers are timely and professionally

Recruit, contract, and administer Independent Contractor Delivery (IC) force

Understand warehouse operating procedures and staging

Ensure site staff are qualified, trained and QA product delivery

Possess excellent client and customer service skills

Experience with newspaper circulation and marketing/distribution industry must

Salary:$35-38K

Please email resumes to ATTN: HR at cwandrey@cipsmarketing.com

CARPENTERS! PAINTERS! LANDSCAPERS!
Place your ad in our Business Card Section or our Service Directory. Our readers will call you! They trust our advertisers to do the job right! Call 203-850-6328

ACCOUNTING & FINANCE

Financial Analyst
Global leading manufacturing company based in central CT with 15 worldwide locations is seeking highly motivated CPA interested in growth opportunity within the finance department reporting directly to the CFO.
Position Requirements: Must be able to travel extensively and have the ability to work independently. Understanding of Financial Analysis in international settings. Understanding of multi-currency environments.
Education Requirements: B.S. in Accounting required. Masters Degree in Accounting or Finance required. MUST BE A CPA.
Compensation based on the skill and background of the candidate.
Please forward your resume to: Fax: (860) 347-9985 or Email to: Jarvis.products.corp@snet.net

CAREER TRAINING

EMT COURSE
STARTS 9-1.
DAY - NIGHT PROGRAMS AVAILABLE.
Call MedEd 203.632.9247 to register or for more info...

LEGAL NOTICES

PUBLIC NOTICE

Pursuant to 12 CFR §303.65 of the regulations of the Federal Deposit Insurance Corporation (the "FDIC"), notice is hereby given that Liberty Bank, whose main office is located at 315 Main Street, Middletown, Connecticut 06457, has filed with the FDIC an application to engage in a merger transaction whereby Naugatuck Valley Savings and Loan ("NVSL") will merge with and into Liberty Bank with Liberty Bank being the surviving bank. It is contemplated that all offices of the above named institutions will continue to be operated with the exception of NVSL's Cheshire Branch located at 1699 Highland Avenue, which will be closed and consolidated with Liberty Bank's Cheshire branch located at 160 Highland Avenue, Cheshire, CT at the effective time of the transaction.

Any person wishing to comment on such application may file his or her comments in writing with the regional director of the FDIC at the appropriate FDIC office: John Vogel, Regional Director, FDIC, 15 Braintree Hill Office Park, Suite 200, Braintree, MA 02184-8701, not later than August 27, 2015. The non-confidential portions of the application are on file at the appropriate FDIC office and are available for public inspection during regular business hours. Photocopies of the non-confidential portion of the application file will be available upon request.

Public Notice:
Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a)(3) for the merger of the two Medical Foundations with NEMG being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") for YNHHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

SHOP FROM your easy chair. Shopping the classifieds is easy, relaxing and you don't have to worry about parking.

LEGAL NOTICES

Public Notice:
Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a) (2) and 19a-486. YNHHSC and L+M will request CON approval for YNHHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital joining and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Montauk Avenue, New London, CT, will not change as a result of this transaction. There is no capital expenditure associated with this Application.

TAX COLLECTOR'S NOTICE
CITY OF WEST HAVEN

Including:
CITY OF WEST HAVEN FIRE DISTRICT
ALLINGTOWN CENTER FIRE DISTRICT
WEST SHORE FIRE DISTRICT

Pursuant to Sec. 12-145 of the Connecticut State Statutes, the undersigned Tax Collector of the City of West Haven gives notice that taxes for the October 1, 2014 grand list, for real estate, motor vehicle, personal property and sewer use fees are due and payable on July 1, 2015 and January 1, 2016. Last day to pay on time, official US Postmark accepted, is August 3, 2015 for the first installment and February 1, 2016 for the second installment. Late payments will be charged interest from the due date at a monthly rate of 1.5 percent or fraction thereof, 18 percent per annum as required by Connecticut Gen Stat 12-130, 145 and 146. The minimum interest charge is $2.00 on each tax bill. Failure to receive a bill does not invalidate the tax nor any interest and penalties incurred per Connecticut Gen Stat Sec. 12-130 and 12-146. Make checks payable to Collector of Taxes and mail, with tax bill, to: Collector of Taxes - City of West Haven, PO Box 150461, Hartford, CT 06115. Payments can also be made at the tax office, 355 Main St., first floor, West Haven, CT - Office hours are Mon-Fri from 8:00 a.m. to 4:00 p.m. During the collection cycle only, a drop box is available outside the tax office weekdays from 7:30 a.m. to 7:30 p.m. Point and Pay, LLC services all credit/debit card payments (convenience fee applies). To pay online log on to - www.cityofwesthaven.com - see Quick Links - Tax Collector Dept info.

Marianne E. Gambardella
Tax Collector
City of West Haven, CT
203-937-3525

CLASSIFIED IS OPEN
8:00 AM - 5:00 PM
MON-FRI
Call 1.800.922.7066
or email:
CLASSIFIEDS@NHREGISTER.COM

CAN'T FIND what you're looking for? Find it the fast & easy, effective way by using the classifieds! Call and place a low cost classified ad under "Wanted To Buy" in next week's paper.

LEGAL NOTICES

The West Haven Inland Wetlands Agency made the following decision at a regular meeting on Tuesday, June 16, 2015 in the Harriet North Room, 2nd Floor, City Hall, 355 Main Street, West Haven, CT.

85 Cooper Road: Application to add a 12'X 16' sunroom and a 16'x16'deck to the existing structure within the wetlands. Applicant: George Nash/ Owner: Philip Ruggiero IW #15-025 APPROVED WITH CONDITIONS

120-140 Fresh Meadow Road: Application to fill 0.25 acres of historic Wetlands for a construction yard/ storage area Applicant/owner GC realty LLC Principal -Giancarlo Colonna IW #15-026 APPROVED WITH CONDITIONS

136 Ivy Street: An application to install an above ground pool in the inland regulated area Applicant/ owner Paul C Dinicola IW #15-028 APPROVED

20 Simos Lane: Application to install an above ground pool with in the regulated inland wetland area Applicant Lydia Brown /Owner Allan Stephanie & Lydia Brown IW # 15-027 APPROVED

15 Industry Dr: Proposed to build a parking area totalling 0.69 acres. The site contains approximately 0.22 acres of wetlands located along the northern edge of the property, and 0.16 acres of upland review area. The existing wetland area will be enhanced with wetland plantings as part of the proposed project. The construction of the parking area is proposed with the 100- year flood hazard zone, and has been designed to increase the flood carrying capacity of the property by 124 cubic yards. Applicant/Owner 15 Industry Drive, LLC IW #15-029 CONTINUED

William Kane
Chairman

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF:
Francis X. Pierce II

The Hon. John A. Keyes, Judge of the Court of Probate, Derby Probate District, by decree dated July 7, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Edward Cleary,
Assistant Clerk

The fiduciary is:

Catherine Pierce
c/o Shelby L. Wilson, Esq., Berchem, Moses & Devlin, P.C.
75 Broad Street
Milford, CT 06460
680347

DOGS

Bull Dogs $950+ Yorkies, $550+ Chih $450+ Bengal Kittens $250+ Health guar, Vet check shots. 860-930-4001

APPLIANCES

Affordable
Washers, Dryers, Stoves, Refrigs. Delivery Available
203 - 284 - 8986

A HOME OF YOUR OWN
The Job of Your Dreams
A Pet for the Children
A Second Car for Commuting
A Tag Sale "Buried Treasure"
Find these and more in the New Haven Register Classifieds.

Legal Notice
Town of Orange

A certified list of Republican party-endorsed candidates for the Town of Orange for election as:

First Selectman
Selectmen
Tax Collector
Board of Finance
Board of Education
Town Planning and Zoning
Town Planning and Zoning (deferred term)
Constable
Amity Regional School Board

is on file in my office at Orange Town Hall 617 Orange Center Rd. Orange, Connecticut, and copies thereof are available for public distribution.
The certified list as received includes fewer names of party-endorsed candidates than the party is entitled to nominate for the following offices:

Office	Number of Names Certified	Number Entitled to be Nominated
Town Clerk	0	1
Board of Education (To fill Vacancy for Two Years)	0	1
Amity Regional School Board	3	4

A primary will be held September 16, 2015 if, for a particular office, the number of party-endorsed candidates plus the number of candidates filing petitions pursuant to Sections 9-382 to 9-450 of the Connecticut General Statutes exceeds the maximum number which the party is entitled to nominate for that office. Petitions must be filed not later than 4:00 p.m. on August 12, 2015. Petition forms, instructions and information concerning the procedure for filing of opposing candidacies, including schedules, may be obtained from:

Frederick Kendrick, Republican Registrar of Voters
Orange Town Hall 617 Orange Center Rd. Orange, Connecticut

Patrick B. O'Sullivan
Orange Town Clerk

HELP WANTED FULL TIME

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Salary:$50-55k

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Must have own car and willing to use to QA distribution, mileage reimbursed at .51/mi driven.

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EMT COURSE
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DAY - NIGHT PROGRAMS AVAILABLE.
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CARPENTERS! PAINTERS! LANDSCAPERS!
Place your ad in our Business Card Section or our Service Directory. Our readers will call you! They trust our advertisers to do the job right!
Call 203-850-8628

LEGAL NOTICES

CITY OF ANSONIA

Motor Vehicle, Real Estate and Personal Property Taxes on the Grand List of October 1, 2014 are due July 1, 2015 and payable during the month of July 2015. Tax payments may be mailed to:

Collector of Taxes
Post Office Box 253
Ansonia, CT

Payments may also be made in person between the Hours of 8:30 – 4:30, M. T. W; THURSDAY 8:30 – 5; FRIDAY 8:30 – 1:00 at the Tax Collector's Office, 253 Main Street, Ansonia.

Taxpayers who have not received a bill in July should contact Tax Office for a duplicate bill since failure to receive a bill does not invalidate the tax or respective penalties should the account become delinquent.

Unpaid taxes will be considered delinquent as of August 4, 2015. On that day interest will be charged from the original date of July 2015. Interest is charged at the rate of **18% per year in accordance with the provisions of Connecticut General Statutes Sec 12-146.**

T. Blackwell, Tax Collector
City of Ansonia
2526168

LEGAL NOTICE

Pursuant to Conn. Gen. Stat. §16-245m, the Public Utilities Regulatory Authority (PURA) will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on **Tuesday, August 4, 2015, at 9:00 a.m.**, concerning Docket No. 15-01-24 – Annual Reconciliation of the Conservation Adjustment Mechanisms Filed by: The Connecticut Light and Power Company, The United Illuminating Company, Connecticut Natural Gas Corporation, The Southern Connecticut Gas Company and Yankee Gas Services Company.

LEGAL NOTICE TO HAMDEN TAXPAYERS

The first installment of taxes levied on the Grand List of October 1, 2014 is due and payable July 1, 2015.

If these taxes are not paid on or before August 3, 2015 they will be subject to interest at the rate of 1 1/2% or fraction thereof from the due date of July 1, 2015 to the date the tax installment is paid. The minimum interest charge is $2.00.

These taxes become delinquent August 4, 2015. In accordance with a Town Ordinance all delinquent motor vehicle taxes requiring a release for motor vehicle registration must be paid by cash, certified check or money order.

Taxes will be received at the Office of the Tax Collector, Hamden Government Center, 2750 Dixwell Ave, Hamden, Monday through Friday 8:30 AM to 4:30 PM.

This is subject to change to conform to the latest Public Acts, General Statutes and local ordinances.

JOHN STEELE, CCMC
TAX COLLECTOR

LEGAL NOTICE:

The Curran Foundation's Form 990-PF is available for public inspection by appointment only at the offices of Halsey Associates, 234 Church Street, 10th Floor, New Haven, CT. To make an appointment, please call 203-772-0740.

LIQUOR PERMIT

Notice of Removal
This is to give notice that I, THOMAS M SMITH 146 PUTTING GREEN RD TRUMBULL, CT 06611-2519
Have filed a request placarded 07/24/2015 with the Department of Consumer Protection for permission to move my PACKAGE STORE LIQUOR business now located at 302 RACEBROOK RD ORANGE, CT 06477
To
374 BOSTON POST RD ORANGE, CT 06477
The business will be owned by: TOMLIZ AND SONS LLC
Remonstrances/Objections must be filed by: 08/01/2015
THOMAS M SMITH

LEGAL NOTICES

NOTICE OF TAX WARRANT AND VEHICLE TAX AUCTION

The Tax Collector of the City of New Haven, Connecticut, hereby gives Notice that a Tax Warrant has been levied on the taxpayer for failure to pay Personal Property Tax on their vehicle/s, and that a Tax Collector's Auction has been scheduled by the Tax Collector through its agent, State Marshal H. Mark DeAngelis. (203) 215-7857, in accordance with (C.G.S.12-155)

TIME AND PLACE OF AUCTION
DATE:(SATURDAY) 8/15/15

TIME: 8:30 A.M. viewing 9:00 A.M. Auction starts
PLACE: CROWN AUTO CENTER 398 Crown Street, New Haven, CT.

VEHICLES

4S4WX83C764417736
2T1KR32E63C042465
1G1ZT54885F189540
2HGES16562H560653
1D4HB48N65F551433
2C8GH78425R434039
1FAHP27136G141837
1J8GR48K18C119602

The Property being auctioned pursuant to this notice is being sold "as is" and "where is"

Public Notice:

Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a)(3) for the merger of the two Medical Foundations with NEMG being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") for YNHHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

Public Notice:

Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a) (2) and 19a-486. YNHHSC and L+M will request CON approval for YNHHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital joining and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Montauk Avenue, New London, CT, will not change as a result of this transaction. There is no capital expenditure associated with this Application.

STATE OF CONN Superior Court Juvenile Matters

NOTICE TO Olivia Simmons-Darveau of Parts Unknown

A petition has been filed seeking: Termination of parental rights of the above named in minor child(ren). The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 08/21/15 at 10:00A.M. at 239 Whalley Avenue, New Haven, CT 06511.
Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the New Haven Register, a newspaper having a circulation in the town/city of: New Haven, CT.
Hon. John Cronan
Judge
M. Lauden
7/24/15
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

CLASSIFIEDS hold many, many opportunities. They give opportunity for you to buy items, meet people, sell unwanted items, find housing, save money, earn a couple bucks, and much, much more.

HOW TO WRITE a classified ad that sells: First – Be complete. Second – Include the price. And third – Be available. Call today and we will be happy to help you write the most effective ad.

LEGAL NOTICES

STATE OF CONN Superior Court Juvenile Matters

NOTICE TO Gerald Thomas of Parts Unknown

A petition has been filed seeking: Commitment of minor child(ren) of the above named or vesting of custody and care of said child(ren) of the above named in a lawful, private or public agency or a suitable and worthy person. The petition, whereby the court's decision can affect your parental rights, if any, regarding minor child(ren) will be heard on: 09/03/15 at 10:00A.M. at 239 Whalley Avenue, New Haven, CT 06511.
Hearing on an Order of Temporary Custody will be heard on: 7/31/15 at 9:00 a.m. at 239 Whalley Avenue, New Haven, CT 06511.
Therefore, ORDERED, that notice of the hearing of this petition be given by publishing this Order of Notice once, immediately upon receipt, in the New Haven Register, a newspaper having a circulation in the town/city of: New Haven, CT.
Hon. John Cronan
Judge
Kathryn A. Coppola
7/24/15
Right to Counsel: Upon proof of inability to pay for a lawyer, the court will provide one for you at court expense. Any such request should be made immediately at the court office where your hearing is to be held.

PROBATE NOTICES

NOTICE TO CREDITORS

ESTATE OF Anna Pela, AKA Anna Raposio

The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated July 7, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Nabil E. Valencia,
Assistant Clerk

The fiduciary is:

Claudia Bujold,
a.k.a Claudia Pela
69 Point Beach Drive
Milford, CT 06460
675264

NOTICE TO CREDITORS

ESTATE OF Elizabeth McCabe Hession, late of Derby in said district deceased, AKA Elizabeth T. Hession

The Hon. Clifford P. Hoyle, Judge of the Court of Probate, District of Derby Probate District, by decree dated July 2, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Kay Jeanette,
Chief Clerk

The fiduciary is:

Kathleen H. Demers
78 George Avenue
Cheshire, CT 06410
672891

NOTICE TO CREDITORS

ESTATE OF Leonard D'Antona

The Hon. John A. Keyes, Judge of the Court of Probate, District of New Haven Probate District, by decree dated July 2, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Edward Cleary,
Assistant Clerk

The fiduciary is:

Lori Riordan
c/o Susan B. Nobleman, Esq.
3127-3129 Whitney Ave
Hamden, CT 06518
680366

YOU'LL NEVER KNOW how effective a classified ad is until you use one yourself! Reach the entire area without leaving the comfort of your home. Call and place your classified today to sell those unwanted items.

CAN'T FIND what you're looking for? Find it the fast & easy, effective way by using the classifieds! Call and place a low cost classified ad under "Wanted To Buy" in next week's paper.

BUY IT · SELL IT · FIND IT · IN THE CLASSIFIEDS

LEGAL NOTICES | LEGAL NOTICES | LEGAL NOTICES

NEW LONDON PUBLIC SCHOOLS

Is seeking applicants for the following administrative position:

NATHAN HALE ARTS MAGNET SCHOOL PRINCIPAL
New London, CT
Grades K – 5

In only its second year as visual and performing arts magnet school in New London, the Nathan Hale Arts Magnet School provides students from Kindergarten through grade 5 an integrated learning environment that combines traditional academics with an arts curriculum that includes vocal and instrumental music, visual art, dance, theatre, creative writing, and interdisciplinary arts.

The school boasts a variety of specialty rooms in which students can express their creative inner selves, including – an outdoor art classroom, a music & instrument room, an art room, a state-of-the-art dance room with spring loaded floor, a choral & music room, a keyboard classroom, video editing room, and a science room.

New London has been designated by state legislation as the only "Magnet District" in Connecticut.

The Nathan Hale Arts Magnet School teaches all facets of the production cycle, and students create projects for both school-based and outside audiences. Instruction in core academic areas, as well as participation in five performances and public showcases of their work, provide students with challenging learning activities that will develop their ability to demonstrate creativity, communicate effectively, collaborate with others, and assume leadership roles.

The school seeks to transcend the work of a traditional elementary school. Teachers focus on educating the whole child and on developing a community of learners that values the work of all individuals.

The district is seeking a dynamic leader to join our journey. Qualified applicants will have:

- Possession of CT Administrative Certificate (092) or eligibility to obtain the CT 092
- Teaching and/or administrative experience in a magnet school environment is a plus
- Certification and instructional or practical experience in one or more of the fine arts (music, visual arts, theater or dance) preferred
- A background in and demonstrated commitment to the arts

Please submit letter of intent, resume, application, three letters of reference, certification, a statement regarding educational philosophy and transcripts to:

Cherese Chery
Chief Talent/Human Resources Officer
New London Public Schools
134 Williams Street, New London, CT 06320

Closing Date for Applications: August 1, 2015

Applications must be submitted electronically through Applitrack.com. http://www.applitrack.com/newlondon/onlineapp/

New London Public School District is an Equal Opportunity/Affirmative Action Employer
Candidates from diverse racial, ethnic and cultural backgrounds are encouraged to apply

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Notice of Tentative Determination to Approve Stationary Source
New Source Review Permit Applications
and Notice of Public Informational Hearing

Applicant: CPV Towantic, LLC
Application No. 201408901, 201408904, 201408905, 201408906, 201408907
City/Town: Oxford, CT

The Commissioner of the Department of Energy and Environmental Protection (DEEP) hereby gives notice that a tentative determination has been reached to approve the following applications. The proposed activity will affect air resources. The Commissioner also gives notice that a hearing may be held on this application if the Commissioner determines that the public interest will best be served thereby, and shall hold a hearing as provided below.

Applicant's Name and Address:	CPV Towantic, LLC, 50 Braintree Hill Office Park, Suite 300 Braintree, MA 02184
Contact Name/Phone/Email:	Mr. Andrew Bashnet, (781) 848-3611, abshnet@cpv.com
Type of Permits:	Five (5) New Source Review permits for an 805 MW Combined Cycle Power Plant consisting of two GE 7HA.01 combustion turbines with duct firing, one auxiliary boiler and two emergency diesel fired engines
Relevant Statute(s)/Regulation:	CGS 22a-174, Clean Air Act Amendments of 1990
Facility Location:	16 Woodruff Hill Road, Oxford, CT 06478

The DEEP has tentatively determined that the Lowest Achievable Emission Rate (LAER) for NOx emissions shall be:

- 2.0 ppmvd and 5.0 ppmvd when combusting natural gas and ultra low sulfur distillate (ULSD) for the turbines.
- 7 ppmvd for the auxiliary boiler burning only natural gas.
- Fuel limitation on hours of operation and latest required USEPA certified engines for the diesel emergency and fire pump engines
- The applicant is required to possess 234 tons of approved serious non-attainment NOx emission reduction credits to offset the potential 194.7 annual tons of NOx that may be emitted from the facility.

According to the ambient air impact analysis, the proposed facility will not cause or contribute significantly to any violation of a National Ambient Air Quality Standard or Prevention of Significant Deterioration (PSD) increment. The predicted PSD multi-source ambient impacts for nitrogen dioxide (NO_2), sulfur dioxide (SO_2) and PM_{10} are presented in the table below:

PARAMETER	PSD INCREMENT (µg/m³)	MAXIMUM IMPACT (µg/m³)
SO_2 annual arithmetic mean	20	0.03
SO_2 24-hr average	91	0.5
SO_2 3-hr average	512	1.4
NO_2 annual	25	2.4
PM-10 annual arithmetic mean	17	0.29
PM-10 24-hr average	30	4.2
PM-2.5 annual arithmetic mean	4	0.29
PM-2.5 24-hr average	9	4.2

INFORMATION REQUESTS/PUBLIC COMMENT
Interested persons may obtain copies of the application from the applicant at the applicant's address noted above. The application, proposed permits and supporting documentation are available for inspection at DEEP, Bureau of Air Management, 79 Elm Street, 5th floor, Hartford, CT from 8:30 AM to 4:30 PM Monday through Friday and at other times by appointment. Interested persons have thirty (30) days from publication of this notice to submit comments in writing to the Department of Energy and Environmental Protection, Bureau of Air Management or request a public hearing concerning the commissioner's tentative determination to approve the permit applications, in accordance with the section 22a-3a-5(b) of the Regulations of Connecticut State Agencies and section 22a-174-2a(c) of the Regulations of Connecticut State Agencies. Please note: **The department has already determined it will hold a public informational hearing as indicated in the remainder of this notice.** Written comments on the application should be directed to Mr. James Grillo, Bureau of Air Management, DEEP, 79 Elm Street, Hartford, CT 06106-5127, no later than 30 days from the publication date of this notice. Comments regarding this application may be submitted via electronic mail to: james.grillo@ct.gov.

NOTICE OF PUBLIC INFORMATIONAL HEARING
As requested and pursuant to section 22a-174-2a(c) of the RCSA, the commissioner will hold a Public Informational Hearing to take public comments concerning the tentative determination to approve the above referenced air permit applications.

The informational hearing will be held on August 27, 2015 at 6:30 pm at Oxford High School, 61 Quaker Farms Road, Oxford, CT 06478. Notice of the hearing is posted on the "Calendar of Events" on DEEP's website at http://www.ctcalendar.ct.gov/calendar/. The public hearing will be rescheduled if inclement weather results in closure of the location of the hearing. Members of the public should check the Calendar of Events for the date and time of the rescheduled hearing if inclement weather prevents the holding of the scheduled hearing.

The informational hearing will be moderated and recorded by a DEEP hearing officer and will proceed in the following order: presentations from the applicant and DEEP staff; a 15-minute off the record break for questions and answers between members of the public and presenters; and then the continuation of the informational hearing to receive oral and written comments from members of the public on the record. Comments will be heard in the order in which members of the public sign up at the informational hearing.

Written comments will be accepted at the informational hearing and until the close of business on September 3, 2015. Instruction on how and where to submit comments between August 27 and September 3 will be provided at the information hearing. Persons seeking to intervene in the hearing process must file a request no later than 5 days prior to the start of the public hearing. Requests may be mailed or delivered to the Office of Adjudications, 79 Elm Street, Hartford, CT 06106 or filed electronically at deep.adjudications@ct.gov. For additional information go to www.ct.gov/deep/adjudications.

ADA PUBLICATION STATEMENT
The Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to the requirements of the Americans with Disabilities Act. To request an accommodation, call 860-418-5910, or deep.accomodations@ct.gov

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LEGAL NOTICES

LIQUOR PERMIT
Notice of Application
This is to give notice that I,
PRATIMA P PATEL
7 PAPA LN
NORTH HAVEN, CT
06473-3622
Have filed an application placarded 07/29/2015 with the Department of Consumer Protection for a PACKAGE STORE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at
71 QUINNIPIAC ST
WALLINGFORD CT
06492-3519
The business will be owned by:
MELOI-MATA LLC
Objections must be filed by:
009/08/2015

PRATIMA P PATEL

LIQUOR PERMIT
Notice of Application

This is to give notice that
I, Kirankumar V Patel
91 Robert Treat Dr. Apt C.
Milford, CT 06460

Have filed an application placarded 07/17/2015 with the Department of Consumer Protection for a PACKAGE STORE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at
332 Newhall St
New Haven, CT 06511

The business will be owned by: MANSI ASSOCIATES LLC
Objections must be filed by: 08/28/2015

NOTICE OF PUBLIC HEARING

The Representative Policy Board of the South Central Connecticut Regional Water District will hold a public hearing to consider the South Central Connecticut Regional Water Authority's Application for the Transfer of Interest in Real Property (Conservation Easement) to the State of Connecticut for 60+/- acres located off Great Hill Rd. in Guilford, CT, which is currently referred to as Land Unit GU 12A at 7:00 p.m. on Thursday, August 20, 2015 at the Nathanael B. Greene Community Center, 32 Church Street, Guilford, CT 06437. The Public Hearing is being held pursuant to Section 10 and 18 of Special Act 77-98, as amended. The applications and accompanying information are available for public inspection between the hours of 8:00 a.m. and 5:00 p.m. at the office of the Regional Water Authority, 90 Sargent Drive, New Haven, Connecticut.

All users of the public water supply system, residents of the Regional Water District, owners of property served or to be served, and other interested persons shall have an opportunity to be heard concerning the matters under consideration.

Thomas P. Clifford III,
Chairman
REPRESENTATIVE POLICY BOARD
South Central Connecticut Regional Water District
90 Sargent Drive
New Haven, CT 06511

Public Notice:
Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a)(3) for the merger of the two Medical Foundations with NEMG being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") for YNHHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

Public Notice:
Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a) (2) and 19a-486. YNHHSC and L+M will request CON approval for YNHHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital joining and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Montauk Avenue, New London, CT, will not change as a result of this transaction. There is no capital expenditure associated with this Application.

LEGAL NOTICES

STATE OF CONNECTICUT
SUPERIOR COURT
Judicial District of
New Haven at New Haven
Witkowski, Norma J.
Plaintiff
vs.
Witkowski, Anthony T
Defendant

NOTICE TO: Witkowski, Anthony T

Return Date: 8/18/15
The Court has reviewed the Motion for Order of Notice and the Complaint/Application/Motion which asks for: divorce (dissolution of marriage). The Court finds that the current address of the party to be notified is unknown and that all reasonable efforts to find him/her have failed. The Court also finds that the last known address of the party to be notified was: 177 Daytona St., West Haven, CT 06516. The Court orders that notice be given to the party to be notified by having a State Marshal or other proper officer place a legal notice in: New Haven Register, a newspaper circulating in New Haven County, containing a true and attested copy of this Order of Notice, and, if accompanying a Complaint for divorce (dissolution of marriage), complaint for dissolution of civil union; legal separation or annulment, or if accompanying an Application for custody or visitation, a statement that Automatic Court Orders have been issued in the case as required by Section 25-5 of the Connecticut Practice Book and are a part of the Complaint/Application on file with the Court. The notice should appear once before 8/6/15 for one time publication and proof of service shall be filed with this Court.
P. Nielsen
Asst. Clerk
7/23/15

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF
George T. Middleton, Jr.,
AKA George Middleton

The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated July 13, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Nabil E. Valencia,
Assistant Clerk

The fiduciary is:

Maryann Middleton
c/o Joel C. Karp, Esq.
Karp & Langerman, P.C.
185 Plains Rd., Ste. 209E
Milford, CT. 06460
690148

NOTICE TO CREDITORS
ESTATE OF
Henrietta Veronica Connelly

The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hamden - Bethany Probate District, by decree dated July 22, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recove on such claim.

Valerie A. Dondi, Clerk

The fiduciary is:

Louis Scoppetto
c/o Allison M. DePaola, Esq.
Floman DePaola, LLC
P.O. Drawer 966
378 Boston Post Rd.
Orange, CT 06477
690257

NOTICE TO CREDITORS
ESTATE OF
Mary Catherine Felton

The Hon. Edward C. Burt, Jr., Judge of the Court of Probate, District of Hamden - Bethany Probate District, by decree dated July 22, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Valerie A. Dondi, Clerk

The fiduciary is:

Laura M. Vitello
c/o Jeffrey R. Borak, Esq.
320 Main Street
Wallingford, CT 06492
690206

PROBATE NOTICES

NOTICE TO CREDITORS
ESTATE OF Phan Au

The Hon. Beverly K. Streit-Kefalas, Judge of the Court of Probate, District of Milford - Orange Probate District, by decree dated July 14, 2015, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim.

Elizabeth Davis,
Chief Clerk

The fiduciary is:

Kiet Dang
38 Clayton Street
Milford, CT 06461
684091

FORECLOSURES

LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.:
NNH-CV-14-6050988-S
Case Name:
Wells Fargo Financial America, Inc.
vs.
Penders, Adrienne G., et al
Property Address:
100 Edgar Street
East Haven, CT
Property Type:
Residential

Date of Sale:
August 8, 2015
at 12:00pm

Committee Name:
Attorney Keith V. Sitinick
Committee
Phone Number:
(203) 488-5822

See Foreclosure Sales at: www.jud.ct.gov for more detailed information

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LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No:
CV-10-6040384-S
Case Name:
J.P. Morgan Chase
vs.
Rajeshwar N. Gaonkar, et al
Property Address:
675 Townsend Ave. Unit # 111
New Haven, CT 06512
Property Type:
Single Family
Residential Condominium
Date of Sale:
August 8, 2015
at 12:00 p.m.
Required Deposit:
$15,300.00
Committee Name:
Carl V. Pantaleo, Esq.
Committee Phone
Number: (203) 481-7472

See Foreclosure Sales at **www.jud.ct.gov** for detailed information

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LEGAL NOTICE FORECLOSURE AUCTION SALE

Docket No.
NNH-CV15-6052720 S
Case Name:
Humphrey Place Condominium Association, Inc.
vs.
M&T Bank aka Manufacturers and Traders Trust Company
Property Address:
55 Walnut Street, Unit S-3,
New Haven, CT 06511
Property Type:
Residential Condominium

Date of Sale:
August 8, 2015

Committee Name:
Nicholas M. Iroiano
Committee
Phone Number:
(203) 562-1192

See Foreclosure Sales at www.jud.ct.gov for more detailed information

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Public Notices | Public Notices | Public Notices

19091

Town of Groton,
Fire Districts, Subdivisions and Special Tax Districts
located in the Town of Groton
Tax Collector's Notice of Taxes Due

All property owners in the Town of Groton are hereby notified that taxes on land, buildings, and personal property including motor vehicles will be due and payable July 1, 2015, based on the Town of Groton abstract of October 1, 2014, for the TOWN OF GROTON, GROTON SEWER DISTRICT, CITY OF GROTON, POQUONNOCK BRIDGE FIRE DISTRICT, MYSTIC FIRE DISTRICT, NOANK FIRE DISTRICT, OLD MYSTIC FIRE DISTRICT, GROTON LONG POINT ASSOCIATION, CENTER GROTON FIRE DISTRICT, WEST PLEASANT VALLEY FIRE DISTRICT, and MUDYARD COVE ASSOCIATION.

The Town of Groton and the Groton Sewer District real estate and personal property tax bills over $100 may be paid in full or in two installments. The first installment will become due July 1, 2015. The second installment will become due January 1, 2016. Real estate and personal property taxes under $100, motor vehicle taxes, and all other fire district/political subdivision taxes will become due in full July 1, 2015.

These taxes shall be payable without penalty on or before August 3, 2015. All taxes paid after that date will become delinquent and due immediately and subject to interest at the rate of one and one-half percent (1.5%) per month or fraction thereof from the due date. Bills will be mailed by the last day of June 2015. Failure to receive a bill does not invalidate the tax or interest. If a bill is not received by July 6, 2015, please contact the tax office.

PAYABLE AT:
TAX OFFICE, GROTON TOWN HALL
45 FORT HILL ROAD, GROTON, CT
8:30 AM TO 4:30 PM MONDAY – FRIDAY
860-441-6670 OPTION #4
BY MAIL:
TAX DIVISION, TOWN OF GROTON
PO BOX 981641
BOSTON, MA 02298-1641

Current taxes may be paid at the Groton and Mystic branches of Citizens Groton Bank. You do not need to be an account holder. For other payment options and information, visit the town website at www.grotonct.gov.

Cynthia L. Small, CCMC
Tax Collector

19265

TOWN OF SALEM
ATTENTION SALEM TAXPAYERS
FIRST INSTALLMENT NOTICE

Notice is hereby given to the taxpayers of the Town of Salem that I have a warrant to collect a tax of 31.1 mills on a dollar on the levy of October 1, 2014 which is due and payable as follows:

1) Real Estate and Personal Property bills over $100.00 may be paid in full, or in two equal installments: first installment due on July 1, 2015 and the second installment on January 1, 2016.
2) Real Estate and Personal Property tax bills under $100.00 are due in full on July 1, 2015.
3) Motor Vehicle taxes are due in full July 1, 2015, regardless of the amount.

You have one month from the due date to pay taxes/installment without interest or penalty. Failure to make payment within the prescribed time will invoke a penalty of 1 1/2% per month (18% per year) with a $2.00 minimum on each tax bill.

Taxpayers who do not have a bill for the Oct. 1, 2014 list should contact the Salem Tax Collector's office for a duplicate bill. Failure to receive a bill does not invalidate the taxes or respective penalties should the account become delinquent.

Taxes may be paid at the Salem Town Office building Monday thru Wednesday from 8:00 a.m. to 5:00 p.m., on Thursday from 8:00 a.m. to 6:00 p.m. The town hall is closed on Friday.

Dated at: Salem Connecticut, this 26th day of June 2014.

Cheryl A. Philopena C.C.M.C. Tax Collector
Town of Salem

19189

CITY CENTER DISTRICT

TAX NOTICE

The Taxpayers of the City Center District are hereby notified that I have a warrant to collect a tax of 3.33 mills on the dollar on the Grand List of October 1, 2014. Real Estate bills may be paid in full on the first date and taxes and bills over $300.00 may be paid in two installments: July 1, 2015 and January 1, 2016.

If the tax due is not paid within one month of the due date, the tax will become delinquent and subject to interest at the rate of one and one-half percent per month or fraction thereof calculated from the due date. Minimum interest is $2.00. The last due to pay the bill without penalty is August 3, 2015. Taxpayers are requested to bring or mail their tax bills with their payment, receipts for payment by mail will be returned if self-addressed stamped envelope is provided.

Bills are mailed to the owner of record as of October 1, 2014. If you do not receive your tax bill please call the tax office at 447-5208. Failure to receive a tax bill does not invalidate the tax or the interest.

MAUREEN A FARRELL, CCMC
Tax Collector
Consolidated Town and City of New London

Like us on Facebook
Facebook.com/theday

19281

TOWN OF SALEM
ATTENTION SALEM TAXPAYERS
FIRST INSTALLMENT NOTICE

Notice is hereby given to the taxpayers of the Town of Salem that I have a warrant to collect a tax of 31.1 mills on a dollar on the levy of October 1, 2014 which is due and payable as follows:

1) Real Estate and Personal Property bills over $100.00 may be paid in full, or in two equal installments: first installment due on July 1, 2015 and the second installment on January 1, 2016.
2) Real Estate and Personal Property tax bills under $100.00 are due in full on July 1, 2015.
3) Motor Vehicle taxes are due in full July 1, 2015, regardless of the amount.

You have one month from the due date to pay taxes/installment without interest or penalty. Failure to make payment within the prescribed time will invoke a penalty of 1 1/2% per month (18% per year) with a $2.00 minimum on each tax bill.

Taxpayers who do not have a bill for the Oct. 1, 2014 list should contact the Salem Tax Collector's office for a duplicate bill. Failure to receive a bill does not invalidate the taxes or respective penalties should the account become delinquent.

Taxes may be paid at the Salem Town Office building Monday thru Wednesday from 8:00 a.m. to 5:00 p.m., on Thursday from 8:00 a.m. to 6:00 p.m. The town hall is closed on Friday.

Dated at Salem Connecticut, this 26th day of June 2014.

Cheryl A. Philopena C.C.M.C. Tax Collector
Town of Salem

19220

CITY OF NEW LONDON
TAX NOTICE

The Taxpayers of the Consolidated Town and City of New London are hereby notified that I have a warrant to collect a tax of 39.00 mills on the dollar on the Grand List of October 1, 2014. Motor Vehicle taxes are due in FULL on July 1, 2015 and any Real Estate and Personal Property bills may be paid in full on that date. Real Estate and Personal Property bills OVER $100.00 may be paid in two installments: July 1, 2015 and January 1, 2016.

If the tax due, or installment due, is not paid within one month of the due date, the tax will become delinquent and subject to interest at the rate of one and one-half percent per month or fraction thereof calculated from the due date. Minimum interest charge is $2.00. The last day to pay the bill without penalty is August 3, 2015. Taxpayers are requested to bring or mail their tax bills with their payment, receipts for payments by mail will be returned if a self-addressed stamped envelope is provided.

There is only one mailing of tax bills, taxpayers paying in installments are reminded that the second installment is due January 1, 2016. Sufficient copies are mailed for both installments and additional bills are not mailed for the second installment.

Bills are mailed to the OWNER OF RECORD as of October 1, 2014. Failure to receive a tax bill does not invalidate the tax or the interest. If you do not receive your tax bill the first week in July, please call the tax office at 447-5208.

Questions pertaining to ASSESSMENT should be directed to the Assessor's office at 447-5216 or 447-5217; TAX questions to 447-5208.

Maureen A. Farrell, CCMC
Tax Collector/Collector of Revenue
Consolidated Town and City of New London, Ct.

19266

LEGAL NOTICE OF DECISION
ZONING BOARD OF APPEALS
TOWN OF OLD LYME

Pursuant to the provisions of Public Act 75-26, effective May 6, 1975, notice is hereby given that the Zoning Board of Appeals has rendered decisions on the following appeals heard at a meeting held on July 23, 2015. The decisions has been filed in the office of the Town Clerk, Old Lyme Town Hall.

Case 15-20 – Harry S. Pfaus, 53 Brown Avenue, requests variances to demolish an existing one story dwelling and construct a new 1 3/4 story residential dwelling that will be FEMA compliant – DENIED without prejudice

Case 15-21 – Joanne Cortale, 70 Grassy Hill Road, requests variances to allow construction of a third bedroom in a pre-approved three bedroom dwelling (one prior bedroom converted to a den), with the proposed addition on the second floor of the east side of the dwelling house – GRANTED

Case 15-24 – Grayhill Properties, LLC, 151 Boston Post Road, requests variances to demolish existing restaurant building, retain the altered one building on the east side of the property and construct a new mixed use building in the vicinity of the existing restaurant building. The new building will be approximately 7,858 s.f. and will include a restaurant and retail/office space on the ground floor and office space on the second floor. The front setback increases from 21.3' to 47.7' (60' required). Parking to remain in front but landscaping will be added to reduce the existing nonconformity – GRANTED

Any party aggrieved by these decisions may appeal to the Superior Court, New London County, within fifteen (15) days from the date of this publication. Dated at Old Lyme, Connecticut, this 27th day of July, 2015. Judy McGrath, Chairman

Make The Connection
in the CLASSIFIEDS

19241

Public Notice

Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (a)(2) for the merger of the two Medical Foundations with NEMG being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") for YNHHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

Public Notices | Public Notices | Public Notices

19125

TAX COLLECTOR'S NOTICE
TOWN OF LEDYARD

All persons liable to pay property taxes in the Town of Ledyard on the October 1, 2014 Grand List are hereby notified that any Real Estate or Personal Property Tax of $07.00 dollars and under is due and payable in full on July 01, 2015. If the tax is more than $60.00 dollars, it may be paid in two installments. The first installment is due and payable July 01, 2015, and the second installment is due and payable on January 01, 2016. All Motor Vehicle Taxes are due and payable in full on July 01, 2015.

If payment is not made by August 3, 2015, the amount due will become delinquent and subject to interest at the rate of one-half percent per annum (one and one-half percent per month) from July 1, 2015. The minimum interest is $ 2.00 dollars. Failure to receive a tax bill does not invalidate the taxes or the interest that accrues.

For collection sake tax, the Tax Collector will maintain the following office hours in the Town Hall:

Monday - Friday 8:30 A.M. to 4:00 P.M.

Current taxes may also be paid at the Dime Savings Bank – Ledyard branch, during the month of July.

John L. Carroll, CCMC
Tax Collector

19345

TOWN OF EAST LYME
ZONING BOARD OF APPEALS
NOTICE OF DECISION

At a meeting of the East Lyme Zoning Board of Appeals held July 20, 2015 at 6:00 p.m. at the East Lyme Town Hall, 108 Pennsylvania Avenue, Niantic, Connecticut, the following decisions were rendered:

1. DENIED: East Lyme Zoning Board of Appeals Case # 6-2015 Application of Andry Construction & Design, for a variance of Section 7.3.1. for property identified on the application as 74 Griswold Drive, Niantic, Connecticut. Said parcel appears on the East Lyme Assessor's map 64A, lot 9.

A full copy of the decision is available in the East Lyme Land Use office, records of the Zoning Board of Appeals.

William Alcombrack
Chairman

19342

Public Notice

Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638(a)(2) and 19a-486. YNHHSC and L+M will request CON approval for YNHHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital joining and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Montauk Avenue, New London, CT, will not change as a result of this transaction. There is no capital expenditure associated with this Application.

19339

TOWN OF GROTON
NOTICE OF PUBLIC HEARING
HISTORIC DISTRICT COMMISSION

The Historic District Commission will hold a public hearing on Tuesday, August 4, 2015 at 7:00 p.m. at the Groton Town Hall Annex, 134 Groton Long Point Road, to hear the following applications requesting a Certificate of Appropriateness:

HDC 15-22 – 42 New London Road: Marcia Schaller, owner; Thomas Gichelli, applicant. Exterior renovations. PIN 7868926430

HDC 15-23 – 108 Water Street: The Mystic Group of Hotels, LLC, owner; Melody Pere, applicant; Work & dust work. PIN 4369926539

HDC 15-24 – 401 Monk Road: AGA Marine Holding Company, owner/applicant. Exterior renovations & signage. PIN 4368926527

HDC 15-25 – 31 Water Street: Randall's Wharf Co. LLC, owner/applicant; Rogers gate. PIN 4368926506 0081

Todd Bendy, Secretary

19220

Liquor Permit
Notice of Application

This is to give notice that L. DARRYL WYCHAM, 33 7TH ST., NORWICH, CT 06360-2612 Have filed an application placarded 07/27/2015 with the Department of Consumer Protection for a CAFE LIQUOR PERMIT for the sale of alcoholic liquor on the premises at 95 PEQUOT ST, NEW HAVEN, CT 06511-4317 The business will be owned by: EAGLES UNITED LIABILITY COMPANY. Entertainment will consist of: Amenities Alec Amplified) Disc Jockeys Karaoke Live Bands Comedians. Objections must be filed by: 08/06/2015. DARRYL WYCHAM

FIND IT in the Classifieds

Announcements

Notice of Interest

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2005 Honda Fit — Theft Proof Radio Standard Trans 98,000 miles Good Condition $7500 860 912-0768

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2004 HONDA GOLD WING, 32000 miles, $6,500. Call 860-442-2900

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Ad Number: d00607989 | Client Name: / PO# E. Goncalves/Pub
Insertion Number: | Advertiser: Mason Inc/Yale New Haven Hospital -...
Size: 2 x 1.51 | Section/Page/Zone: Daybreak/D005/
Color Type: B&W | Description: 19342 Public Notice Yale-New Haven

The Day
Publication Date: 07/28/2015

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Public Notices

REPRESENTATIVE TOWN MEETING
August 3, 2015

The members of the Representative Town Meeting, electors and other legal voters of the Town of Waterford are warned the Representative Town Meeting will hold its Regular Meeting in the Town Hall Auditorium, 15 Rope Ferry Road, Waterford, on Monday, August 3, 2015, at 7:30 P.M., for the following reasons:

1. To consider and act upon the Minutes of the June 3, 2015 Regular Meeting.
2. To consider and act upon Committee Reports.
3. To consider and act upon an appointment to fill a vacancy on the Senior Citizens Commission for the unexpired term April 6, 2015 – April 6, 2016.
4. To consider and act upon an appointment to fill a vacancy on the Board of Police Commissioners for the unexpired term August 5, 2013 – August 7, 2017.
5. To consider and act upon appointments to fill two vacancies on the Board of Police commissioners for the term August 3, 2015 – August 5, 2018.
6. To consider a request from Helmut Schmitt, Managing Member of Millers Pond, LLC, postponed from the April 6, 2015 meeting, to release a real estate option to the Town of Waterford for property known as Millers Pond, subject to approval of the proposed release by the Board of Selectmen.
7. To consider and act upon a request from the Board of Selectmen on behalf of the Chief Engineer, based on its compliance with the Capital Improvement Plan, for an appropriation in the amount of $200,000 from Capital and Nonrecurring Undesignated Fund Balance, Line Item 20500-31520 to Line Item 20581-59773, Harvey Avenue Pump Station Upgrade, as recommended by the Board of Finance.
8. To consider and act upon a proposed amendment to Section 8.26.030A and C of the Waterford Code of Ordinances, Fines for false alarms (non-fire), to establish that payments for all fines for false alarms be paid into the general fund of the town, pending recommendation by the Public Protection & Safety Standing Committee of the Representative Town Meeting.
9. To consider and act upon a proposed amendment to Section 2.32.020C of the Waterford Code of Ordinances, Assignment of town employees, employees and officials, regarding the terms and conditions of all work by town employees or employees of the town on police matters, as recommended by the Public Protection & Safety Standing Committee of the Representative Town Meeting.

Dated at Waterford, Connecticut, this 21st day of July, 2015.

Thomas J. Dombek
RTM Moderator

July 28, 2015
TOWN OF LEDYARD
INVITATION TO BID – #2015-04
SURPLUS VEHICLES AND EQUIPMENT

The Town of Ledyard invites sealed bids for Surplus Vehicles and Equipment. A complete list is available on our web site: www.ledyard.ct.org.

Sealed bids will be received until 2:00 P.M. on Tuesday, August 11, 2015, at 741 Col. Ledyard Hwy, Ledyard, CT, at which time they will be opened. Proposals received after that time will not be accepted. Sealed proposals should be clearly marked "SEALED BID #2015-04, SALE OF SURPLUS ITEMS." Bid proposals shall clearly identify items for which bids are offered by Item No. (as listed on the bid list) and description.

All vehicles, equipment, and materials are offered in "as-is" condition and no warranties are offered nor implied for any of the items. All items must be removed by the purchaser. Winning bidders must remit buyer payment within 30 calendar days of the bid opening or their respective bid(s) will be forfeited.

The awards will be to the highest responsible bidder, provided that the bid is reasonable, and provided that it is in the best interest of the Town of Ledyard to accept such bid.

Andrea Caldwell
Assistant Director of Finance

CITY OF NEW LONDON
NOTICE OF TAX SALE

At a tax sale held on June 18, 2015 the City of New London sold the following properties:

Chester Street sold to City of New London for $3,630.00
250 Crystal Avenue sold to Lois E. Diaz for $11,452.71
20 Grand Street sold to DOMCO LLC for $36,000.00
19 Hawthorne Drive, #166 sold to DOMCO LLC for $30,000.00
64 Hempstead Street sold to City of New London for $12,725.21
24 Nutis Lane sold to Niven Smith for $70,350.00
22 Williams Street sold to DOMCO LLC for $70,000.00

The redemption period will expire December 17, 2015. If redemption does not take place by December 17, 2015 in the manner provided by law, the delinquent taxpayer, and all mortgagees, lien holders and other recorded encumbrancers who have received actual or constructive notice of such sale as provided by law, shall thereafter have no right, title, mortgage, lien and other encumbrances in such property shall be extinguished.

Public Notice
Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes §19a-638 (a) (2) and §19a-486. YNHHSC and L+M will request CON approval for YNHHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital owning and becoming part of the Yale New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Montauk Avenue, New London, CT, will not change as a result of this transaction. There is no capital expenditure associated with this Application.

Public Notice
Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes §19a-638 (a)(2) for the merger of the two Medical Foundations with NEMG being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction involving Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") for YNHHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

LEGAL NOTICE
Pursuant to Conn. Gen. Stat. §16-245m, the Public Utilities Regulatory Authority (PURA) will conduct a public hearing at Ten Franklin Square, New Britain, Connecticut, on Tuesday, August 4, 2015, at 9:00 a.m., regarding Docket No. 15-03-24 – Annual Reconciliation of the Conservation Adjustment Mechanisms Filed by The Connecticut Light and Power Company, The Hartford Steam Company, Connecticut Natural Gas Corporation, The Southern Connecticut Gas Company and Yankee Gas Services Company.

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theday.com/pets

CITY OF GROTON
Conservation Commission/ Inland Wetlands Agency
Notice of Public Hearing

The City of Groton Conservation Commission/ Inland Wetlands Agency will hold a public hearing on August 4, 2015 at 7:30 p.m. at the Municipal Building, 295 Meridian Street, Groton, to hear and act on the following matter:

Robert Schoch, as agent for 541 Eastern Point Road seeks to install 765.5' sidewalk, construct 9'x 50' building addition and replace existing paved parking areas to provide 8'-0.5" widths to accommodate 326 parking spaces. This is a modification of a previously approved permit.

Interested persons may be heard and written communications relative to the above will be received. A copy of the violation letter is on file for public inspection at the Office of the Zoning and Building Department, 295 Meridian Street, Groton, CT.

Dated at Groton, Connecticut, this 28th day of July 2015.

Conservation Commission/
Inland Wetlands Agency

Richard Fallwell, Chairperson

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Announcements

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Impounded Car: Domestic SAAB, Dark Green, Female, Hamilton St, New London Animal Ctrl. 860-447-3031

Impounded: Found Parrot, Waterford Animal Ctrl. Call 860-447-3031

LOST KEYS – 7/20/15 in vicinity of Seaway Garden (E.L.)Apts. Fob and silver keys. Please call 860-625-8356.

Notice of Interest
CT SCRAP Will buy your scrap metals, copper & aluminum. 15 Phelps Rd Montville 860-848-2366

Automotive

Automobiles
2007 Chrysler Pacifica Touring – 4 cooler, great condition, brand new transmission, brand new radiator, 108k miles, $4,500, Call or Text. 860-961-2563

2007 Honda CRV EX – 5-speed, 30+MPG, recent clutch, new brakes, 90,000+ miles, clean/nice. $5,900. 860-334-4009.

2010 Honda FR – Thole Road Auto Standby Fleet. 80000 miles Good Condition $9500 860 917-9768

Do You Need A Vehicle – Bad Credit, No Credit, Bad Credit, Dealer, Call Nancy 800-965-4931

Vans
1999 Ford Econoline Van – propane conversion/chrysler & northeast. $2,000.00. Call 860-625-7512

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to participate in a one hour research project. Participants will receive $100. We want to know your opinions about what appears in the great newspapers from the good ones. The research will be conducted during the last two weeks of July in Windham, ME, and your 3-hour interview can be scheduled at your convenience. If you are the kind of daily and/or weekly newspaper reader whose opinions matter, please call the New England Newspaper & Press Association at (781) 334-8042 for more info, or go to www.nenpa.com.

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DENTAL ASSISTANT/ RECEPTIONIST
Wanted PT for a Norwich office. Tues 7:30-4:30, Wed & Thurs 12-8 and Sat 7:30-1. Flexibility with Eagle Soft, x-ray, digital. Must be X-ray Certified.
Please Fax resume to 860-887-6055 or email to norwichsmiles@norwichsmiles.net

CDA TRAINING 2 weeks – days or 10 weeks – eves. Starts 8/3. 38 hours of CEU. New London 860-447-8079

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Labradoodle puppies – Great variety, Call for selection. Also standard labradoodles. (860) 625-6328

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MORKIE PUPPY – 8 weeks Old, Registered, Shots, Potty Trained. Call (860) 213-4253 $750

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Color Type: B&W Description: 19342 Public Notice Yale-New Haven

The Day
Publication Date: 07/29/2015

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Public Notices

Notice of Tentative Determination to Approve a Title V Operating Permit

Applicant: Electric Boat Corporation
Application No.: 201203894
City/Town: Groton, CT

The Commissioner of the Department of Energy and Environmental Protection (DEEP) hereby gives notice that a tentative determination has been reached regarding the following application to renew a source registration under the federal Clean Air Act Amendments of 1990. This permit combines all permit conditions and applicable requirements for air pollutant emitting sources at the facility into a single permit. The proposed activity will affect air resources. The Commissioner also gives notice that a hearing may be held on this application if the Commissioner determines that the public interest will best be served thereby, and shall hold a hearing as provided below.

Applicant's Name and Address: Electric Boat Corporation
Contact Name/Phone/Email: Donna Eiks, deiks2@csub.com, 860-433 2791

Type of Activity: nonsignificant modification to a Title V permit

Relevant Statute(s)/Regulation: CGS 22a-174, RCSA section 22a-174-33, CFR Title 40 Part 70

Facility Location: Electric Boat Corporation, 75 Eastern Point Road, Groton, CT

INFORMATION REQUESTS/PUBLIC COMMENT
Interested persons may obtain copies of the application from the applicant at the above address. The application, proposed permit and supporting documentation are available for inspection at DEEP, Bureau of Air Management, 79 Elm Street, 5th floor, Hartford, CT from 8:30 AM to 4:30 PM Monday through Friday and at other times by appointment. All interested persons are invited to express their views on the tentative determination concerning this application in accordance with RCSA, Section 22a-174-3a(j). Written comments or a request for a public information meeting or hearing on the application should be directed to Mr. David Laflamme, Bureau of Air Management, DEEP, 79 Elm Street, Hartford, CT 06106-5127, no later than 30 days from the publication date of this notice. This draft Title V permit has also been submitted to the U.S. Environmental Protection Agency (EPA) as a proposed Title V permit in accordance with RCSA Section 22a-174-33(k), EPA shall review the proposed permit within 45 days from receipt. The public comment and EPA review periods shall run concurrently. If any substantive changes to federally enforceable applicable requirements are made in the draft Title V permit based on public comment, DEEP will recommit the proposed permit to EPA, for another 45-day review period. Comments regarding this application may be submitted via electronic mail to dlaw@csub.net.

This notice is required by CGS section 22a-6h and RCSA section 22a-174-33(f).

ADA PUBLICATION STATEMENT
The Connecticut Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to complying with the Americans with Disabilities Act. To request an accommodation, contact us at (860) 418-5910, or dep.accommodation@ct.gov.

Town of East Lyme
Notice of Special Town Meeting

Notice is hereby given of a Special Town Meeting of the Town of East Lyme to be held on August 5, 2015 at 7:00 p.m. at the East Lyme Town Hall for the following purposes:

1. To approve an Alteration in the amount of $200,000 from Open Space Fund 59 for the purpose of purchasing a conservation easement on property to be owned by the New England Forestry Foundation at the closing of the purchase and sale of the property consisting of approximately 166 acres with an entrance at the intersection of Goldfinch Terrace and Cedarbrook Road in East Lyme. The conservation easement shall be in a form satisfactory to the Board of Selectmen and the Town Attorney. Also attached, that said amount shall not be paid unless and until other funds from the following sources are made available to the New England Forestry Foundation at the closing of the purchase and sale of the property: $500,000 from the Connecticut Department of Energy and Environmental Protection; $375,000 from private or public funding received by the New England Forestry Foundation.
2. To approve a special appropriation in the amount of $20,600 in CNRE Fund 22 in an amount to be matched on a grant awarded by Connecticut Office of Policy and Management (OPM) to install and lease for 20 years a fiber optic connection from the Town Hall to the Niantic Fire Station where it will tie into the Connecticut Education Network (CEN).
3. To approve a special appropriation in the amount of $40,000 to upgrade the Town Hall Servers and purchase and install a new firewall and redundant back-up units.
4. To approve a special appropriation in the amount of $414,460 to complete projects consistent with the Capital Improvement Plan.
5. To approve a special appropriation in the amount of $474,465 in the 2015/16 budget in the following budget amounts $178,660 in Fund 224 (Town Aid Road) and corresponding revenue account 01-03-300-381 due to the adoption of the State of CT budget. Total amount is $196,226 Town Aid funds and $22,242 LOCIP for municipal projects to be used for roads.

Dated at East Lyme, CT this 1st day of July, 2015.

Board of Selectmen

Mark C. McKiernan, Kevin Scavey, Mary Salerno, Holly Chessman, Rose Ann Hardy, Rob Wilson

Liquor Permit
Notice of Application

This is to give notice that I, SALVATORE J CARUSO JR, of 6 ELYS FERRY RD, OLD LYME, CT 06371-3406 have filed an application for a package store liquor permit at 6 ELYS FERRY RD, OLD LYME, CT 06371-3405. The business will be owned by SUNSET HILL VENTURES LLC. Entertainment will consist of: None (Not Amplified). Objections must be filed by 09/08/2015. SALVATORE J CARUSO

Public Notice

Northeast Medical Group, Inc. (NEMG) and L&M Physician Association, Inc. are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (k)(2) for the merger of the two Medical Foundations with NEMG being the surviving entity. This transfer of ownership of a group practice is part of the larger transaction between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") for YNHHSC to become sole member of L+M. There is no capital expenditure associated with this Application.

Public Notice

Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") are jointly filing a Certificate of Need Application pursuant to Connecticut General Statutes 19a-638 (k) (2) and 19a-639. YNHHSC and L+M also request CON approval for YNHHSC to become the sole member of L+M, which will result in Lawrence + Memorial Hospital becoming and becoming part of the Yale-New Haven Health System. Lawrence + Memorial Hospital's current location at 365 Montauk Avenue, New London, CT, will not change as a result of this transaction. There is no capital expenditure associated with the Application.

Notice of Interest

CT SCRAP Will buy your scrap steel, gears & motors etc. 339 Pequot Rd Uncasville 860-848-1555

Automotive

Do You Need A Vehicle? — Used Credit, No Credit, Bad Credit, Dealer, Call Manny 860-536-4926

WE BUY CARS, TRUCKS, & SUVS Alliance is a Dealer, Ask For Pete Sale Ac Bob Walcott Auto Mall 860-536-4931

Vans

1999 Ford Econoline Van — powerstroke diesel/full-sliding & mechanic $3,000.00. Call 860-437-7562

Wanted

Wanted

BOOS RECYCLING WILL BUY YOUR Axes, Mauls, Hatchets Pick Up Is Available Call 860-848-1344

Employment

Announcements

Automotive

Lost & Found

Automobiles

LOST KEYS — 2/3/2015 in vicinity of Subway Garden (Rte) Route. Fob and chain brand new. Please call 860-912-2595

2007 Chrysler Pacifica Touring — 4 seater, power sunroof, brand new transmission, brand new engine, pearl white. Must Sell $4,000. Call or Text. 860-961-2363

2007 Honda Civic EX — 5-speed, 32+MPG, recent clutch, new brakes, well-cared condition, 98,000 miles, $8,995. 860-334-4078.

2010 Honda Fit — Theft Proof Anti-Standard Tires. Keyless entry. Excellent condition. $9950 860-917-0703

Employment

Cemetery

Gilchrist's Riverside Sales & Service is Hiring for the following Positions:

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Call 860-599-1370

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There are Various Full Time, Part Time and On-Call Positions Listed – Housekeeping – Food Operations – EVS Culinary – Cashiering Operations – Valet Attendant – Shuttle Driver...and many more

All applications must be submitted no later than Wed. Aug. 5th to be considered.

See us displayed in the lobby's center.

Medical

BEECHWOOD

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CNA 7-3 Shift Full Time

CNA 7-3 Shift Part Time

CNA 3-9 Shift Part time

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Please fax resume to 860-887-8258 or email to nsmiles@sbcglobal.net

Office Clerical

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TYPIST (Full Time)

With benefits in a busy worker's compensation law firm. Experience with Microsoft Word is required. Applicant must be detail oriented with strong grammar skills. Some college and familiarity with legal terminology helpful.

Please email resume to: P.O. Box 1409 Groton, CT 06340 Attn: Office Manager

GOING, GOING, GONE to the Bloodhounds

Cats/Pets

LOST CAT - Gerona STILL MISSING 12 April ET, 49/Metallic Rose 2 year, Sink, Grey & White, Parents Rptw. 860-912-8705.

Marine/ Boats

Boats

1994 Boat — Boat, trailer, trailer & power pack, runs & drives great. $1,000. Call for more info at 860-599-4598.

2003 21.5' Four Winns Boat/trailer in good condition, 5.7L motor needs work. Must sell. 860-889-5162

Campers/RVs

2012 Jayco Eagle Lead Bed/Slide/Fully Loaded, see specs on www.jayco.com $44,500 call for Eric 860-908-4194

CCT Dealer — empty dealership lot and warehouse must be sold. Will consider any reasonable offer. 860-599-8954.

Dutchman 40sbh — Loaded gen, excellent condition, New Price. Sell for $35,000. 860-536-6956

Free Items

FREE PIANO — Gulbransen console, very attractive. 860-536-2225

Television, 32" Panasonic, flat-tube/wood — definitely not a flat screen, works great! 860-437-8868 $100

Furniture

Gib, Twin dressers, Grayish blue/white/cream — Good cond. Asking $500. 860-444-6463

Living Room & Bedroom Set, Beds in & Good. BEST OFFER. CALL 860-941-8075

Log Living Table & chairs — $500 860-536-2958

Mattress Upholstery Sale — Brand new! 100% Pillow Top Mattress Sets. Still in plastic with warranty. Can deliver. Must sell! Queen $150 Queen $150 Full/Set Base $60 Full/Set Base $60 860-414-7646

Antique/ Collectibles/Art

Wolff's Vintage Wine Cleaner — Set of 6 crystals green, red wines. $ For $50 for the set. 860-443-6364

Autographed Baseball — Cecil Fielder, Blue Jay, + Ball Display Case & Signed w/Steve Sax. $35. 860-912-6263

Uncle Sam — 1970's Four Bell clock. $50.00. 860-464-4255

Llanwell & Williams — Orchard Fruits cup & saucer/Aynsley. Normally $85.99, now $60. (860) 691-4993

Royal Albert Bone China — Serenade Tableware Sugar, Normally $30, now $20. 860-464-8054

Royal Staffordshire Clarence/Saxon Pattern Sugar — Normally $30, now $20 860-912-6263

Vintage Crown Staffordshire — 4 tea cups & saucers. Normally $50 now $25 for all 8. 860-691-8954

Merchandise

Classifieds are "AUTO" MATIC

Building Materials

Stone, Brick — 36 X 22, full pallet & more. $25. 860-912-8954

Computer Equipment

Canon Pixma Ink Cartridges — Color Stamp Holders w/ Stamps — Brand New! 860-464-8054

Photo Printer — Lexmark, P705, print up to 4 x 6, see www.cnet.com, like new, $40. 860-536-9576

Clothing

Orthofeet Shoes — Used/excellent condition/see below the ankle/size 11/$40 860-464-8054

Winter Coat — Heathers, navy, red & black. $30 860-536-8576

Cross Wheels & Axles

3/4" Peroxide Blonde Human Hair Extensions — Brand new, still in package. $40 860-464-8054

A-1 SEASONED OAK — CUT SPLIT/DELIVERED/STACKED CALL FOR PRICE 860 848-8577

Camping

Cozy Zipper — Easy Bend Fleece/Pullover, Brand new, see www.cnet.com. $40. 860-464-8054 Call for Eric 860-908-4194

Dutchman 40sbh — Loaded gen, excellent condition, New Price. Sell for $35,000. 860-536-6956

Free Items

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Log Living Table & chairs — $500 860-536-2958

Mattress Upholstery Sale — Brand new! 100% Pillow Top Mattress Sets. Still in plastic with warranty. Can deliver. Must sell! Queen $150 Queen $150 Full/Set Base $60 Full/Set Base $60 860-414-7646

Office Desk/Credenza — Wood laminate w/hutch, Like New Condition — $300.00 Call 860-912-6263 or 860-460-4255

QUEEN SLEIGH BED w/ Mattress, Good, Clean and Comfortable. $150 Call 860-599-3449

Roll Top Desk — Has 5 drawers & 2 compartments, excellent shape. $400 860-536-9576

Household Goods

Air Conditioner — 6000 BTU, for air conditioner. Excellent condition. $75 Call 860-334-4088

Camping Equipment China — 6 bowls/6 plates, Lenox Pattern w/gold trim/ $100 860-912-8954

CD Dishwasher, Almost Old, Dishwasher. $225. Call 860-848-1344

Hearthside Classics Stoneware — 26 pieces/great for camping. $50 860-536-9576

Lenox Manchester China — Dinner, salad, bread & butter plates plus bowls — Never used. $90. 860-961-8954

Lenox — Oil vinegar set/cruet, handpainted/Lenox 24k gold & pearl. Brand new in box. $40 860-961-8954

Used Stoneware Honey Butter — and Pot Roaster/Brand new $20.00 860-961-8954

Vacuum Cleaner — Eureka Boss Smartvac, Model SC888A, Like New, Used Once. $50. 860-917-0703

Wood Stacking Heavy Duty — Holds 1/2 cord of wood. $30. 860-536-6956

Heating & Fuel

Wanted

Wanted

BOOS RECYCLING WILL BUY YOUR Axes, Mauls, Hatchets Pick Up Is Available Call 860-848-1344

Heating & Fuel

Bob Stanley Stoves — Salem, model 2700-29961. On display, look stoves to it $ 1,195 Call 860-536-8576

Fireplace Protector — Extra wide brass, 46. Phone (203) 887-3342, 848-5301 Call 860-536-8576

Fire — Mitchells Radial 365-LP, Like New, Call & email 860-464-4255. Asking $1,000 or best offer.

Slide Stainless Steel — Dbl. bowl, 33" x 22" with faucet. Comes as one slab. $50.00. 860-464-8702.

Slide with a 4" wood grain overlay top — Item 55 Slide Faucet. Comes as one slab. $50.00. 860-464-8702

Medical Supplies

Foot Massager — Model 5 in 1, 2 speed, w/heated feet. $35. 860-536-8576

Medical Supplies

Musical Instruments

Keyboard w/Adjustable Stand — Casio, Model WK-1800, 76 Keys, Like New. $200. 860-535-0979

Other Miscellaneous

12 Pcs CHINA Setting Elegance Fine China, Made in China Unused. SOLD 60 to view. Call 860-464-8344

Acrylic Light House Painting Supplies, Portland ME & Providence, Narragansett, 4th in Frames. $50 Obo Call 860-536-8344

Wanted to Buy

Air Conditioner — 5,000 BTU Condition with 24 hr. timer. Call Richard 536-0000. 860-464-6155

Alabama Archery — Bows, Hoyt, Nerf Carbon 37, 4 Fiber, Excellent Cond. $$$ 860-917-8564

Cargo Mat — Subaru, grey, all new, protects the back seat & your fold down tailgate. $50 860-536-8576

CD/CD-ROM Organizer/Media Tower — Holds 120 Count. Brand new, still in package. Cost $30, Sell $15. 860-535-0979

Collection Package 5000 — Hummel Book, Hummels 1988 all sold, make offer. 860-575-0439

Musical Instrument — Twin Chorus w/reverb/guitar-$50 new, now only $15 860-961-8954

Pipes, Set — Brand new, Cache with pipe rack, pouch, tools, cure. $20. 860-961-8954

Stream — Deluxe size stone sculpture converter/pump. 860-510-9021/860-961-8954

Sink, Stainless Steel — Dbl. bowl, 33" x 22" with faucet. Comes as one slab. $50.00. 860-464-8702.

Slide with a 4" wood grain overlay top — Item 55 Slide Faucet. Comes as one slab. $50.00. 860-464-8702

Stream Protector — Extra wide brass, 46. Phone (203) 887-3342, 848-5301 Call 860-536-8576

Tire — Mitchells Radial 365-LP, Like New, Call & email 860-464-4255. Asking $1,000 or best offer.

Pro GO Choice League Golf — disc golf, Like new, aluminum, Cushions & Midnight, White Diamond. 1 Mile Rd 739-0991

Sporting Goods

ARCHERY — 48 Bale with 1000 of lbs for bows up to 60 lbs. $ 150 call 860-536-2593

Sporting Goods

Golf Clubs — Complete Set for left man with Mens 1-PW irons, Call 860-536-8576

Skates — Mens skating skates, up to 13" shoe, medium, only $15, call 860-536-8576

Stereo, TV, Radio

Stereo — Complete 1st & 2nd seasons both for $30 860-961-8954

JVC Stereo Player — Model DRX-5762. Records, plays, radio, cassettes, and audio. $ 150.00 860 536-8576

Magnavox VCR VHS Player — w/Remote & Manual. VCR-222, 14"L x 13"D x 13.5"H. Excellent Cond. $25. 860-535-0979

Sony Receiver/Stereo Speakers — SS-A2100M, 2-Way, 8 Ohm/100W, 10"L x 8"D x 16"H Cond. $40. 860-536-8576

Stereo Receiver components — Technics receiver, turntable, CD changer, speakers, all in music. 860-443-8554

Turntables — Garrard/AR/BSR, Working, $50. Each Piece, Or sealed Package $100. Good Stylus. 203-245-2593

Vintage Stereo Tuner — Sherwood KT-45, Made in Japan, Stylish, Collectable, Antique. $55. 860-917-6344

Wanted to Buy

A AARDVARK ANTIQUES Cash for Coins, Gold & Silver Watches, Gold All Jewelry, Rolex, Old Wristwatches, Old Pocketwatches, Military Items, Pins, Medals, Swords, Daggers, Antiques, Oriental Rugs, Paintings, Lamps, Instruments. Anything Old. FREE HOUSE CALLS 860-645-8468 860-227-7338

ARCHERY ALL Antiques, Vintage, Electronics, Audio, Ham, Radios, Cameras, Watches, Art, Toys, Military Items, Gun Items or anything else. Cash Paid. Call 860-705-8950

CT SCRAP Will buy your scrap steel, gears & motors etc. 339 Pequot Rd Uncasville 860-848-1555

Win Buy Antiques: Cash paid for Artifacts and sunday used furniture, old clocks, gold, toys, musical items, jewelry, nautical & military items. Call at The Antiques Door. For Free Appraisal. 860-887-2122

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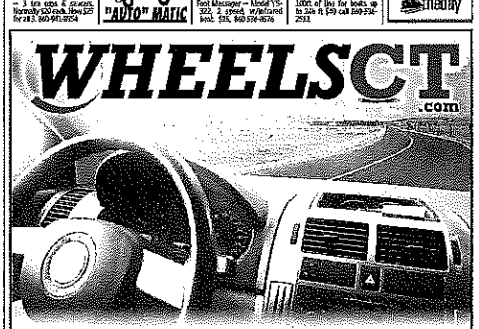

CURRENTLY LOOKING FOR A

SALES CONTRACTOR

PRIMARY DUTIES & RESPONSIBILITIES:

- Establishes prospect roster of potential clients within New Haven County
- Makes sales contacts and closes sales
- Processes weekly dealer inventory information to appear within magazine
- Communicates information to creative liason
- Process of advertising payments
- Contacts The Day Sales Management for the processing of orders and any/all marketing materials needed
- Provides superior customer service to active accounts and prospects

JOB REQUIREMENTS:

- Knowledge of automotive sales or industry.
- Ability to learn product offering and to effectively sell to customers. Skills needed include problem solving, organization, customer relations, decision-making and written and verbal communication skills. Ability to operate a supplied Apple I-pad computer to secure creative images.
- Two-year college degree or equivalent preferred.

EXPERIENCE:

- Minimum of one year of sales experience in a similar or related industry preferred.

COMPENSATION:

- A guarantee of income for the first four weeks and then a set percentage of sales.

email resume to:
j.muro@theday.com
860-701-4422

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NOW HIRING

CUSTOMER —SERVICE— REPRESENTATIVE

Position Description: This is a part-time (25 hours/week) position. Responsible for communicating with customers via telephone, email and mail, as well as producing reports and the upkeep of customer records.

Qualifications Required: The person requires strong communication and customer service skills, data input experience and familiarity with the Courier service phone support environment. Experience in Microsoft Office preferred. Flexibility in hours and days worked required.

We're Looking for Game Changers. Contact us Today to Learn More.

—OPERATIONS— MOTOR ROUTE DRIVERS

Position Description: The Day is currently accepting applications for motor route drivers in the towns of Ledyard and Old Lyme.

Qualifications Required: Valid driver's license, a good driving record, proof of insurance, and a reliable vehicle is required. Must be able to lift up to 40 lbs. Excellent pay, early morning hours.

Send this ad along with a resume and salary requirements to:
Human Resources Department
47 Eugene O'Neill Drive, PO Box 1231 New London, CT 06320
humanresources@theday.com | fax 860-442-3257

theday

EXHIBIT III

Affidavit

Applicant: Yale New Haven Health Services Corporation

Project Title: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation

I, Marna Borgstrom, Chief Executive Officer
(Name) (Position – CEO or CFO)

of Yale New Haven Health Services Corporation being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 9/16/15 Date

Subscribed and sworn to before me on 9/16/15

Notary Public/Commissioner of Superior Court

My commission expires: Irene Noel
NOTARY PUBLIC
State of Connecticut
My Commission Expires 5/31/2019

Affidavit

Applicant: Lawrence + Memorial Corporation

Project Title: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation

I, Bruce D. Cummings, President & Chief Executive Officer
(Name) (Position – CEO or CFO)

of Lawrence + Memorial Corporation being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 9.16.2015
Date

Subscribed and sworn to before me on 9.16.2015

Notary Public/Commissioner of Superior Court

My commission expires: KAREN M. SANTACROCE Notary Public, State of Connecticut My Commission Expires September 30, 2017

EXHIBIT IV

Checklist

Instructions:

1. Please check each box below, as appropriate; and
2. The completed checklist *must* be submitted as the first page of the CON application.

☒ Attached is a paginated hard copy of the CON application including a completed affidavit, signed and notarized by the appropriate individuals.

☒ *(*New*).* A completed supplemental application specific to the proposal type, available on OHCA's website under "OHCA Forms." A list of supplemental forms can be found on page 2.

☒ Attached is the CON application filing fee in the form of a certified, cashier or business check made out to the "Treasurer State of Connecticut" in the amount of $500.

☒ Attached is evidence demonstrating that public notice has been published in a suitable newspaper that relates to the location of the proposal, 3 days in a row, at least 20 days prior to the submission of the CON application to OHCA. (*OHCA requests that the Applicant fax a courtesy copy to OHCA (860) 418-7053, at the time of the publication)*

☒ Attached is a completed Financial Attachment

☒ Submission includes one (1) original and four (4) hard copies with each set placed in 3-ring binders.

☒ The following have been submitted on a CD

1. A scanned copy of each submission in its entirety, including all attachments in Adobe (.pdf) format.
2. An electronic copy of the applicant's responses in MS Word (the applications) and MS Excel (the financial attachment).

For OHCA Use Only:

Docket No.: 15-32033-CON **Check No.:** 1321105812
OHCA Verified by: [signature] **Date:** 10/8/15

General Information

Main Site

MAIN SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
N/A	N/A	Parent Corporation	Yale New Haven Health Services Corporation
STREET & NUMBER			
789 Howard Avenue			
TOWN			ZIP CODE
New Haven			06519

Project Site

PROJECT SITE	MEDICAID PROVIDER ID	TYPE OF FACILITY	PROJECT SITE NAME
New London, CT	N/A	Non-stock, tax exempt corporation	Lawrence + Memorial Corporation
STREET & NUMBER			
365 Montauk Avenue			
TOWN			ZIP CODE
New London			06320

Operator

OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
STREET & NUMBER		
TOWN		ZIP CODE

Chief Executive

NAME		TITLE	
Marna P. Borgstrom		President and Chief Executive Officer	
STREET & NUMBER			
789 Howard Avenue			
TOWN		STATE	ZIP CODE
New Haven		**CT**	**06519**
TELEPHONE	FAX	E-MAIL ADDRESS	
203-688-2608	203-688-3257	marna.borstrom@ynhh.org	

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a copy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☒ NO ☐	Attachment I
Does the Applicant have non-profit status? If yes, attach documentation.	YES ☒ NO ☐	Attachment II

Identify the Applicant's ownership type.	PC ☐ LLC ☐ Corporation ☒	Other: _____
Applicant's Fiscal Year (mm/dd)	Start 10/1	End 9/30

Contact:

Identify a single person that will act as the contact between OHCA and the Applicant.

Contact Information			
NAME		TITLE	
Nancy Rosenthal		Senior Vice President, Strategy and Regulatory Planning	
STREET & NUMBER			
5 Perryridge Road			
TOWN	STATE	ZIP CODE	
Greenwich	CT	06830	
TELEPHONE	FAX	E-MAIL ADDRESS	
203-863-3908	203-863-4736	nancy.rosenthal@ynhh.org	
RELATIONSHIP TO APPLICANT	Employee		

Identify the person primarily responsible for preparation of the application (optional):

Prepared by			
NAME		TITLE	
Karen Banoff, KMB Consulting, LLC		Principal	
STREET & NUMBER			
91 Old Hollow Road			
TOWN	STATE	ZIP CODE	
Trumbull	CT	06611	
TELEPHONE	FAX	E-MAIL ADDRESS	
203-459-1601	203-459-1601	kbanoff@kmbconsult.com	
RELATIONSHIP TO APPLICANT	Consultant		

Executive Summary

The purpose of the Executive Summary is to give the reviewer a conceptual understanding of the proposal. In the space below, provide a succinct overview of your proposal (this may be done in bullet format). Summarize the key elements of the proposed project. Details should be provided in the appropriate sections of the application that follow.

Yale New Haven Health Services Corporation ("YNHHSC") proposes to become the sole corporate member of Lawrence + Memorial Corporation ("L+M"). This Certificate of Need Application ("CON") is being submitted as required by Connecticut General Statutes §19a-638 (a) (2) which requires CON approval for the transfer of ownership of Lawrence +Memorial Hospital ("L+MH").

Community hospitals are finding it increasingly difficult to remain independent and thus, are integrating with larger integrated delivery systems to gain the resources and expertise needed to meet the challenges of health care reform and succeed long into the future. The proposed affiliation is also the result of a long-standing collaborative and supportive working relationship between YNHHSC and L+M, shared values between the two systems, and a mutual desire to further each organization's mission in today's rapidly changing health care marketplace. L+MH will continue as an independently licensed hospital, with its own separate medical staff and bylaws, rules, regulations, and elected officers, but will become part of a larger integrated health system that can offer it the support and resources it needs.

The applicants believe that the proposed affiliation will provide significant benefits to both organizations and the communities they serve L+M and YNHHSC seek an affiliation where access to primary and advanced specialty care will be greatly enhanced for L+M patients, efficiencies achieved, quality of care improved, collaboration promoted, risk managed more effectively, and population health is a priority. There are no planned closures or reductions in any of the clinical services currently offered by L+M. The applicants are planning service enhancements and expansions to minimize the need for area residents to have to travel outside the service area for many specialty services.

Overall, this proposal will allow L+M to continue to respond to the demands of health care reform while maintaining access for high quality services for its patients.

This proposal is financially feasible for both applicants and is expected to offer certain operational efficiencies.

Pursuant to Section 19a-639 of the Connecticut General Statutes, the Office of Health Care Access is required to consider specific criteria and principles when reviewing a Certificate of Need application. Text marked with a "§" indicates it is actual text from the statute and may be helpful when responding to prompts.

Project Description

1. Provide a detailed narrative describing the proposal. Explain how the Applicant(s) determined the necessity for the proposal and discuss the benefits for each Applicant separately (if multiple Applicants). Include all key elements, including the parties involved, what the proposal will entail, the equipment/service location(s), the geographic area the proposal will serve, the implementation timeline and why the proposal is needed in the community.

Response

Overview:
Yale New Haven Health Services Corporation ("YNHHSC") proposes to become the sole corporate member of Lawrence + Memorial Corporation ("L+M") pursuant to the Affiliation Agreement attached hereto as Attachment III. This Certificate of Need Application ("CON") is being submitted as required by Connecticut General Statutes §19a-638 (a) (2) which requires CON approval for transfer of ownership of a hospital. L+M is the sole corporate member of Lawrence +Memorial Hospital ("L+MH"). A brief description of each of the applicants is provided below.

Applicants:
YNHHSC is a Connecticut non-stock, tax-exempt corporation that was organized in 1983 to provide support services to a nonprofit network of affiliated health care providers known, collectively, as the Yale New Haven Health System ("YNHHS"). YNHHSC directs and implements certain programs and activities that assist its members in providing high quality, cost-effective health services for the benefit of the communities they serve. YNHHSC also collaborates with Yale University to provide high quality, highly specialized health care services as well as initiate, develop, and maintain educational programs for health care professionals and the public.

YNHHSC consists of the following main health care providers:

- Yale-New Haven Hospital ("YNHH") is a 1,541-bed acute care destination hospital that provides complex care to residents of Connecticut and beyond. It is the primary teaching hospital for the Yale University's Schools of Medicine and Nursing. YNHH has two main campuses located at 20 York Street and 1540 Chapel Street in New Haven. Its primary service area consists of 48 towns with a total of 116 zip codes. YNHH's primary and secondary service areas combined consist of 88 towns with 220 zip codes. In fiscal year ("FY") 2014, there were 78,529 inpatient discharges from YNHH with an 80% occupancy rate. YNHH includes the Yale-New Haven Children's Hospital, the Yale-New Haven Psychiatric Hospital and the Smilow Cancer Hospital. YNHH offers multi-specialty services in its outpatient centers in New Haven, North Haven, and Guilford as well as dozens of radiology and blood-drawing patient service centers throughout the region.
- Bridgeport Hospital ("BH") is a 383-bed licensed acute care hospital located in Bridgeport, Connecticut. BH had 18,208 inpatient discharges in FY 2014. BH also offers a wide range of outpatient services for residents of the

communities it serves.

- Greenwich Hospital ("GH") is a 206-bed licensed acute care hospital located in Greenwich, Connecticut. GH had 12,208 inpatient discharges in FY 2014. GH also offers a wide range of outpatient services for residents of the communities it serves.
- Northeast Medical Group ("NEMG") is a YNHHS multispecialty physician medical foundation organized under Connecticut General Statutes §33-182aa et seq. NEMG supports YNHHSC hospitals in offering primary care practices, hospitalist services and offers specialty care.

L+M is a Connecticut non-stock, tax-exempt corporation that is the sole member of subsidiaries that operate acute care hospitals and community based services throughout its service area. L+M's primary and secondary service area consists of 18 and 12 towns respectively.

L+M consists of the following health care providers:

- L+MH is a 280-bed licensed acute care community hospital located in New London, Connecticut. L+MH's primary and secondary service areas consist of 20 towns. L+MH had 14,151 inpatient discharges in FY 2014. L+MH's major clinical programs include oncology, heart and vascular care, including a primary and elective angioplasty program, maternity including a Level III Neonatal Intensive Care Unit, orthopedics, surgery, including two ambulatory surgery centers, and eight (8) outpatient facilities.
- Westerly Hospital ("Westerly") located in Westerly, Rhode Island, is a 125-bed licensed community hospital with a particular focus on primary (or routine) medical and surgical services. Westerly had 2,903 inpatient discharges in FY 2014 and offers major clinical programs in heart and vascular care as well as surgery.
- L&M Physician Association, Inc. ("L&MPA") is a medical foundation consisting of 71 physicians with 11 practice locations in Connecticut and Rhode Island.
- Visiting Nurse Association of Southeastern Connecticut ("VNASC") is a licensed and Medicare certified home health agency providing skilled nursing and therapy services in the home, a school health program and community wellness initiatives. VNASC provided more than 140,000 visits to care for almost 3,400 patients living in the communities served.

Proposal:

The proposed affiliation is the result of a long-standing collaborative and supportive working relationship between YNHHSC and L+M, shared values between the two systems and a mutual desire to further each organization's mission in today's rapidly changing health care marketplace.

In early 2015 and at the direction of the L+M Board of Directors, L+M approached YNHHSC to begin discussions relating to a corporate affiliation. After several months of deliberate and focused discussions, YNHHSC and L+M agreed to the terms of an Affiliation Agreement, previously referenced as Attachment III, which will permit YNHHSC to become the sole corporate member of L+M. L+MH and Westerly will continue as independently licensed hospitals, with their own separate medical staffs and bylaws, rules, regulations, and elected officers. This is the same corporate relationship that currently exists between YNHHSC and YNHH, BH and GH. Pursuant to Connecticut law that allows one medical foundation per health care

system, L&MPA will be merged into NEMG and a separate CON application for the transfer of ownership of a group practice is being submitted along with this CON for a transfer of ownership of a hospital. See, C.G.S. § 33-182 et seq.

The applicants believe that the proposed affiliation will provide significant benefits to both organizations and the communities they serve. Patients will be able to receive the right care, at the right place, at the right time, and in the most cost-effective setting. Together, L+M and YNHHSC will be better positioned to sustain their charitable missions in the demanding and rapidly changing health care marketplace. Both organizations share similar missions and values as it relates to having a strong focus on service excellence, a commitment to serving uninsured and underinsured patients, and providing community benefit.

L+MH, as a cost-effective acute care provider, with a vibrant outpatient and primary care capacity, strong management, and a strong history as a high quality, high value, patient-centered provider will add to the strength of the YNHHSC. L+M and YNHHSC seek an affiliation wherein one and one is more than two, or more specifically, wherein efficiencies are achieved, quality of care improved, collaboration encouraged, risk managed more effectively, and population health is a priority.

Determination of Need & Benefits to Both Applicants:
In response to health care reform, more and more community hospitals are finding it increasingly difficult to go it alone and thus, are affiliating with larger integrated delivery systems to gain the resources and expertise needed to meet the challenges of today and succeed long into the future. As OHCA is aware, Connecticut hospitals are now faced with even lower Medicaid reimbursement and increased taxation. The consistent Medicaid reimbursement cuts result in hospitals receiving 42 cents on the dollar according to the Connecticut Hospital Association. Every dollar of revenue that Connecticut hospitals receive is reinvested in maintaining and updating their aging physical plants, acquisition of new technology such as an electronic medical record, and implementing strategies designed to ensure that hospitals continue to provide critically needed primary and specialty services to their communities. Community hospitals, in particular, will be negatively affected in the next fiscal year as they deal with these cuts and taxes with their increasingly limited resources.

The focus of health care providers has shifted to developing the capacity to assume greater financial risk for health care services and outcomes, improved quality outcomes, formation of new models such as accountable care organizations placing greater emphasis on primary and outpatient care, and population health management. Hospitals that are not part of a larger health system do not have the clinical and financial resources and expertise necessary to create and support a continuum approach to care delivery, which is required to achieve the Institute for Healthcare Improvement's "Triple Aim" of:

- improving the population's health over time;
- improving the patient experience (quality and service); and
- reducing per capita health care cost.

Benefits to L+M:
L+M's goal for the proposed affiliation is to be part of a clinically integrated, financially sustainable health system that improves the health of its communities, and preserves and enhances access to high quality patient care. It seeks to transform its organization to enable it to continue to thrive as the advent of population health

strategies, value-based payment models, telehealth, and other significant forces reshape how health care is organized and delivered.

Pursuing this affiliation is necessary for L+M to maintain its community service commitments, continue to provide high quality health care services in the local community, and ensure its financial health. Today, health care reform at both the national and state levels is requiring providers to integrate service delivery and assume responsibility for achieving specific quality, cost, and service outcomes. L+M, on its own, lacks the clinical and financial resources to accomplish these goals. The proposed affiliation and integration will provide L+M with economies of scale as they relate to information technology, finance, insurance, equipment, supplies and other administrative services.

Through an affiliation with YNHHSC, L+M and the community it serves will significantly benefit from:

- Enhanced access to clinical services available to its patients through clinical integration and collaboration with YNHHSC affiliated physicians;
- A strengthened ability to retain, develop, and recruit the best talent available as part of YNHHSC ;
- Access to needed capital,(once L+M becomes part of the YNHHS Obligated Group), that better enables L+M to re-invest in the communities it serves and in itself, including state-of-the-art facilities and technologies, including diagnostic capabilities that preserve its ability to provide high quality health care services;
- Access to population health expertise and infrastructure; and
- Greater financial stability by virtue of being part of a large health system.

Benefits to YNHHSC:

YNHHSC's vision is as follows:

"Yale New Haven Health enhances the lives of the people we serve by providing access to high value, patient-centered care in collaboration with those who share our values."

L+M is an ideal partner with its:

- Compatible vision and culture;
- Commitment to alignment/integration with local physicians;
- Commitment to safety, quality and service performance; and
- Collaboration across the continuum of care.

History of Collaboration:

YNHHSC has strong historical ties and a positive clinical collaborative relationship with L&M and its physicians. There are a number of existing and successful service line and clinical relationships between the two organizations which have demonstrated the success relating to clinical collaboration by the applicants.

Specifically, L+M has existing clinical affiliations with YNHH or Yale Medical Group (YMG) in the following areas:

- Heart and vascular care
    - Primary and elective angioplasty
    - Vascular surgery and endovascular procedures

- Radiation oncology services
- Neonatology physician coverage
- Pediatric hospitalists staffing
- Pediatric emergency department staffing
- Neurosurgical services
- Telestroke services

YNHH serves as a destination hospital for many smaller hospitals throughout the State of Connecticut because it offers specialized tertiary and quaternary services not available in smaller facilities. With respect to L+MH, YNHH is the preferred provider for L&M service area residents for such services. L+MH transfers approximately 1,000 patients each year to YNHH in New Haven, Connecticut, via the Y-Access Transfer Service, more than are transferred from any other hospital in the State. These patients are historically referred back to the L+M community once they are discharged.

Governance:
As with the other affiliate hospitals in YNHHSC, a meaningful and active local hospital Board of Trustees ("Board") with community representation will be maintained at L+M.

L+M will continue to remain a separate entity with its own separate Board responsible for overseeing and managing L+MH and Westerly. The L+M Board will continue to play a meaningful role in the stewardship of L+M, subject to certain reserved rights of YNHHSC with respect to fundamental strategic, financial and governance matters, as is the case with other YNHHCS hospital affiliates. The L+M Board will be composed of the existing L+M Board, (except that in lieu of the ex officio Board seat reserved for the Chair of an L+M affiliated physician organization, an additional Board seat is reserved for a Medical Staff member of L+MH or Westerly), plus one member appointed by YNHHSC. Subject to all regulatory approvals, the L+M trustees will be elected by YNHHSC from nominees proposed by the L+M Board. As of the effective date of the proposed affiliation, the Chair of the Board of L+M will be elected as a voting member of the Board of YNHHSC for six years. During such time, the person will have the opportunity to be a member of the YNHHSC Nominating and Governance Committee. Other members of the L+M Board will also have the opportunity to serve on YNHHSC Board committees and be elected to the YNHHSC Board.

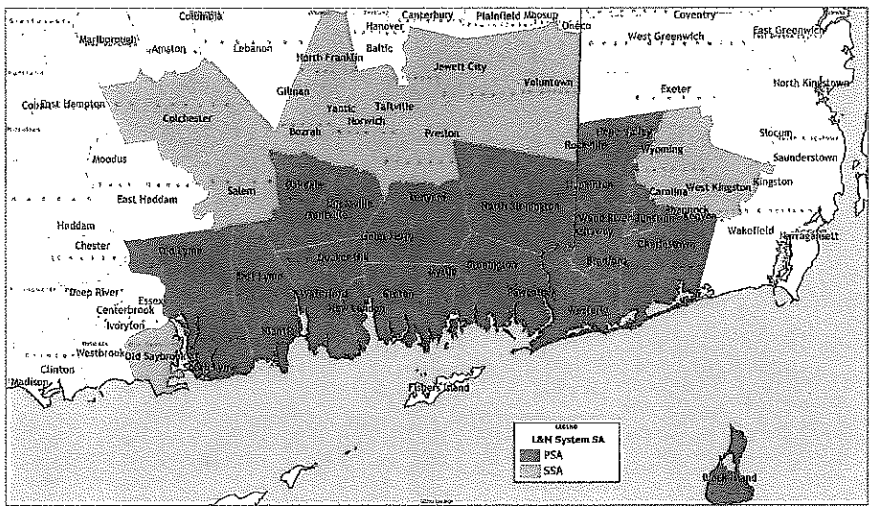
The L+MH Board will likewise continue as a fiduciary board and will be responsible for oversight and management of matters such as patient care, safety, licensure, accreditation, medical staff credentialing, election and removal of officers, and approval of such L+MH actions that have not otherwise been reserved to L+M and/or to YNHHSC. A YNHHSC appointee also will serve on the L+MH Board, and the L+MH Board's scope of responsibility and authority will be largely unchanged as a result of the L+M and YNHHSC affiliation.

Geographic Area Served:
L+M Service Area
The service area for L+M as a whole encompasses the Connecticut and Rhode Island communities served by L+MH, Westerly, and L&MPA. There are 18 communities in the primary service area and 12 in the secondary service area. The table below lists these communities and identifies those in both Connecticut and

Rhode Island.

L+M Service Area	
PSA	SSA
Connecticut:	Connecticut:
East Lyme	Bozrah
Groton	Colchester
Ledyard	Franklin
Lyme	Griswold+Lisbon
Montville	Norwich
New London	Old Saybrook
North Stonington	Preston
Old Lyme	Salem
Stonington	Voluntown
Waterford	
Rhode Island:	Rhode Island:
Ashaway	Carolina
Block Island	W. Kingstown
Bradford	Wyoming
Charlestown	
Hope Valley	
Hopkinton	
Westerly	
Wood River Junction	

See below for a map of the L+M service area which includes the service areas for L+MH, Westerly, and L&MPA.



The overall L+M service area population size is estimated to be 324,416 in 2015 and is projected to remain relatively flat at 325,101 in 2020. However, service area residents in the 65+ age cohort are projected to increase significantly (12.5%) between 2015 and 2020 as shown in the table below. Accordingly, we expect demand for health care services to increase significantly with more elderly adults

consistent with published findings[1].

		2015						2020				
		0-17	18-44	45-64	65+	Total		0-17	18-44	45-64	65+	Total
L+M												
PSA		42,132	72,937	62,272	36,986	214,327		40,386	72,934	60,037	41,035	214,392
SSA		23,392	35,638	34,061	16,998	110,089		22,354	35,575	33,069	19,711	110,709
Total		65,524	108,575	96,333	53,984	324,416		62,740	108,509	93,106	60,746	325,101
% Change								-4.2%	-0.1%	-3.3%	12.5%	0.2%

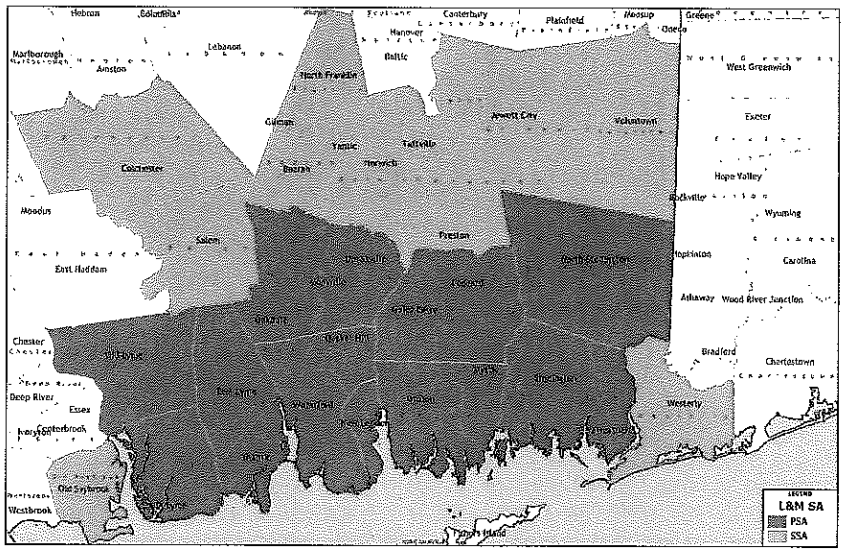
Source: YNHHS Planning, Claritas

L+MH Service Area

L+MH's service area includes a total of 10 communities in its primary service area and 10 communities in its secondary service area. The table below lists these communities and identifies those in both Connecticut and Rhode Island.

L+MH Service Area	
PSA	SSA
Connecticut:	Connecticut:
East Lyme	Bozrah
Groton	Colchester
Ledyard	Franklin
Lyme	Griswold+Lisbon
Montville	Norwich
New London	Old Saybrook
North Stonington	Preston
Old Lyme	Salem
Stonington	Voluntown
Waterford	
Rhode Island:	Rhode Island:
None	Westerly

See below for a map of the L+MH service area.



1 Agency for Healthcare Research and Quality (2014). Overview of Hospital Stays in the United States, 2012; Health Care Cost Institute (2013). 2013 Health Care Cost and Utilization Report. (See Attachment IV for copies of these reports)

The overall L+MH service area population size is estimated to be 296,296 in 2015 and projected to remain relatively flat at 296,981 in 2020. However, service area residents in the 65+ age cohort are projected to increase significantly (13.5%) between 2015 and 2020 as shown in the table below. As noted above, demand for health care services is expected to increase significantly with more elderly adults.

		2015						2020				
L+MH		0-17	18-44	45-64	65+	Total		0-17	18-44	45-64	65+	Total
PSA		33,757	61,049	49,192	30,006	174,004		32,011	61,046	46,957	34,055	174,069
SSA		25,637	38,992	37,569	20,094	122,292		24,599	38,929	36,577	22,807	122,912
Total		59,394	100,041	86,761	50,100	296,296		56,610	99,975	83,534	56,862	296,981
% Change								-4.7%	-0.1%	-3.7%	13.5%	0.2%

Source: YNHHS Planning Department, Claritas

2. Provide the history and timeline of the proposal (i.e., When did discussions begin internally or between Applicant(s)? What have the Applicant(s) accomplished so far?).

Response

As stated previously, there is a long history between the organizations that included regular and ongoing communication and collaboration. Formal discussions between the Applicants began internally in early 2015. Specific discussions pertaining to the proposed affiliation began formally in the first quarter of calendar year 2015 and were followed by a thorough due diligence process.

The due diligence process began in March 2015, and will continue through to the closing. In addition to this CON application, the following regulatory process will be required:

- A Hart-Scott-Rodino filing was submitted to the Federal Trade Commission (FTC) on August 7, 2015, and a courtesy copy was sent to the Connecticut Attorney General on August 10, 2015. On September 8, 2015, the FTC informed YNHHSC and L+M that it would allow the waiting period outlined by the Hart-Scott-Rodino Antitrust Improvements Act to expire without further investigating the transaction.
- A CON application for the merger of L&MPA with and into NEMG will be filed simultaneously with this application.
- A Notice of Material Change regarding the merger of L&MPA will be filed shortly with the Connecticut Attorney General.
- Regulatory approval filings with the Rhode Island Department of Health and the Rhode Island Attorney General are planned for October 2015.
- The closing will occur once all regulatory approvals are obtained.

The Boards of both L+M and YNHHSC each approved execution of the Affiliation Agreement and seeking regulatory approval for the affiliation on July 9, 2015 and July 10, 2015 respectively. Copies of board resolutions were previously referenced (see Attachment I).

3. Provide the following information:

a. utilizing **OHCA Table 1**, list all services to be added, terminated or modified, their physical location (street address, town and zip code), the population to be served and the existing/proposed days/hours of operation;

Response
No services are planned to be terminated and the population to be served is expected to be from the same geographic service area. There are no plans to modify existing hours of operation.

b. identify in **OHCA Table 2** the service area towns and the reason for their inclusion (e.g., provider availability, increased/decreased patient demand for service, market share);

Response
Table 2 has been completed. The service area towns will remain the same as L+M's and L+MH's current service areas (see response to question 1).

4. List the health care facility license(s) that will be needed to implement the proposal;

Response
There are no other facility licenses that will be needed to implement the proposal.

5. Submit the following information as attachments to the application:

a. a copy of all State of Connecticut, Department of Public Health license(s) currently held by the Applicant(s);

Response
Please refer to Attachment V for a copy of L+MH's Department of Public Health license.

b. a list of all key professional, administrative, clinical and direct service personnel related to the proposal and attach a copy of their Curriculum Vitae;

Response
Key professional, administrative, clinical and direct service personnel related to the proposal are listed below.

YNHHSC
- Marna Borgstrom, President and Chief Executive Officer, YNHHS, Chief Executive Officer, YNHH
- James Staten, Executive Vice President, Corporate & Financial Services, YNHHS; Chief Financial Officer and Senior Vice President for Finance, YNHH
- Gayle Capozzalo, Executive Vice President and Chief Strategy Officer, YNHHS
- Christopher O'Connor, Executive Vice President and Chief Operating Officer, YNHHS

L+M
- Bruce D. Cummings, President and Chief Executive Officer
- Daniel Rissi, M.D., Vice President and Chief Medical and Clinical Operations Officer

- Seth Van Essendelft, Vice President, Chief Financial and Support Services Officer

Please refer to Attachment VI for copies of the Curriculum Vitae.

c. copies of any scholarly articles, studies or reports that support the need to establish the proposed service, along with a brief explanation regarding the relevance of the selected articles;

Response
Not applicable. This CON application is not a request for establishment of a new service.

d. letters of support for the proposal;

Response
Please prefer to Attachment VII for letters of support for this CON application.

e. the protocols or the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet the protocols or guidelines.

Response
Not applicable. This CON application does not request any change to specific clinical services where protocols or practice guidelines may apply.

f. copies of agreements (e.g., memorandum of understanding, transfer agreement, operating agreement) related to the proposal. If a final signed version is not available, provide a draft with an estimated date by which the final agreement will be available.

Response
The Affiliation Agreement executed between YNHHSC and L+M was previously referenced as Attachment III.

Public Need and Access to Care

§ *"Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;" (Conn.Gen.Stat. § 19a-639(a)(1))*

6. Describe how the proposed project is consistent with any applicable policies and standards in regulations adopted by the Connecticut Department of Public Health.

Response
This proposal is consistent with all policies and standards in regulations adopted by the Connecticut DPH in that the proposal is focused upon expanding local access for L+MH patients to more sophisticated services, quality improvements, population

health and achieving greater efficiencies.

§ "The relationship of the proposed project to the statewide health care facilities and services plan;" (Conn.Gen.Stat. § 19a-639(a)(2))

7. Describe how the proposed project aligns with the Connecticut Department of Public Health Statewide Health Care Facilities and Services Plan, available on OHCA's website.

Response

This proposal aligns well with the Connecticut DPH *Statewide Health Care Facilities and Services Plan* (the "Plan"). Specifically, the 2014 update stresses the changes that have occurred in the State of Connecticut since the passage and implementation of the Patient Protection and Affordable Care Act ("PPACA"). The Plan acknowledges that the PPACA has influenced providers to focus on creating new models of care that bring higher quality and greater value. The PPACA has led to affiliations and mergers of health care providers throughout the country and the State, and across the country to maintain access to needed services, improve financial viability and enhance organizations' ability to meet technology needs. This proposal is focused on sustaining and enhancing the commitment that L+MH has had to serving its community. Through the affiliation and the parties continued commitment to collaboration, L+MH will be stronger and better positioned to meet the challenges of not only today, but those in the future.

§ "Whether there is a clear public need for the health care facility or services proposed by the applicant;" (Conn.Gen.Stat. § 19a-639(a)(3))

8. With respect to the proposal, provide evidence and documentation to support clear public need:

   a. identify the target patient population to be served;

Response

The target population to be served is the population that L+MH is currently serving. Please refer to the response in Question 1 for a description and quantification of the service area. The needs of the population served by L+MH will not diminish. In fact, as noted, the 65+ cohort is projected to increase significantly between 2015 and 2020. This trend is consistent with statewide and national trends. As outlined in L+MH's most recent Community Health Needs Assessment ("CHNA"), which can be found in Attachment VIII, based on the 2010 census, the service area has a higher proportion of middle age and older adults than the State of Connecticut and the nation overall (see page 6 of the CHNA). The older population has a higher incidence of many illnesses and diseases, such as heart disease, cancer and certain lung diseases, and therefore

utilizes health care services at a higher rate than the younger population[2]. As the population continues to age, the public need for health care services offered by L+MH is expected to increase.

Other significant health issues exist in the service area as outlined in the CHNA including:

- Higher cancer incidence than statewide and national levels for all cancers in particular, breast, colorectal (particularly in females), and lung;
- Higher cancer mortality than statewide and national levels for all cancer particularly in breast and lung cancer;
- High Chlamydia rates;
- Obesity levels higher than the state average;
- Increasing diabetes incidence; and
- High alcohol consumption as compared to national benchmarks.

Public need for L+MH's health care services will continue and increase due to existing and future health care issues as well as the aging of the population. L+MH has provided health care services to service area residents for more than a century. The proposed affiliation will ensure continued access to high quality health care services provided by L+MH as well as access to the advanced clinical services in collaboration with YNHHSC. The proposed affiliation will strengthen L+MH's ability to continue to provide community benefits as described in response to Supplement question 4.

b. discuss how the target patient population is currently being served;

Response
The target population is currently served by L+M either through one of its two acute care hospitals, home health agency and by its affiliates' physicians.

c. document the need for the equipment and/or service in the community;

Response
Not applicable. This proposal does not involve a specific service or piece of equipment.

d. explain why the location of the facility or service was chosen;

Response
Not applicable. There is no new location being chosen as part of this proposal.

e. provide incidence, prevalence or other demographic data that demonstrates community need;

Response
Please refer to question 8(a) above.

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2 American Heart Association (2015). National Health and Nutrition Examination Survey: 2009-2012; American Lung Association (2008). Lung Disease Data (2008); National Cancer Institute (n.d.). Surveillance, Epidemiology, and End Results Program. Cancer Incidence by Age Cohort (see Attachment IX for copies of these reports).

f. discuss how low income persons, racial and ethnic minorities, disabled persons and other underserved groups will benefit from this proposal;

Response
Both YNHHS and L+M have always provided services to a diverse population including underinsured and uninsured individuals. YNHHS and L+MH provide services to all regardless of race, ethnicity, religion, income or ability to pay for services. This will not change as a result of this proposal.

YNHHS and L+MH have a long history of providing charity care and financial assistance to those in need. Should the proposal be approved, L+MH will continue in its commitment to providing charity care pursuant to the YNHHSC system-wide charity care and free care policy.

g. list any changes to the clinical services offered by the Applicant(s) and explain why the change was necessary;

Response
Please refer to the response to question 3(a) and 8(h). There are no planned closures or reductions in any of the clinical services currently offered by L+M. The applicants are planning service enhancements and expansions to minimize the need for area residents to have to travel outside the service area for many specialty services.

h. explain how access to care will be affected;

Response
The applicants believe that access to primary and advanced care will be greatly enhanced as a result of this proposal. Through enhanced collaboration, the proposed affiliation will improve patient access to advanced care offered by YNHHS clinicians currently unavailable to the L+M service community. In addition, L+M expects because of its affiliation with YNHHS that it will be more competitive in recruiting the clinicians it needs for its service area, but to date has struggled to attract (e.g. primary care physicians and other specialists). Patients in L+M's service area will get the right care, at the right place, and at the right time. Currently, some patients in L+M's service area are traveling to more expensive, distant and out-of-state medical centers for their care. The proposed affiliation will enable L+M patients to receive care in the most convenient and appropriate setting. Lower acuity patients will be able to access "enhanced care" in their local area due to the added resources and expertise to be provided by YNHHSC. For those patients needing high-acuity services at a quaternary or tertiary medical center, access to YNHH will be seamless, and more often than not, these same patients will be able to return home and receive their follow up care in their community.

i. discuss any alternative proposals that were considered.

Response
Over the last five years, L+M has carefully considered all of its strategic options in connection with achieving its goals of (i) improving the population's health over time; (ii) improving the patient experience (quality and service), and (iii) reducing per capita health care cost. In connection with its strategic planning process,

L+M initially considered remaining independent by participating in a network of community hospitals working collectively to achieve greater efficiencies. While there are measurable benefits to L+M's participation in such network, L+M soon realized that the economic impact of health care reform was taking a greater toll on its financial viability than the resources of the network could address. To remain clinically vibrant, financially stable and offer patients superior patient care and services, L+M concluded that it had to affiliate with a larger regional health system. Consideration was given to Hartford HealthCare, but given its affiliation with Backus Hospital, Hartford HealthCare was not viewed as a viable option. Consideration was also given to more distant hospitals and locations such as Boston and New York, but there was considerable concern about patients migrating out of Connecticut and that the distance might be a barrier to achieving substantial efficiencies and having all of L+M's needs met, especially as it relates to clinical collaborations. Given L+M's long history of collaboration on clinical programs with YNHHSC and its shared commitment and mission, its geographic location in relation to YNHHSC and the strength of the YNHHSC leadership team, it was determined that YNHHSC represented the best fit for L+M. Given the geographic proximity, YNHHS also offers significant synergies to L+M. In essence, it was determined by the L+M Board that by combining L+M's local strength and community commitment with YNHHSC' leading clinical capabilities and system resources, L+M could be best positioned to meet the ongoing challenges associated with health reform.

> § *"Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, (A) provision of or any change in the access to services for Medicaid recipients and indigent persons, and (B) the impact upon the cost effectiveness of providing access to services provided under the Medicaid program;" (Conn.Gen.Stat. § 19a-639(a)(5))*

9. Describe how the proposal will:

   a. improve the quality of health care in the region;

Response

The proposed affiliation between L+M and YNHHSC will provide L+M with access to quality improvement resources that L+M cannot, on its own, cost-effectively invest in or support. In particular, as a YNHHSC member, L+M will gain access to population health analytic tools, more reliable data for achieving improved outcomes, and additional support staff with expertise in quality improvement. With greater access to cutting- edge clinical developments, and academicians who are committed to education and evidence-based best practices, L+M will be able to offer the patients in its service area the same world class care that YNHHSC hospitals are known for. In addition, through affiliation with YNHHSC, L+M firmly believes that it will be better positioned to recruit the best and brightest clinicians.

The YNHHS Performance Management program provides leadership and coordinates system-wide efforts to improve clinical quality and patient safety along with the necessary resources to support its affiliates. YNHHS annually

prepares priority performance improvement initiatives and measures. The YNHHS Quality Council identifies key performance improvement objectives for the entire health system, and coordinates these with the performance management initiatives designed by each affiliate. Each affiliated entity develops individual plans centered on YNHHS' priority initiatives.

Data abstractors help define specific metrics for performance assessment and follow strict data definitions to abstract data from patient records. Data analysts provide assistance to structure data queries and analyze clinical data. Together they develop and deploy tools for data analysis and reports useful for understanding clinical performance and for sustaining continuous quality improvement. In addition, performance improvement patient safety nurses are embedded in clinical areas of high risk (e.g., emergency department, peri-operative areas and obstetric delivery services), offering observation, coaching and workshops on-site to caregivers to sustain a culture of safety and improve safe care.

L+M will be included in YNHHSC-wide quality and safety programs and initiatives and will have access to YNHHSC's quality experts and data analytic resources. As a result, L+MH believes that with these added resources, L+M providers will be able to enhance the quality of care provided.

b. improve accessibility of health care in the region; and

Response
Please refer to the response to 8(h).

c. improve the cost effectiveness of health care delivery in the region.

Response
From a clinical perspective, some L+M service area residents have sought certain specialty services and physician services from more expensive and distant hospitals because the care was unavailable to them in the L+M service area. The proposed affiliation will enhance the services available in L+M's service area, especially as it relates to access to specialty physicians. In addition, through improved care coordination and avoidance of duplication of services between the applicants, and the ability to engage in population health initiatives, the applicants believe that they will be better positioned to provide more cost-effective health care services to the L+M service area.

In order to achieve operating efficiencies and savings, upon approval of this proposal, L+M and YNHHSC will review areas of non-clinical shared services. Opportunities will be identified to centralize some back office services and L+MH stands to benefit by achieving cost efficiencies that it would otherwise not have as a standalone small hospital system.

There is no question that the challenges facing all hospitals today are greater than they have ever been, but in particular, community hospitals are facing the greatest challenges due to health reform-related demands for greater value with lower reimbursement. Specifically, reduced payer reimbursement, particularly pertinent in Connecticut, coupled with greater demand for data-driven best practices, technologic advancements, aging infrastructure, and evolving health

care delivery models requires synergistic approaches to achieve cost-effective access to capital, medical technology, information technology, and highly competent clinicians.

L+M believes that the proposed affiliation will provide L+M with synergistic benefits in leadership, efficiencies and growth. Efficiencies will come from economies of scale as they relate to information technology, finance, insurance, equipment and supplies and other administrative services. Sustained success will result from the coordination and implementation of clinical programs that are designed to improve the quality, cost-effectiveness and accessibility to health care services to the communities served by L+M.

Specifically, synergistic benefits are initially expected to be achieved in the following areas:

(1) L+M's adoption of Epic, Lawson and other IT platforms used by YNHHSC will result in decreased clinical variation for L+M through standardized protocols;
(2) L+M is expected to achieve savings in supply chain related costs as a result of volume discounts;
(3) Improved and more efficient clinical and business practices resulting from the proposed merger of L&MPA into NEMG;
(4) Access to capital on more favorable terms, once L+M becomes a member of the YNHHSC Obligated Group;
(5) Access to YNHHSC's population health infrastructure;
(6) Development of clinical programs identified as needed in the L+M service community along with more effective physician recruitment; and
(7) Management expertise and efficiencies.

Therefore, cost effectiveness of health care delivery in the L+M service area is expected to improve with the proposed affiliation as L+M acquires the new tools needed under health care reform for the management of patient care. With reduced reimbursement, L+M has no other choice but to align with a historical partner to tap into these expensive and complex patient management tools.

10. How will this proposal help improve the coordination of patient care (explain in detail regardless of whether your answer is in the negative or affirmative)?

Response

The proposed affiliation will improve the coordination of patient care between the L+M and YNHHS. L+M will pursue the implementation of Epic's electronic medical record system ("EMR") at both of its hospitals as well as within its affiliated physician practices. Although YNHHS can extend Epic to community hospitals through Epic's Connect Client platform, and L+M intends to implement Epic even if the proposed affiliation does not come to fruition, future costs to L+M will be considerably higher as a standalone community hospital.

The addition of Epic and other clinical information systems to L+M will provide a uniform, integrated and seamless EMR between and within L+M and YNHHSC organizations which will aid in the coordination of patient care. Easy access to medical records from previous hospitalizations, physician office visits or ancillary

testing facilitates the delivery of efficient care that avoids unnecessary duplications of services. Well-informed providers can quickly direct patients to appropriate care and ensure the delivery of the best possible clinical care.

11. Describe how this proposal will impact access to care for Medicaid recipients and indigent persons.

Response
Access to care for Medicaid recipients and indigent persons will not be negatively impacted by this proposal. L+M affiliated entities participate in the Medicaid program. Approximately 21% of L+MH's payer mix is Medicaid and ~1% is uninsured and this is expected to remain constant. The proposed affiliation will only strengthen L+M's financial position and therefore strengthen the organization's ability to continue its commitment to care for Medicaid recipients and indigent persons.

> *§ "Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;" (Conn.Gen.Stat. § 19a-639(a)(10))*

12. If the proposal fails to provide or reduces access to services by Medicaid recipients or indigent persons, provide explanation of good cause for doing so.

Response
Not applicable. The proposal does not reduce access or fail to provide services to Medicaid recipients or indigent persons.

> *§ "Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care." (Conn.Gen.Stat. § 19a-639(a)(12))*

13. Will the proposal adversely affect patient health care costs in any way? Quantify and provide the rationale for any changes in price structure that will result from this proposal, including, but not limited to, the addition of any imposed facility fees.

Response
There are no planned changes to the price structure which will result from this proposal. As with other YNHHSC affiliates, separate payor contracts are maintained for each hospital and the normal contract renewal process will be continued. However, it is expected that with greater cost efficiencies, resulting from the affiliation, L+M will have greater financial stability.

Financial Information

§ "Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the application," (Conn.Gen.Stat. § 19a-639(a)(4))

14. Describe the impact of this proposal on the financial strength of the state's health care system or demonstrate that the proposal is financially feasible for the applicant.

Response
The financial strength of the State of Connecticut's health care system is dependent on the strength of its individual health care providers. This proposal is fully consistent with state and national trends wherein providers collaborate to reduce costs, share resources and promote best practices. As stated earlier, providers need to form integrated networks, develop advanced care management capabilities, and partner across the care continuum to be successful under a population health model and value-based reimbursement systems. This proposed affiliation will ultimately strengthen the financial health of both organizations which in turn will positively impact the financial strength of the state's health care system.

The proposal is financially feasible for the Applicants. Please refer to Financial Worksheet A referenced in response to question 17(b).

15. Provide a final version of all capital expenditure/costs for the proposal using **OHCA Table 3**.

Response
Commencing with the closing of the proposed affiliation, YNHHSC has committed to deploy as much as $300 million in resources in the Eastern Connecticut and Western Rhode Island region over a period of five years for the purpose of enhancing L+M's clinical and operational capabilities and services. Such expenditures must: (i) be consistent with YNHHSC's overall strategic plan; (ii) be consistent with the business plans of the Applicants; (iii) have a positive return on investment; and (iv) be responsive to the needs of the community. Essentially, should the proposal be approved, the Applicants will engage in an ongoing and deliberate strategic planning process that will be focused upon enhancing the quality and breadth of clinical services that are mutually identified as needed by the L+M community.

16. List all funding or financing sources for the proposal and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges and funds received to date; letter of interest or approval from a lending institution.

Response
Please refer to the response to question 15. There is no financing contemplated at this time.

17. Include as an attachment:

    a. audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, provide other financial documentation (e.g., unaudited balance sheet, statement of operations, tax return, or other set of books.). Connecticut hospitals required to submit annual audited financial statements may reference that filing, if current;

    Response
    L+M has previously submitted annual audited financial statements to OHCA.

    b. a complete **Financial Worksheet A (not-for-profit entity)** or **B (for-profit entity)**, available on OHCA's website under "OHCA Forms," providing a summary of revenue, expense, and volume statistics, "without the CON project," "incremental to the CON project," and "with the CON project." Note: the actual results reported in the Financial Worksheet must match the audited financial statement that was submitted or referenced.

    Response
    A separate Financial Worksheet A has been completed for each entity including; L+M, L+MH and YNHHSC, and can be found in Attachment X.

18. Complete **OHCA Table 4** utilizing the information reported in the attached Financial Worksheet.

    Response
    OHCA Table 4 has been completed for each L+M, L+MH and YNHHSC.

19. Explain all assumptions used in developing the financial projections reported in the Financial Worksheet.

    Response
    All assumptions used in developing the financial projections reported in the Financial Worksheets are included in Attachment XI.

20. Explain any projected incremental losses from operations resulting from the implementation of the CON proposal.

    Response
    Except for the first six months of FY 2016, there are no incremental losses due to the affiliation when comparing the five (5) year forecast with and without the proposed affiliation. Specifically, L+M and L+MH's losses will be incrementally lower with the affiliation as L+M is expected to achieve certain operational efficiencies.

21. Indicate the minimum number of units required to show an incremental gain from operations for each projected fiscal year.

    Response:

Not applicable. There are no projected incremental operating losses.

Utilization

> *§ "The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;" (Conn.Gen.Stat. § 19a-639(a)(6))*

22. Complete **OHCA Table 5** and **OHCA Table 6** for the past three fiscal years ("FY"), current fiscal year ("CFY") and first three projected FYs of the proposal, for each of the Applicant's existing and/or proposed services. Report the units by service, service type or service level.

Response:
OHCA Tables 5 and 6 have been completed.

23. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected service volume; explain any increases and/or decreases in volume reported in OHCA Tables 4 and 5.

Response:
The inpatient volume projections were based on a combination of historical market trends within the L+M and Westerly service areas and also published national projections. All incremental volume projections are based off of the established baseline. The inpatient incremental volume, due to the affiliation, was based on understanding existing demand by service line and applying growth factors where, through the affiliation, there is potential to develop new clinical programs and bring specialty care to Eastern Connecticut / Westerly Rhode Island. Such program assumptions include musculoskeletal, neurosurgery/spine, cardiovascular, general surgery, maternity and children's services.

24. Provide the current and projected patient population mix (number and percentage of patients by payer) for the proposal using **OHCA Table 7** and provide all assumptions. **Note: payer mix should be calculated from patient volumes, not patient revenues.**

Response:
Current and projected patient population mix has been provided in OHCA Table 7. Payer mix is not projected to change as L+MH will continue to serve the same patient population that they currently serve.

> *§ "Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily*

demonstrated that the identified population has a need for the proposed services;" (Conn.Gen.Stat. § 19a-639(a)(7))

25. Describe the population (as identified in question 8(a) by gender, age groups or persons with a specific condition or disorder and provide evidence (i.e., incidence, prevalence or other demographic data) that demonstrates a need for the proposed service or proposal. ***Please note: if population estimates or other demographic data are submitted, provide only publicly available and verifiable information (e.g., U.S. Census Bureau, Department of Public Health, CT State Data Center) and document the source.***

Response:
Please refer to question 8(a).

26. Using **OHCA Table 8**, provide a breakdown of utilization by town for the most recently completed FY. Utilization may be reported as number of persons, visits, scans or other unit appropriate for the information being reported.

Response:
OHCA Table 8 has been completed.

§ "The utilization of existing health care facilities and health care services in the service area of the applicant;" (Conn.Gen.Stat. § 19a-639(a)(8))

27. Using **OHCA Table 9**, identify all existing providers in the service area and, as available, list the services provided, population served, facility ID (see table footnote), address, hours/days of operation and current utilization of the facility. Include providers in the towns served or proposed to be served by the Applicant, as well as providers in towns contiguous to the service area.

Response:
OHCA Table 9 has been completed.

28. Describe the effect of the proposal on these existing providers.

Response:
The applicants believe that the proposal will have little to no effect on existing providers in the service area.

29. Describe the existing referral patterns in the area served by the proposal.

Response:
Existing referral patterns in the area served by the proposal are well established and driven by professional clinical expertise of area physicians. Patients in need of inpatient or specialty care are referred either to local hospitals and specialists or providers throughout the state based on their physician's assessment. As previously

described in response to question 1, YNHHSC and L+M have a long history of collaboration and patients have been referred between the organizations for many years. As stated in response to question 1, a significant number of L+M service area residents have sought specialized acute care services from YNHH.

30. Explain how current referral patterns will be affected by the proposal.

Response:
Current referral patterns are expected to remain in place after completion of the affiliation.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;" (Conn.Gen.Stat. § 19a-639(a)(9))*

31. If applicable, explain why approval of the proposal will not result in an unnecessary duplication of services.

Response:
Through better coordination of care between L+MH and YNHHS, there will be less duplication of services.

> *§ "Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region. . ." (Conn.Gen.Stat. § 19a-639(a)(11))*

32. How will the proposal impact the diversity of health care providers and patient choice or reduce competition in the geographic region?

Response:
The proposal will positively impact the diversity of heath care providers and patient choice. YNHHSC will establish access to specific specialists in the service area based upon identified need increasing access to a broader group of providers on a more local basis. Patient choice will be enhanced through access to more providers and competition will not be reduced. Patients within the community will continue to have the choice of Backus Hospital or other hospitals in the State.

Tables

TABLE 1
APPLICANT'S SERVICES AND SERVICE LOCATIONS

Service	Street Address, Town	Population Served	Days/Hours of Operation	New Service or Proposed Termination
Acute care hospital services	365 Montauk Avenue, New London	L+M's service area as outlined in Table 2	24/7	N/A

[back to question]

TABLE 2
SERVICE AREA TOWNS – L+MH

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Primary Service Area includes: • East Lyme • Groton • Ledyard • Lyme • Montville • New London • North Stonington • Old Lyme • Stonington • Waterford	Represented by L+MH to OHCA that these towns collectively fit the definition of "Primary Service Area" as set forth in the Statewide Facilities and Services Report published in 2012 ("that geographic area (by town), for the service location in the application, consisting of the lowest number of contiguous zip codes from which the applicant draws at least 75% of its patients for this service at such location").
Secondary Service Area includes: • Bozrah • Colchester • Franklin • Griswold+Lisbon • Norwich • Old Saybrook • Preston • Salem • Voluntown • Westerly, RI	L+MH currently services these towns to fulfill its mission in serving the community's health care needs and these towns are part of the service area that L+M has represented to OHCA for years during the CON process

* Village or place names are not acceptable.

[back to question]

TABLE 3
TOTAL PROPOSAL CAPITAL EXPENDITURE

Purchase/Lease	Cost
Equipment (Medical, Non-medical Imaging)	$0
Land/Building Purchase*	
Construction/Renovation**	
Other (specify)	
Total Capital Expenditure (TCE)	**$0**
Lease (Medical, Non-medical Imaging)***	$0
Total Capital Cost (TCO)	**$0**
Total Project Cost (TCE+TCO)	**$0**

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.

** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross square feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.

*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

[back to question]

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES – L+M

	FY 2016*	FY 2017*	FY 2018*	FY2019*
Revenue from Operations	($13,647,000)	($24,943,000)	($19,073,000)	($14,035,000)
Total Operating Expenses	($13,575,000)	($32,219,000)	($31,338,000)	($29,548,000)
Gain/Loss from Operations	($72,000)	$7,276,000	$12,265,000	$15,513,000

* Fill in years using those reported in the Financial Worksheet attached.

Note: Incremental revenue and expenses are negative values due to the removal of L&MPA which will be merged into NEMG.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES – L+MH

	FY 2016*	FY 2017*	FY 2018*	FY2019*
Revenue from Operations	$5,505,000	$14,066,000	$19,404,000	$24,104,000
Total Operating Expenses	$4,429,000	$7,168,000	$7,605,000	$8,672,000
Gain/Loss from Operations	$1,076,000	$6,898,000	$11,799,000	$15,432,000

* Fill in years using those reported in the Financial Worksheet attached.

TABLE 4
PROJECTED INCREMENTAL REVENUES AND EXPENSES – YNHHSC

	FY 2016*	FY 2017*	FY 2018*	FY2019*
Revenue from Operations	$240,689,000	$487,621,000	$496,647,000	$501,940,000
Total Operating Expenses	$241,388,000	$473,052,000	$479,588,000	$485,542,000
Gain/Loss from Operations	($699,000)	$14,569,000	$17,059,000	$16,398,000

* Fill in years using those reported in the Financial Worksheet attached.

[back to question]

TABLE 5
HISTORICAL UTILIZATION BY SERVICE – L+MH

DISCHARGES				
Service	Actual FY 2012	Actual FY 2013	Actual FY 2014	Estimated FY 2015
Med/Surg	10,319	10,139	9,525	9,609
Ob/gyn	1,786	1,704	1,811	1,827
Psych	866	822	812	819
Rehab	331	334	310	309
Pediatrics	89	98	41	40
Newborns/Neonates	1,546	1,562	1,652	1,666
Total	14,936	14,659	14,151	14,271

(1) -- Fiscal year is Oct 1- Sept. 30. FY 2015 annualized is based on 6 months actual. (Source: L+MH)
* For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than 6 months, report actual volume and identify the period covered.
** Identify each service type and level adding lines as necessary. Provide the number of visits or discharges as appropriate for each service type and level listed.
*** Fill in years. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 6
PROJECTED UTILIZATION BY SERVICE – L+MH

	PROJECTED DISCHARGES				
	FY2016	FY2017	FY2018	FY2019	FY2020
Med/Surg	9,649	9,633	9,607	9,608	9,623
OB/Gyn	1,836	1,833	1,829	1,827	1,824
Psychiatry	839	847	852	856	860
Rehab	310	310	310	310	310
Pediatrics	61	77	93	108	124
Newborn/Neonates	1,696	1,712	1,727	1,741	1,754
Grand Total	14,391	14,412	14,418	14,450	14,495

* Identify each service type by location and add lines as necessary. Provide the number of visits/discharges as appropriate for each service listed.

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. If the time period reported is not *identical* to the fiscal year reported in Table 4 of the application, provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 7
APPLICANT'S CURRENT & PROJECTED PAYER MIX – L+MH

Payer	Current FY 2015**		Projected FY 2016**		FY 2017**		FY 2018**	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	5,603	39.3%	5,650	39.3%	5,658	39.3%	5,661	39.3%
Medicaid*	3,037	21.3%	3,062	21.3%	3,067	21.3%	3,068	21.3%
CHAMPUS & TriCare	1,771	12.4%	1,785	12.4%	1,788	12.4%	1,789	12.4%
Total Government	**10,411**	**73.0%**	**10,498**	**73.0%**	**10,514**	**73.0%**	**10,518**	**73.0%**
Commercial Insurers	3,698	25.9%	3,729	25.9%	3,734	25.9%	3,736	25.9%
Uninsured	87	0.6%	88	0.6%	88	0.6%	88	0.6%
Workers Compensation	75	0.5%	76	0.5%	76	0.5%	76	0.5%
Total Non-Government	**3,860**	**27.0%**	**3,892**	**27.0%**	**3,898**	**27.0%**	**3,900**	**27.0%**
Total Payer Mix	**14,271**	**100.0%**	**14,391**	**100.0%**	**14,412**	**100.0%**	**14,418**	**100.0%**

* Includes managed care activity.

** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided. New programs may leave the "current" column blank.

[back to question]

TABLE 8
UTILIZATION BY TOWN – L+MH

Town	Utilization – Discharges FY 2014
Primary Service Area (PSA) Towns:	
East Lyme	1,291
Groton	3,733
Ledyard	911

Town	Utilization – Discharges FY 2014
Lyme	1
Montville	679
New London	3,019
North Stonington	207
Old Lyme	227
Stonington	536
Waterford	1,797
Subtotal - PSA	12,401
Secondary Service Area (SSA) Towns:	
Bozrah	22
Colchester	31
Franklin	10
Griswold+Lisbon	122
Norwich	428
Old Saybrook	35
Preston	86
Salem	86
Voluntown	14
Westerly, RI	273
Subtotal - SSA	1,107
Other Towns	643
TOTAL	14,151

* List inpatient/outpatient/ED volumes separately, if applicable

** Fill in year if the time period reported is not *identical* to the fiscal year reported on pg. 2 of the application; provide the date range using the mm/dd format as a footnote to the table.

[back to question]

TABLE 9

Service or Program Name	Population Served	Facility ID*	Facility's Provider Name, Street Address and Town	Hours/Days of Operation	Current Utilization
Backus Hospital	Norwich and surrounding towns in New London County as well as Plainfield & Canterbury	1730243536 (NPI)	326 Washington Street, Norwich, CT	24/7	11,396 (as per *Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals, FY 2013*)

* Provide the Medicare, Connecticut Department of Social Services (DSS), or National Provider Identifier (NPI) facility identifier and label column with the identifier used.

[back to question]

Connecticut Department of Public Health

Supplemental CON Application Form

Transfer of Ownership/Sale of Hospital

Conn. Gen. Stat. § 19a-638(a)(2) & § 19a-486

Applicant: Yale New Haven Health Services Corporation & Lawrence + Memorial Corporation

Project Name: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation

Affidavit

Applicant: Yale New Haven Health Services Corporation

Project Title: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation

I, Marna Borgstrom, Chief Executive Officer
(Name) (Position – CEO or CFO)

of Yale New Haven Health Services Corporation being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 9/16/15
Date

Subscribed and sworn to before me on 9/16/15

Notary Public/Commissioner of Superior Court

My commission expires: Irene Noel
NOTARY PUBLIC
State of Connecticut
My Commission Expires 5/31/2018

Affidavit

Applicant: Lawrence + Memorial Corporation

Project Title: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation

I, Bruce D. Cummings, President & Chief Executive Officer
(Name) (Position – CEO or CFO)

of Lawrence + Memorial Corporation being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 9.16.2015
Date

Subscribed and sworn to before me on 9.16.2015

Notary Public/Commissioner of Superior Court

My commission expires: KAREN M. SANTACROCE
Notary Public, State of Connecticut
My Commission Expires September 30, 2017

1. Project Description and Need: Change of Ownership or Control

a. Describe the transition plan and how the Applicants will ensure continuity of services. Provide a copy of a transition plan, if available.

Response:
The structure and proposed relationship between YNHHSC and L+M is outlined in the Affiliation Agreement. Subject to approval, there will be a number of workgroups that will work on integration plans. A full integration plan should be complete in early 2016.

Please refer to the response in main CON application, question 2.

b. For each Applicant (and any new entities to be created as a result of the proposal), provide the following information as it would appear **prior** and **subsequent** to approval of this proposal:

i. Legal chart of corporate or entity structure including all affiliates.
ii. Governance or controlling body.
iii. List of owners and the % ownership and shares of each.

Response:
Copies of YNHHSC and L+M's legal chart of corporate entities prior and subsequent to approval of this proposal are provided in Attachment A.

2. Historical and Projected Volume

a. In table format, provide historical volumes (three **full** years and the current year-to-date) for the number of discharges and patient days by service.

TABLE A
HISTORICAL AND CURRENT DISCHARGES – L+MH

DISCHARGES				
Service	Actual FY 2012	Actual FY 2013	Actual FY 2014	Estimated FY 2015
Med/Surg	10,319	10,139	9,525	9,609
Ob/gyn	1,786	1,704	1,811	1,827
Psych	866	822	812	819
Rehab	331	334	310	309
Pediatrics	89	98	41	40
Newborns/Neonates	1,546	1,562	1,652	1,666
Total	14,936	14,659	14,151	14,271

Fiscal year is October 1 – September 30. (Source: L+MH)
FY 2015 annualized based on 6 months of data (methodology = doubling 1st 6 months actual experience).

* Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).
** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).
*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

TABLE B
HISTORICAL AND CURRENT PATIENT DAYS – L+MH

PATIENT DAYS				
Service	Actual FY 2012	Actual FY 2013	Actual FY 2014	Estimated FY 2015
Med/Surg	48,738	46,352	44,415	43,675
Ob/gyn	4,890	4,264	4,804	5,108
Psych	6,433	6,367	6,679	7,101
Rehab	4,721	4,536	4,494	4,730
Pediatrics	238	213	129	134
Newborns/Neonates	5,537	5,581	5,811	6,183
Total	70,556	67,314	66,332	66,931

Fiscal year is October 1 – September 30. (Source: L+MH)
FY 2015 annualized based on 10 months of data (methodology = use average length of stay (ALOS) for actual 10 months, and assume that figure for full year; use ALOS and projected discharges from Table A to calculate annualized patient days).

* Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).
** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g., July 1-June 30, calendar year, etc.).
*** For periods greater than 6 months, report annualized volume, identifying the number of actual months covered and the method of annualizing. For periods less than six months, report actual volume and identify the period covered.

b. Complete the following tables for the first three **full** fiscal years ("FY") following adoption of the proposal, if the first year is a partial year, include that as well.

TABLE C
PROJECTED DISCHARGES BY SERVICE – L+MH

	PROJECTED DISCHARGES				
	FY2016	FY2017	FY2018	FY2019	FY2020
Med/Surg	9,649	9,633	9,607	9,608	9,623
OB/Gyn	1,836	1,833	1,829	1,827	1,824
Psychiatry	839	847	852	856	860
Rehab	310	310	310	310	310
Pediatrics	61	77	93	108	124
Newborn/Neonates	1,696	1,712	1,727	1,741	1,754
Grand Total	14,391	14,412	14,418	14,450	14,495

Fiscal year is October 1 – September 30.

Project start expected on April 1, 2016.

* Provide the number of discharges for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g., July 1-June 30, calendar year, etc.).

TABLE D
PROJECTED PATIENT DAYS BY SERVICE- L+MH

	PROJECTED PATIENT DAYS				
	FY2016	FY2017	FY2018	FY2019	FY2020
Med/Surg	42,852	42,150	41,489	41,512	41,596
OB/Gyn	5,059	4,975	4,900	4,895	4,890
Psychiatry	7,146	7,104	7,059	7,094	7,127
Rehab	4,653	4,583	4,524	4,526	4,528
Pediatrics	200	247	293	343	393
Newborn/Neonates	6,142	6,081	6,037	6,078	6,113
Grand Total	66,052	65,140	64,302	64,448	64,647

Fiscal year is October 1 – September 30.
Project start expected on April 1, 2016.

* Provide the number of patient days for each service listed (Medical/Surgical, Maternity, Psychiatric, Rehabilitation, and Pediatric).

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary. In a footnote, identify the period covered by the Applicant's fiscal year FY (e.g. July 1-June 30, calendar year, etc.).

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

Response:

Between FY 2012 and FY 2014, L+MH experienced inpatient volume declines commensurate with decreases in inpatient demand in the L+MH service area and statewide, which were, in part, due to the following factors:

- Implementation of CMS' two-midnight rule (and resultant shift from inpatient to observation status);
- More stringent requirements for inpatient status from other payors;
- Advances in technology shifting certain procedures from inpatient to outpatient setting or expanding use of non-surgical options to treat disease; and
- Increased prevalence of high deductible health plans and the weak economy which led to delays in care for some patients.

Estimated inpatient volume for FY 2015 suggests a slight increase in inpatient volume overall due to continued impact of Westerly's closure of its maternity service, and program development initiatives at L+MH in the cardiac, oncology, and surgical realm.

d. Provide a detailed explanation of all assumptions used in the derivation/ calculation of

the projected volume.

Response:
Please refer to the response to question 23 in the main CON application.

3. Clear Public Need

a. Is the proposal being submitted due to provisions of the Federal Sherman Antitrust Act and Conn. Gen Stat. §35-24 et seq. statutes? Explain in detail.

Response:
The proposal is not being submitted due to provisions of the Federal Sherman Antitrust Act. The proposed affiliation CON is being submitted in accordance with OHCA Certificate of Need requirements; however, the parties also intend to comply with all applicable federal and state antitrust laws and regulations. The transaction did require a Hart-Scott-Rodino filing with the Federal Trade Commission under 18 USC S. 18a, and that filing was made on August 7, 2015. The Connecticut Attorney General also received a courtesy copy of that filing on August 10, 2015.

On September 8, 2015, the FTC informed YNHHSC and L+M that it would allow the waiting period outlined by the Hart-Scott-Rodino Antitrust Improvements Act to expire without further investigating the transaction.

b. Is the proposal being submitted due to provisions of the Patient Protection and Affordable Care Act (PPACA)? Explain in detail.

Response:
The proposed affiliation is consistent with the PPACA in that the parties will strive to enhance quality, achieve efficiencies, avoid duplication of services and provide evidence-based health care services.

4. Supplemental Questions

a. How will this proposal affect the implementation plan developed to address priority health needs identified in the most recent Community Health Needs Assessment (CHNA)?

Response:
The proposal, as described in the application, will only strengthen L+M, and in particular, L+MH's commitment to deliver, on a local level, high-quality, cost-effective health care to the communities it serves. L+MH delivered over $22 million in free programs and services in 2014. This was accomplished through ensuring access to care for more than 34,000 people with a benefit value of $19 million, educating almost 4,000 future health care providers with a benefit value of $1.1 million and serving almost 10,000 people through health promotion programs with a benefit value of almost $2.3 million.

L+MH will continue to dedicate and commit resources to fund and to support community benefit programs and make reinvestments in the communities that L+MH serves. By

way of example, based upon triennial community needs assessments in the past or otherwise in furtherance of L+MH's charitable mission, L+MH implements community health improvement programs and health care support services such as cardiac rehabilitation, pediatric weight management, support for cancer patients in the form of transportation and nutrition assessment and planning, intervention on pediatric asthma and transportation for indigent patients. Programs promote a healthy community and include those that go beyond the walls of the hospital to reach into the community and address identified needs. L+MH hosts several grant-funded programs which include HIV outreach, Nurturing Families Network, Healthy Start, and the Connecticut Early Detection and Prevention Program which contribute to health education, and improved access to care. Students from a wide range of disciplines are provided with training and internship opportunities. L+MH coordinates a paramedics services program, facilitates research studies to further knowledge in relation to cancer, and supports through direct contributions a range of community organizations. L+MH serves as a safety net provider to the community's at risk populations. Decisions regarding community needs will continue to be made on a local level and thus, the proposal will not change the autonomy that L+MH currently has to identify, understand and prioritize the needs and its commitment to the communities it serves.

b. Describe any changes to the Hospital's current charity care, uncompensated care, financial assistance policies and procedures and bed funds that will result from the proposal.

Response:
See response 8(f) in main application.

c. Describe any plans to work with other community providers, such as federally qualified health centers or community health centers, to provide specialty care to patients or offer low cost programs tailored to the uninsured or underinsured.

Response:
L+M regularly works with community stakeholders, including the Community Health Center of New London and United Community and Family Services on collaborations to improve the health of the region, meet unmet health needs, identify vulnerable populations at-risk, promote health, prevent disease, and encourage healthy lifestyles without duplicating efforts among community providers and stakeholders. Most of these initiatives are tailored to the uninsured or underinsured. For example, L+M collaborates with: (i) local community based shelters and behavioral health providers to meet the needs of the homeless, including enrolling clients in entitlement programs, connecting them to primary care and community health services, finding permanent or transitional housing, and identifying training and employment opportunities as appropriate; (ii) Child and Family Agency of SE CT to address childhood obesity by providing coordinated instruction on diet, nutrition, and exercise and providing personalized individual and group support; (iii) Visiting Nurse Association of Southeastern Connecticut and primary care providers to provide whole person, coordinated care across all settings with an emphasis on quality and safety; (iv) Community Health Center, United Community and Family Services and other community providers to provide free early detection cancer screening services; and (v) Community medical providers and local public health entities, such as Ledge Light Health District and the Asthma Action Partnership to assist providers in better recognizing and diagnosing asthma, learning to better classify asthma severity and developing treatment plans for more effective and efficient care for children

with asthma. These collaborations with community providers described above and others will continue should the proposal be approved.

d. Explain in detail the capital projects that are deemed top priorities by the Applicants.

Response:
Please refer to the responses to questions 9(c) and 15 in the main application for the priorities of L+M. L+M (which includes L+MH) and YNHHSC will be reviewing additional capital project needs and will finalize the priorities within the first several months post-closing.

e. Explain in detail the service improvements that are deemed top priorities by the Applicants.

Response:
The applicants will engage in an ongoing and deliberate strategic planning process that will be focused upon enhancing the quality and breadth of clinical services that are mutually identified as needed by the L+M community. The applicants are committed to sustained level of community benefit programs relevant to the L+MH triennial community needs assessments.

f. Describe any anticipated changes as a result of this proposal to existing payer contracts (e.g., Medicare, Medicaid or commercial payers).

Response:
There are no anticipated changes to existing payer contracts as a result of this proposal. The YNHHS managed care department negotiates payer contracts for each individual hospital separately, with fee schedules that are specific to each hospital.

g. Explain in detail how the proposal will address any existing debt and/or pension obligations.

Response:
Existing debt and/or pension obligations of L+M will remain unchanged as a result of this proposal.

h. Describe how the quality of care will be maintained with this proposal.

Response:
Please refer to the response to question 9(a) in the main CON application.

L+M will have access to YNHHS's quality experts and resources and rich data analysis. As a result, L+M anticipates that with these added resources, providers will be able to enhance the quality of care they provide.

i. For all Applicants, provide copies of all Centers for Medicare & Medicaid Services (CMS) statement of deficiencies and corrective action plans for the two most recently completed federal fiscal years.

Response:
L+MH has not been surveyed by CMS in the most recently completed fiscal years (FY

2013 or FY 2014).

j. Provide a copy of and describe any changes to any of the following policies and procedures as a result of this proposal:

i. hospital collection policies (including charity care and bad debt);

Response:
Please refer to the response to question 8(f) in the main CON application for a description of charity care and bad debt policies.

Should this proposal be approved, L+M will adopt YNHHSC's charity care policies.

ii. annual or periodic review and/or revision to the hospital's pricing structure (charge master or price master); and

Response:
No changes are planned to L+MH's chargemaster.

iii. the annual or periodic market rate assessment of the hospital.

Response:
Not applicable as per OHCA.

k. Provide monthly financial reports that include statistics for the current month, year-to-date and comparable month from the previous year for the following:

Monthly Financial Measurement/Indicators

A.	**Operating Performance:**
	Operating Margin
	Non-Operating Margin
	Total Margin
	Bad Debt as % of Gross Revenue
B.	**Liquidity:**
	Current Ratio
	Days Cash on Hand
	Days in Net Accounts Receivables
	Average Payment Period
C.	**Leverage and Capital Structure:**
	Long-term Debt to Equity
	Long-term Debt to Capitalization
	Unrestricted Cash to Debt
	Times Interest Earned Ratio
	Debt Service Coverage Ratio
	Equity Financing Ratio
D.	**Additional Statistics**
	Income from Operations
	Revenue Over/(Under) Expense

EBITDA
Patient Cash Collected
Cash and Cash Equivalents
Net Working Capital
Unrestricted Assets
Credit Ratings (S&P, Fitch, Moody's)

Response:
Please refer to Attachment B for monthly financial reports for L+MH.

l. For the most recent tax year, provide a copy of the Hospital's IRS Form 990 (you may reference the filing if previously submitted to OHCA). With respect to the amounts listed on each line item within Part 1, Section 7 of Schedule H (Financial Assistance and Certain Other Community Benefits at Cost) and Part II of Schedule H (Community Building Activities), provide a projected amount for each line item for the first three years following the change in ownership and describe the hospital's future commitment to programmatic and financial support for the community benefit programs and building activities listed on Schedule H.

Response:
L+MH previously filed its 2014 IRS Form 990. Projected amounts for the items listed within Part 1, Section 7 of Schedule H and Part II of Schedule H are listed below for the first three years following the affiliation. These figures represent estimates and are subject to change.

L+MH's future commitment to programmatic and financial support for the community benefit programs and building activities listed on Schedule H is expected to remain at the same level as previous years. Approximately $22 million dollars of net community benefit expense are provided each year.

Schedule 7: Part 1, Section 7		**Year 1 ($)**	**Year 2 ($)**	**Year 3 ($)**
Financial Assistance & Means-Tested Government Programs	a Financial Assistance at cost	1,000,000	1,000,000	1,000,000
	b Medicaid	16,000,000	16,000,000	16,000,000
	c Other means-tested gov't programs	500,000	500,000	500,000
d Total Financial Assistance & Mean-Tested Gov't Programs		**17,500,000**	**17,500,000**	**17,500,000**
Other Benefits	e Community health improvement	2,000,000	2,000,000	2,000,000
	f Health professions education	1,000,000	1,000,000	1,000,000
	g Subsidized health	2,000,000	2,000,000	2,000,000

Schedule 7: Part 1, Section 7		Year 1 ($)	Year 2 ($)	Year 3 ($)
	services			
	h Research	500,000	500,000	500,000
	i Cash and in-kind contributions	40,000	40,000	40,000
j Total Other Benefits		5,540,000	5,540,000	5,540,000
Grand Total		23,040,000	23,040,000	23,040,000

Schedule 7: Part 2		Year 1 ($)	Year 2 ($)	Year 3 ($)
Community Building Activities	1 Physical improvements and housing			
	2 Economic development			
	3 Community support	42,000	42,000	42,000
	4 Environmental improvements			
	5 Leadership development and training for community			
	6 Coalition building	7,000	7,000	7,000
	7 Community health improvement			
	8 Workforce development			
	9 Other			
10 Total		49,000	49,000	49,000
Grand Total				

m. Discuss in detail how the proposal will impact the hospital's negotiating position with vendors and/or payers?

Response:
With respect to payers, please refer to the response to question 3(f). With respect to vendors, the parties anticipate that the YNHHS supply chain management department will be able to obtain volume discounts and reduce supply and other costs for L+M overall.

n. If an improved negotiating position is anticipated, quantify the tangible savings for the health care consumer.

Response:
Although an improved negotiating position is anticipated for L+M with respect to supply and other costs via YNHHS supply chain management services, it is difficult to quantify tangible savings for the health care consumer. However, L+M believes that if it does not affiliate with YNHHSC, its costs will likely significantly increase as it responds to the demands of the health care marketplace.

o. Provide details of plans to ensure that future health care services provided, in relation to the proposal, adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality and help eliminate health care disparities in the projected service area. (For more details on CLAS standards can be found at http://minorityhealth.hhs.gov/.

Response:

L+MH offers a number of programs which address the National Standards on Culturally and Linguistically Appropriate Services (CLAS). L+MH takes steps to ensure that persons with Limited English Proficiency (LEP) or are deaf/hard of hearing have access to, and equal opportunity to participate in, L+MH's services, activities, programs and other benefits. L+MH's goal is to ensure meaningful communication with LEP, deaf and hard of hearing patients, and any authorized representatives involved in their medical conditions and treatment. This includes communication of information contained in vital documents.

L+MH offers language assistive services which can be accessed by any employee when needed for interacting with a patient or family. The primary resource is the AT&T Language Line which provides quick access to a large variety of languages via telephone or video remote interpreting. Linguistica is another service provider used if a language or dialect is not offered by Language Line. In addition, Lifebridge and Linguistica provide on-site interpreters for LEP, deaf and hard of hearing patients or family members. L+MH also offers Assistive Listening Devices and TTY/TDD equipment.

Linguistica provides document translation services. This resource is used as needed to prepare patient information and education materials as well as translate medical records that may be written in a foreign language. All interpreters, translators and other aids are provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

In an effort to promote L+MH's commitment to cultural awareness and embracing diversity, staff receive annual education to review services and equipment available for LEP, deaf and hard of hearing patients and families.

In addition to the programs and services noted above, L+MH staff are provided with the following programs and information related to diversity training:

- Diversity and cultural awareness is discussed at orientation, which every employee must complete upon hire.
- A diversity handbook is also provided to every new employee at orientation.
- L+MH's employee intranet site includes a link to "Cultural Briefs" which is a reference guide for cultural and religious-based beliefs. All employees can access and it provides specific beliefs that can impact patient's and family's preferences for care, how care is delivered, etc. It also includes information on non-verbal communication, cultural aspects of the birthing experience, cultural aspects of pain, and cultural and religious aspects of dietary practices.

5. For-profit Purchasers Only (Conn. Gen. Stat. § 19a-486d)

a. Describe in detail how the surrounding community will be assured of continued access to high quality and affordable health care after accounting for any proposed change impacting hospital staffing.

b. Describe in detail the purchasers commitment to provide health care to the uninsured and the underinsured following the hospital acquisition.

c. In a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or a related entity, what safeguards will be created to avoid a conflict of interest in regard to patient referral?

ATTACHMENT I

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

BOARD OF TRUSTEES

RESOLUTIONS RELATING TO AFFILIATION BETWEEN
YALE NEW HAVEN HEALTH SYSTEM AND L+M HEALTHCARE

July 10, 2015

I. AFFILIATION AGREEMENT BETWEEN HSC AND LAWRENCE + MEMORIAL CORPORATION

WHEREAS, Yale-New Haven Health Services Corporation ("***HSC***") is the parent of the health care delivery system known as the Yale New Haven Health System (the "***System***"); and

WHEREAS, the System includes various affiliates, including but not limited to Yale-New Haven Hospital, Inc. ("***YNHH***"), Bridgeport Hospital ("***BH***"), Greenwich Hospital ("***GH***"), and Northeast Medical Group, Inc. ("***NEMG***"); and

WHEREAS, Lawrence + Memorial Corporation *("**L+M**")* is the parent of the health care delivery system known as L+M Healthcare (the *"**L+M System**"*); and

WHEREAS, the L+M System includes various affiliates, including but not limited to Lawrence & Memorial Hospital, Inc. (*"**L+M Hospital**"*), LMW Healthcare, Inc. d/b/a Westerly Hospital ("***WH***"), and L&M Physician Association, Inc. d/b/a L+M Medical Group ("***LMMG***"); and

WHEREAS, the current members of L+M are individuals who reside or work in or around the areas served by L+M Hospital and WH and who have an interest in furthering the purposes of L+M and the L+M System, plus certain *ex officio* individual members; and

WHEREAS, the L+M System shares the System's mission and values, has a strong focus on service excellence, is a lower cost provider committed to its community, has a vibrant outpatient and primary care strategy and strong management, and provides high quality, high value, patient-centered care; and

WHEREAS, the L+M System shares the System's commitment of continuing to serve uninsured and underinsured patients, and of continuing to provide robust community benefit and uncompensated care; and

WHEREAS, the L+M System, with the support of its members, and HSC seek an affiliation that will drive broader efficiencies while increasing high quality outcomes, address

increasing consumer demands for integrated collaborative care, manage risk more effectively, enhance the population health infrastructure, improve the efficient access to capital, and maintain and grow provider diversity, consumer choice and access to quality and affordable care; and

WHEREAS, the Board of Trustees has determined, after due consideration of alternative proposals or offers in light of maintaining provider diversity, consumer choice and access to quality and affordable care, that it is in the best interest of HSC to enter into an Affiliation Agreement with L+M, a detailed summary of which is set forth in the Summary of Principle Terms attached hereto as *Exhibit A* and a current draft of which is attached hereto as *Exhibit B* (the "***Affiliation Agreement***").

II. HSC TO BECOME THE SOLE CORPORATE MEMBER OF LAWRENCE + MEMORIAL CORPORATION

WHEREAS, in furtherance of the affiliation contemplated by the Affiliation Agreement, HSC will become the sole corporate member of L+M, replacing the community and *ex officio* individuals who are currently L+M's members; and

WHEREAS, the Board of Trustees has reviewed a proposed Amended and Restated Certificate of Incorporation and Bylaws of HSC, attached hereto as *Exhibit C* and *Exhibit D*, respectively, revised to incorporate L+M into the System's governance framework; and

WHEREAS, the Board of Trustees has reviewed the proposed Amended and Restated Certificate of Incorporation and Bylaws of L+M, attached hereto as *Exhibit E*, revised to incorporate the L+M System into the System's governance framework, and which will be proposed for approval and adoption by L+M on or around the date of these Resolutions; and

WHEREAS, the Board of Trustees has determined that it is in the best interest of HSC to become the sole corporate member of L+M.

III. MERGER OF LMMG WITH AND INTO NEMG

WHEREAS, LMMG and NEMG are non-stock, tax-exempt medical foundations organized pursuant to the Connecticut Medical Foundations Law; and

WHEREAS, LMMG and NEMG share a mission to promote a high quality of medical care and other services for the benefit of all persons in the communities each serves; and

WHEREAS, pursuant to the Connecticut Medical Foundations Law, a health system may operate only a single affiliated medical foundation; and

WHEREAS, in accordance with NEMG's Bylaws, HSC approval is required for NEMG's merger with another entity; and

WHEREAS, in furtherance of the affiliation contemplated by the Affiliation Agreement, the Board of Trustees has determined that it is in the best interest of HSC and NEMG for NEMG to execute and implement the Agreement and Plan of Merger attached hereto as *Exhibit F*, following which NEMG remains the surviving corporation and LMMG shall cease to exist; and

WHEREAS, in accordance with NEMG's Bylaws, HSC approval is required for the amendment and restatement of NEMG's Certificate of Incorporation and Bylaws; and

WHEREAS, in furtherance of the Affiliation Agreement and of the merger of LMMG with and into NEMG, the Board of Trustees has reviewed a proposed Amended and Restated Certificate of Incorporation and Bylaws attached hereto as *Exhibit G* and *Exhibit H*, respectively.

NOW, THEREFORE, BE IT RESOLVED AS FOLLOWS:

Section 1. The Board of Trustees hereby authorizes HSC to enter into the Affiliation Agreement substantially containing the material terms set forth in the Summary of Principle Terms attached hereto as *Exhibit A* and in the draft Affiliation Agreement attached hereto as *Exhibit B* with such changes as may be approved by the HSC President and Chief Executive Officer, the HSC Executive Vice President Corporate and Financial Services and the HSC Senior Vice President and General Counsel.

Section 2. The Board of Trustees hereby authorizes HSC to become the sole corporate member of L+M and, in connection therewith, hereby authorizes and approves HSC's adoption of the Amended and Restated HSC Certificate of Incorporation and Bylaws substantially in the form attached hereto as *Exhibit C* and *Exhibit D*, respectively.

Section 3. The Board of Trustees hereby authorizes the merger of LMMG with and into NEMG pursuant to, and the execution by NEMG of, the Agreement and Plan of Merger substantially in the form attached hereto as *Exhibit F*, and the Board of Trustees hereby further authorizes NEMG's adoption of the Amended and Restated Certificate of Incorporation and Bylaws substantially in the form attached hereto as *Exhibit G* and *Exhibit H*, respectively.

Section 4. The HSC President and Chief Executive Officer, the HSC Executive Vice President Corporate and Financial Services, and the HSC Senior Vice President and General Counsel, Executive Vice President/Chief Strategy Officer, and their designees (the "***Authorized Officers***") are, and each of them hereby is, authorized and directed to do the following as related to the transactions contemplated by these resolutions: (a) negotiate, conclude terms with, execute and deliver, for and on behalf of HSC, any agreements, documents or instruments,

including any amendments to such documents that such Authorized Officer determines are appropriate to accomplish the intent and purposes expressed in these resolutions, including without limitation a definitive Affiliation Agreement; (b) approve the preparation, execution and distribution of disclosures and disclosure documents consistent with and pursuant to the terms of an Affiliation Agreement; (c) approve the preparation and execution of any and all notices and submissions, oral and written, including but not limited to documents, analyses, financial assessments, fair market value determinations, and the like, necessary to seek and obtain all government and regulatory approvals required to accomplish the intent and purposes expressed in these resolutions, including without limitation HSC becoming the sole corporate member of L+M and the merger of LMMG with and into NEMG; and (d) to perform and take any actions that such Authorized Officer determines are appropriate to accomplish the intent and purposes expressed in these resolutions and a definitive Affiliation Agreement.

Section 5. Any and all actions previously taken by the Authorized Officers and the officers or employees of HSC or any of its corporate affiliates in connection with the foregoing resolution are hereby ratified, approved and confirmed in all respects.

CERTIFICATION

The undersigned secretary of Yale-New Haven Health Services Corporation hereby certifies that the foregoing resolution was adopted by the Board of Trustees and remains in full force and effect without amendment as of the date hereof.

Adopted this 10th day of July, 2015

V Calarco

Vincent A. Calarco
Secretary

LAWRENCE + MEMORIAL CORPORATION
(d/b/a L+M Healthcare)

RESOLUTIONS OF BOARD OF DIRECTORS

Adopted on July 9, 2015

WHEREAS, the Board of Directors of Lawrence + Memorial Corporation ("L+M") previously established an ad hoc Affiliation Oversight Committee (the "Committee"), for the purpose of exploring, evaluating and advising the Board regarding a potential strategic affiliation with Yale New Haven Health Services Corporation ("YNHHSC"); and

WHEREAS, the Committee has been working with a consultant and with the management of L+M in evaluating such an affiliation; and

WHEREAS, the Committee has concluded that a strategic affiliation with YNHHSC is in the best interests of L+M, its patients, its employees and the community L+M serves;

WHEREAS, the Committee has recommended to the L+M Board of Directors (the "Board") that L+M proceed with an affiliation with YNHHSC, and has presented to the Board a proposed Affiliation Agreement between L+M and YNHHSC (the "Affiliation Agreement"), pursuant to which YNHHSC will become the sole member of L+M (the "Yale New Haven Affiliation") in a manner that will reaffirm L+M's commitment to the delivery of high-quality, effective health care to the communities it serves, and to supporting, enhancing and sustaining the ability of the affiliates of L+M, within the framework of and as members of the Yale New Haven Health System, to provide high-quality, cost-effective care that will drive broader efficiencies while increasing high quality outcomes, address increasing consumer demands for integrated collaborative care, manage risk more effectively, enhance the population health infrastructure, improve the efficient access to capital, and maintain and grow provider diversity, consumer choice and access to quality and affordable care; and

WHEREAS, the Board deems it to be in the best interest of L+M, and in furtherance of its charitable and exempt purposes, to enter into the Affiliation Agreement, and to proceed with the Yale New Haven Affiliation.

NOW, THEREFORE, it is hereby

RESOLVED, that L+M is authorized to enter into the Affiliation Agreement and all such documents, instruments, agreements, and certificates referenced therein or required under the terms thereof; and further

RESOLVED, that the President & Chief Executive Officer, or any other appropriate officer of L+M (each, an "Authorized Officer"), is hereby authorized and directed, in the name and on behalf of L+M, to execute and deliver the Affiliation Agreement, substantially in the form presented to the Board, with such changes thereto as the Authorized Officer approves, such

approval to be conclusively evidenced by the Authorized Officer's execution and delivery of the Affiliation Agreement; and further

RESOLVED, that any Authorized Officer is hereby authorized and empowered, in the name and on behalf of L+M, to execute and deliver any and all documents, instruments, agreements and certificates as such Authorized Officer shall deem necessary or appropriate in connection with the Yale New Haven Affiliation and the transactions contemplated by the Affiliation Agreement, all in such form as an Authorized Officer shall approve, such approval to be conclusively evidenced by the Authorized Officer's execution and delivery thereof; and further

RESOLVED, that any Authorized Officer is hereby, authorized and empowered, in the name and on behalf of L+M, to take or cause to be taken any and all acts necessary or appropriate to effectuate the Yale New Haven Affiliation and the transactions contemplated by the Affiliation Agreement, including, without limitation, obtaining the approval of the State of Connecticut Office of Health Care Access, the Rhode Island Department of Health, and the Rhode Island Attorney General, the preparation and filing of a notification under the Hart-Scott-Rodino Antitrust Improvements Act, and other required regulatory approvals and licenses, and the execution, delivery and/or filing of all documents and the payment of all fees contemplated by or required in connection with the Affiliation Agreement; and further

RESOLVED, that, subject to and effective upon the closing of the Yale New Haven Affiliation as contemplated by the Affiliation Agreement (the "Closing"), the Board hereby approves an amendment to L+M's Certificate of Incorporation and Bylaws, each in the form attached as an exhibit to the Affiliation Agreement, to provide, among other things, that Yale New Haven will become the sole member of L+M; and further

RESOLVED, that, subject to and effective upon the Closing, the Board hereby approves amendments to the Certificate of Incorporation and to the Bylaws of each of Lawrence + Memorial Hospital, Inc., LMW Healthcare, Inc. d/b/a Westerly Hospital, and Visiting Nurse Association of Southeastern Connecticut, Inc. (each a "Subsidiary" and, collectively, the "Subsidiaries"), which documents currently require the approval of L+M as the sole member of each such Subsidiary, all substantially in the forms attached as exhibits to the Affiliation Agreement, with such changes thereto as may be approved by the Authorized Officers of L+M or by the board of directors of any of the Subsidiaries, as the case may be, prior to the Closing; and further

RESOLVED, that, subject to and effective upon the Closing, the Board hereby approves the merger of L+M's medical foundation, L&M Physician Association, Inc. ("LMPA") with and into YNHHSC's medical foundation, Northeast Medical Group, Inc. ("NEMG"), upon the terms and conditions contained in the Agreement and Plan of Merger (the "Plan") attached as an exhibit to the Affiliation Agreement, with NEMG as the surviving corporation in the merger (the "Merger"); and further

RESOLVED, that the Plan and the Merger are hereby approved in all respects; and further

RESOLVED, that the board of directors and the officers of LMPA are hereby authorized and empowered to take or cause to be taken any and all such actions as may be deemed necessary or appropriate to carry out the Plan and consummate the Merger, effective upon the Closing; and further

RESOLVED, that the Authorized Officers be, and each of them hereby is, authorized, empowered and directed in the name and on behalf of L+M to take such other and further action as they or any one of them shall deem necessary, appropriate or desirable to carry out the purpose and intent of the foregoing resolutions and to effectuate the transactions contemplated thereby; and further

RESOLVED, that the Authorized Officers be, and each of them hereby is, authorized and directed to take or cause to be taken such further actions, and to execute and deliver such additional documents, certificates, notices or instruments, as they or any of them shall deem necessary to carry out the intent of the foregoing resolutions; and further

RESOLVED, that all actions heretofore taken by any of the Authorized Officers or any representative of L+M in furtherance of any of the foregoing resolutions and the transactions contemplated thereby are hereby approved, ratified and confirmed in all respects; and further

RESOLVED, that any Authorized Officer be, and hereby is, authorized to certify to YNHHSC that these resolutions have been duly adopted and that they are in conformity with the Certificate of Incorporation and the Bylaws of L+M.

LAWRENCE + MEMORIAL CORPORATION

ASSISTANT SECRETARY'S CERTIFICATE

The undersigned, as Assistant Secretary of LAWRENCE + MEMORIAL CORPORATION, a Connecticut nonstock corporation ("L+M"), does hereby certify that attached hereto is a true, correct and complete copies of the resolutions of L+M with respect to the affiliation with Yale New Haven Health Services Corporation, which resolutions were duly adopted by the Board of Directors of L+M at a meeting duly called and held on July 9, 2015. Each of such resolutions is in full force and effect on the date hereof and has not been amended, altered or repealed since the date of its adoption.

IN WITNESS WHEREOF, the undersigned has executed this Certificate as of this 1st day of October, 2015.

Maureen Anderson, Assistant Secretary

ATTACHMENT II

Internal Revenue Service

RECEIVED

JUL 30 1984

GENERAL ACCOUNTING

Department of the Treasury

Washington, DC 20224

Person to Contact: Stan Margolies
Telephone Number: (202) 566-4524

Refer Reply to:
OP:E:EO:R:5
Date: JUL 24 1984

Yale-New Haven Health
Services Corporation
789 Howard Ave.
New Haven, CT 06504

Employer Identification Number: 22-2529464
Key District: Brooklyn
Accounting Period Ending: September 30
Foundation Status Classification: 509(a)(3)

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.

We have further determined that you are not a private foundation within the meaning of Code section 509(a), because you are an organization described in the sections of the Code shown above.

If your sources of support, or your purposes, character, or method of operation change, please let your key district know so that office can consider the effect of the change on your exempt status and foundation status. Also, you should inform your key District Director of all changes in your name or address.

Unless specifically excepted, beginning January 1, 1984, you must pay taxes under the Federal Insurance Contributions Act (social security taxes) for each employee who is paid $100 or more in a calendar year. You are not required to pay tax under the Federal Unemployment Tax Act (FUTA).

Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, you are not automatically exempt from other federal excise taxes. If you have questions about excise, employment, or other federal taxes, contact your key District Director.

Donors may deduct contributions to you as provided in Code section 170. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522.

You are required to file Form 990, Return of Organization Exempt From Income Tax, only if your gross receipts each year are normally more than $25,000. (For tax years ending before December 31, 1982, organizations whose

gross receipts are not normally more than $10,000 are excused from filing Form 990.) For guidance in determining if your gross receipts are "normally" not more than the $25,000 limit, see the instructions for the Form 990. If a return is required, it must be filed by the 15th day of the fifth month after the end of your annual accounting period. There is a penalty of $10 a day, up to a maximum of $5,000, when a return is filed late unless there is reasonable cause for the delay.

You are not required to file federal income tax returns unless you are subject to the tax on unrelated business income under Code section 511. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter, we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513.

Please show your employer identification number on all returns you file and in all correspondence with the Internal Revenue Service.

We are informing your key District Director of this ruling. Because this letter could help resolve any questions about your exempt status and foundation status, you should keep it in your permanent records

If you have any questions about this ruling, please contact the person whose name and telephone number are shown in the heading of this letter. For other matters, including questions concerning reporting requirements, please contact your key District Director.

Sincerely yours,

J. E. Griffith

J. E. Griffith
Chief, Exempt Organizations

Internal Revenue Service

Department of the Treasury

Washington, DC 20224

Person to Contact:

Telephone Number:

Refer Reply to:
OP:E:EO:R:3-CCH
Date:
FEB 27 1985

Lawrence and Memorial Hospitals
365 Montauk Avenue
New London, CT 06320

Employer Identification Number: 06-0646704

Legend:

M = Lawrence and Memorial Hospitals
N = Lawrence and Memorial Corporation
O = Lawrence and Memorial Foundation, Inc.
P = L & M Health Care, Inc.
Q = L & M Systems, Inc.

Dear Applicant:

This letter is in reference to your joint request for rulings, with three other organizations, regarding a proposed corporate reorganization and proposed transactions relating thereto.

Currently, M, N, O, and P are organizations recognized as exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code. M is a public charity described in sections 170(b)(1)(A)(iii) and 509(a)(1) of the Code. N is a supporting organization described in section 509(a)(3). O is a public charity described in sections 170(b)(1)(A)(vi) and 509(a)(1). P is a public charity described in section 509(a)(2). Q is a for-profit organization.

M is a voluntary and not-for-profit hospital considering a reorganization. M's plan of reorganization is proposed in order to:

(1) assure M's continued leadership role in the community and continued capacity to provide patient care at a lower cost;

(2) facilitate compliance with governmental reporting requirements;

(3) segregate hospital assets from non-hospital assets so as to limit third party liability;

(4) separate regulated and non-regulated activities;

(5) isolate unrelated business activities from exempt activities;

(6) remove the management of non-hospital activities and assets from hsopital management;

(7) increase investment opportunitites;

(8) improve recruitment opportunities;

(9) increase flexibility in undertaking capital expenditure projects; and

(10) facilitate long range planning.

After the proposed reorganization, M, N, O, P, and Q will, as a group, conduct the activities formerly conducted by M alone.

In order to implement the proposed reorganization, M will amend its organizing instruments to designate N as its sole member. M will continue to operate the general acute care hospital and provide medical and hospital care. N was formed to benefit, perform the functions of, carry out the purposes of, and uphold, promote, and further the welfare, programs, and activities of M. All of N's members are currently persons who are members of M. In the future, a majority of N's trustees will also be trustees of M. N will function as the parent corporation in the new structure and will provide overall direction and control to M, O, P, and Q.

O was formed to assist M, N, and other section 501(c)(3) organizations associated with M and N, by soliciting and receiving contributions, grants, donations, bequests, and devises, and to make distributions to such organizations for proper purposes. P was formed, among other purposes, to operate and maintain programs directed toward improving the efficiency of utilization of health care facilities, including the education for health professionals, the public, nursing, and residency training, and delivery of health care services. P may assume certain of the outpatient medical care programs or community health education programs previously performed by M, as well as outpatient programs unexplored by M. N is the sole member of both O and P.

Q is a stock corporation with N as its sole shareholder. Q's primary purpose is to render health care related and other services which M has avoided since such services would constitute an unrelated business activity. It is not anticipated that M, N, O, or P will provide any services to Q, but if services are provided, an arm's-length fee will be charged.

M will transfer sufficient cash to provide working capital to N, O, and P at the consummation of the reorganization. Following the initial transfer, it is anticipated that there will be further cash transfers among the exempt organizations. M may also transfer philanthropic monies previously raised

by M to O on the condition that O hold these dollars in a separate, segregated fund that will be used solely for the benefit of M. After the reorganization, M, N, O, and P will share some assets, personnel, and services in an effort to reduce, through economies of scale, the overall cost of providing health care services. To the extent there are transactions between the exempt organizations and Q, such transactions will be conducted on an arm's-length basis and it is anticipated that the charges for goods or services provided in connection with such transactions would be at fair market value.

Section 501(c)(3) of the Code provides for the exemption from federal income tax of organizations that are organized and operated exclusively for charitable purposes.

Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations provides that the term "charitable" is used in section 501(c)(3) of the Code in its generally accepted legal sense. In the law of charity, the promotion of health is considered to be a charitable purpose.

Section 509(a)(1) of the Code provides that organizations described in section 170(b)(1)(A) (other than in clauses (vii) and (viii)) are excepted from classification as private foundations.

Section 170(b)(1)(A)(iii) of the Code, in part, describes an organization the principal purpose or functions of which are the providing of medical education or medical research, if the organization is a hospital.

Section 170(b)(1)(A)(vi) of the Code describes an organization which normally receives a substantial part of its support (exclusive of income received in the exercise or performance by such organization of its charitable, educational, or other purpose or function constituting the basis for its exemption under section 501(a)) from a governmental unit referred to in section 170(c)(1) or from direct or indirect contributions from the general public.

Section 1.170A-9(e)(6)(ii) of the regulations provides that unusual grants may be excluded from the calculation used to determine whether an organization is normally supported by direct or indirect contributions from the general public. Section 1.170A-9(e)(6)(iii) provides that all pertinent facts and circumstances will be taken into consideration to determine whether a particular contribution may be excluded.

Section 509(a)(2)(A) of the Code provides that an organization which normally receives more than one-third of its support from any combination of gifts, grants, contributions, or membership fees; and gross receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in an activity which is not an unrelated trade or business, is excepted from classification as a private foundation.

Lawrence and Memorial Hospitals

Section 509(a)(3) of the Code, in part, provides for exception from classification as private foundations for organizations organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of organizations described in section 509(a)(1), and which are operated, supervised, or controlled by or in connection with one or more organizations described in section 509(a)(1).

Section 511(a) of the Code imposes a tax on the unrelated business taxable income of organizations described in section 501(c).

Section 512(a)(1) of the Code defines the term "unrelated business taxable income" as the gross income derived by any organization from any unrelated trade or business regularly carried on by it, less certain allowable deductions and modifications. Section 512(b)(1) provides that dividends are excluded from this definition.

Section 513(a) of the Code defines the term "unrelated trade or business" as any trade or business the conduct of which is not substantially related (aside from the need of such organization for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of the functions constituting the basis for its exemption.

Section 1.513-1(d)(2) of the regulations provides that trade or business is "related" to exempt purposes, in the relevant sense, only where the conduct of the business activities has causal relationship to the achievement of exempt purposes; and it is "substantially related" only if the causal relationship is a substantial one. The regulation continues that for the conduct of trade of business from which a particular amount of gross income is derived to be substantially related to purposes for which exemption is granted, the production or distribution of the goods or the performance of the services from which the gross income is derived must contribute importantly to the accomplishment of those purposes.

Section 514 of the Code provides for the taxation under section 512 of income from debt-financed property. Section 514(b)(1)(A)(i), however, provides that the definition of debt-financed property does not include any property substantially all the use of which is substantially related to the exercise or performance by such organization of its charitable purpose constituting the basis for its exemption under section 501.

Subsequent to the proposed reorganization and transfer of activities and funds, M, N, O, and P will operate exclusively for the charitable purpose of promotion of health within the meaning of section 501(c)(3) of the Code. The transfers and sharing of assets, personnel, and services described, in themselves, will have no adverse effect on a determination of exempt status or exception from private foundation status.

Further, the proposed transfers and sharing of assets, personnel, and services do not involve the regular carrying on of unrelated trade or business within the meaning of section 513 of the Code, and do not involve the use of assets other than substantially in furtherance of exempt purposes within the meaning of section 514.

Based on the above, we rule as follows:

(1) M, after its amendments of its organizing instruments and the proposed reorganization, will continue to qualify as an organization described in sections 501(c)(3), 509(a)(1), and 170(b)(1)(A)(iii) of the Code.

(2) N, after the proposed reorganization, will continue to qualify as an organization described in sections 501(c)(3) and 509(a)(3) of the Code.

(3) O, after the proposed reorganization, will continue to qualify as an organization described in section 501(c)(3) of the Code and, provided the requisite public support is received, sections 509(a)(1) and 170(b)(1)(A)(vi).

(4) P, after the proposed reorganization, will continue to qualify as an organization described in section 501(c)(3) of the Code and, provided it meets the support tests thereunder, section 509(a)(2).

(5) N's ownership of 100% of the issued and outstanding voting stock of Q and N's receipt of dividends from Q will have no adverse effect on N's status under sections 501(c)(3) and 509(a)(3) of the Code, and the taxable income of Q will not be construed to be unrelated business income to N.

(6) The proposed transfers of cash and other assets and the sharing of personnel, services, facilities, and expenses by and between M, N, O, and P will not:

(a) jeopardize the continued status of M, N, O, and P as organizations described in section 501(c)(3) of the Code;

(b) adversely affect the status of M, N, O, and P as organizations described in section 509(a); or

(c) give rise to unrelated business taxable income under sections 511-514 to M, N, O, or P.

(7) M's transfer of philanthropic monies to O will qualify as an unusual grant within the meaning of section 1.170A-9(e)(6)(ii) of the regulations and may be excluded from the calculation used to determine public support for purposes of section 170(b)(1)(A)(vi) of the Code.

(8) After the amendments to M's organizing instruments and the proposed reorganization, contributions to M, N, O, and P will continue to be deductible by donors as provided in section 170 of the Code.

These rulings are based on the understanding that there will be no material changes in the facts upon which they are based. Any such change should be reported to your key District Director. A copy of this ruling is being sent to your key District Director. Because it could help resolve questions concerning your federal income tax status, this ruling should be kept in your permanent records.

This ruling is directed only to the organization that requested it. Section 6110(j)(3) of the Code provides that it may not be used or cited as precedent.

Sincerely yours,

(Signed) J. E. Griffith

J. E. Griffith
Chief, Exempt Organizations
Rulings Branch

ATTACHMENT III

AFFILIATION AGREEMENT

BY AND BETWEEN

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

LAWRENCE + MEMORIAL CORPORATION

Execution Version

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

TABLE OF CONTENTS
(continued)

Page

Exhibits

Disclosure Schedules

Schedule 3.8	–	Subsequent Events
Schedule 3.10.2	–	Tax Deficiencies and Assessments
Schedule 3.10.6	–	Real Property Certiorari Proceedings
Schedule 3.10.14	–	L+M Non-Hospital Bonds
Schedule 3.12	–	Intellectual Property
Schedule 3.13	–	Transactions with Affiliates
Schedule 3.16.1	–	Collective Bargaining Matters
Schedule 3.16.2	–	Certain Labor-Related Claims
Schedule 3.16.4	–	Violation of Certain Agreements
Schedule 3.17.1	–	L+M Plans
Schedule 3.17.4	–	Benefits Triggered by Agreements
Schedule 3.26.1	–	Deficiencies Asserted by Governmental Authorities
Schedule 3.27	–	Consents and Approvals
Schedule 3.28.2	–	Cost Report Periods
Schedule 4.1.1	–	YNHHSC Subsidiaries
Schedule 4.8	–	Subsequent Events
Schedule 4.10.2	–	Tax Deficiencies and Assessments
Schedule 4.12	–	Intellectual Property
Schedule 4.16.1	–	Collective Bargaining Matters
Schedule 4.16.2	–	Certain Labor-Related Claims
Schedule 4.16.4	–	Violation of Certain Agreements
Schedule 4.26	–	Deficiencies Asserted by Governmental Authorities
Schedule 4.27	–	Consents and Approvals
Schedule 6.5	–	L+M Third Party Approvals
Schedule 7.5	–	YNHHSC Third Party Approvals

AFFILIATION AGREEMENT

This Affiliation Agreement (this "***Affiliation Agreement***") is entered into as of July 17, 2015 (the "***Effective Date***"), by and between Yale-New Haven Health Services Corporation ("***YNHHSC***") and Lawrence + Memorial Corporation ("***L+M***") and pursuant to which, on and subject to the terms and conditions hereof, YNHHSC shall become the sole member of L+M (the "***Affiliation***"). YNHHSC and L+M may be individually referred to herein as a "***Party***" or collectively referred to herein as the "***Parties***."

RECITALS

A. L+M. L+M is a Connecticut non-stock, tax-exempt corporation that is the sole member of its Subsidiaries that operate licensed acute care general hospitals, one in New London, Connecticut and one in Westerly, Rhode Island. L+M and the L+M Affiliates also provide other health care services for the benefit of the communities they serve.

B. YNHHSC. YNHHSC is a Connecticut non-stock, tax-exempt corporation that was organized in 1983 to provide support services to a nonprofit network of affiliated health care providers known, collectively, as the Yale New Haven Health System. YNHHSC also directs and implements certain programs and activities that assist its members in providing high quality, cost-effective health services for the benefit of the communities they serve. The mission of YNHHSC includes collaborating with Yale University to initiate, develop, and maintain educational programs for health care professionals and for the public.

C. System Support. The Parties believe that the Affiliation will provide L+M with benefits in leadership, efficiencies and growth. Efficiencies will result from economies of scale as they relate to information technology, finance, insurance, equipment, supplies and other administrative services. Growth will result from the coordination and implementation of clinical and health programs that are designed to improve the quality, cost-effectiveness and accessibility of health care and educational services in the communities served by L+M. The Affiliation will enable the L+M Affiliates to achieve their mission more effectively and to continue to serve their communities.

D. Shared Values. L+M shares YNHHSC's mission and values, has a strong focus on service excellence, is a lower cost provider committed to its community, has a vibrant outpatient and primary care strategy and strong management, and provides high quality, high value, patient-centered care. L+M shares YNHHSC's commitment of continuing to serve uninsured and underinsured patients, and of continuing to provide robust community benefit and uncompensated care. L+M, with the support of the L+M Subsidiaries, and YNHHSC seek an affiliation that will drive broader efficiencies while increasing high quality outcomes, address increasing consumer demands for integrated collaborative care, manage risk more effectively, enhance the population health infrastructure, improve the efficient access to capital, and maintain and grow provider diversity, consumer choice and access to quality and affordable care.

E. Furthering Mission. The Parties further believe that L+M will add to the strength of the Yale New Haven Health System by sharing its leadership, best practices and community-based services. The Affiliation also will (i) further the commitment of YNHHSC to support the delivery of high quality, cost-effective and accessible health care services in the region; and (ii)

allow both L+M and YNHHSC to further their charitable missions and shared vision for the changing health care marketplace.

F. Best Interests. For these reasons, the Parties believe that the Affiliation as set forth in this Affiliation Agreement is in the best interests of each Party.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE 1

INCORPORATION OF RECITALS; DEFINITIONS

1.1 Recitals. The recitals set forth above are incorporated herein and made a part hereof.

1.2 Definitions. All capitalized terms used in this Affiliation Agreement and not otherwise defined shall have the meanings set forth in Exhibit 1.

ARTICLE 2

TERMS OF AFFILIATION

2.1 Affiliation Structure. Effective as of the Closing Date, subject to the terms and conditions of this Affiliation Agreement, YNHHSC shall become the sole corporate member of L+M and the corporate governance provisions described in this Section 2.1 shall become effective.

2.1.1 Organization and Operation of L+M. The Certificate of Incorporation and Bylaws of L+M shall be amended to appoint YNHHSC as the sole corporate member of L+M. As the sole member, YNHHSC will have certain retained and reserved powers consistent with the structure established for membership in the YNHHSC Obligated Group and will be accorded the direct authority, as the sole member of and on behalf of L+M as the sole member of the L+M Subsidiaries, to exercise with respect to the L+M Subsidiaries the same retained and reserved powers as are accorded to YNHHSC as the sole member of L+M, all as described in more detail in the L+M Amended Certificate of Incorporation and the L+M Amended Bylaws (each as defined below). The Amended and Restated Certificate of Incorporation of L+M shall, as of the Closing Date, be in the form attached as Exhibit 2.1.1(A) (the "***L+M Amended Certificate of Incorporation***"), and the Amended and Restated Bylaws of L+M shall, as of the Closing Date, be in the form attached as Exhibit 2.1.1(B) (the "***L+M Amended Bylaws***").

2.1.2 L+M Governance. Effective as of the Closing, the Parties agree that the individuals serving on the Board of Trustees of L+M as of the Closing Date shall remain on the Board of Trustees of L+M for the remainder of their respective terms, subject to the L+M Amended Bylaws, and YNHHSC shall appoint an additional member of the Board of Trustees of L+M in accordance with the L+M Amended Bylaws. Thereafter, trustees shall be elected to the Board of Trustees of L+M as set forth in the L+M Amended Bylaws.

2.1.3 Organization and Operation of YNHHSC. As of the Closing Date, the Certificate of Incorporation of YNHHSC shall be amended to include L+M as an organization that YNHHSC supports as set forth in the Amended and Restated Certificate of Incorporation of YNHHSC attached as Exhibit 2.1.3(A) (the "***YNHHSC Amended Certificate of Incorporation***"). As of the Closing Date and through at least the sixth anniversary of the Closing Date, the person who serves from time to time as the Chair of the Board of L+M shall be elected as a voting member of the Board of Trustees of YNHHSC, and such person shall be provided with the opportunity to be a member of the YNHHSC Nominating and Governance Committee; provided, however, that in the event that after the Closing Date and during the Initial Period YNHHSC becomes the sole member of a health care organization or health system of similar size, revenue and scope of clinical services to L+M of which YNHHSC is not the member as of the Effective Date and such new health care organization or health system is provided greater rights with respect to representation on the Board of Trustees of YNHHSC than L+M is afforded pursuant to this Affiliation Agreement, L+M shall be provided with the same or substantially similar rights with respect to representation on the Board of Trustees of YNHHSC as are afforded to such health care organization or health system. Other members of the Board of Trustees of L+M shall have opportunities to serve on other YNHHSC committees, as set forth in the Amended and Restated Bylaws of YNHHSC attached hereto as Exhibit 2.1.3(B) (the "***YNHHSC Amended Bylaws***").

2.1.4 Medical Foundation Matters. As of the Closing Date, (i) LMMG shall be merged with and into NEMG with NEMG surviving pursuant to an Agreement and Plan of Merger (the "***LMMG-NEMG Agreement and Plan of Merger***") in the form attached as Exhibit 2.1.4(A); (ii) two physician employees of NEMG who are members of the medical staff of LMH and/or LMW, nominated in accordance with the bylaws of NEMG, shall be elected to the board of trustees of NEMG; (iii) the president of L+M or his or her designee shall be elected to the board of trustees of NEMG; (iv) the bylaws of NEMG shall be amended and restated in the form of the Amended and Restated Bylaws of NEMG (the "***Amended and Restated Bylaws of NEMG***") attached hereto as Exhibit 2.1.4(B); (v) the certificate of incorporation of NEMG shall be amended and restated in the form of the Amended and Restated Certificate of Incorporation of NEMG (the "***Amended and Restated Certificate of Incorporation of NEMG***") attached hereto as Exhibit 2.1.4(C); and (vi) the contracts held by Sound Medical Associates, P.C. will be assigned to NEMG PLLC.

2.1.5 Other L+M Subsidiaries. As of the Closing Date, the following organizational documents of LMH, LMW and VNA of Southeastern Connecticut shall be amended and restated to provide to YNHHSC direct authority, as sole member of and on behalf of L+M as sole member of each such L+M Subsidiary, to exercise with respect to each such L+M Subsidiary the same retained and reserved powers as are provided to YNHHSC by the YNHHSC Subsidiaries that are members of the YNHHSC Obligated Group:

(a) the Certificate of Incorporation of LMH shall be amended and restated in the form of the LMH Amended Certificate of Incorporation attached as Exhibit 2.1.5(a)(1), and the Bylaws of

LMH shall be amended and restated in the form of the LMH Amended Bylaws attached as Exhibit 2.1.5.(a)(2);

(b) the Certificate of Incorporation of LMW shall be amended and restated in the form of the LMW Amended Certificate of Incorporation attached as Exhibit 2.1.5(b)(1), and the Bylaws of LMW (subject to any applicable LMW Acquisition-Related Obligations) shall be amended and restated in the form of the LMW Amended Bylaws attached as Exhibit 2.1.5.(b)(2); and

(c) the Certificate of Incorporation of VNA of Southeastern Connecticut shall be amended and restated in the form of the VNA of Southeastern Connecticut Amended Certificate of Incorporation attached as Exhibit 2.1.5(c)(1), and the Bylaws of VNA of Southeastern Connecticut shall be amended and restated in the form of the VNA of Southeastern Connecticut Amended Bylaws attached as Exhibit 2.1.5.(c)(2).

The LMH Amended Certificate of Incorporation, the LMW Amended Certificate of Incorporation and the VNA of Southeastern Connecticut Amended Certificate of Incorporation shall be referred to herein as the "***L+M Subsidiaries Amended Certificates of Incorporation***;" the LMH Amended Bylaws, the LMW Amended Bylaws and the VNA of Southeastern Connecticut Amended Bylaws shall be referred to herein as the "***L+M Subsidiaries Amended Bylaws***." From and after the Closing Date, any other L+M Subsidiaries shall be operated in conformity with the principles reflected in the L+M Subsidiaries Amended Certificates of Incorporation and the L+M Subsidiaries Amended Bylaws.

2.1.6 Support of VNA. After the Closing, YNHHSC shall support and maintain VNA of Southeastern Connecticut in a manner that is consistent with the objective of developing the capability of VNA of Southeastern Connecticut and the Yale New Haven Health System to effectively and efficiently engage in population health management and to manage the health of patients across the continuum of care.

2.1.7 Educational and Research Opportunities. After the Closing, YNHHSC and L+M shall jointly explore educational and research opportunities at the L+M Affiliates in light of their respective academic strengths and mission commitments.

2.1.8 Healthcare Facilities Commitments. After the Closing, YNHHSC and L+M shall develop and implement their strategic plans so as to maintain healthcare services facilities that support the evolving clinical service needs in the communities served by L+M. Moreover, the Parties' further agree:

(a) to work cooperatively to minimize travel for patients requiring healthcare services that can be appropriately provided by the L+M Affiliates and to encourage the return of patients originating within the communities served by the L+M Affiliates back to the originating facility and its physicians for local and specialty care

following treatment at any other Yale New Haven Health System facility;

(b) that LMW shall continue to provide the services and commitments it is obligated to provide under the LMW Acquisition-Related Obligations; and

(c) that the L+M Affiliates may maintain and preserve existing relationships with hospital-based physicians holding exclusive relationships with such L+M Affiliates, including, without limitation hospitalists, emergency physicians, pathologists, anesthesiologist, and radiologists.

2.1.9 Donor Restricted Funds. After the Closing, (i) L+M shall continue to honor any donor restrictions (temporary, permanent or as to purpose) on charitable donations made prior to the Closing Date, and (ii) any donor-imposed restrictions (temporary, permanent or as to purpose) on charitable donations made after the Closing Date shall also be honored by L+M.

2.1.10 Streamlining and Alignment of Board Structure of L+M Affiliates. During the Initial Period, and subject in the case of LMW to the LMW Acquisition-Related Obligations, YNHHSC and the L+M Affiliates shall work together to streamline and align the board structure of LMH, LMW and VNA of Southeastern Connecticut with the board structure of L+M.

2.2 Maintenance of Separate Corporate Existence. After giving effect to the Closing, the corporate existence, names, rights, privileges, immunities, powers, franchises, facilities and other licenses, duties and liabilities of L+M and each L+M Subsidiary, other than LMMG, shall be governed by the Board of Trustees of L+M or such L+M Subsidiary, as applicable, subject to the L+M Amended Certificate of Incorporation and the L+M Amended Bylaws or the L+M Subsidiaries Amended Certificates of Incorporation and L+M Subsidiaries Amended Bylaws, as applicable. Except as otherwise contemplated by this Agreement, the Affiliation shall not result in a transfer or conveyance as of the Closing Date of any asset or the assumption of any liability of either Party or any Affiliate of either Party.

2.3 Continuation of Missions and Dedication to Community Benefit. Without limiting the generality of the foregoing, each Party reaffirms its commitment to the delivery of high-quality, effective health care to the communities it serves, and to supporting, enhancing and sustaining the ability of the L+M Affiliates, within the framework of and as members of the Yale New Haven Health System, to provide high-quality, cost-effective care that will drive broader efficiencies while increasing high quality outcomes, address increasing consumer demands for integrated collaborative care, manage risk more effectively, enhance the population health infrastructure, improve the efficient access to capital, and maintain and grow provider diversity, consumer choice and access to quality and affordable care. In furtherance of the foregoing, during the five-year period after the Closing Date, L+M may dedicate and commit at least $11,000,000 ("***L+M Community Benefit Funds***") to support community benefit programs and reinvestments in the communities that the L+M Affiliates serve, including, without limitation, instituting, maintaining, preserving, and/or reinvesting in ambulance services, mental health

programs, smoking cessation programs, pediatric asthma programs, diabetes outreach, and/or services important to the community and/or at risk populations, in each case, as may be identified in a biennial community needs assessment or that otherwise are in furtherance of L+M's charitable mission; *provided, however*, that when calculating the amount of L+M Community Benefit Funds expended, such calculation shall not take into account Medicaid and/or Medicare shortfalls incurred by the L+M Affiliates. The annual amount of such L+M Community Benefit Funds shall be set forth in the L+M Affiliates' capital and operating budgets, as applicable, and so long as the L+M Community Benefit Funds set forth on such budgets are consistent with the requirements of this Section 2.3, the inclusion of such L+M Community Benefit Funds on a budget shall not be grounds for YNHHSC to disapprove, withhold, delay or condition its consent to such budgets.

2.4 Employment Matters.

2.4.1 L+M Chief Executive Officer. The president of L+M shall report to an executive officer of YNHHSC designated by the President and Chief Executive Officer of YNHHSC and to the Board of Trustees of L+M.

2.4.2 Other Employment Matters. It is the Parties' intent to minimize the impact of the Affiliation on the employees of LMH, LMW, LMMG and VNA of Southeastern Connecticut (each an "***Employee***"). In furtherance of the foregoing:

(a) In the event any Employee who is employed by an L+M Affiliate ceases such employment within ninety (90) days after the Closing and becomes employed by a different YNHHSC Affiliate within ninety (90) days after ceasing to be employed by such L+M Affiliate, the Parties agree that such Employee shall be subject to, and shall receive the benefits of, YNHHSC's applicable employment practices governing inter-affiliate transfers that are in effect at the time of the applicable employer change, as if such Employee's cessation of employment with such L+M Affiliate occurred immediately prior (and without interruption) to such Employee's employment with such other YNHHSC Affiliate. YNHHSC's current practice is to provide each Employee that becomes employed by a different YNHHSC Affiliate credit for his or her length of service at the applicable L+M Affiliate as of the date such employee ceases to be employed by such L+M Affiliate for purposes of seniority, benefits eligibility and vesting at the applicable YNHHSC Affiliate.

(b) From and after the Closing Date, all Employees of LMH, LMW and VNA of Southeastern Connecticut shall remain subject to, and shall receive the benefits of, the applicable L+M Affiliate's employment policies that are in effect from time to time. For the avoidance of doubt, from and after the Closing Date each L+M Affiliate shall be an affiliate of YNHHSC and shall have the benefit of YNHHSC's inter-affiliate employment transfer practices or policy as is in effect from time to time.

(c) All current collective bargaining agreements to which the L+M Affiliates are parties as of the Closing Date will remain in full force and effect in accordance with their terms.

2.5 YNHHSC System-wide Policies. At or after the Closing, on a mutually-agreed timetable that is no longer than twelve (12) months after Closing, L+M shall adopt and

implement YNHHSC's system-wide policies and procedures consistent with the adoption and implementation thereof by the members of the Yale New Haven Health System, including without limitation the YNHHSC Obligated Group Policies.

2.6 Maintenance of Medical Staff. The medical staffs of LMH and LMW shall remain constituted in accordance with their respective medical staff bylaws (the "***LMH Medical Staff Bylaws***" and the "***LMW Medical Staff Bylaws***", respectively) and such LMH Medical Staff Bylaws and LMW Medical Staff Bylaws shall be consistent with the requirements of Applicable Law and the applicable accrediting agencies.

2.7 YNHHSC Branding. From and after the Closing, subject to compliance with the LMW Acquisition-Related Obligations, YNHHSC and the L+M Affiliates shall work collaboratively to build the YNHHSC brand across the communities served by the L+M Affiliates and LMH, LMW and the other L+M Provider Subsidiaries shall use the YNHHSC brand in accordance with YNHHSC's graphic standards, guidelines and policies; *provided, however*, that the names "Lawrence + Memorial" and "Westerly" shall be changed only with the approval of the L+M Board of Trustees and the YNHHSC Board of Trustees. YNHHSC shall develop advertising, marketing and promotional policies for the Yale New Haven Health System. YNHHSC shall promote LMH and LMW and identify them as member hospitals of YNHHSC in the same manner as the other Hospital Members with a similar scope of services. In furtherance of the intent and purpose of this Section 2.7, promptly upon the Closing, YNHHSC shall commence a comprehensive rebranding campaign (the "***Rebranding Campaign***") to rebrand the L+M Affiliates as members of the Yale New Haven Health System. All costs and expenses associated with such Rebranding Campaign shall be the sole responsibility of YNHHSC.

2.8 Management Services. YNHHSC shall provide management support services to the L+M Affiliates subject to needs of all members of the Yale New Haven Health System and available financial resources. These services shall include, but not be limited to, the following: internal audit, strategic planning and marketing support, business diversification and development assistance, human resource support, trustee orientation and development programs, management information systems' hardware and software support, telecommunications assistance, facilities development, compliance, legal services, quality assessment and risk management support, fund development assistance, physician recruitment and retention support, and managed care contracting (provided that YNHHSC may revise, delete from or add to such list of services on a basis that is equitably applied to all Hospital Members). Upon Closing, an implementation plan for the integration and use of these services by the L+M Affiliates will be agreed to by the Parties. The L+M Affiliates will be assessed fees for these services on a basis that is consistent with the basis of assessment for other similarly situated YNHHSC Subsidiaries.

2.9 Benefits and Privileges. YNHHSC represents and covenants that LMH and LMW shall, in addition and without prejudice to any benefits, rights or privileges contained in this Agreement, enjoy the same privileges and benefits as the Hospital Members and be treated in a manner no less than consistent with the treatment of the Hospital Members, in each case taking into account the different sizes, clinical and financial attributes and performance of the respective Hospital Members. In addition, for so long as YNHHSC determines to continue to provide or implement programs and initiatives for the enhancement of quality, cost efficiency, professional development and/or other improvements for the members of the Yale New Haven Health System, each L+M Affiliate shall, in addition and without prejudice to any benefits, rights or

privileges contained in this Agreement, participate in such programs and initiatives on an equitable basis along with other YNHHSC Affiliates having attributes (including corporate purpose, size, scope of services and staff) that are similar to those of such L+M Affiliate. At such time in the future as YNHHSC determines to offer any new programs or initiatives for the enhancement of quality, cost efficiency, professional development and/or other improvements for the members of the Yale New Haven Health System, each L+M Affiliate shall, in addition and without prejudice to any benefits, rights or privileges contained in this Agreement, participate in such programs and initiatives on an equitable basis along with other YNHHSC Affiliates having attributes (including corporate purpose, size, scope of services and staff) that are similar to those of such L+M Affiliate.

2.10 Obligated Group. On the earliest date following the Closing Date that is reasonably determined by YNHHSC and in accordance with the requirements of the L+M Master Trust Indenture, YNHHSC shall have the authority to cause L+M and LMH, LMW and/or such other L+M Subsidiaries as YNHHSC shall determine to become YNHHSC Obligated Group Members, and effective upon becoming a YNHHSC Obligated Group Member the applicable L+M Affiliate shall execute a joinder to become a party to the YNHHSC Obligated Group Agreement and shall take such other steps as YNHHSC may require in connection with such status.

2.11 YNHHSC Resource Commitments.

(a) YNHHSC commits, on and subject to the terms of this Section 2.11 and in accordance with the strategic plan described in Section 2.12, to deploy, directly and through its Affiliates, $300 million in resources in the Yale New Haven Health System's Eastern Connecticut and Western Rhode Island region over a period of five years commencing with the Closing to enhance and support clinical and operational capabilities and services consistent with community need, the Yale New Haven Health System strategic plan, and mutually agreed upon business plans which display positive return on investment (or in the case of physical plant and infrastructure projects, mutually agreed upon facility management plans and/or project budgets).

(b) As part of the $300 million commitment described in Section 2.11(a), subject to the Closing, YNHHSC commits to make available (from resources other than those generated by the L+M Affiliates) in the Yale New Haven Health System's Eastern Connecticut and Western Rhode Island region an aggregate of $41 million in resources over the five-year period commencing with the Closing to support the initiatives described in this Section 2.11(b), which the Parties acknowledge are consistent with community need and the Yale New Haven Health System Strategic Plan, and are subject to mutually agreed upon business plans that display positive returns on investment:

(i) Implementation of Epic, Lawson and other IT platforms;

(ii) Effectuation and implementation of the branding contemplated by Section 2.7;

(iii) Up to $10 million in value represented by participation in and access to YNHHSC population health infrastructure;

(iv) Development of clinical programs and services and associated physician recruitment.

(c) As part of the $300 million commitment described in Section 2.11(a), subject to the Closing, YNHHSC commits to make available (from resources other than those generated by the L+M Affiliates) in the Yale New Haven Health System's Eastern Connecticut and Western Rhode Island region an aggregate of $44 million in resources over the five-year period commencing with the Closing to support the clinical programs and services described in Section 2.11(d) in accordance with mutually agreed-upon individual project business plans that are consistent with community need and the Yale New Haven Health System's strategic plan, display a positive return on investment and include implementation plans and budget allocations.

(d) As part of the $300 million commitment described in Section 2.11(a), subject to the Closing, YNHHSC and Affiliates of YNHHSC (including the L+M Affiliates) shall deploy $215 million in resources (in addition to the resources described in Section 2.11(b) and (c)) in the Yale New Haven Health System's Eastern Connecticut and Western Rhode Island region over a period of five years from and after the Closing Date to enhance and support the clinical and operational capabilities and services described in this Section 2.11(d) consistent with (i) community need, (ii) Yale New Haven Health System's strategic plan, (iii) mutually agreed-upon individual project business plans which display a positive return on investment (or in the case of physical plant and infrastructure projects, mutually agreed upon facility management plans and/or project budgets), and (iv) the performance of the L+M Affiliates measured against the Key Financial Metrics. It is understood that if YNHHSC and L+M mutually determine that the performance of the L+M Affiliates for any year during the applicable five-year period has materially deviated (whether positively or negatively) from the Key Financial Metrics, taken collectively, then the level of resources to be deployed by YNHHSC and Affiliates of YNHHSC pursuant to this Section 2.11(d) will be affected in a way that is mutually agreed by YNHHSC and L+M. The clinical and operational capabilities and services described in this Section 2.11(d) are the following clinical and operational capabilities and services (or such other programs and services as YNHHSC and L+M may mutually agree):

(i) Expansion of primary care network and ambulatory presence, including ambulatory surgery;

(ii) Access to pediatric specialty services;

(iii) Development of a multi-disciplinary musculoskeletal center with orthopedic, neurosurgery, spine and physiatry clinical complements;

(iv) Expansion of maternal fetal medicine and obstetrics capabilities;

(v) Enhancement of oncology services associated with Smilow Cancer Hospital;

(vi) Reintroduction and expansion of bariatric and/ or laparoscopic surgical programs;

(vii) Expansion of neuromuscular and stroke programs;

(viii) Development of a multidisciplinary vascular program and enhancement of cardiac services including electrophysiology;

(ix) Enhancement of endocrinology/thyroid services;

(x) Development of population health and risk contracting capabilities and participation in population health infrastructure;

(xi) Continued access to SkyHealth;

(xii) Expanded emergency services; and

(xiii) Physical plant and infrastructure maintenance, development and renovations.

For the avoidance of doubt, the financial performance of the L+M Affiliates as measured against the Key Financial Metrics shall not affect the resources committed by YNHHSC under Sections 2.11(b) and (c).

2.12 Strategic Plan. Prior to the Closing, YNHHSC, working with L+M, will develop a mutually agreed-upon five-year strategic plan including L+M that will address the major categories of the overall resource deployment described in Sections 2.11(b), (c) and (d). The strategic plan will focus on the retention and enhancement of healthcare services to communities in the Yale New Haven Health System's Eastern Connecticut and Western Rhode Island region, and will include projected resource availability and estimated timeframes in furtherance of the development of the programs and initiatives described in Section 2.11. The strategic plan will be updated every fiscal year and with a rolling three-year horizon consistent with YNHHSC practice. As the strategic plan for L+M that forms a component of the overall Yale New Haven Health System strategic plan, the strategic plan described in this Section 2.12 shall be subject to the approval of the board of L+M and the board of YNHHSC. This Section 2.12 and the Yale New Haven Health System Strategic Plan shall not be construed or applied so as to limit or restrict the level of the commitments of YNHHSC pursuant to Section 2.11, but the strategic plan and the Yale New Haven Health System Strategic Plan may affect the sequence and pacing of the implementation of the deployment of resources to support specific programs and services. The failure of YNHHSC and L+M to agree upon a strategic plan for L+M shall not result in a failure of a condition to the Parties' obligations to close the Affiliation or a right of either party to terminate this Affiliation Agreement.

2.13 Compliance with YSM Affiliation Agreement. From and after the Closing Date, the L+M Affiliates will comply with their obligations as applicable under Article IV of the YSM Affiliation Agreement.

ARTICLE 3

REPRESENTATIONS AND WARRANTIES WITH RESPECT TO L+M AFFILIATES

L+M represents and warrants to YNHHSC that the statements contained in this Article 3 are correct and complete as of the date of this Agreement, except as set forth in the Disclosure Schedule and except as specifically disclosed to YNHHSC. The Disclosure Schedule will be arranged in sections corresponding to the lettered and numbered sections contained in this Article 3. The Parties acknowledge and confirm that any competitively sensitive information called for by this Article 3 (including any schedules of the Disclosure Schedule) shall only be disclosed pursuant to such procedures as the Parties shall mutually agree upon so as to avoid violation of Applicable Law.

3.1 Organization of L+M. L+M is a nonstock corporation which is duly organized, validly existing and in good standing under the laws of the State of Connecticut, and has (and at the Closing will have) full corporate power and authority to own its assets and conduct its operations (as now conducted and as conducted at the Closing). Each of the L+M Subsidiaries is duly organized, validly existing and in good standing under the laws of the state of its formation and has (and at the Closing will have) full corporate power and authority to own its assets and conduct its operations as currently being conducted (as now conducted and as conducted at the Closing).

3.1.1 Schedule 3.1.1 lists all Subsidiaries of L+M. Except as indicated on Schedule 3.1.1: (i) each of the L+M Subsidiaries is a nonstock corporation of which L+M is the sole member and (ii) each of the L+M Affiliates is a Tax-Exempt Organization. Schedule 3.1.1 identifies each of the L+M Affiliates that is inactive.

3.1.2 The certificates of incorporation (or similar organizational documents) and bylaws of the L+M Affiliates, copies of which have heretofore been provided or made available to YNHHSC, are true, complete and correct copies of such documents.

3.1.3 Schedule 3.1.1 sets forth the name of each other Person in which any of the L+M Affiliates has any equity or limited liability company membership interest other than a passive minority investment.

3.2 Authorization of Transaction. L+M has full corporate power and authority to execute and deliver this Affiliation Agreement and to perform its obligations hereunder. This Agreement has been duly authorized by all requisite corporate action of L+M. This Agreement has been duly executed and delivered by L+M and, assuming due authorization, execution and delivery by YNHHSC, and receipt of the consents and approvals listed in Schedule 3.27, constitutes a valid and binding obligation of L+M, enforceable against L+M in accordance with its terms (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization, preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)). The amendment of the certificate of incorporation of L+M in the form of the L+M Amended Certificate of Incorporation and the amendment of the bylaws of L+M in the form of the L+M Amended Bylaws, in each case

effective as of and subject to the Closing, has been duly authorized by all requisite corporate action of L+M. The LMMG-NEMG Agreement and Plan of Merger to become effective as of and subject to the Closing: (a) have been duly authorized by all requisite corporate action of L+M; and (b) in the case of LMMG, have been (or upon Closing will be) duly authorized by all requisite corporate action of LMMG. The amendment of the certificate of incorporation of each applicable L+M Subsidiary in the form of: (i) the LMH Amended Certificate of Incorporation; (ii) the LMW Amended Certificate of Incorporation; and (iii) the VNA of Southeastern Connecticut Amended Certificate of Incorporation and the amendment of the bylaws of each applicable L+M Subsidiary in the form of: (x) the LMH Amended Bylaws; (y) the LMW Amended Bylaws; and (z) the VNA of Southeastern Connecticut Amended Bylaws, in each case effective as of and subject to the Closing: (a) has been duly authorized by all requisite corporate action of L+M; and (b) in the case of each applicable L+M Subsidiary, has been (or upon Closing will be) duly authorized by all requisite corporate action of such L+M Subsidiary.

3.3 Non-Contravention. Neither the execution and delivery by L+M of this Affiliation Agreement nor the consummation by L+M and the L+M Subsidiaries of the transactions contemplated hereby, will:

3.3.1 violate any provision of the certificate of incorporation (or similar organizational documents) or, subject only to obtaining any necessary approvals described in Article 5, bylaws of any of the L+M Affiliates; or

3.3.2 subject only to obtaining the approvals set forth in Schedule 3.27, constitute a violation on the part of the L+M Affiliates of any statute, Applicable Law, judgment, decree, order, regulation or rule of any court or Governmental Authority applicable to any of the L+M Affiliates; or

3.3.3 subject only to obtaining the consents set forth in Schedule 3.27, (i) violate, or be in conflict with, or constitute a default (or an event which, with notice or lapse of time or both, would constitute a default) under, or accelerate the performance required by, or cause the acceleration of the maturity of, any debt, or the revocation or loss of any material license, or (ii) violate, or be in conflict with, or constitute a default (or an event which, with notice or lapse of time or both, would constitute a default) under, or accelerate the performance required by, any obligation pursuant to any Material Contract to which any of the L+M Affiliates is a party (other than any Material Contract evidencing debt for borrowed money), or result in the revocation or loss of any Material Contracts, grants, endowment funds, permits or insurance policies listed in the Disclosure Schedule, or give any third party any option, right of first refusal or other rights under any Material Contract relating to the operations of any L+M Affiliate which, in case of any document, instrument or policy described in this clause (ii), individually or in the aggregate, would reasonably be expected to have a Material Adverse Effect.

3.4 Brokers' Fees. L+M has no liability or obligation to pay any fees or commissions to any broker, finder, or agent with respect to the transactions contemplated by this Agreement.

3.5 Title to Assets. Each of the applicable L+M Affiliates has (subject to Permitted Encumbrances and the Liens described in Schedule 3.5.1) good, valid and marketable title to all (i) real property comprising main hospital facility of LMH; (ii) real property comprising the main

hospital of LMW, and (iii) real property comprising the L+M Cancer Center (the real properties described in clauses (i), (ii) and (iii), collectively, the "***Principal Properties***").

3.5.1 Schedule 3.5.1 sets forth a true and complete list of the Owned Real Property, including the address and owner of each such Owned Real Property. Except as described in Schedule 3.5.1, each of the Principal Properties is owned by the applicable L+M Affiliate in fee simple, free and clear of all Liens, except Permitted Encumbrances. Except as set forth in Schedule 3.5.1, none of the Principal Properties is subject to any right or option of any other Person to purchase or lease an interest in such Principal Property. None of the L+M Affiliates has received any written notice of (i) a condemnation proceeding relating to Owned Real Property, (ii) a violation of Applicable Law relating to the Owned Real Property, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect or (iii) the imposition of a general or special assessment relating to the Owned Real Property. L+M has provided to YNHHSC a copy of current title reports relating to the Principal Properties. The Owned Real Property is in compliance in all material respects with all Applicable Laws, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

3.5.2 Schedule 3.5.2 sets forth a true and complete list of the real property leased or subleased by an L+M Affiliate, with lease payments that in the case of any one lease (i) exceed $1,000,000 annually or (ii) have a remaining term in excess of three years and lease payments that exceed $500,000 annually, (the "***L+M Leased Real Property***"), including the address of each such L+M Leased Real Property, the date and names of the parties to the applicable lease. L+M has provided a list or copies to YNHHSC of all currently-effective leases or subleases relating to the L+M Leased Real Property, together with all material waivers, amendments, extensions, renewals, guaranties and other Contracts with respect to such leases (collectively, "***L+M Real Property Leases***"). To the Knowledge of L+M, each of the L+M Affiliates has complied and is in compliance in all material respects with the terms of L+M Real Property Leases to the extent that non-compliance would give the counterparty a valid right to terminate the applicable L+M Real Property Lease and none of the L+M Affiliates has received written notice that it is in material breach of or default under such lease or sublease. All L+M Real Property Leases are in full force and effect. To the Knowledge of L+M, no material default exists under any L+M Real Property Lease by any other party thereto that would give the applicable L+M Affiliate a valid right to terminate the applicable L+M Real Property Lease.

3.5.3 No portion of the L+M Real Property has suffered any material damage by fire or other casualty which has not heretofore been repaired and restored or for which insurance proceeds adequate to effect the repair or restoration of such damage or casualty is not available that would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. No portion of any Principal Property is located in a special flood hazard area as designated by a federal Governmental Authority, except as set forth in Schedule 3.5.3. To the Knowledge of L+M, except as permitted by Environmental, Health and Safety Requirements, there has been no release, discharge, emission or disposal of Hazardous Substances on or under the L+M Real Property that

would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

3.5.4 Except as set forth in Schedule 3.5.4 and for any conditions, defects or other items noted in engineering, property, environmental or other reports obtained by or provided to YNHHSC by or on behalf of L+M, the improvements on the L+M Real Property and the Personal Property owned or leased by L+M Affiliates have been reasonably maintained in the ordinary course of business, are in good operating condition (ordinary wear and tear excepted), and are reasonably suitable for the uses for which they are intended.

3.6 Subsidiaries and Related Entities. Except as set forth in Schedule 3.1.1, neither LMH nor LMW has any Subsidiaries and neither owns beneficially or of record any equity interest in any other Person, and neither is a member, shareholder, or partner in any other Person.

3.7 Financial Statements. L+M has provided or made available to YNHHSC true and correct copies of (i) the audited consolidated statements of financial position of each of the L+M Affiliates, and related statements of activities and change in net assets, functional expenses and cash flows of each of the L+M Affiliates for the fiscal years ending as of September 30, 2011, 2012 and 2013 including the notes thereto; (ii) the audited consolidated statements of financial position of each of the L+M Affiliates, and related statements of activities and change in net assets, functional expenses and cash flows of each of the L+M Affiliates as of December 31, 2014, including the notes thereto (the "***L+M 2014 Audited Financial Statements***"); and (iii) an unaudited consolidated statement of financial position of each of the L+M Affiliates and unaudited statements of activities, functional expenses and cash flows of each of the L+M Affiliates as of March 31, 2015 (the "***L+M Interim Financial Statements***" and together with the L+M 2014 Audited Financial Statements, the "***L+M Financial Statements***"). The L+M 2014 Audited Financial Statements (i) have been prepared in accordance with GAAP and (ii) fairly present in all material respects the consolidated financial position and the results of operations and cash flows of each of the L+M Affiliates at and as of the dates or for the periods indicated. The L+M Interim Financial Statements (i) have been prepared in accordance with GAAP (subject to certain presentation items consistent with the ordinary course of business, to the absence of footnote disclosure and to normal year-end adjustments) and (ii) fairly present in all material respects the consolidated financial position and the results of operations and cash flows of each of the L+M Affiliates at and as of the respective dates thereof or for the periods ended on such dates, as applicable.

3.7.1 Each of the L+M Affiliates maintains systems of internal accounting controls to provide reasonable assurances that: (i) all transactions are executed in accordance in all material respects with management's general or specific authorization, (ii) all transactions are recorded as necessary to permit the preparation of the L+M Financial Statements in conformity with GAAP and maintain proper accountability for items and (iii) all reserves reflected on the L+M Financial Statements are sufficient for the purposes for which they were established. Since October 1, 2011, none of the L+M Affiliates has received and, to the Knowledge of L+M, there has not been, any complaint, allegation, assertion or claim regarding the L+M Affiliates' accounting or auditing practices, procedures, methodologies or methods, including any complaint, allegation, assertion or claim that any of the L+M Affiliates has engaged in questionable accounting or

auditing practices that would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

3.7.2 A true, correct and complete copy of the L+M 2015 Budgets have been delivered to YNHHSC.

3.7.3 LMI maintains and at all times has maintained unimpaired statutorily-required paid-in capital and surplus in the form permitted by Applicable Law.

3.8 Subsequent Events. Since the date of the most recent L+M Interim Financial Statements, (i) the L+M Affiliates have conducted their business operations in the ordinary course, and (ii) except as described in Schedule 3.8, there has not been:

(a) Any L+M Material Adverse Effect or event or occurrence of any condition that would reasonably be expected to have a Material Adverse Effect;

(b) Any increase in compensation or other remuneration payable to or for the benefit of or committed to be paid to or for the benefit of any, manager, officer, agent or employee of any L+M Affiliate, or in any benefits granted under any Employee Benefits Plan with or for the benefit of such, manager, officer, agent or employee (other than increases in wages or salaries required under existing contracts or otherwise in the ordinary course of business);

(c) Any borrowing or incurrence of any indebtedness (other than accounts payable in the ordinary course of business) contingent or otherwise for borrowed money, by or on behalf of any L+M Affiliate in excess of any amount not included in the L+M 2015 Budget;

(d) Any purchase by any L+M Affiliate of capital assets or any interests in real property or any lease arrangement (whether as a lessor or lessee or sub-lessor or sub-lessee) entered into by any L+M Affiliate with respect to real property in excess of $1,000,000;

(e) Any acquisition of or material capital investment in (by merger, exchange, consolidation, purchase, or otherwise) any Person by any L+M Affiliate;

(f) Any acquisition of any assets by any L+M Affiliate (whether through capital spending or otherwise) which are outside of the ordinary course of business or which are in excess of $500,000, individually or in the aggregate, to any L+M Affiliate;

(g) Any waiver of any claims or rights by any L+M Affiliate that are material or otherwise involve amounts individually or in the aggregate in excess of $500,000;

(h) Any change in any method of accounting or accounting policies of any L+M Affiliate or any write down in the accounts receivable of any L+M Affiliate in excess of reserves on the L+M Interim Financial Statements;

(i) Any amendment to the certificate of incorporation, bylaws or other organizational documents of any L+M Affiliate;

(j) Any damage to or destruction or loss of any asset or property of any L+M Affiliate, whether or not covered by insurance, adversely affecting the assets, financial condition or prospects of any L+M Affiliate or the business operations thereof in an amount in excess of $500,000;

(k) Any material change in any Tax election or Tax status of any L+M Affiliate;

(l) Any exhaustion of any primary or excess layers of insurance maintained by or for LMI;

(m) Any binding commitment or agreement by any L+M Affiliate that will result in any of the effects described in the foregoing.

3.9 Compliance with Law.

3.9.1 Regulatory Compliance. To the Knowledge of L+M, each of the L+M Affiliates have, during the previous three years, conducted and continues to conduct the business operations of such L+M Affiliate in substantial compliance with all Applicable Laws, including Environmental, Health and Safety Requirements, and have timely filed all material reports, data, and other information related to the business operations of the L+M Affiliates, except for (i) matters specifically disclosed to YNHHSC and (ii) violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Except as specifically disclosed to YNHHSC, to the Knowledge of L+M none of the L+M Affiliates that are engaged in the delivery of healthcare has, nor have any of their respective employees, committed a violation of federal or state laws regulating health care fraud, including but not limited to the federal Anti-Kickback Law, 42 U.S.C. §1320a-7b, the Stark I and II Laws, 42 U.S.C. §1395nn, as amended, and the False Claims Act, 31 U.S.C. §3729, et seq. (collectively, "***Health Care Fraud and Abuse Laws***"), except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. L+M has provided to YNHHSC true, correct and complete copies of any voluntary self-disclosure filings made with CMS or any other Governmental Authority and a description of the status of each such self-disclosure filing. To the Knowledge of L+M, each of the L+M Affiliates that are engaged in the delivery of healthcare services is in compliance in all material respects with the administrative simplification provisions required under the HIPAA, including the electronic data interchange regulations and the health care privacy regulations, as of the applicable effective dates for such requirements, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Each of the L+M Affiliates that are engaged in the delivery of healthcare services that is a "covered entity" under HIPAA has designated a director-level employee of the L+M Affiliates as its HIPAA privacy officer. To the Knowledge of L+M, the practices of the L+M Affiliates regarding the collection, access, maintenance, transmission, use, and disclosure of Confidential Information, including Protected Health Information, in connection with the conduct and operations of the L+M Affiliates' business are and have been in all material respects in compliance with any of the L+M Affiliates' contracts or commitments with third parties. To the Knowledge of L+M, the practices of the L+M Affiliates regarding the collection, access, maintenance,

transmission, use, and disclosure of Confidential Information, including Protected Health Information, in connection with the conduct and operations of the L+M Affiliates' business are and have been in accordance in all material respects with any applicable written policy or procedure of the L+M Affiliates since October 1, 2011 (or such later date on which the relevant policy or procedure shall have taken effect). To the Knowledge of L+M, the L+M Affiliates have not had any breach of information security that would constitute (i) a "security incident" (as defined in 45 CFR § 164.304) that resulted in material and actual unauthorized access, use, disclosure, modification or destruction of Protected Health Information or (ii) a "breach" under Section 13402 of the American Recovery and Reinvestment Act of 2009 and any regulations promulgated thereunder or state information security laws or regulations that require notification to or of government officials, or to individuals whose information may have been breached.

3.9.2 Investigations and Penalties. To the Knowledge of L+M, since January 1, 2012, none of the L+M Affiliates that are engaged in the delivery of healthcare services, and, no officer, director or trustee, or board officer or employee thereof with respect to the conduct of business operations of the L+M Affiliates:

(a) has been subject to any investigation, inquiry or suit by any Governmental Authority that has not been fully and finally resolved regarding any alleged violation of applicable governmental authorization or legal requirement which if adversely determined would reasonably be expected to have a Material Adverse Effect;

(b) has paid or been subject to any fine, penalty, corrective action plan, remediation plan, exclusion or other sanction by, or made a self-disclosure to, any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect;

(c) is a party to any written arrangement, including without limitation a corporate integrity agreement, deferred prosecution agreement, consent decree or settlement agreement, with any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect;

(d) has been or is currently a defendant in any qui tam, false claims or similar litigation that would reasonably be expected to have a Material Adverse Effect if adversely determined;

(e) to the Knowledge of L+M, is currently subject to any investigation, inquiry or suit by any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect; or

(f) to the Knowledge of L+M, has received any complaint from any employee, independent contractor, vendor, or any other Person regarding any alleged material violation of any governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect.

3.9.3 Compliance Program. Each of the L+M Affiliates has established and maintains a corporate compliance program which addresses the material requirements of all material Applicable Laws of the Governmental Authorities having jurisdiction over its business and operations. Each of the L+M Affiliates that is engaged in the delivery of healthcare services has designated an executive employee of such L+M Affiliate or of L+M as its chief compliance officer. Except as specifically disclosed to YNHHSC, to the Knowledge of L+M, there are no material pending internal investigations that could reasonably be expected to lead to a material fine, penalty, corrective action plan, remediation plan, exclusion or other material sanction by, or a self-disclosure to, any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement. To the Knowledge of L+M, each of the L+M Affiliates have established and maintain policies or procedures, including without limitation conflict of interest and related policies, for the review of all compensation arrangements and other arrangements that could involve the referral of patients with other Persons, including but not limited to its officers, directors or trustees, physicians, executives, their immediate family members, their professional practice entities and other referral sources, that are reasonably designed to maintain compliance with (i) all Applicable Laws, including but not limited to Health Care Fraud and Abuse Laws and the intermediate sanction provisions of the Code and regulations promulgated pursuant thereto, and (ii) their internal policies, including but not limited to any applicable conflicts of interest policy. Except as specifically disclosed to YNHHSC, all such compensation and other arrangements with potential referral sources are, to the Knowledge of L+M, in compliance with all Applicable Laws, including but not limited to Health Care Fraud and Abuse Laws.

3.9.4 Communications and Environmental Claims. Except as specifically disclosed to YNHHSC, during any applicable statute of limitations, none of the L+M Affiliates have received any communication (written or, to the Knowledge of L+M, oral), whether from any Governmental Authority or third party, alleging that any of the L+M Affiliates are not in compliance with any Health Care Laws and there is no Environmental Claim pending or, to the Knowledge of L+M, threatened against any of the L+M Affiliates, or, to the Knowledge of L+M, pending or threatened, against any other Person or entity with respect to any of the L+M Affiliates, or for whose Liability for any Environmental Claim, with respect to any of the L+M Affiliates, any of the L+M Affiliates have or may have retained or assumed by Contract or by operation of Applicable Law which in any such case would give rise to a Material Adverse Effect.

3.9.5 Permits, Licenses and Accreditations.

(a) Each of the L+M Affiliates has all Permits of Governmental Authorities, including those required under Environmental, Health and Safety Requirements, necessary to conduct the business operations of the L+M Affiliates including without limitation (i) in the case of the L+M Provider Subsidiaries, such Permits as are required to obtain reimbursement under all Contracts, including provider Contracts such as network participation agreements and discount agreements, programs and other arrangements with Payer Programs and (ii) in the case of LMI, such Permits as are required to be duly licensed as a sponsored captive insurance company under the laws administered by the LMI Insurance Regulatory Agency (all such Permits described in this sentence, the "***L+M Permits***"). To the Knowledge of L+M, none of the

L+M Affiliates is in material breach or violation of, or material default under any L+M Permit, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. To the Knowledge of L+M, none of the L+M Affiliates is currently subject to or has been given notice of any threatened audit, review or investigation by a Governmental Authority with respect to any L+M Permit.

(b) Each of the L+M Affiliates maintain the accreditations related to its business and operations that are required to be maintained in order for the L+M Affiliates to continue to operate their respective businesses in accordance with their respective past practices, without contingencies, including without limitation accreditation by the Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (the "***Joint Commission***"). To the Knowledge of L+M, each of the L+M Affiliates have taken all actions required to be taken to maintain such accreditations. There is no pending, and to the Knowledge of L+M, there is no threatened, investigation of any of the L+M Affiliates by any accreditation organization with respect to any material accreditation. None of the L+M Affiliates is subject to any notice of deficiency, plan of correction or similar action with respect to any such material accreditation.

3.9.6 Additional Contracts. True, correct and complete copies of the following Contracts have been provided to YNHHSC:

(a) each Contract (other than employment contracts) between any of the L+M Affiliates and any of its officers, directors or trustees (or any Person controlled by any of these individuals);

(b) each employment Contract, including but not limited to employment Contracts and severance Contracts, between any L+M Affiliate and a physician;

(c) each lease of real property or equipment with a physician or a physician's professional practice entity (such as a professional corporation or professional limited liability company) and specifying the material terms thereof, including the names of the lessor and lessee, the address, the term and a description of the real property or equipment leased thereunder; and

(d) each Contract and plan providing for payments by any of the L+M Affiliates to any officers, directors, key employees or physicians upon a change of control of L+M or the applicable L+M Subsidiaries or upon severance or termination of their employment, other than Collective Bargaining Agreements and Contracts with individual physicians.

3.9.7 Certain Matters Respecting LMI. LMI is and at all times since October 1, 2011 has been in compliance with requirements of Applicable Law of the jurisdiction of its organization including any conditions attached to its insurance license and any directions to LMI issued by the LMI Insurance Regulatory Agency, except for minor violations the effect of which is not material. LMI has not made any reductions of capital or paid any dividends or distributions during the period since September 30, 2013. LMI has delivered to YNHHSC copies of all financial statements and declarations required to be filed by LMI with the LMI Insurance Regulatory Agency since October 1, 2014. LMI is prohibited from joining or contributing to any plan, pool, association or guaranty or insolvency fund under the laws of the jurisdiction of its organization, and LMI is not

entitled to any benefits from any such plan, pool, association or guaranty or insolvency fund for claims arising out of the operations of LMI.

3.10 Tax Matters.

3.10.1 For the six year period preceding the Closing Date, each L+M Affiliate has (i) duly filed or caused to be filed with the appropriate taxing authorities all Tax Returns required to be filed by it (giving effect to as-of- right extensions) and all such Tax Returns are true, correct and complete in all material respects, (ii) timely paid or caused to be paid in full all Taxes shown to be due on such Tax Returns or otherwise due and payable with respect to the operations of the L+M Affiliates and (iii) except as specifically disclosed to YNHHSC, complied in all material respects with all Applicable Laws, rules and regulations relating to the withholding of Taxes and the payment of withheld Taxes, and timely and properly withheld and paid over to the appropriate Governmental Authorities all amounts required to be so withheld and paid under all Applicable Laws, rules and regulations.

3.10.2 No deficiencies or assessments for any Taxes of, or relating to, the operations of the L+M Affiliates have been proposed, asserted or assessed which have not been resolved and paid in full except for deficiencies and assessments being contested in good faith as listed and described in Schedule 3.10.2 or as specifically disclosed to YNHHSC, and no United States federal, state, local or foreign audits or other administrative or judicial proceedings are presently pending with regard to any Taxes or Tax Returns of, or relating to, the operations of the L+M Affiliates. There are no Liens for Taxes upon any assets owned by the L+M Affiliates except for Permitted Encumbrances.

3.10.3 As of the Closing, except for the L+M Affiliates specifically identified on Schedule 3.1.1, each of the L+M Affiliates is recognized by the IRS as exempt from United States federal income taxation, and is recognized by the State of Connecticut and the State of Rhode Island as exempt from state and local income taxes, real property taxes, and qualifies for sales tax exemptions available to organizations described in Section 501(c)(3) of the Code.

3.10.4 The L+M Affiliates have provided a list to YNHHSC of all Tax Returns filed by or with respect to the L+M Affiliates for fiscal years 2011, 2012 and 2013, including without limitation Form 990 "Return of Organization Exempt From Income Tax". The L+M Affiliates also have provided a list to YNHHSC of all examination reports of any Tax Return by any Governmental Authorities and statements of deficiencies assessed by any Governmental Authority with respect to Tax Returns of the L+M Affiliates for fiscal years 2011, 2012 and 2013.

3.10.5 Except as listed in Schedule 3.1.1, none of the L+M Affiliates is a party to any joint venture, partnership, or other business arrangement which is treated as a partnership for United States federal income tax purposes.

3.10.6 Except for the real property certiorari proceedings described in Schedule 3.10.6, there are no Tax rulings, requests for rulings or closing agreements either

in effect or pending with any Governmental Authority relating to any of the L+M Affiliates which could affect the L+M Affiliates' Liability for Taxes after the Closing.

3.10.7 L+M has provided to YNHHSC copies of the letters and/or rulings from the IRS in its possession which recognize that the L+M Affiliates indicated on Schedule 3.1.1 are Tax-Exempt Organizations exempt from United States federal income taxes under Section 501(a) of the Code as organizations described in Section 501(c)(3) of the Code and not as "private foundations" as such term is defined in Section 509 of the Code (the "***L+M Determination Letters***"). The L+M Determination Letters have not been modified, limited or revoked, in whole or in part, and none of the L+M Affiliates for which L+M Determination Letters have been provided has been notified that the IRS is proposing to revoke a L+M Determination Letter. In the case of L+M Affiliates for which L+M Determination Letters have not been provided, but that are Tax-Exempt Organizations exempt from United States federal income taxes under Section 501(a) of the Code as organizations described in Section 501(c)(3) of the Code and not as "private foundations" as such term is defined in Section 509 of the Code, such L+M Affiliates are listed on the list maintained by the U.S. Internal Revenue Service and known as the IRS Exempt Organizations Select Check (the "***IRS List of Exempt Organizations***"). There is no pending request by any of the L+M Affiliates for a redetermination of tax-exempt status as an organization described in Section 501(c)(3) of the Code. Each of the L+M Affiliates that are the subject of the L+M Determination Letters, or that are listed on the IRS List of Exempt Organizations, are in compliance with all of the terms, conditions, and limitations (i) contained in the L+M Determination Letters or (ii) required for inclusion on the IRS List of Exempt Organizations, as applicable, if any, and there has been no conduct by any such L+M Affiliates, of such nature that would warrant modification, limitation or revocation of the L+M Determination Letters or removal from the IRS List of Exempt Organizations, as applicable. To the best of L+M's Knowledge, none of any such L+M Affiliates has any "unrelated business income" as defined in Sections 511 through 514 of the Code which would adversely affect any of the L+M Affiliates' status as an organization described in Section 501(c)(3) of the Code. None of any such L+M Affiliates has been notified that the IRS is proposing to investigate its continued qualification as an organization described in Section 501(c)(3) of the Code or that there are any administrative or judicial proceedings pending or threatened which may adversely affect the classification of any of any such L+M Affiliates as an organization described in Section 501(c)(3) of the Code and not a private foundation under Section 509 of the Code.

3.10.8 The L+M 2014 Audited Financial Statements identify each tax-exempt financing, including its principal amount outstanding as of September 30, 2014 and the date of original issue, benefiting any of the L+M Affiliates. Each of the L+M Affiliates is in compliance in all material respects with all covenants required to be complied with by it under the L+M Tax-Exempt Bonds.

With respect to the L+M Tax-Exempt Bonds no action has been taken or omitted to be taken by any of the L+M Affiliates which would cause such the L+M Tax-Exempt Bonds to be an "arbitrage bond" under Section 148(a) of the Code. Each of the L+M Tax-Exempt Bonds is in compliance with the arbitrage rebate requirement of Section 148(f) of the Code. No action has been taken or omitted to be taken by any of the L+M

Affiliates which would cause any L+M Tax Exempt Bonds not to be "qualified 501(c)(3) bonds" within the meaning of Section 145 of the Code. Each of the L+M Tax-Exempt Bonds satisfies all applicable requirements set forth in Sections 147 and 149 of the Code in order for interest thereon to be excluded from gross income for federal income tax purposes.

3.10.10 With respect to each issue of the L+M Tax-Exempt Bonds, the applicable L+M Affiliates have timely filed with the IRS all Tax Returns, notices and other documents and forms necessary to be filed by the L+M Affiliates to qualify interest thereon for exclusion from gross income for federal income tax purposes and to maintain such exclusion.

3.10.11 At least 95% of the proceeds of the L+M Tax-Exempt Bonds have been used to provide facilities that are owned and operated by a Tax-Exempt Organization (i.e., L+M and LMH), except to the extent that portions of such facilities are permitted to be operated pursuant to a Safe Harbor Management Contract or pursuant to other recognized private business use exceptions.

3.10.12 All of the facilities financed by the L+M Tax-Exempt Bonds are owned for federal income tax purposes by L+M and LMH, each of which is a Tax-Exempt Organization.

3.10.13 At least 95% of the net proceeds of the L+M Tax-Exempt Bonds (net of and after deducting the costs of issuance thereof) are used only by L+M and LMH, each of which is a Tax-Exempt Organization, in activities that are substantially related to the exercise or performance by such Tax-Exempt Organization of purposes or functions constituting the basis for its exemption from federal income taxation under Section 501(a) of the Code.

3.10.14 Except as set forth on Schedule 3.10.14, All of the L+M Tax-Exempt Bonds constitute "qualified hospital bonds" within the meaning of Section 145(c) of the Code.

3.11 Material Contracts.

3.11.1 L+M has made available to YNHHSC true, correct and complete copies, including all amendments, supplements and modifications, of all Material Contracts (other than Material Contracts with Payer Programs); provided, however, that those Material Contracts relating to arrangements between an L+M Affiliate on the one hand and any physician on the other hand have been made available only to outside counsel or consultants for YNHHSC, who shall be instructed not to provide YNHHSC with any pricing, compensation, price sensitive or competitive information.

3.11.2 With respect to each Material Contract, L+M represents that (i) each of the Material Contracts is in full force and effect and constitutes a valid and binding obligation of the L+M Affiliate enforceable against the L+M Affiliate in accordance with its terms, and, to the Knowledge of L+M, against each other party thereto (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization,

preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)); (ii) the L+M Affiliates are not and, to the Knowledge of L+M, no other party thereto is, in breach or default in any material respect under any of the Material Contracts if such breach or default, individually or in the aggregate with other such breaches or defaults, would be reasonably expected to have a Material Adverse Effect; and (iii) the L+M Affiliates have not given and, to the Knowledge of L+M, it has not received from any other Person, any notice or other communication (whether written or oral) regarding any actual or potential violation or breach of, default under, termination of, any Material Contract (other than a termination by expiration of the term of a Material Contract) if such breach or default, individually or in the aggregate with other such breaches or defaults, would reasonably be expected to have a Material Adverse Effect. Except as set forth in Schedule 3.27, none of the Material Contracts for borrowed money or for the lease of real property or Material Contracts with Third Party Payers requires the consent of any other party thereto in connection with the transactions contemplated by this Affiliation Agreement.

3.12 Intellectual Property. To the Knowledge of L+M, each of the L+M Affiliates owns free and clear of all Liens, other than Permitted Encumbrances, Liens securing the L+M Tax-Exempt Bonds and Liens listed or described in Schedule 3.12, or is licensed or otherwise has the valid and enforceable right to use, all Intellectual Property used in or necessary to the conduct of its operations other than failures to own, be licensed or have the right to use Intellectual Property that would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. All such licenses and agreements with third parties relating to such Intellectual Property that are material to the business operations of the L+M Affiliates, taken as a whole, are valid and binding and in full force and effect, and to the Knowledge of L+M, none of the parties thereto is in default thereunder or breach thereof if such breach or default, individually or in the aggregate with such other breaches or defaults and the breaches or defaults described in Section 3.11.2, would reasonably be expected to have a Material Adverse Effect. To the Knowledge of L+M, there is no pending claim by any third party challenging the ownership, validity or use of any material Intellectual Property that is material to the business operations of the L+M Affiliates, taken as a whole.

3.13 Transactions with Affiliates. Except for tuition reimbursement and/or housing assistance loans to employees that are made pursuant to L+M's existing policies, there are no notes receivable of any L+M Affiliate or any other amount payable to any L+M Affiliate owing by any director, officer, member or employee of any L+M Affiliate. Except as set forth in Schedule 3.13 (other than compensation and benefits received in the ordinary course of business as an employee of any L+M Affiliate), and to the Knowledge of L+M no member of any L+M Affiliate's board of directors, and no officer, of any L+M Affiliate, has any interest in: any contract, arrangement or understanding with, or relating to the business or operations of any L+M Affiliate; any loan, arrangement, understanding, agreement or contract for or relating to indebtedness of any L+M Affiliate; or any property (real, personal or mixed), tangible, or intangible, used or currently intended to be used in, the business or operations of any L+M Affiliate.

3.14 [Reserved].

3.15 Litigation.

3.15.1 Except as specifically disclosed to YNHHSC or as disclosed pursuant to Section 3.9, there is no suit, claim, action, proceeding, arbitration, hearing, inquiry or investigations whether at law or equity (individually or collectively as the contest shall require, "***Litigation or Proceedings***") pending or, to the Knowledge of L+M, threatened against the L+M Affiliates, except for any such suit, claim, action, proceeding, arbitration, hearing, inquiry or investigation which (i) is not reasonably expected as of the date hereof, together with any related claims arising out of the same set of facts, to involve an amount in controversy in excess of $5,000,000, in the aggregate, excluding malpractice, general liability and other claims which are fully insured (subject to customary deductible and retention amounts), or (ii) would not be reasonably expected to have a Material Adverse Effect.

3.15.2 There are no outstanding orders, injunctions or decrees of any Governmental Authority (other than orders, injunctions or decrees of general applicability and which do not specifically name an L+M Affiliate) which would have a Material Adverse Effect.

3.16 Labor Relations.

3.16.1 Except for the Collective Bargaining Agreements described in Schedule 3.16.1 and except as disclosed to YNHHSC, (i) none of the L+M Affiliates is a party to, nor bound by, any labor agreement, collective bargaining agreement, written work rules or practices, or any other labor-related agreement or arrangement, with any labor union, trade union or labor organization (collectively, a "***Collective Bargaining Agreement***"); (ii) none of the L+M Affiliates' employees are covered by the terms of any Collective Bargaining Agreements; (iii) to the Knowledge of L+M, no labor union, trade union or labor organization of the L+M Affiliates has since December 31, 2011, made a pending demand for recognition or certification, as a collective bargaining representative of the L+M Affiliates' employees and, to the Knowledge of L+M, there are no representation election petitions filed with the National Labor Relations Board pertaining to the L+M Affiliates' employees; (iv) L+M has no Knowledge of any union organizing activities with respect to any employees of the L+M Affiliates; (v) since October 1, 2011, to the Knowledge of L+M, there have been no actual or threatened arbitrations, grievances, unfair labor practices, labor disputes, strikes, lockouts, slowdowns or collective work stoppages against the L+M Affiliates except for those that would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect; and (vi) since October 1, 2011, neither the L+M Affiliates nor any of their employees, agents or representatives have committed any material unfair labor practice as defined in the National Labor Relations Act which could reasonably be expected to have a Material Adverse Effect.

3.16.2 Each of the L+M Affiliates: (i) is not in violation in any material respect of any Applicable Law pertaining to labor, employment or employment practices including, but not limited to, all Applicable Laws regarding health and safety, wages and hours, labor relations, employment discrimination, disability rights or benefits, equal opportunity, immigration, plant closures and layoffs, affirmative action, employee leave issues, unemployment insurance and workers' compensation, except for violations the

effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect, or (ii) except as listed in Schedule 3.16.2, is not a party to any currently pending claim, action, arbitration, audit, hearing, investigation, complaint, charges, litigation or suit or governmental inquiry alleging a violation of any Applicable Law pertaining to labor, employment or employment practices, nor, to the Knowledge of L+M, is any such claim, action, arbitration, audit, hearing, investigation, complaint, charges, litigation or suit or governmental inquiry pending or threatened, except in each case for matters the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

3.16.3 Except as specifically disclosed to YNHHSC, to the Knowledge of L+M, each of the L+M Affiliates: (i) has taken reasonable steps to properly classify and treat all of their workers, interns, trainees and volunteers as independent contractors or employees, (ii) has taken reasonable steps to properly classify and treat all of their employees as "exempt" or "nonexempt" from overtime requirements under Applicable Law, (iii) is not delinquent in any material payments to, or on behalf of, any current or former independent contractors or employees for any services or amounts required to be reimbursed or otherwise paid, (iv) has withheld and reported all material amounts required by Applicable Law or by agreement to be withheld and reported with respect to wages, salaries and other payments to any current or former independent contractors or employees; and (v) is not liable for any material payment to any trust or other fund governed by or maintained by or on behalf of any Governmental Authority with respect to unemployment compensation benefits, social security or other benefits or obligations for any current or former independent contractors or employees (other than routine payments to be made in the normal course of business and consistent with past practice). To the Knowledge of L+M, none of the L+M Affiliates has direct or indirect material Liability as a result of any misclassification of any Person as an independent contractor rather than as an employee.

3.16.4 Except as listed in Schedule 3.16.4, to the Knowledge of L+M, no employee or former employee of the L+M Affiliates is in any material respect in violation of any term of any employment agreement, nondisclosure agreement, common law nondisclosure obligation, fiduciary duty, non-competition agreement, restrictive covenant or other obligation: (i) to the L+M Affiliates or (ii) to a former employer of any such employee relating (A) to the right of any such employee to be employed by the L+M Affiliates or (B) to the knowledge or use of trade secrets or proprietary information in connection with his or her employment with the L+M Affiliates, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

3.16.5 Each of L+M Affiliates is and for the last 18 months has been in compliance with all notice and other requirements under the Worker Adjustment and Retraining Notification Act and any similar state or local Applicable Law relating to plant closings or layoffs (collectively, the "***WARN Act***"). In the 18 months prior to the date hereof, each of the L+M Affiliates has not (i) effectuated a "plant closing" (as defined in the WARN Act) or (ii) effectuated a "mass layoff" (as defined in the WARN Act).

3.17 Employee Benefits.

3.17.1 No individuals who are not employees of the L+M Affiliates provide any substantial services to the L+M Affiliates except under contracts between an L+M Affiliate and such individual or a business entity which is not an Affiliate. Schedule 3.17.1 lists, as of the date of this Affiliation Agreement, all Employee Benefit Plans maintained by or with respect to which contributions are made by the L+M Affiliates or the L+M Affiliates has any liability (collectively the "***L+M Plans***"). Prior to the date hereof, L+M has provided to YNHHSC as part of the Due Diligence Information accurate and complete copies of the L+M Plans (and, if applicable, related trust agreements) and all amendments thereto; the two most recent actuarial reports relating to such L+M Plans; the two most recent annual reports (Form 5500 series) filed with respect to each such L+M Plan; in the case of any L+M Plan that is intended to be qualified under Section 401(a) of the Code, the most recent determination letter or opinion letter issued by the IRS with respect to each such L+M Plan and/or any pending request for such a determination letter; the two most recent nondiscrimination tests performed under the Code (including 401(k) and 401(m) tests) for each such L+M Plan; and all material filings made with any governmental entity for the two most recently completed plan years, including but not limited to any filings under the IRS Voluntary Compliance Resolution or Closing Agreement Program with respect to any such L+M Plan.

3.17.2 Each L+M Plan has been operated in all material respects in accordance with its terms and the requirements of Applicable Law. Neither L+M nor, to the Knowledge of L+M, any ERISA Affiliate has engaged in any transaction or failed to act in a manner that violates the fiduciary requirements of Section 404 of ERISA with respect to any L+M Plan. Neither L+M nor, to the Knowledge of L+M, any ERISA Affiliate has engaged in any prohibited transaction with respect to any L+M Plan that could result in material liability to L+M or any ERISA Affiliate.

3.17.3 All required contributions to each L+M Plan (including both employee and employer contributions), and all material premiums due or payable with respect to insurance policies funding any L+M Plan, have been timely made or paid in full or, if not yet paid, have been properly accrued for. The funding level of each L+M Plan has been specifically disclosed to YNHHSC. During the period since October 1, 2010, all distributions required or due to be made from any L+M Plan has been timely and accurately made except (i) as specifically disclosed to YNHHSC, and (ii) to the extent that any failure to make any distribution in a timely and accurate manner would not adversely affect the tax attributes or consequences of the applicable L+M Plan taken as a whole.

3.17.4 Except as set forth in Schedule 3.17.4, no Covered Person will become entitled to any bonus, retirement, severance, job security or similar benefit or enhanced such benefit (including acceleration of vesting or exercise of an incentive award) pursuant to a L+M Plan or other agreement (whether written or unwritten) as a result of the transactions contemplated by this Agreement.

3.17.5 No employee is employed outside of the United States by any L+M Affiliate.

3.17.6 A copy of L+M's written severance policy as in effect on the date of this Affiliation Agreement has been provided to YNHHSC as part of the Due Diligence Information.

3.17.7 Except as specifically disclosed to YNHHSC, no L+M Plan or other arrangement provides for retiree health, retiree life insurance or other retiree welfare benefits (other than COBRA continuation benefits).

3.17.8 No L+M Plan that is a welfare benefit arrangement is (i) a multiple employer welfare arrangement (within the meaning of Section 3(40) of ERISA, (ii) a voluntary employee benefit association under Section 501(c)(9) of the Code, or (iii) any other arrangement that would cause an employee welfare benefit plan to be funded for purposes of ERISA.

3.17.9 No payment or benefit provided under any L+M Plan provides for the deferral of compensation that is not in compliance with Sections 409A and 457(f) of the Code (to the extent applicable). Except as specifically disclosed to YNHHSC, no L+M Plan provides for a gross-up, make whole or other additional payment with respect to any Tax, including those imposed by Section 409A.

3.17.10 None of the L+M Affiliates has at any time been obligated to contribute to a multiemployer plan as defined in Section 3(37) of ERISA, and has no unsatisfied actual or inchoate liability (including withdrawal liability) with respect thereto.

3.18 Environmental, Health, and Safety Matters.

3.18.1 Each L+M Affiliate is in material compliance with all Environmental, Health, and Safety Requirements except to the extent that any non-compliance with Environmental, Health, and Safety Requirements would not reasonably be expected to have a Material Adverse Effect.

3.18.2 Except as specifically disclosed to YNHHSC, no L+M Affiliate has received any written notice, report or other written information regarding any actual or alleged material violation of Environmental, Health, and Safety Requirements, or any material liabilities or potential material liabilities (whether accrued, absolute, contingent, unliquidated or otherwise), concerning the Remediation of any Environmental Condition or Hazardous Substances relating to the L+M Affiliates that remains outstanding or unresolved.

3.19 Books and Records. The books of account and other financial records of the L+M Affiliates, all of which shall have been made available to YNHHSC prior to Closing, are accurate and complete in all material respects. Each transaction of the L+M Affiliates is properly and accurately recorded on the books and records of the applicable L+M Affiliate except for immaterial omissions or inaccuracies, the effect of which is insubstantial. L+M has made or will make available to YNHHSC a correct and complete copy of the minute books of the L+M Affiliates, except such portions as may have been redacted or excluded that contain records or discussions pertaining to the entry into or consummation of the transactions contemplated by this Agreement or the process of negotiation leading to the development of this

Agreement. To the extent permitted by Applicable Law and to the extent that doing so would not reasonably be expected to result in the waiver of privilege, L+M has made available to YNHHSC a correct and complete copy of the minutes maintained by the L+M Affiliates quality assurance committees since October 1, 2011.

3.20 Illegal Payments. To the Knowledge of L+M, none of the L+M Affiliates, nor any of their respective officers, directors, agents or employees or any other person on behalf of the L+M Affiliates, has made directly or indirectly any illegal payment to or on behalf of, or provided any illegal benefit or inducement for, any physician, supplier or patient of the L+M Affiliates. To the Knowledge of L+M neither the L+M Affiliates, nor any of their respective officers, directors, employees or agents has, directly or indirectly, paid or delivered a fee, commission or other sum of money or item or property, however characterized, to any finder, agent, Governmental Authority or other party, in the United States or any other country, which was or is illegal under any Applicable Law. To the Knowledge of L+M, none of the L+M Affiliates, nor any of their respective officers, directors, employees or agents has made any payment to any supplier of the L+M Affiliates or any officer, director, employee or agent of any patient or supplier of the L+M Affiliates, for the unlawful sharing of fees or to any such patient or supplier or any such officer, director, employee or agent for the unlawful rebating of charges, or engaged in any other unlawful payment or given any other unlawful consideration to any such enrollee, patient or supplier or any such officer, director, employee or agent.

3.21 Bankruptcy. None of the L+M Affiliates is the subject of bankruptcy, insolvency or any similar proceedings.

3.22 Information Systems. L+M has specifically disclosed to YNHHSC each major information technology system owned or leased by the L+M Affiliates and used by the L+M Affiliates in their business operations as now conducted.

3.23 Foreign Operations. Other than LMI, the L+M Affiliates have no operations outside the United States.

3.24 [Reserved]

3.25 Insurance Coverage. Each of the L+M Affiliates maintains, and, during the past three-year period, has maintained without interruption, (i) self-insurance arrangements or (ii) policies of insurance, including, without limitation, general liability, property, casualty, malpractice and worker's compensation insurance, issued by responsible insurers, and the coverage provided under such insurance policies has in the applicable L+M Affiliate's reasonable judgment been reasonable in scope and amount in light of the risks attendant to the operation and activities of such L+M Affiliate. A true, correct and complete copy of each insurance policy maintained by an L+M Affiliate as of the date of this Affiliation Agreement has been provided to YNHHSC prior to the Effective Date as part of the Due Diligence Information. None of the L+M Affiliates has received written notice of termination (other than termination by expiration of the term thereof) or cancellation of any such policy that is currently in effect. All premiums required to be paid with respect to all such policies covering all periods up to and including the date of this Agreement have been paid. There has been no lapse in coverage under such policies during any period for which any of the L+M Affiliates have conducted their business operations and for which any claim covered by any such policy could be made under

applicable statutes of limitations. Each general liability and malpractice insurance policy under which one of the L+M Affiliates is the named insured is adequate to cover all claims of the kind intended to be covered, and which have been made, under such policies. Each of the L+M Affiliates has complied in all material respects with the terms and provisions of such policies, and is not in default, whether as to payment of premium or of any other material obligation thereunder, under the terms of any such policy. All of the policies described in this Section 3.25 are in full force and effect and such coverage will be continued in full force and effect to and including the Closing Date and thereafter in accordance with their terms.

3.26 Regulatory Matters.

3.26.1 To the Knowledge of L+M, since October 1, 2011, the L+M Affiliates have timely filed all material reports, statements, documents, registrations, filings or submissions required to be filed by the L+M Affiliates with any Governmental Authorities, including in connection with or required by any Material Contracts or in connection with the L+M Tax-Exempt Bonds, except where the failure to timely file has not resulted and would not reasonably be expected to result in a Material Adverse Effect. All such reports, statements, documents, registrations, filings and submissions were true, correct and complete in all material respects when filed, complied in all material respects with Applicable Law in effect when filed. Except as set forth on Schedule 3.26.1, since October 1, 2011, no material deficiencies have been asserted by any such Governmental Authority with respect to such reports, statements, documents, registrations, filings or submissions that have not been satisfied, or, if not yet satisfied, where satisfaction is not yet due. To the Knowledge of L+M, the Material Contracts are in compliance with Applicable Law.

3.26.2 Except as specifically disclosed to YNHHSC, since October 1, 2011, the L+M Affiliates have not been subject to any finding, agreement, settlement or fine regarding noncompliance with any Applicable Law (including fraudulent procedures or practices but excluding any finding, agreement, settlement or fine that resulted only in a monetary penalty of $50,000.00 or less) that resulted in or would reasonably be expected to result in a Material Adverse Effect. Except as specifically disclosed to YNHHSC, to the Knowledge of L+M, since October 1, 2011, the L+M Affiliates have not been subject to any pending or threatened audit, investigation or other regulatory review relating to any noncompliance with any Applicable Law (including fraudulent procedures or practices, or, to the Knowledge of L+M, OSHA violations and any warning letters or observations (including any FDA warning letters or FDA Form 483 observations)), other than regularly scheduled periodic audits and reviews.

3.26.3 Neither L+M nor any L+M Subsidiary has been excluded, debarred or otherwise deemed ineligible to participate in Medicare, Medicaid or any other federal or state health care programs or in any federal or state procurement or non-procurement programs, nor has L+M or any L+M Subsidiary been convicted of a criminal offense related to the provision of federal health care items or services, nor, to L+M's Knowledge, is an investigation or proceeding regarding the foregoing pending or threatened. L+M and each of the L+M Subsidiaries that provides services to beneficiaries of Government Payer programs is (i) qualified for participation in, and has current and valid provider contracts with, the Government Payer programs and /or their fiscal

intermediaries or paying agents and is in material compliance with the conditions of participation or requirements applicable with respect to such participation and (ii) eligible for payment under the Government Payer programs for services rendered to qualified beneficiaries.

3.27 Consents and Approvals. No consents with respect to Material Contracts or approvals of any Governmental Authority are required to be obtained by any L+M Affiliate in connection with the execution, delivery and performance by L+M of this Agreement or the consummation of the transactions contemplated by this Agreement, except for (a) the requirements of the HSR Act and (b) as set forth in Schedule 3.27, which shall include, but not be limited to, any filings with, and approvals from, (i) OHCA, (ii) RIDOH upon the recommendation of the Rhode Island Health Services Council and (iii) the Rhode Island Attorney General.

3.28 Billing, Recoupments and Overpayments.

3.28.1 To the Knowledge of L+M, during the period of the applicable statutes of limitation, all claims for reimbursement ("***Reimbursement Claims***") submitted by the L+M Affiliates comply in all material respects with all Applicable Laws, including but not limited to Health Care Fraud and Abuse Laws, and all Payer Program contracts, provider manuals, policies, guidance, and reimbursement requirements governing reimbursement and payment of claims and do not contain any material errors, omissions or disallowances, except as specifically disclosed to YNHHSC, to the extent that non-compliance or errors or omissions would not individually or in the aggregate be reasonably expected to have a Material Adverse Effect. Except as specifically disclosed to YNHHSC, none of the L+M Affiliates have any outstanding overpayment or refund obligations due to any individual Payer Program in excess of $5,000,000 in the aggregate. Except as specifically disclosed to YNHHSC, none of the L+M Affiliates has received notice of any material disallowance, overpayment, refund or dispute between the L+M Affiliates, on the one hand, and any Payer Program, or agent thereof, on the other hand, regarding such Reimbursement Claims that has not been resolved and, to the Knowledge of L+M, there are no facts or circumstances which may reasonably be expected to give rise to any disallowance, overpayment, refund or dispute that individually or in the aggregate would be reasonably expected to have a Material Adverse Effect.

3.28.2 With respect to each of the last three complete reporting periods, the Cost Reports for L+M and each L+M Subsidiary that provides services to beneficiaries of Government Payer programs have been filed when due, and have been audited (with Notices of Program Reimbursement issued), for the Cost Report periods described in Schedule 3.28.2

3.28.3 Except as specifically disclosed to YNHHSC, with respect to each of the last three complete reporting periods, all amounts shown as due from L+M or any L+M Subsidiary in the applicable Cost Reports that either were remitted with such Cost Reports or will be remitted when required by Applicable Law. Except to the extent liabilities and contractual adjustments with respect to L+M and any L+M Subsidiary under the Government Payer programs have been properly reflected and adequately reserved in the L+M Financial Statements, to L+M's Knowledge, neither L+M nor any L+M

Subsidiary has received or submitted any claim for payment to the Government Payer programs (or their fiscal intermediaries or paying agents) in excess in any material respect of the amount provided by Applicable Law or applicable provider contracts, and L+M and the L+M Subsidiaries have not received notice of any dispute or claim by any Governmental Authority, fiscal intermediary or other Person regarding L+M or any of the L+M Subsidiaries in such programs, in each case, that individually or in the aggregate, would be reasonably expected to have a Material Adverse Effect.

3.29 Medical Staff Matters. Prior to the date of this Affiliation Agreement, L+M has provided to YNHHSC as part of the Due Diligence Information true, correct, and complete copies of the bylaws, rules and regulations of the medical staff of each of LMH and LMW, as well as a list of all current members of their medical staffs. To the Knowledge of L+M, all actions undertaken by LMH and LMW respectively with respect to its medical staff, including corrective discipline or other professional review, have been carried out in accordance with all Applicable Laws.

3.30 Clinical Trials. To the Knowledge of L+M, all clinical trials currently being conducted at the L+M Affiliates are being conducted (i) with the approval and/or waiver of an appropriately constituted and duly registered institutional review board ("***IRB***") and (ii) in compliance with the applicable IRB policies and procedures, study agreements with trial sponsors and/or contract research organizations, and all Applicable Law, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Within the past two years, no clinical trial conducted at the L+M Affiliates has been subject to suspension or termination (other than by the sponsor of the trial due to reasons unrelated to the L+M Affiliate's performance of its obligations) due to patient safety concerns, material non-compliance with the applicable study agreement or Applicable Law, except for suspensions or terminations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Within the past two years, none of the L+M Affiliates, nor to the Knowledge of L+M, any investigator involved in a clinical trial at the L+M Affiliates, has received any correspondence or communication relating to the applicable L+M Affiliate's conduct from any trial sponsor, contract research organization, IRB or Governmental Authority, including without limitation the Connecticut Department of Public Health, FDA or the Department of Health and Human Services Office for Human Research Protections ("***OHRP***"), regarding patient safety breaches, billing issues associated with care provided to clinical trial subjects, obligations to register and report results of clinical trials, research misconduct, notice of pending debarment or disqualification, or other material non-compliance with the applicable study agreement or Applicable Law, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

3.31 Relationship with Pharmaceutical and Medical Device Manufacturers, Vendors and Suppliers. Except as specifically disclosed to YNHHSC, (i) to the Knowledge of L+M, each of the L+M Affiliates is in compliance with the applicable L+M Affiliate's policies and procedures regarding interactions with pharmaceutical manufacturers, medical device manufacturers, equipment and supply vendors, including without limitation, those relating to conflicts of interest, product samples, transfers of value and remuneration arrangements, and (ii) such policies and procedures are reasonably designed to comply with Applicable Law.

3.32 Solvency of the L+M Affiliates. Immediately after giving effect to the transactions contemplated by this Agreement, none of the L+M Affiliates will (a) be insolvent (either because its financial condition is such that the sum of its Liabilities is greater than the fair value of its assets or because the fair salable value of its assets is less than the amount required to pay probable Liabilities as they mature), (b) have unreasonably small capital with which to engage in its business or (c) have incurred Liabilities beyond its ability to pay as they become due. No transfer of property is being made and no obligation is being incurred in connection with the transactions contemplated by this Agreement with the intent to hinder, delay or defraud either present or future creditors of the L+M Affiliates. LMI is solvent according to all applicable standards of solvency administered by the LMI Insurance Regulatory Agency.

3.33 Charitable Funds. To the Knowledge of L+M, L+M and the L+M Subsidiaries have solicited, received, held, invested, expended and applied charitable funds donated to them in all material respects in accordance with all restrictions placed thereon by donors, the terms of any applicable solicitation and Applicable Laws. Neither L+M nor any of the L+M Subsidiaries has received written notice of any, whether actual or alleged, misuse of funds, failure to comply with any donor-imposed restriction, breach of duty related to the funds, or violation of any Applicable Laws which would reasonably be expected to have a L+M Material Adverse Effect, nor to the Knowledge of L+M, has any such misuse, failure, breach or violation occurred.

3.34 No Undisclosed Liabilities. Except as specifically disclosed to YNHHSC, none of the L+M Affiliates has material Liabilities or material obligations of any nature (including, without limitation, any direct or indirect Indebtedness, guaranty, endorsement, claim, loss, damage, deficiency, cost, expense, obligation or responsibility, fixed or unfixed, known or unknown, asserted or unasserted, liquidated or unliquidated, secured or unsecured, absolute, accrued, contingent or otherwise and whether due or to become due, or liability or obligations for an overpayment, duplicate payments, refunds discounts or adjustments due to any Third Party Payer, including any federal or state health care program) arising out of, or relating to, the business operations of L+M Affiliates and which are required to be reflected on a balance sheet prepared in accordance with GAAP, except: (i) liabilities or obligations as and to the extent reflected on or accrued or reserved against as set forth in the L+M 2014 Audited Financial Statements; and (ii) liabilities incurred since the date of the L+M 2014 Audited Financial Statements in the ordinary course of business. Neither L+M nor any of the L+M Subsidiaries is in default of any term or condition of any Indebtedness or other Liability in excess of $250,000, including any trade payable.

3.35 Completeness of Disclosure. No representation or warranty by L+M in this Agreement, or any written certificate, schedule or exhibit when taken as a whole with all such other representations, warranties, certificates, schedules and exhibits contains or will contain any untrue statement of a material fact or will omit to state a material fact required to be stated herein or therein or necessary to make any statement herein or therein not misleading in light of the circumstances under which it was made.

ARTICLE 4

REPRESENTATIONS AND WARRANTIES OF YNHHSC

YNHHSC represents and warrants to L+M that the statements contained in this Article 4 are correct and complete as of the date of this Agreement, except as set forth in the Disclosure Schedule and except as specifically disclosed to L+M. The Disclosure Schedule will be arranged in sections corresponding to the lettered and numbered sections contained in this Article 4. The Parties acknowledge and confirm that any competitively sensitive information called for by this Article 4 (including any schedules of the Disclosure Schedule) shall only be disclosed pursuant to such procedures as the Parties shall mutually agree upon so as to avoid violation of Applicable Law.

4.1 Organization of YNHHSC. YNHHSC is a nonstock corporation, without members, which is duly organized, validly existing and in good standing under the laws of the State of Connecticut, and has (and at the Closing will have) full corporate power and authority to own its assets and conduct its operations (as now conducted and as conducted at the Closing). Each of the YNHHSC Subsidiaries is duly organized, validly existing and in good standing under the laws of the state of its formation, and has (and at the Closing will have) full corporate power and authority to own its assets and conduct its operations as currently being conducted (as now conducted and as conducted at the Closing).

Schedule 4.1.1 lists all Subsidiaries of YNHHSC. Except as indicated on Schedule 4.1.1, each of the YNHHSC Subsidiaries is a nonstock corporation of which YNHHSC is the sole member. Except as indicated on Schedule 4.1.1, each of the YNHHSC Affiliates is a Tax-Exempt Organization.

4.1.1 The certificates of incorporation (or similar organizational documents) and bylaws of the YNHHSC Affiliates, copies of which have heretofore been provided or made available to L+M, are true, complete and correct copies of such documents.

4.1.2 Schedule 4.1.1 sets forth the name of each other Person in which any of the YNHHSC Affiliates has any equity or membership interest other than a passive minority investment.

4.2 Authorization of Transaction. YNHHSC has full corporate power and authority to execute and deliver this Affiliation Agreement and to perform its obligations hereunder. This Agreement has been duly authorized by all requisite corporate action of YNHHSC. This Agreement has been duly executed and delivered by YNHHSC and, assuming due authorization, execution and delivery by L+M, and receipt of the consents and approvals listed in Schedule 4.27, constitutes a valid and binding obligation of YNHHSC, enforceable against YNHHSC in accordance with its terms (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization, preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)). The LMMG-NEMG Agreement and Plan of Merger to become effective as of and subject to the Closing have been duly authorized by all requisite corporate action of NEMG.

4.3 Non-Contravention. Neither the execution and delivery by YNHHSC of this Affiliation Agreement nor the consummation by YNHHSC and the YNHHSC Subsidiaries of the transactions contemplated hereby, will:

4.3.1 violate any provision of the certificate of incorporation (or similar organizational documents) or, subject only to obtaining any necessary approvals described in Article 5, bylaws of any of the YNHHSC Affiliates; or

4.3.2 subject only to obtaining the approvals set forth in Schedule 4.27, constitute a violation on the part of the YNHHSC Affiliates of any statute, Applicable Law, judgment, decree, order, regulation or rule of any court or Governmental Authority applicable to any of the YNHHSC Affiliates; or

4.3.3 subject only to obtaining the consents set forth in Schedule 4.27, (i) violate, or be in conflict with, or constitute a default (or an event which, with notice or lapse of time or both, would constitute a default) under, or accelerate the performance required by, or cause the acceleration of the maturity of, any debt, or the revocation or loss of any material license, or (ii) violate, or be in conflict with, or constitute a default (or an event which, with notice or lapse of time or both, would constitute a default) under, or accelerate the performance required by, any obligation pursuant to any Material Contract to which any of the YNHHSC Affiliates is a party (other than any Material Contract evidencing debt for borrowed money), or result in the revocation or loss of any Material Contracts, grants, endowment funds, permits or insurance policies listed in the Disclosure Schedule, or give any third party any option, right of first refusal or other rights under any Material Contract relating to the operations of any YNHHSC Affiliate which, in case of any document, instrument or policy described in this clause (ii), individually or in the aggregate, would reasonably be expected to have a Material Adverse Effect.

4.4 Brokers' Fees. YNHHSC has no liability or obligation to pay any fees or commissions to any broker, finder, or agent with respect to the transactions contemplated by this Agreement.

4.5 Title to Assets. Each of the YNHHSC Affiliates has (subject to the Liens granted pursuant as the YNHHSC Master Trust Indenture) good, valid and marketable title to, or in the case of leased premises as to which it is a tenant a valid, binding and enforceable leasehold or subleasehold interest in, all of the real property owned or leased, as the case may be, by the such YNHHSC Affiliate in connection with the conduct the YNHHSC Activities, except as would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

4.5.1 [Reserved]

4.5.2 [Reserved]

4.5.3 [Reserved]

4.5.4 [Reserved]

4.6 [Reserved].

4.7 Financial Statements. YNHHSC has provided or made available to L+M true and correct copies of (i) the audited consolidated statements of financial position of each of the YNHHSC Affiliates, and related statements of activities and change in net assets, functional expenses and cash flows of each of the YNHHSC Affiliates for the fiscal years ending as of September 30, 2011, 2012 and 2013 including the notes thereto; (ii) the audited consolidated statements of financial position of each of the YNHHSC Affiliates, and related statements of activities and change in net assets, functional expenses and cash flows of each of the YNHHSC Affiliates as of December 31, 2014, including the notes thereto (the "***YNHHSC 2014 Audited Financial Statements***"); and (iii) an unaudited consolidated statement of financial position of each of the YNHHSC Affiliates and unaudited statements of activities, functional expenses and cash flows of each of the YNHHSC Affiliates as of March 31, 2015 (the "***YNHHSC Interim Financial Statements***" and together with the YNHHSC 2014 Audited Financial Statements, the "***YNHHSC Financial Statements***"). The YNHHSC 2014 Audited Financial Statements (i) have been prepared in accordance with GAAP and (ii) fairly present in all material respects the consolidated financial position and the results of operations and cash flows of each of the YNHHSC Affiliates at and as of the dates or for the periods indicated. The YNHHSC Interim Financial Statements (i) have been prepared in accordance with GAAP (subject to certain presentation items consistent with the ordinary course of business, to the absence of footnote disclosure and to normal year-end adjustments) and (ii) fairly present in all material respects the consolidated financial position and the results of operations and cash flows of each of the YNHHSC Affiliates at and as of the respective dates thereof or for the periods ended on such dates, as applicable.

4.7.1 Each of the YNHHSC Affiliates maintains systems of internal accounting controls to provide reasonable assurances that: (i) all transactions are executed in accordance in all material respects with management's general or specific authorization, (ii) all transactions are recorded as necessary to permit the preparation of the YNHHSC Financial Statements in conformity with GAAP and maintain proper accountability for items and (iii) all reserves reflected on the YNHHSC Financial Statements are sufficient for the purposes for which they were established. Since October 1, 2011, none of the YNHHSC Affiliates has received and, to the Knowledge of YNHHSC, there has not been, any complaint, allegation, assertion or claim regarding the YNHHSC Affiliates' accounting or auditing practices, procedures, methodologies or methods, including any complaint, allegation, assertion or claim that any of the YNHHSC Affiliates has engaged in questionable accounting or auditing practices that would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

4.7.2 [Reserved]

4.7.3 [Reserved]

4.8 Subsequent Events. Since the date of the most recent YNHHSC Interim Financial Statements, (i) the YNHHSC Affiliates have conducted their business operations in the ordinary course, and (ii) except as described in Schedule 4.8, there has not been:

(a) Any YNHHSC Material Adverse Effect or event or occurrence of any condition that would reasonably be expected to have a Material Adverse Effect;

(b)-(v) [Reserved]

4.9 Compliance with Law.

4.9.1 Regulatory Compliance. To the Knowledge of YNHHSC, each of the YNHHSC Affiliates have, during the previous three years, conducted and continues to conduct the business operations of such YNHHSC Affiliate in substantial compliance with all Applicable Laws, including Environmental, Health and Safety Requirements, and have timely filed all material reports, data, and other information related to the business operations of the YNHHSC Affiliates, except for (i) matters specifically disclosed to L+M and (ii) violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Except as specifically disclosed to L+M, to the Knowledge of YNHHSC none of the YNHHSC Affiliates that are engaged in the delivery of healthcare has, nor have any of their respective employees, committed a violation of federal or state laws regulating health care fraud, including but not limited to the Health Care Fraud and Abuse Laws, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Each of the YNHHSC Affiliates that are engaged in the delivery of healthcare services is in compliance in all material respects with the administrative simplification provisions required under the HIPAA, including the electronic data interchange regulations and the health care privacy regulations, as of the applicable effective dates for such requirements, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Each of the YNHHSC Affiliates that are engaged in the delivery of healthcare services that is a "covered entity" under HIPAA has designated an executive employee of the YNHHSC Affiliates as its HIPAA privacy officer. To the Knowledge of YNHHSC, the practices of the YNHHSC Affiliates regarding the collection, access, maintenance, transmission, use, and disclosure of Confidential Information, including Protected Health Information, in connection with the conduct and operations of the YNHHSC Affiliates' business are and have been in all material respects in compliance with any of the YNHHSC Affiliates' contracts or commitments with third parties. To the Knowledge of YNHHSC, the practices of the YNHHSC Affiliates regarding the collection, access, maintenance, transmission, use, and disclosure of Confidential Information, including Protected Health Information, in connection with the conduct and operations of the YNHHSC Affiliates' business are and have been in accordance in all material respects with any applicable written policy or procedure of the YNHHSC Affiliates since October 1, 2011 (or such later date on which the relevant policy or procedure shall have taken effect). To the Knowledge of YNHHSC, the YNHHSC Affiliates have not had any breach of information security that would constitute (i) a "security incident" (as defined in 45 CFR § 164.304) that resulted in material and actual unauthorized access, use, disclosure, modification or destruction of Protected Health Information or (ii) a "breach" under Section 13402 of the American Recovery and Reinvestment Act of 2009 and any regulations promulgated thereunder or state information security laws or regulations that require notification to or of government officials, or to individuals whose information may have been breached.

4.9.2 Investigations and Penalties. To the Knowledge of YNHHSC, since January 1, 2012, none of the YNHHSC Affiliates that are engaged in the delivery of

healthcare services, and, no officer, director or trustee, or board officer or employee thereof with respect to the conduct of business operations of the YNHHSC Affiliates:

(a) has been subject to any investigation, inquiry or suit by any Governmental Authority that has not been fully and finally resolved regarding any alleged violation of applicable governmental authorization or legal requirement which if adversely determined would reasonably be expected to have a Material Adverse Effect;

(b) has paid or been subject to any fine, penalty, corrective action plan, remediation plan, exclusion or other sanction by, or made a self-disclosure to, any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect;

(c) is a party to any written arrangement, including without limitation a corporate integrity agreement, deferred prosecution agreement, consent decree or settlement agreement, with any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect;

(d) has been or is currently a defendant in any qui tam, false claims or similar litigation that would reasonably be expected to have a Material Adverse Effect if adversely determined;

(e) to the Knowledge of YNHHSC, is currently subject to any investigation, inquiry or suit by any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect; or

(f) to the Knowledge of YNHHSC, has received any complaint from any employee, independent contractor, vendor, or any other Person regarding any alleged material violation of any governmental authorization or legal requirement that would reasonably be expected to have a Material Adverse Effect.

4.9.3 Compliance Program. Each of the YNHHSC Affiliates has established and maintains a corporate compliance program which addresses the material requirements of all material Applicable Laws of the Governmental Authorities having jurisdiction over its business and operations. Each of the YNHHSC Affiliates that is engaged in the delivery of healthcare services has designated an executive employee of such YNHHSC Affiliate or of YNHHSC as its chief compliance officer. Except as specifically disclosed to YNHHSC, to the Knowledge of YNHHSC, there are no material pending internal investigations that could reasonably be expected to lead to a material fine, penalty, corrective action plan, remediation plan, exclusion or other material sanction by, or a self-disclosure to, any Governmental Authority regarding any alleged violation of any applicable governmental authorization or legal requirement. To the Knowledge of YNHHSC, each of the YNHHSC Affiliates have established and maintain policies and procedures, including without limitation conflict of interest and related policies, for the review of all compensation arrangements and other arrangements that could involve the referral of patients with other Persons, including but not limited to its officers, directors or

trustees, physicians, executives, their immediate family members, their professional practice entities and other referral sources, that are reasonably designed to maintain compliance with (i) all Applicable Laws, including but not limited to Health Care Fraud and Abuse Laws and the intermediate sanction provisions of the Code and regulations promulgated pursuant thereto, and (ii) their internal policies, including but not limited to any applicable conflicts of interest policy. Except as specifically disclosed to YNHHSC, all such compensation and other arrangements with potential referral sources are, to the Knowledge of YNHHSC, in compliance with all Applicable Laws, including but not limited to Health Care Fraud and Abuse Laws.

4.9.4 Communications and Environmental Claims. Except as specifically disclosed to L+M, during any applicable statute of limitations, none of the YNHHSC Affiliates have received any communication (written or, to the Knowledge of YNHHSC, oral), whether from any Governmental Authority or third party, alleging that any of the YNHHSC Affiliates are not in compliance with any Health Care Laws and there is no Environmental Claim pending or, to the Knowledge of YNHHSC, threatened against any of the YNHHSC Affiliates, or, to the Knowledge of YNHHSC, pending or threatened, against any other Person or entity with respect to any of the YNHHSC Affiliates, or for whose Liability for any Environmental Claim, with respect to any of the YNHHSC Affiliates, any of the YNHHSC Affiliates have or may have retained or assumed by Contract or by operation of Applicable Law which in any such case would give rise to a Material Adverse Effect.

4.9.5 Permits, Licenses and Accreditations.

(a) Each of the YNHHSC Affiliates has all Permits of Governmental Authorities, including those required under Environmental, Health and Safety Requirements, necessary to conduct the business operations of the YNHHSC Affiliates and obtain reimbursement under all Contracts, including provider Contracts such as network participation agreements and discount agreements, programs and other arrangements with Payer Programs ("***YNHHSC Permits***"). To the Knowledge of YNHHSC, none of the YNHHSC Affiliates is in material breach or violation of, or material default under any YNHHSC Permit, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. None of the YNHHSC Affiliates has made a decision not to renew any YNHHSC Permit. To the Knowledge of YNHHSC, none of the YNHHSC Affiliates is currently subject to or has been given notice of any threatened audit, review or investigation by a Governmental Authority with respect to any YNHHSC Permit.

(b) Each of the YNHHSC Affiliates maintain the accreditations related to its business and operations that are required to be maintained in order for the YNHHSC Affiliates to continue to operate their respective businesses in accordance with their respective past practices, without contingencies, including without limitation accreditation by the Joint Commission. To the Knowledge of YNHHSC, each of the YNHHSC Affiliates have taken all actions required to be taken to maintain such accreditations. There is no pending, and to the Knowledge of YNHHSC, there is no threatened, investigation of any of the YNHHSC Affiliates by any accreditation organization with respect to any material accreditation. None of the YNHHSC Affiliates is subject to any notice of deficiency, plan of correction or similar action with respect to any such material accreditation.

(c) [Reserved]

4.9.6 [Reserved]

4.9.7 [Reserved]

4.10 Tax Matters.

4.10.1 For the six year period preceding the Closing Date, each YNHHSC Affiliate has (i) duly filed or caused to be filed with the appropriate taxing authorities all Tax Returns required to be filed by it (giving effect to as-of- right extensions) and all such Tax Returns are true, correct and complete in all material respects, (ii) timely paid or caused to be paid in full all Taxes shown to be due on such Tax Returns or otherwise due and payable with respect to the operations of the YNHHSC Affiliates and (iii) except as specifically disclosed to L+M, complied in all material respects with all Applicable Laws, rules and regulations relating to the withholding of Taxes and the payment of withheld Taxes, and timely and properly withheld and paid over to the appropriate Governmental Authorities all amounts required to be so withheld and paid under all Applicable Laws, rules and regulations.

4.10.2 No deficiencies or assessments for any Taxes of, or relating to, the operations of the YNHHSC Affiliates have been proposed, asserted or assessed which have not been resolved and paid in full except for deficiencies and assessments being contested in good faith as listed and described in Schedule 4.10.2 or as specifically disclosed to L+M, and no United States federal, state, local or foreign audits or other administrative or judicial proceedings are presently pending with regard to any Taxes or Tax Returns of, or relating to, the operations of the YNHHSC Affiliates. There are no Liens for Taxes upon any assets owned by the YNHHSC Affiliates except for Permitted Encumbrances.

4.10.3 As of the Closing, except as specifically disclosed to L+M, each of the YNHHSC Affiliates is recognized by the IRS as exempt from United States federal income taxation, and is recognized by the State of Connecticut as exempt from state and local income taxes, real property taxes and qualifies for sales tax exemptions available to organizations described in Section 501(c)(3) of the Code.

4.10.4 [Reserved]

4.10.5 [Reserved]

4.10.6 [Reserved]

4.10.7 YNHHSC has provided to L+M copies of the letters and/or rulings from the IRS which recognize that the YNHHSC Obligated Group Members are Tax-Exempt Organizations exempt from United States federal income taxes under Section 501(a) of the Code as organizations described in Section 501(c)(3) of the Code and not as "private foundations" as such term is defined in Section 509 of the Code (the "***YNHHSC Determination Letters***"). The YNHHSC Determination Letters have not been modified, limited or revoked, in whole or in part, and none of the YNHHSC Obligated Group

Members for which YNHHSC Determination Letters have been provided has been notified that the IRS is proposing to revoke an YNHHSC Determination Letter. There is no pending request by any of the YNHHSC Obligated Group Members for a redetermination of tax-exempt status as an organization described in Section 501(c)(3) of the Code. Each of the YNHHSC Obligated Group Members that are the subject of the YNHHSC Determination Letters are in compliance with all of the terms, conditions, and limitations contained in the YNHHSC Determination Letters, if any, and there has been no conduct by any such YNHHSC Obligated Group Members, of such nature that would warrant modification, limitation or revocation of the YNHHSC Determination Letters. To the best of YNHHSC's Knowledge, none of any such YNHHSC Affiliates has any "unrelated business income" as defined in Sections 511 through 514 of the Code which would adversely affect any of the YNHHSC' status as an organization described in Section 501(c)(3) of the Code. None of any such YNHHSC Obligated Group Members has been notified that the IRS is proposing to investigate its continued qualification as an organization described in Section 501(c)(3) of the Code or that there are any administrative or judicial proceedings pending or threatened which may adversely affect the classification of any of any such YNHHSC Obligated Group Members as an organization described in Section 501(c)(3) of the Code and not a private foundation under Section 509 of the Code.

4.10.8 The YNHHSC 2014 Bond Disclosure Documents contains a description of each tax-exempt financing, benefiting any of the Members of the YNHHSC Obligated Group. Each of the Members of the YNHHSC Obligated Group is in compliance in all material respects with all covenants required to be complied with by it under the YNHHSC Tax-Exempt Bonds.

4.10.9 With respect to the YNHHSC Tax-Exempt Bonds no action has been taken or omitted to be taken by any of the Members of the YNHHSC Obligated Group which would cause such YNHHS Tax-Exempt Bonds to be an "arbitrage bond" under Section 148(a) of the Code. Each of the YNHHS Tax-Exempt Bonds is in compliance with the arbitrage rebate requirement of Section 148(f) of the Code. No action has been taken or omitted to be taken by any of the Members of the YNHHSC Obligated Group which would cause any YNHHS Tax-Exempt Bonds not to be "qualified 501(c)(3) bonds" within the meaning of Section 145 of the Code. Each of the YNHHS Tax-Exempt Bonds satisfies all applicable requirements set forth in Sections 147 and 149 of the Code in order for interest thereon to be excluded from gross income for federal income tax purposes.

4.11 [Reserved]

4.12 Intellectual Property. To the Knowledge of YNHHSC, each of the YNHHSC Affiliates owns free and clear of all Liens other than Permitted Encumbrances described in clause (b) or (c) of the definition of such term, Liens granted under the YNHHSC Master Trust Indenture securing indebtedness that is disclosed and described in the YNHHSC 2014 Audited Financial Statements and Liens listed or described in Schedule 4.12, or is licensed or otherwise has the valid and enforceable right to use, all Intellectual Property used in or necessary to the conduct of its operations other than failures to own, be licensed or have the right to use Intellectual Property that would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. All such licenses and agreements with third parties relating to

such Intellectual Property that are material to the business operations of the YNHHSC Affiliates, taken as a whole, are valid and binding and in full force and effect, and to the Knowledge of YNHHSC, none of the parties thereto is in default thereunder or breach thereof if such breach or default, individually or in the aggregate, would reasonably be expected to have a Material Adverse Effect. To the Knowledge of YNHHSC, there is no pending claim by any third party challenging the ownership, validity or use of any material Intellectual Property that is material to the business operations of the YNHHSC Affiliates, taken as a whole.

4.13 [Reserved]

4.14 [Reserved]

4.15 Litigation.

4.15.1 Except as specifically disclosed to L+M or as disclosed pursuant to Section 4.9, there are no Litigations or Proceedings pending or, to the Knowledge of YNHHSC, threatened against the YNHHSC Affiliates, except for any such suit, claim, action, proceeding, arbitration, hearing, inquiry or investigation which (i) is not reasonably expected as of the date hereof, together with any related claims arising out of the same set of facts, to involve an amount in controversy in excess of $5,000,000, in the aggregate, excluding malpractice, general liability and other claims which are fully insured (subject to customary deductible and retention amounts), or (ii) would not be reasonably expected to have a Material Adverse Effect.

4.15.2 There are no outstanding orders, injunctions or decrees of any Governmental Authority (other than orders, injunctions or decrees of general applicability and which do not specifically name an YNHHSC Affiliate) which would have a Material Adverse Effect.

4.16 Labor Relations.

4.16.1 Except for the Collective Bargaining Agreements described in Schedule 4.16.1 and except as disclosed to L+M, (i) none of the YNHHSC Affiliates is a party to, nor bound by, any Collective Bargaining Agreement; (ii) none of the YNHHSC Affiliates' employees are covered by the terms of any Collective Bargaining Agreements; (iii) to the Knowledge of YNHHSC, no labor union, trade union or labor organization of the YNHHSC Affiliates has since December 31, 2011, made a pending demand for recognition or certification, as a collective bargaining representative of the YNHHSC Affiliates' employees and, to the Knowledge of YNHHSC, there are no representation election petitions filed with the National Labor Relations Board pertaining to the YNHHSC Affiliates' employees; (iv) YNHHSC has no Knowledge of any union organizing activities with respect to any employees of the YNHHSC Affiliates; (v) since October 1, 2011, to the Knowledge of YNHHSC, there have been no actual or threatened arbitrations, grievances, unfair labor practices, labor disputes, strikes, lockouts, slowdowns or collective work stoppages against the YNHHSC Affiliates except for those that would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect; and (vi) since October 1, 2011, neither the YNHHSC Affiliates nor any of their employees, agents or representatives have committed any material unfair labor practice as defined in the

National Labor Relations Act which could reasonably be expected to have a Material Adverse Effect.

4.16.2 Each of the YNHHSC Affiliates: (i) is not in violation in any material respect of any Applicable Law pertaining to labor, employment or employment practices including, but not limited to, all Applicable Laws regarding health and safety, wages and hours, labor relations, employment discrimination, disability rights or benefits, equal opportunity, immigration, plant closures and layoffs, affirmative action, employee leave issues, unemployment insurance and workers' compensation, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect, or (ii) except as listed in Schedule 4.16.2, is not a party to any currently pending claim, action, arbitration, audit, hearing, investigation, complaint, charges, litigation or suit or governmental inquiry alleging a violation of any Applicable Law pertaining to labor, employment or employment practices, nor, to the Knowledge of YNHHSC, is any such claim, action, arbitration, audit, hearing, investigation, complaint, charges, litigation or suit or governmental inquiry pending or threatened, except in each case for matters the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

4.16.3 Except as specifically disclosed to L+M, to the Knowledge of YNHHSC, each of the YNHHSC Affiliates: (i) has taken reasonable steps to properly classify and treat all of their workers, interns, trainees and volunteers as independent contractors or employees, (ii) has taken reasonable steps to properly classify and treat all of their employees as "exempt" or "nonexempt" from overtime requirements under Applicable Law, (iii) is not delinquent in any material payments to, or on behalf of, any current or former independent contractors or employees for any services or amounts required to be reimbursed or otherwise paid, (iv) has withheld and reported all material amounts required by Applicable Law or by agreement to be withheld and reported with respect to wages, salaries and other payments to any current or former independent contractors or employees; and (v) is not liable for any material payment to any trust or other fund governed by or maintained by or on behalf of any Governmental Authority with respect to unemployment compensation benefits, social security or other benefits or obligations for any current or former independent contractors or employees (other than routine payments to be made in the normal course of business and consistent with past practice). To the Knowledge of YNHHSC, none of the YNHHSC Affiliates has direct or indirect material Liability as a result of any misclassification of any Person as an independent contractor rather than as an employee.

4.16.4 Except as listed in Schedule 4.16.4, to the Knowledge of YNHHSC, no employee or former employee of the YNHHSC Affiliates is in any material respect in violation of any term of any employment agreement, nondisclosure agreement, common law nondisclosure obligation, fiduciary duty, non-competition agreement, restrictive covenant or other obligation: (i) to the YNHHSC Affiliates or (ii) to a former employer of any such employee relating (A) to the right of any such employee to be employed by the YNHHSC Affiliates or (B) to the knowledge or use of trade secrets or proprietary information in connection with his or her employment with the YNHHSC

Affiliates, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

4.16.5 Each of YNHHSC Affiliates is and for the last 18 months has been in compliance with all notice and other requirements under the WARN Act. In the 18 months prior to the date hereof, each of the YNHHSC Affiliates has not (i) effectuated a "plant closing" (as defined in the WARN Act) or (ii) effectuated a "mass layoff" (as defined in the WARN Act).

4.17 [Reserved]

4.18 Environmental, Health, and Safety Matters.

4.18.1 Each YNHHSC Affiliate is in material compliance with all Environmental, Health, and Safety Requirements except to the extent that any non-compliance with Environmental, Health and Safety Requirements would not reasonably be expected to have a Material Adverse Effect.

4.18.2 Except as specifically disclosed to L+M, no YNHHSC Affiliate has received any written notice, report or other written information regarding any actual or alleged material violation of Environmental, Health, and Safety Requirements, or any material liabilities or potential material liabilities (whether accrued, absolute, contingent, unliquidated or otherwise), concerning the Remediation of any Environmental Condition or Hazardous Substances relating to the YNHHSC Affiliates that remains outstanding or unresolved.

4.19 [Reserved]

4.20 Illegal Payments. To the Knowledge of YNHHSC, none of the YNHHSC Affiliates, nor any of their respective officers, directors, agents or employees or any other person on behalf of the YNHHSC Affiliates, has made directly or indirectly any illegal payment to or on behalf of, or provided any illegal benefit or inducement for, any physician, supplier or patient of the YNHHSC Affiliates. To the Knowledge of YNHHSC neither the YNHHSC Affiliates, nor any of their respective officers, directors, employees or agents has, directly or indirectly, paid or delivered a fee, commission or other sum of money or item or property, however characterized, to any finder, agent, Governmental Authority or other party, in the United States or any other country, which was or is illegal under any Applicable Law. To the Knowledge of YNHHSC, none of the YNHHSC Affiliates, nor any of their respective officers, directors, employees or agents has made any payment to any supplier of the YNHHSC Affiliates or any officer, director, employee or agent of any patient or supplier of the YNHHSC Affiliates, for the unlawful sharing of fees or to any such patient or supplier or any such officer, director, employee or agent for the unlawful rebating of charges, or engaged in any other unlawful payment or given any other unlawful consideration to any such enrollee, patient or supplier or any such officer, director, employee or agent.

4.21 Bankruptcy. None of the YNHHSC Affiliates is the subject of bankruptcy, insolvency or any similar proceedings.

4.22 [Reserved]

4.23 Foreign Operations. The YNHHSC Affiliates have no operations outside the United States.

4.24 [Reserved]

4.25 [Reserved]

4.26 Regulatory Matters.

4.26.1 To the Knowledge of YNHHSC, since October 1, 2011, the YNHHSC Affiliates have timely filed all material reports, statements, documents, registrations, filings or submissions required to be filed by the YNHHSC Affiliates with any Governmental Authorities, including in connection with or required by any Material Contracts, except where the failure to timely file has not resulted and would not reasonably be expected to result in a Material Adverse Effect. All such reports, statements, documents, registrations, filings and submissions were true, correct and complete in all material respects when filed, complied in all material respects with Applicable Law in effect when filed. Except as set forth on Schedule 4.26, since October 1, 2011, no material deficiencies have been asserted by any such Governmental Authority with respect to such reports, statements, documents, registrations, filings or submissions that have not been satisfied, or, if not yet satisfied, where satisfaction is not yet due. To the Knowledge of YNHHSC, the Material Contracts are in compliance with Applicable Law.

4.26.2 Except as specifically disclosed to L+M, since October 1, 2011, the YNHHSC Affiliates have not been subject to any finding, agreement, settlement or fine regarding noncompliance with any Applicable Law (including fraudulent procedures or practices but excluding any finding, agreement, settlement or fine that resulted only in a monetary penalty of $350,000.00 or less) that resulted in or would reasonably be expected to result in a Material Adverse Effect. Except as specifically disclosed to L+M, to the Knowledge of YNHHSC, since October 1, 2011, the YNHHSC Affiliates have not been subject to any pending or threatened audit, investigation or other regulatory review relating to any noncompliance with any Applicable Law (including fraudulent procedures or practices, or, to the Knowledge of YNHHSC, OSHA violations and any warning letters or observations (including any FDA warning letters or FDA Form 483 observations)), other than regularly scheduled periodic audits and reviews.

4.26.3 Neither YNHHSC nor any YNHHSC Subsidiary has been excluded, debarred or otherwise deemed ineligible to participate in Medicare, Medicaid or any other federal or state health care programs or in any federal or state procurement or non-procurement programs, nor has YNHHSC or any YNHHSC Subsidiary been convicted of a criminal offense related to the provision of federal health care items or services, nor, to YNHHSC's Knowledge, is an investigation or proceeding regarding the foregoing pending or threatened. YNHHSC and each of the YNHHSC Subsidiaries that provides services to beneficiaries of Government Payer programs is (i) qualified for participation in, and has current and valid provider contracts with, the Government Payer programs and /or their fiscal intermediaries or paying agents and is in material compliance with the conditions of

participation or requirements applicable with respect to such participation and (ii) eligible for payment under the Government Payer programs for services rendered to qualified beneficiaries.

4.27 Consents and Approvals. No consents with respect to Material Contracts or approvals of any Governmental Authority are required to be obtained by any YNHHSC Affiliate in connection with the execution, delivery and performance by YNHHSC of this Agreement or the consummation of the transactions contemplated by this Agreement, except for (a) the requirements of the HSR Act and (b) as set forth in Schedule 4.27, which shall include, but not be limited to, any filings with, and approvals from (i) OHCA, (ii) RIDOH upon the recommendation of the Rhode Island Health Services Council, and (iii) the Rhode Island Attorney General.

4.28 Billing, Recoupments and Overpayments.

4.28.1 To the Knowledge of YNHHSC, during the period of the applicable statutes of limitation, all Reimbursement Claims submitted by the YNHHSC Affiliates comply in all material respects with all Applicable Laws, including but not limited to Health Care Fraud and Abuse Laws, and all Payer Program contracts, provider manuals, policies, guidance, and reimbursement requirements governing reimbursement and payment of claims and do not contain any material errors, omissions or disallowances, except as specifically disclosed to L+M, to the extent that non-compliance or errors or omissions would not individually or in the aggregate be reasonably expected to have a Material Adverse Effect. Except as specifically disclosed to L+M, none of the YNHHSC Affiliates have any outstanding overpayment or refund obligations due to any individual Payer Program in excess of $5,000,000 in the aggregate. Except as specifically disclosed to L+M, none of the YNHHSC Affiliates has received notice of any material disallowance, overpayment, refund or dispute between the YNHHSC Affiliates, on the one hand, and any Payer Program, or agent thereof, on the other hand, regarding such Reimbursement Claims that has not been resolved and, to the Knowledge of YNHHSC, there are no facts or circumstances which may reasonably be expected to give rise to any disallowance, overpayment, refund or dispute that individually or in the aggregate would be reasonably expected to have a Material Adverse Effect.

4.28.2 [Reserved]

4.29 [Reserved]

4.30 Clinical Trials. To the Knowledge of YNHHSC, all clinical trials currently being conducted at the YNHHSC Affiliates are being conducted (i) with the approval and/or waiver of an appropriately constituted and duly registered IRB and (ii) in compliance with the applicable IRB policies and procedures, study agreements with trial sponsors and/or contract research organizations, and all Applicable Law, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Within the past two years, no clinical trial conducted at the YNHHSC Affiliates has been subject to suspension or termination (other than by the sponsor of the trial due to reasons unrelated to the YNHHSC Affiliate's performance of its obligations) due to patient safety concerns, material non-compliance with the applicable study agreement or Applicable Law, except for suspensions

or terminations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect. Within the past two years, none of the YNHHSC Affiliates, nor to the Knowledge of YNHHSC, any investigator involved in a clinical trial at the YNHHSC Affiliates, has received any correspondence or communication relating to the applicable YNHHSC Affiliate's conduct from any trial sponsor, contract research organization, IRB or Governmental Authority, including without limitation the Connecticut Department of Public Health, FDA or the OHRP, regarding patient safety breaches, billing issues associated with care provided to clinical trial subjects, obligations to register and report results of clinical trials, research misconduct, notice of pending debarment or disqualification, or other material non- compliance with the applicable study agreement or Applicable Law, except for violations the effect of which would not, individually or in the aggregate, be reasonably expected to have a Material Adverse Effect.

4.31 Relationship with Pharmaceutical and Medical Device Manufacturers, Vendors and Suppliers. Except as specifically disclosed to L+M, (i) to the Knowledge of YNHHSC, each of the YNHHSC Affiliates is in compliance with the applicable YNHHSC Affiliate's policies and procedures regarding interactions with pharmaceutical manufacturers, medical device manufacturers, equipment and supply vendors, including without limitation, those relating to conflicts of interest, product samples, transfers of value and remuneration arrangements, and (ii) such policies and procedures are reasonably designed to comply with Applicable Law.

4.32 Solvency of the YNHHSC Affiliates. Immediately after giving effect to the transactions contemplated by this Agreement, none of the YNHHSC Affiliates will (a) be insolvent (either because its financial condition is such that the sum of its Liabilities is greater than the fair value of its assets or because the fair salable value of its assets is less than the amount required to pay probable Liabilities as they mature), (b) have unreasonably small capital with which to engage in its business or (c) have incurred Liabilities beyond its ability to pay as they become due. No transfer of property is being made and no obligation is being incurred in connection with the transactions contemplated by this Agreement with the intent to hinder, delay or defraud either present or future creditors of the YNHHSC Affiliates.

4.33 Charitable Funds. To the Knowledge of YNHHSC, YNHHSC and the YNHHSC Subsidiaries have solicited, received, held, invested, expended and applied charitable funds donated to them in all material respects in accordance with all restrictions placed thereon by donors, the terms of any applicable solicitation and Applicable Laws. Neither YNHHSC nor any of the YNHHSC Subsidiaries has received written notice of any, whether actual or alleged, misuse of funds, failure to comply with any donor-imposed restriction, breach of duty related to the funds, or violation of any Applicable Laws which would reasonably be expected to have a YNHHSC Material Adverse Effect, nor to the Knowledge of YNHHSC, has any such misuse, failure, breach or violation occurred.

4.34 No Undisclosed Liabilities. Except as specifically disclosed to L+M, none of the YNHHSC Affiliates has material Liabilities or material obligations of any nature (including, without limitation, any direct or indirect Indebtedness, guaranty, endorsement, claim, loss, damage, deficiency, cost, expense, obligation or responsibility, fixed or unfixed, known or unknown, asserted or unasserted, liquidated or unliquidated, secured or unsecured, absolute, accrued, contingent or otherwise and whether due or to become due, or liability or obligations for an overpayment, duplicate payments, refunds discounts or adjustments due to any Third Party

Payer, including any federal or state health care program) arising out of, or relating to, the business operations of YNHHSC Affiliates and which are required to be reflected on a balance sheet prepared in accordance with GAAP, except: (i) liabilities or obligations as and to the extent reflected on or accrued or reserved against as set forth in the YNHHSC 2014 Audited Financial Statements; and (ii) liabilities incurred since the date of the YNHHSC 2014 Audited Financial Statements in the ordinary course of business. Neither YNHHSC nor any of the YNHHSC Subsidiaries is in default of any term or condition of any Indebtedness or other Liability in excess of $250,000, including any trade payable.

4.35 Completeness of Disclosure. No representation or warranty by YNHHSC in this Agreement, or any written certificate, schedule or exhibit, when taken as a whole with all such other representations, warranties, certificates, schedules and exhibits, and when taken as a whole with the YNHHSC 2014 Bond Disclosure Documents, contains or will contain any untrue statement of a material fact or will omit to state a material fact required to be stated herein or therein or necessary to make any statement herein or therein not misleading in light of the circumstances under which it was made.

ARTICLE 5

OBLIGATIONS BEFORE CLOSING

5.1 L+M's Obligations. From the Effective Date until the Closing (or the earlier termination of this Affiliation Agreement pursuant to Article 8):

5.1.1 Access to Premises and Information. YNHHSC and its counsel, accountants, and other representatives shall have reasonable access during normal business hours and upon reasonable prior notice to all properties, books, accounts, records, contracts and documents of or relating to L+M and the L+M Affiliates. Upon reasonable request by YNHHSC, L+M shall furnish or cause to be furnished to YNHHSC and its representatives all data and information concerning the businesses, finances and properties of L+M and the L+M Affiliates, so long as responding to such requests does not unreasonably interfere with the operations of the L+M Affiliates.

5.1.2 Conduct of Business in Normal Course. L+M shall and shall cause the L+M Subsidiaries to carry on their businesses and activities not other than in the ordinary course of business and in accordance with the terms of this Article 5.

5.1.3 Preservation of Business and Relationships. L+M shall and shall cause the L+M Subsidiaries to use their commercially reasonable efforts to preserve their assets, subject to normal wear and tear and casualty, and business organizations, to keep available their present officers and employees and to substantially preserve their present material relationships with suppliers, payors, patients and others having business relationships with L+M or the L+M Affiliates; provided, however, that nothing in this Section 5.1.3 shall limit or restrict the right of L+M and the L+M Affiliates to terminate, discipline, or change the duties of any officers or employees, or to engage in staff reductions or consolidations prior to the Closing Date (to the extent such actions are consistent with the then current applicable policies and procedures of L+M and /or the L+M Subsidiaries, as applicable, any collective bargaining agreement, any employment

agreements and Applicable Law and do not give rise to executive severance obligations that exceed standards of reasonableness for services and roles within the L+M Affiliates).

5.1.4 Corporate Matters. L+M shall not shall and shall cause the L+M Subsidiaries not to, without the prior written consent of YNHHSC, amend their certificates of incorporation or bylaws (or other governing documents) except as permitted or required by this Affiliation Agreement to do so.

5.1.5 Maintenance of Insurance. L+M shall and shall cause the L+M Subsidiaries to continue to carry their existing insurance, including any self-insured insurance plans, subject to variations in amounts required by the ordinary operations of its businesses.

5.1.6 Employees and Compensation. Except in the ordinary course of business, as contemplated in the Applicable L+M Budget, required in an express term of a contract, as required by Applicable Law or with YNHHSC's prior written consent, L+M shall not and shall cause the L+M Subsidiaries not to do or agree to do any of the following acts:

(a) Grant any increase in salaries payable or to become payable by any of them to any officer or employee;

(b) Increase benefits payable to any officer or employee under any bonus or pension plan or other contract or commitment, other than reasonable and customary retention bonuses; or

(c) Modify any collective bargaining agreement to which L+M or any L+M Affiliate is a party or by which any of them may be bound unless required by Applicable Law or an express term of a collective bargaining agreement (provided that this Section 5.1.6 shall not limit or restrict the right of any L+M Affiliate to renegotiate any collective bargaining agreement that is expired as of or expires after the date of this Affiliation Agreement).

5.1.7 New Transactions. L+M shall not and shall cause the L+M Subsidiaries not to do or agree to do any of the following acts without the prior written consent of YNHHSC:

(a) Enter into any contract, commitment or transaction not in the ordinary course of business;

(b) [Reserved];

(c) Make any capital expenditure or expenditures in excess of $5,000,000 not contemplated by the Applicable L+M Budget, except that on notice to YNHHSC L+M or an L+M Subsidiary may make unbudgeted capital expenditures that L+M determines are necessary (i) to remediate unexpected life safety or property safety issues, or (ii) to comply with unexpected issues that, if not remediated, would cause noncompliance with regulatory requirements.

(d) Enter into any lease of capital equipment or property under which the annual lease charge is in excess of $500,000 that is not contemplated by the Applicable L+M Budget;

(e) Sell or dispose of any capital assets with a net book value in excess of $500,000 with respect to any individual transaction or $2,000,000 in the aggregate;

(f) [Reserved];

(g) Incur any Indebtedness (other than a line or lines of credit under which the aggregate availability does not exceed the amount contemplated by the Applicable L+M Budget) or make any loans or advances to any Person other than (i) inter-company advances in the ordinary course of business and (ii) tuition reimbursement and/or housing assistance loans to employees that are made pursuant to L+M's existing policies and are reasonably consistent with past practice;

(h) Enter into any compromise or settlement of any Litigation or Proceeding involving a payment by L+M or any L+M Affiliate exceeding the greater of (i) $500,000.00 or (ii) the amount reserved, if any, with respect to such Litigation or Proceeding in the Financial Statements, unless (in either case) covered by insurance;

(i) Enter into any agreement that restrains, limits or impedes the ability of L+M or any L+M Affiliate to compete with or conduct any business or line of business;

(j) [Reserved]; or

(k) Enter into any new collective bargaining agreement unless required by law or an express term of a collective bargaining agreement (provided that this Section 5.1.7 shall not limit or restrict the right of any L+M Affiliate to renegotiate any collective bargaining agreement that is expired as of or expires after the date of this Affiliation Agreement).

5.1.8 Consents of Third Parties. L+M shall use its and shall cause the L+M Subsidiaries to use their Commercially Reasonable Best Efforts to obtain the consents of all third parties required to be obtained by L+M or the L+M Subsidiaries for the consummation of the transactions contemplated by this Affiliation Agreement.

5.1.9 Certain Compliance Matters.

(a) After the Effective Date and prior to the Closing Date L+M shall engage a qualified environmental consultant to conduct an operational compliance self-audit of the operations of LMH, LMW, LMMG and VNA of Southeastern Connecticut with respect to Environmental, Health and Safety Requirements and to complete a written report of such self-audit prior to the Closing Date. Prior to the Closing Date, to the extent reasonably feasible, the applicable L+M Affiliates shall implement any necessary corrective or remediation plans or recommendations included in such report (as reasonably determined by L+M) in accordance with the time periods set forth in such reports; *provided, however*, that to the extent that the applicable L+M Affiliates are continuing in good faith to implement such plans or recommendations at

Closing, the failure to have completed such plans and recommendations as of the Closing Date shall not be deemed to be a breach of this Section 5.1.9.

(b) L+M shall be responsible at its expense for preparing and filing with DEEP as transferor and (if applicable) as "certifying party" any filings required by the Transfer Act with respect to any real properties owned, leased or occupied by LMMG (collectively, the "LMMG Properties") or LMMG's business operations that the Parties mutually determine may be deemed to constitute an "establishment" as such terms are defined in the Transfer Act and for prosecuting any investigatory or remediation obligations under the Transfer Act.

(c) To the extent that any Governmental Authority determines that any L+M Real Property or business operation other than the LMMG Properties and business operations is subject to the requirements of the Transfer Act, L+M, or the L+M Affiliate that owns such L+M Real Property or conducts such business operation, shall be responsible at its expense for preparing and filing with DEEP as transferor and (if applicable) as "certifying party" any filings required by the Transfer Act with respect to such L+M Real Property or business operation and for prosecuting any investigatory or remediation obligations under the Transfer Act.

(d) Prior to the Closing Date L+M shall cause to be conducted a Phase I environmental site assessment of each Owned Real Property (which may be an updated Phase I assessment if a Phase I assessment has already been conducted) and, if any Recognized Environmental Condition (as such term is defined in the applicable American Society for Testing and Materials standard) is identified in any such assessment, L+M shall cause such condition to be further investigated through a Phase II or Phase III investigation, as appropriate. Prior to the Closing Date, L+M shall cause a qualified environmental consultant to make recommendations with respect to any corrective or remediation actions that should be carried out based on such environmental site assessments and the requirements of Environmental, Health and Safety Requirements, and to the extent reasonably feasible, L+M shall complete all compliance or remediation recommendations required by Environmental, Health and Safety Requirements; *provided, however*, that to the extent that L+M is continuing in good faith to implement such recommendations at Closing, the failure to have completed such plans and recommendations as of the Closing Date shall not be deemed to be a breach of this Section 5.1.9.

5.1.10 Governmental Approvals. L+M shall and shall cause the L+M Subsidiaries to use their Commercially Reasonable Best Efforts to obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities as are necessary for each to consummate the transactions contemplated hereby, including, without limitation, the Hart-Scott-Rodino Act filing and the approvals of OHCA, RIDOH and the Rhode Island Attorney General.

5.1.11 No-Shop Clause. From the Effective Date until Closing, L+M shall not and shall cause the L+M Subsidiaries not to, without the prior written consent of YNHHSC: (a) offer for sale or consider any offer to purchase, all or substantially all of the assets of or any ownership or control interest of or in L+M or any L+M Subsidiaries or to admit any Person as a member of L+M or any L+M Subsidiary; (b) solicit or consider offers to buy all or substantially all of the assets of or any ownership or control interest of or in L+M or any L+M Affiliate or to admit any Person as a member of L+M or any L+M Subsidiary; (c) hold discussions with any Person or organization (other than YNHHSC)

looking toward such an offer or solicitation or looking toward a merger or consolidation of or in or admission of a member to L+M or any L+M Subsidiaries or (d) enter into any agreement with any Person or organization (other than YNHHSC) with respect to the sale, management, operation or other disposition of all or substantially all of the assets of or any ownership or control interest in L+M or any L+M Subsidiary, or with respect to any merger, consolidation or similar transaction involving L+M or any L+M Subsidiary, or with respect to the admission of any member to L+M or any L+M Subsidiary, (each such transaction set forth in clauses (a), (b), (c) and (d) being referred to herein as an "***L+M Corporate Transaction***"); provided, however, that nothing in this Section 5.1.11 shall prohibit or restrict L+M from entering into, or causing a L+M Subsidiary to enter into, an L+M Corporate Transaction with L+M or another L+M Subsidiary for the purpose of consolidating an L+M Subsidiary that does not have material business operations as of the date of this Affiliation Agreement.

5.1.12 Satisfaction of Conditions. L+M shall and shall cause each L+M Subsidiary to take all steps reasonably necessary to be taken on its part to cause the conditions precedent to the consummation of the transactions contemplated by Article 6 to be satisfied and to close the Affiliation.

5.1.13 Notice of Breach. In the event that L+M or any L+M Subsidiary breaches, in any material respect, any of its covenants contained in this Article 5, L+M shall promptly deliver written notice of such breach to YNHHSC and such notice shall provide a detailed description of such breach and the date that the breach first occurred.

5.1.14 Covered Transactions. At least prior to the consummation by any L+M Affiliate of any Covered Transaction, L+M shall give notice to YNHHSC of the intent of such L+M Affiliate to consummate such Covered Transaction, of the parties thereto and of the material terms thereof (except for any such information that counsel to L+M deems to be competitively sensitive, in which case L+M shall cause its counsel to give notice of such information to counsel to YNHHSC). Upon the consummation by any L+M Affiliate of any Covered Transaction, L+M shall give notice to YNHHSC of the consummation of such Covered Transaction and of any change in the parties thereto and of the material terms thereof as compared to the prior notice given to YNHHSC with respect to such Covered Transaction (except for any such information that counsel to L+M deems to be competitively sensitive, in which case L+M shall cause its counsel to give notice of such information to counsel to YNHHSC).

5.1.15 L+M Budgets. No later than the last day of each fiscal year of the L+M Affiliates that occurs between the Effective Date and the Closing Date, L+M shall cause each L+M Affiliates to adopt a capital and operating budget for the ensuing fiscal year and to deliver to YNHHSC true, correct and complete copies of such capital and operating budget.

5.1.16 Renegotiated Collective Bargaining Agreements. Upon executing any renegotiated collective bargaining agreement that is expired as of or expires after the date of this Affiliation Agreement, L+M shall deliver a true, correct and complete copy of such renegotiated collective bargaining agreement to YNHHSC.

5.1.17 L+M Subsidiaries Amended Certificates of Incorporation and Bylaws. On or prior to the Closing Date, L+M shall cause: (i) LMH to adopt the LMH Amended Certificate of Incorporation and the LMH Amended Bylaws; (ii) LMW to adopt the LMW Amended Certificate of Incorporation and the LMW Amended Bylaws; and (iii) VNA of Southeastern Connecticut to adopt the VNA of Southeastern Connecticut Amended Certificate of Incorporation and the VNA of Southeastern Connecticut Amended Bylaws.

5.1.18 YNHHSC Consent Rights. Except as otherwise expressly contemplated in this Affiliation Agreement, to the extent that L+M requests the consent of YNHHSC with respect to any transaction, action or event contemplated in Section 5.1.6 or Section 5.1.7 (i) YNHHSC shall not unreasonably withhold, condition or delay such consent and (ii) YNHHSC shall respond to such request for consent within ten (10) business days after the date on which notice of such request is given in accordance with this Section 5.1.18. Any request under this Section 5.1.18 shall be transmitted by L+M via electronic mail and overnight courier to the persons and in accordance with the address information set forth on Exhibit 5.1.18 and shall be confirmed by telephonic communication to each such person using the telephone numbers set forth on Exhibit 5.1.18. If no response is received from YNHHSC within five (5) business days after notice of the initial request for consent has been so given, a second notice shall be transmitted by L+M via electronic mail and overnight courier, and confirmed by telephone, in the same manner and in accordance with the instructions set forth on Exhibit 5.1.18. If following the giving of both such notices, and the expiration of the ten (10) business day response period, YNHHSC fails to respond to any such request for consent, YNHHSC shall be deemed to have consented to the transaction, action or event described in such request. If YNHHSC responds to any such request for consent within the applicable ten (10) business day period, including by requesting additional information with respect to the request, then YNHHSC's consent shall only be deemed granted if YNHHSC expressly consents in writing to such transaction, action or event.

5.2 YNHHSC Obligations.

5.2.1 Access and Information. YNHHSC shall furnish or cause to be furnished to L+M and its counsel, accountants and other representatives all data and information concerning the businesses and finances of YNHHSC that is pertinent to the transactions contemplated by this Agreement and that is reasonably requested by L+M.

5.2.2 Governmental and Other Approvals. YNHHSC shall use its Commercially Reasonable Best Efforts to (i) obtain all licenses, permits, consents, approvals, authorizations, qualifications and orders of any Governmental Authorities that are required to be obtained by YNHHSC in order to consummate the transactions contemplated hereby, including, without limitation, the Hart-Scott-Rodino Act filing and the approvals of OHCA and RIDOH; and (ii) participate in all other meetings related to obtaining approval for this transaction requested by L+M including without limitation, meetings with (a) local communities as required by Applicable Law; and (b) L+M's Board of Trustees.

5.2.3 Consents of Third Parties. YNHHSC shall use its Commercially Reasonable Best Efforts to obtain the consents of all third parties required to be obtained by YNHHSC for the consummation of the transactions contemplated by this Agreement.

5.2.4 Satisfaction of Conditions. YNHHSC shall take all steps reasonably necessary to be taken on its part to cause the conditions precedent to the consummation of the transactions contemplated by Article 7 to be satisfied and to close the Affiliation.

5.2.5 Notice of Breach. In the event that YNHHSC breaches, in any material respect, any of its covenants contained in this Article 5, YNHHSC shall promptly deliver written notice of such breach to L+M and such notice shall provide a detailed description of such breach and the date that the breach first occurred.

5.2.6 Notice of YNHHSC Change of Control. Within five (5) days after the execution of a definitive agreement contemplating a YNHHSC Change of Control (or simultaneously with the execution of a definitive agreement contemplating a YNHHSC Change of Control if such execution occurs less than five (5) days prior to the Closing), YNHHSC shall give notice to L+M of such contemplated YNHHSC Change of Control and of the nature of and the identity of the parties to such YNHHSC Change of Control.

5.3 Additional Due Diligence; Disclosure Schedules. YNHHSC and L+M have each furnished to the other certain requested Due Diligence Information in order to permit each of the Parties to perform a due diligence analysis of the Affiliation. From the date hereof through the Closing, (i) each Party will promptly disclose to the other Party any information of which such first mentioned Party has Knowledge that has not previously been disclosed in writing as part of the Due Diligence Information and that could, individually or in the aggregate, reasonably be expected to cause a Material Adverse Effect; (ii) L+M will provide to YNHHSC, on a monthly basis, a financial information packet on the financial condition of the L+M Affiliates, in the same form provided to L+M's Board of Trustees (except for the deletion of any competitively sensitive information); (iii) L+M will provide YNHHSC a copy of each Medicare cost report filed by any L+M Affiliate after the date hereof within five (5) business days after such filing and (iv) prior to the Closing Date (but in no event less than three (3) business days prior to the Closing Date) each Party shall deliver to the other Party updates of such Party's Disclosure Schedule (each, a "***Schedule Supplement***") solely with respect to (x) any information that first arises or of which the Party delivering such Schedule Supplement first obtains Knowledge after the date of this Affiliation Agreement and that if it existed on the date of this Agreement would be required to be reflected on the Disclosure Schedules and (y) any other information that is necessary to correct any disclosure schedule or representation or warranty and that first arises or of which the Party delivering such Schedule Supplement first obtains Knowledge after the date of this Affiliation Agreement. Each Schedule Supplement shall be deemed to be incorporated into and to supplement and amend the Disclosure Schedules as of the Closing.

5.4 Obligations in Respect of Consents and Approvals.

(a) Each Party shall use its Commercially Reasonable Best Efforts to take, or cause to be taken, all actions, and to do, or cause to be done, all things necessary, proper or advisable under Applicable Law to consummate and make effective in the most expeditious

manner possible the transactions contemplated by this Affiliation Agreement, including (i) the preparation and filing of all forms, registrations and notices required to be filed to consummate such transactions, (ii) taking all reasonable actions consistent with the definition of Commercially Reasonable Best Efforts to obtain (and cooperating with the other Party in obtaining) any consent, authorization, order or approval of, or any exemption by, any third party, including any Governmental Authority (which actions will include furnishing all information required under the Hart-Scott-Rodino Act and any other Applicable Law relating to antitrust, competition or trade regulation ("***Competition Law***") required to be obtained or made by any Party or their Affiliates in connection with the transactions contemplated by this Affiliation Agreement) and (iii) the execution and delivery of any additional instruments necessary to consummate the transactions contemplated by this Agreement and to fully carry out the purposes of this Agreement. Additionally, each Party will use its Commercially Reasonable Best Efforts to fulfill all conditions precedent to this Affiliation Agreement and will not take any unreasonable action that is not consistent with the definition of Commercially Reasonable Best Efforts after the date of this Affiliation Agreement that would reasonably be expected to materially delay the obtaining of, or result in not obtaining, any permission, approval or consent from any such Governmental Authority or third party required to be obtained prior to the Closing.

(b) Prior to the Closing, the parties will keep each other apprised of the status of matters relating to the completion of the transactions contemplated by this Affiliation Agreement and work cooperatively consistent with the definition of Commercially Reasonable Best Efforts in connection with obtaining all required consents, authorizations, orders or approvals of, or any exemptions by, any Governmental Authorities. In this regard, prior to the Closing, each Party will promptly provide the other Party (or its counsel) with copies of all filings and communications made by such Party with or to any Governmental Authority or any other information supplied by such Party to, or correspondence with, a Governmental Authority in connection with or with respect to this Affiliation Agreement. Each Party will promptly inform the other Party, and if in writing, furnish the other Party with copies of (or, in the case of material oral communications, advise the other parties orally of) any filing or communication from any Governmental Authorities regarding any of the transactions contemplated by this Agreement, and permit the other parties to review and discuss in advance, and consider in good faith the views of the other Party in connection with, any proposed written (or any material proposed oral) communication with any such Governmental Authority. If any Party or any representative of such Party receives a request for additional information or documentary material from any Governmental Authority with respect to the transactions contemplated by this Affiliation Agreement, then such Party will use its Commercially Reasonable Best Efforts to make, or cause to be made, promptly and after consultation with the other Party, an appropriate response in compliance with such request. Each Party will furnish the other Party with such necessary information and reasonable assistance as the other parties may reasonably request consistent with the definition of Commercially Reasonable Best Efforts in connection with its preparation of necessary filings or submissions of information to any Governmental Authority in connection with or with respect to this Agreement. Each Party may, as each deems advisable and necessary, reasonably designate any competitively sensitive material provided to the other parties under this Section 5.4 as "outside counsel and corporate in-house antitrust counsel only." Such materials and the information contained therein will be given only to the outside legal counsel and corporate in-house antitrust counsel of the recipient and will not be disclosed by such outside counsel and corporate in-house antitrust counsel to the directors, officers or

employees (other than corporate in-house antitrust counsel) of the recipient unless express permission is obtained in advance from the source of the materials or its legal counsel. Furthermore, materials provided pursuant to this Section 5.4 may be redacted to remove references concerning each party's evaluation of the terms of the transactions envisioned by this Affiliation Agreement, as necessary to comply with contractual arrangements or as necessary to address reasonable privilege and business confidentiality considerations. To the extent that transfers of any permits issued by any Governmental Authority are required as a result of the execution of this Affiliation Agreement or the consummation of the transactions contemplated hereby, the parties will use their respective Commercially Reasonable Best Efforts to effect such transfers.

(c) The Parties will use their respective Commercially Reasonable Best Efforts to file, as promptly as practicable but in any event no later than sixty (60) days after the date of this Affiliation Agreement, notifications under the Hart-Scott-Rodino Act, and the Parties will use their respective Commercially Reasonable Best Efforts to file, as promptly as practicable, any other filings or notifications that are required under any other applicable Competition Laws. In the event that the parties receive a formal request for additional information or documentary materials after an initial notification pursuant to the Hart-Scott-Rodino Act or any other Competition Law (a "Second Request"), the Parties will use their respective Commercially Reasonable Best Efforts to respond to such Second Request, as applicable, as promptly as practicable and the Parties shall cause their respective counsel to closely cooperate during the entirety of any such Second Request review process.

(d) The parties will use their respective Commercially Reasonable Best Efforts to resolve such objections, if any, as may be asserted by any Governmental Authority respect to the transactions contemplated by this Agreement under the Hart-Scott-Rodino Act or any other applicable Competition Law.

5.5 Certain Expenses. L+M and YNHHSC hereby agree that the costs and expenses incurred by the Parties in relation to (i) the preparation and filing of all forms, registrations and notices required to be filed to consummate such transactions, (ii) taking all actions necessary to obtain (and cooperating with each other in obtaining) any consent, authorization, order or approval of, or any exemption by, any third party, including any Governmental Authority, which actions will include furnishing all information required under the Hart-Scott-Rodino Act and any other applicable Competition Laws required to be obtained or made by any Party or their Affiliates in connection with the transactions contemplated by this Agreement, and/or (iii) participation in any antitrust or other review, proceedings or actions of any Governmental Authority relating to this Affiliation Agreement or any of the transactions envisioned hereby, including any Second Request or other request for information relating to the Affiliation, in each case, shall be allocated and paid for by the Parties in accordance with Exhibit 5.5 attached hereto. This provision shall survive in accordance with Section 11.14 hereof, whether or not the transaction contemplated by this Agreement is ever consummated.

ARTICLE 6

CONDITIONS PRECEDENT TO OBLIGATIONS OF YNHHSC

The obligations of YNHHSC hereunder are subject to the satisfaction or written waiver (in the sole discretion of YNHHSC), on or prior to the Closing Date, of the following conditions:

6.1 Representations/Warranties. The representations and warranties of L+M contained in Article 3 shall be true and correct on and as of the Closing Date as though such representations had been made on the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date), except as set forth in the Disclosure Schedule, except as specifically disclosed to YNHHSC and except for (i) matters not set forth in the Disclosure Schedule or specifically disclosed to YNHHSC because of the "Material Adverse Effect" qualification in any specific section of this Article 3 and (ii) matters arising from a material breach of a representation or warranties of L+M Article 3 which in the case of clauses (i) and (ii) together do not cumulatively and in the aggregate result in and are not reasonably likely to result in a Material Adverse Effect. No L+M Schedule Supplement individually, nor all L+M Schedule Supplements considered in the aggregate, when taken together with (i) matters not set forth in the Disclosure Schedule or specifically disclosed to YNHHSC because of the "Material Adverse Effect" qualification in any specific section of Article 3, and (ii) matters arising from a material breach of any representation or warranty in Article 3, shall cumulatively and in the aggregate result in or be reasonably likely to result in a Material Adverse Effect.

6.2 Covenants. Each covenant contained in this Affiliation Agreement to be complied with or performed by L+M or an L+M Affiliate on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects.

6.3 Officer's Certificate. YNHHSC shall have received from L+M an officer's certificate, executed on behalf of L+M by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date and stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, as the case may be, that the conditions in Section 6.1 and Section 6.2 have been satisfied.

6.4 Litigation or Proceedings. No Litigation or Proceedings before a court or any other Governmental Authority or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

6.5 Third Party Approvals. All notices, reports and other filings required to be made prior to Closing by L+M or any L+M Affiliate with, and all licenses, permits, consents, certificates of need, approvals, authorizations, clearances, qualifications or orders required to be obtained prior to Closing by YNHHSC (provided YNHHSC has pursued the same as required by

the terms hereof), L+M or any L+M Affiliate from, any Governmental Authority or any other third party for the consummation of the transactions contemplated hereby that are listed or described on Schedule 6.5 or that are otherwise required to be obtained by Applicable Law shall have been made or obtained.

6.6 Closing Deliveries. L+M shall have made the deliveries required to be made by it under Section 9.2.

6.7 Notification of TD Bank. L+M shall have provided to TD Bank, National Association, the notification required by Section 5.30 of that certain Letter of Credit and Reimbursement Agreement, dated as of November 5, 2013, by and among L+M and LMH on the one hand and TD Bank, National Association, on the other hand.

6.8 Bank of America Consent and Confirmation. L+M and LMH shall have obtained the consent of Bank of America, N.A., to the consummation of the transactions contemplated by this Affiliation Agreement under Section 7(p), and shall have obtained the confirmation of Bank of America, N.A. that the transactions contemplated by this Affiliation Agreement will not contravene Section 7(g), of that certain Continuing Covenants Agreement, dated as of October 13, 2013, by and among L+M and LMH on the one hand and Bank of America, N.A. on the other hand.

6.9 Consent of CHEFA. L+M and LMH shall have obtained the consent of the Connecticut Health and Education Facilities Authority ("CHEFA") to the consummation of the transactions contemplated by this Affiliation Agreement under Section 6.11 of the Master Trust Indenture, dated as of February 1, 1990, by and among L+M and LMH on the one hand and the Master Trustee named therein on the other hand, as the same has been amended or supplemented from time to time in accordance with its terms.

6.10 [[Intentionally Omitted]]

6.11 No L+M Material Adverse Effect. No L+M Material Adverse Effect shall have occurred since the Effective Date.

6.12 No Bankruptcy. No L+M Affiliate shall have: (i) filed for receivership or dissolution; (ii) made any assignment for the benefit of creditors; (iii) admitted in writing its inability to pay its debts as they mature; (iv) been adjudicated bankrupt; or (v) filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or entered into an arrangement with creditors under the federal bankruptcy law or any other similar law or statute of the United States or any state and shall not have caused any L+M Subsidiary to take such actions set forth in clauses (i) - (v) above.

6.13 Certain Environmental Matters. L+M shall have delivered to YNHHSC copies of the reports referred to in Section 5.1.9(a) and Section 5.1.9(d).

ARTICLE 7

CONDITIONS PRECEDENT TO OBLIGATIONS OF L+M

The obligations of L+M hereunder are subject to the satisfaction or written waiver in the sole discretion of L+M, on or prior to the Closing Date, of the following conditions:

7.1 Representations/Warranties. The representations and warranties of YNHHSC contained in Article 4 shall be true and correct on and as of the Closing Date as though such representations had been made on the Closing Date (other than representations and warranties made as of a specified date which shall speak as of such specific date), except as set forth in the Disclosure Schedule, except as specifically disclosed to L+M and except for (i) matters not set forth in the Disclosure Schedule or specifically disclosed to L+M because of the "Material Adverse Effect" qualification in any specific section of Article 4 and (ii) matters arising from a material breach of a representation or warranties of YNHHSC Article 4 which in the case of clauses (i) and (ii) together do not cumulatively and in the aggregate result in and are not reasonably likely to result in a Material Adverse Effect. No YNHHSC Schedule Supplement individually, nor all YNHHSC Schedule Supplements considered in the aggregate, when taken together with (i) matters not set forth in the Disclosure Schedule or specifically disclosed to L+M because of the "Material Adverse Effect" qualification in any specific section of Article 4, and (ii) matters arising from a material breach of any representation or warranty in Article 4, shall cumulatively and in the aggregate result in or be reasonably likely to result in a Material Adverse Effect.

7.2 Covenants. Each covenant contained in this Affiliation Agreement to be complied with or performed by YNHHSC on or before the Closing Date pursuant to the terms hereof shall have been complied with and performed in all material respects.

7.3 Officer's Certificate. L+M shall have received from YNHHSC an officer's certificate, executed by YNHHSC by its president and/or chief executive officer, chief financial officer or treasurer (solely in his or her capacity as such), dated as of the Closing Date, stating, to the actual knowledge of such individual including the knowledge such person would have absent any grossly negligent or reckless or intentional acts or omissions in the performance of his/her duties as president and/or chief executive officer, chief financial officer or treasurer, that the conditions in Section 7.1 and Section 7.2 have been satisfied.

7.4 Litigation or Proceedings. No Litigation or Proceedings before a court or any other Governmental Authority or authority seeking to materially restrain or prohibit the transactions contemplated hereby shall be pending or threatened, and no injunction, judgment, order, decree, statute, law, rule or regulation that restrains or prohibits the transactions contemplated hereby shall have been issued, enacted or promulgated by a court or any other Governmental Authority.

7.5 Third Party Approvals. All notices, reports and other filings required to be made prior to Closing by YNHHSC with, and all licenses, permits, consents, approvals, authorizations, qualifications or orders required to be obtained prior to Closing by L+M or any L+M Subsidiary (provided that each applicable L+M Affiliate has pursued the same as required by the terms hereof), or YNHHSC from, any Governmental Authority or other third party in connection with

the execution and delivery of this Affiliation Agreement and the consummation of the transactions contemplated hereby that are listed on Schedule 7.5 or that are otherwise required to be obtained by Applicable Law shall have been made or obtained.

7.6 Closing Deliveries. YNHHSC shall have made the deliveries required to be made by it under Section 9.3.

7.7 Notification of TD Bank. L+M shall have provided to TD Bank, National Association, the notification required by Section 5.30 of that certain Letter of Credit and Reimbursement Agreement, dated as of November 5, 2013, by and among L+M and LMH on the one hand and TD Bank, National Association, on the other hand.

7.8 Bank of America Consent and Confirmation. L+M and LMH shall have obtained the consent of Bank of America, N.A., to the consummation of the transactions contemplated by this Affiliation Agreement under Section 7(p), and shall have obtained the confirmation of Bank of America, N.A. that the transactions contemplated by this Affiliation Agreement will not contravene Section 7(g), of that certain Continuing Covenants Agreement, dated as of October 13, 2013, by and among L+M and LMH on the one hand and Bank of America, N.A. on the other hand.

7.9 Consent of CHEFA. L+M and LMH shall have obtained the consent of the Connecticut Health and Education Facilities Authority ("CHEFA") to the consummation of the transactions contemplated by this Affiliation Agreement under Section 6.11 of the Master Trust Indenture, dated as of February 1, 1990, by and among L+M and LMH on the one hand and the Master Trustee named therein on the other hand, as the same has been amended or supplemented from time to time in accordance with its terms.

7.10 No YNHHSC Material Adverse Effect. No YNHHSC Material Adverse Effect shall have occurred since the Effective Date.

7.11 No Bankruptcy. YNHHSC shall not have: (i) filed for receivership or dissolution; (ii) made any assignment for the benefit of creditors; (iii) admitted in writing its inability to pay its debts as they mature; (iv) been adjudicated bankrupt; or (v) filed a petition in voluntary bankruptcy, a petition or answer seeking reorganization or entered into an arrangement with creditors under the Federal bankruptcy law or any other similar law or statute of the United States or any state and shall not have caused any YNHHSC Subsidiary to take such actions set forth in clauses (i) - (v) above.

ARTICLE 8

TERMINATION

8.1 Termination. This Affiliation Agreement may be terminated prior to Closing as follows:

(a) by the mutual written consent of L+M and YNHHSC; or

(b) by either Party by notice to the other Party if the Closing shall not have occurred within twenty-four (24) months after the Effective Date (the "***Outside Date***") other than as a result of a breach or default by the Party giving such notice; or

(c) by L+M or YNHHSC prior to Closing, upon the entry of a final and non-appealable injunction issued by a court of competent jurisdiction preventing the consummation of the transactions contemplated by this Affiliation Agreement; or

(d) by L+M prior to Closing, by written notice to YNHHSC, if YNHHSC shall have (i) breached any of its representations or warranties contained in this Affiliation Agreement (A) that are qualified by reference to "Material Adverse Effect" or (B) that are not qualified by reference to Material Adverse Effect in any manner which results or could reasonably be expected to result in a YNHHSC Material Adverse Effect or (ii) materially breached any of its covenants contained in this Affiliation Agreement, in each case which breach cannot be or has not been cured within sixty (60) calendar days after the giving of written notice to YNHHSC, or such longer period as is necessary if such breach cannot be cured within such sixty (60) day period, so long as YNHHSC is continuing in good faith to use its best efforts to cure such breach (provided that in no event will the provisions of this 8(d) override or extend the Outside Date provisions of Section 8.1(b)); it is understood for purposes of this Section 8.1(d) that if YNHHSC is required by the terms of Section 5.2 to take an action by a specific date and fails to take such action by such date but takes such action within the cure period specified in this Section 8.1(d) then YNHHSC shall not be deemed to have breached such covenant so long as L+M is not prejudiced by such delay; or

(e) by YNHHSC prior to Closing, by written notice to L+M, if L+M shall have (i) breached any of its representations or warranties contained in this Affiliation Agreement (A) that are qualified by reference to "Material Adverse Effect" or (B) that are not qualified by reference to Material Adverse Effect in any manner which results or could reasonably be expected to result in a L+M Material Adverse Effect or (ii) materially breached any of its covenants contained in this Affiliation Agreement, in each case which breach cannot be or has not been cured within sixty (60) calendar days after the giving of written notice to L+M; or such longer period as is necessary if such breach cannot be cured within such sixty (60) day period, so long as L+M is continuing in good faith to use its best efforts to cure such breach (provided that in no event will the provisions of this 8(e) override or extend the Outside Date provisions of Section 8.1(b)); it is understood for purposes of this Section 8.1(e) that if L+M is required by the terms of Section 5.1 to take an action by a specific date and fails to take such action by such date but takes such action within the cure period specified in this Section 8.1(e) then L+M shall not be deemed to have breached such covenant so long as YNHHSC is not prejudiced by such delay; or

(f) by YNHHSC prior to Closing by written notice to L+M, if there occurs any L+M Material Adverse Effect; or

(g) by L+M prior to the Closing by written notice to YNHHSC, if there occurs any YNHHSC Material Adverse Effect occurs; or

(h) by YNHHSC by notice to L+M if any consent or approval of any Governmental Authority that is required to be obtained as a condition of the Closing is obtained but contains or is subject to the fulfillment of conditions or requirements that YNHHSC in good

faith determines are materially inconsistent with YNHHSC's obligations under this Affiliation Agreement or YNHHSC's business and strategic plan, or such consent or approval includes additional conditions or requirements that could reasonably be expected to result in a L+M Material Adverse Effect or a YNHHSC Material Adverse Effect; provided, however that YNHHSC shall not exercise the termination right described in this Section 8.1(h) unless the senior executives of YNHHSC and L+M have met to discuss such conditions or requirements; or

(i) if L+M gives notice to YNHHSC that an L+M Affiliate proposes to undertake a Covered Transaction, and if within thirty (30) days after such notice YNHHSC gives notice to L+M that if such Covered Transaction is consummated then YNHHSC will determine that such Covered Transaction alone or together with the other Covered Transactions undertaken by L+M after the date of this Affiliation Agreement are materially inconsistent with the business and strategic objectives and plans of YNHHSC or is materially adverse to the ability of YNHHSC to accomplish its objectives with respect to the Affiliation, and if the applicable L+M Affiliate consummates such Covered Transaction, then within thirty (30) days after L+M gives notice to YNHHSC of the consummation of such Covered Transaction, YNHHSC shall have the right to terminate this Affiliation Agreement, provided, however that YNHHSC shall not exercise the termination right described in this Section 8.1(i) unless YNHHSC shall first have offered to L+M the opportunity to have the respective senior executives of L+M and YNHHSC meet to discuss such determination; or

(j) by L+M by notice to YNHHSC given within sixty (60) days after YNHHSC gives notice to L+M of a YNHHSC Change of Control.

8.2 Effect of Pre-Closing Termination. In the event of the termination of this Affiliation Agreement prior to Closing and the abandonment of the transactions contemplated hereby pursuant to Section 8.1, neither Party shall have any rights or obligations under this Agreement, except for those rights and obligations of the Parties under this Affiliation Agreement that expressly survive any such termination.

8.3 [Reserved]

8.4 Effect of Affiliation Agreement Post-Closing. The survival of the covenants or agreements of the Parties contained in this Agreement, and in any instrument, certificate, exhibit, schedule or other writing provided for in it, shall be governed by the provisions of Section 11.14, without prejudice to the terms and conditions of the Parties' respective corporate organizational documents and such contractual and other arrangements as may be in effect from time to time between them.

ARTICLE 9

CLOSING

9.1 Closing; Closing Date. The closing (the "***Closing***") of the transactions contemplated by this Agreement shall be as soon as practicable after all the conditions precedent in Article 6 and Article 7 have been satisfied; provided, however, that such date shall not be later than sixty (60) days after the Parties and any related Subsidiaries have received all necessary approvals of Governmental Authorities (the date of the Closing, the "***Closing Date***"). The

Closing shall take place at the offices of YNHHSC, or at such other place as the Parties may agree. The Closing of all transactions contemplated by this Affiliation Agreement shall be effective as of 12:01 a.m. on the day after the Closing Date (the "***Effective Time***").

9.2 Deliverables of L+M at Closing. At Closing, L+M shall deliver or cause to be delivered to YNHHSC:

(a) A copy of the L+M Amended Certificate of Incorporation, and of the L+M Subsidiaries Amended Certificates of Incorporation for each L+M Subsidiary other than LMMG, with evidence of filing thereof with the Secretary of the State;

(b) A copy of the L+M Amended Bylaws, and of the L+M Subsidiaries Amended Bylaws for each of the applicable L+M Subsidiaries other than LMMG, certified to be in full force and effect and to be true and correct by the secretary or assistant secretary of L+M;

(c) An executed copy of the LMMG-NEMG Agreement and Plan of Merger in proper form for filing with the Secretary of State;

(d) Certified resolutions of L+M and the L+M Affiliates authorizing the transactions contemplated by this Affiliation Agreement;

(e) The Officer's Certificate required by Section 6.3 hereof;

(f) [Reserved];

(g) [Reserved]; and

(h) All other documents required to be delivered by the L+M hereunder or deemed reasonably necessary or advisable by legal counsel to YNHHSC.

9.3 Deliverables of YNHHSC at Closing. At Closing, YNHHSC shall deliver to L+M:

(a) A copy of the YNHHSC Amended Certificate of Incorporation, with evidence of filing thereof with the Secretary of the State;

(b) A copy of the YNHHSC Amended Bylaws, certified to be true and correct by the secretary or assistant secretary of YNHHSC;

(c) Certified resolutions of YNHHSC authorizing the transactions contemplated by this Affiliation Agreement;

(d) The Officer's Certificate required by Section 7.3 hereof;

(e) An executed copy of the LMMG-NEMG Agreement and Plan of Merger in proper form for filing with the Secretary of State;

(f) A copy of the Amended and Restated Bylaws of NEMG and the Amended and Restated Certificate of Incorporation of NEMG, certified to be true and correct by the Secretary or Assistant Secretary of NEMG; and

(g) All other documents required to be delivered by the YNHHSC hereunder or deemed reasonably necessary or advisable by legal counsel to L+M.

ARTICLE 10

LIMITATION OF REMEDIES

10.1 [Reserved]

10.2 [Reserved]

10.3 Exclusive Remedies.

(a) If this Agreement is terminated pursuant to Section 8.1(d) or Section 8.1(e) and a Party (the "***Defaulting Party***") is determined by a final judgment of a court of competent jurisdiction to have breached or defaulted in respect of its representations and/or warranties hereunder in a manner that permits the other Party (the "***Non-Defaulting Party***") to terminate this Agreement, then the Defaulting Party shall be liable to the Non-Defaulting Party for damages in an aggregate amount equal to the third party out-of-pocket transaction expenses expended by the Non-Defaulting Party in connection with the transactions contemplated by this Agreement up to a maximum amount of $500,000 (Five Hundred Thousand Dollars) (the "***Third Party Expenses***"). If this Agreement is terminated pursuant to Section 8.1(d) or Section 8.1(e) due to a breach of Section 5.1 or Section 5.2. and the Defaulting Party is determined by a final judgment of a court of competent jurisdiction to have breached or defaulted in respect of its obligations under such covenants in a manner that permits the Non-Defaulting Party to terminate this Agreement, then the Defaulting Party shall be liable to the Non-Defaulting Party for damages in an aggregate amount equal to the sum of (i) the Third Party Expenses of the Non-Defaulting Party and (ii) a breakup fee (the "***Breakup Fee***") in an aggregate amount equal to (A) $5,000,000 (Five Million Dollars) if the Defaulting Party is L+M or (B) $35,000,000 (Thirty Five Million Dollars) if the Defaulting Party is YNHHSC. The Parties agree and confirm that the Breakup Fee is in the nature of liquidated damages, that the actual damages that would be suffered by a Party in the event of a breach or default by the other Party of Section 5.1 or 5.2 would be impossible to calculate and that the Breakup Fee does not constitute a penalty. In all other respects, the Parties hereto expressly waive and agree to forgo any and all rights to seek and obtain any form of monetary, economic or other damages (including actual, consequential, punitive and other forms of monetary or economic damages), and each of the Parties further agrees that each of the Parties will be solely entitled to injunctive relief to prevent a violation of this Agreement and to obtain specific performance to require adherence to the obligations created by this Affiliation Agreement.

(b) Before any Party brings legal action against the other Party (the "***Alleged Defaulting Party***") for failure to perform in any material respect any of its obligations under this Agreement, the entity alleging the breach (the "***Alleging Party***") will first give the Alleged Defaulting Party written notice setting forth such failure in reasonable detail and stating that the

Alleging Party requires such obligation to be performed, and will give the Alleged Defaulting Party the opportunity to perform such obligation in all material respects within sixty (60) days of its receipt of such notice, or such longer period as is necessary if for reasons outside the control of the Alleged Defaulting Party such obligation cannot be performed within such sixty (60) day period, so long as the Alleged Defaulting Party is continuing in good faith to use its best efforts to perform such obligation (provided that in no event will the provisions of this Section 10.3 override or extend the Outside Date provisions of Section 8.1(b)). If any legal action relating to the enforcement of this Agreement is brought by a Party against the other Party, the prevailing Party will be entitled to recover its reasonable costs, expenses and attorneys' fees.

(c) If the Closing shall occur, then each Party hereby waives and agrees not to assert any remedy that is in the nature of the rescission of this Agreement or the Affiliation.

ARTICLE 11

GENERAL PROVISIONS

11.1 Headings. The subject headings of the sections of this Affiliation Agreement are included for convenience only and shall not affect the construction or interpretation of any of its provisions.

11.2 Entire Agreement. This Affiliation Agreement, including any Exhibits or Disclosure Schedules, constitutes the entire agreement between the Parties regarding the terms of the Affiliation.

11.3 Third Party Beneficiaries. Except for intended third party beneficiaries expressly contemplated herein, nothing in this Affiliation Agreement, whether expressed or implied, is intended to confer any rights or remedies under or by reason of this Affiliation Agreement upon any persons other than the parties to it and their respective successors and assigns, nor is anything in this Affiliation Agreement intended to relieve or discharge any obligation or liability of any third persons to a party to this Affiliation Agreement, nor shall any provisions give any third parties any rights of subrogation or action against or with respect to a party to this Affiliation Agreement.

11.4 Notices. All notices, requests, demands, waivers, consents and other communications hereunder shall be in writing, shall be delivered either in person, by overnight air courier or by mail, and shall be deemed to have been duly given and to have become effective (a) upon receipt if delivered in person, (b) one business day after having been delivered to an air courier for overnight delivery, or (c) three (3) business days after having been deposited in the mail as certified or registered mail, return receipt requested, all fees prepaid, directed to the Party at the addresses listed below (or at such other address as shall be given in writing by a Party). A Party may change its address for purposes of this Section by giving the other Party written notice of the new address in the manner set forth in this Section 11.4.

If to YNHHSC:

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06510
Attention: President and Chief Executive Officer

With a copy to:

Yale-New Haven Health Services Corporation
Legal & Risk Services Department
789 Howard Avenue, CB 230
New Haven, CT 06510
Attention: General Counsel

If to L+M:

Lawrence + Memorial Hospital
365 Montauk Avenue
New London, CT 06320
Attention: Chief Executive Officer

With a copy to:

Lawrence + Memorial Hospital
365 Montauk Avenue
New London, CT 06320
Attention: General Counsel

11.5 Counterparts. This Agreement may be executed in one or more counterparts, and when so executed each counterpart shall be deemed to be an original; said counterparts together shall constitute one and the same instrument. The transmission of an executed signature page of this Agreement or of any document, certificate, instrument or agreement required or contemplated to be executed and delivered hereby by facsimile or portable document format (.pdf) shall have the same effect as the delivery of a manually executed counterpart of this Agreement or of such document, certificate, instrument or agreement.

11.6 Assignment. Neither Party may assign or transfer any rights under this Affiliation Agreement without prior written consent of the other Party in its sole discretion.

11.7 Binding Effect. This Affiliation Agreement shall be binding upon and inure to the benefit of the Parties hereto. Each Party shall be responsible hereunder only for its own obligations and shall not be deemed to guarantee or otherwise have responsibility for the representations, acts or omissions of the other Party. Notwithstanding any assignment or delegation of rights or duties under this Affiliation Agreement by a Party that may be consented to by the other Party, no such assignment or delegation shall relieve the assigning Party of any obligation or liability under this Affiliation Agreement.

11.8 [Reserved]

11.9 Governing Law and Forum Selection. This Affiliation Agreement shall be interpreted and construed in accordance with the laws of the State of Connecticut, without regard to conflict of laws principles. Any action or proceeding between the parties relating to the Agreement must be brought in the courts of the State of Connecticut or the United States District Court for Connecticut. Each Party consents to the jurisdiction of such courts, agrees to accept service of process by mail, and waives all jurisdictional and venue defenses otherwise available to the Parties.

11.10 Severability. Should any provision of this Affiliation Agreement, or part thereof, be determined to be invalid for any reason, it shall be severed from this Affiliation Agreement and the remaining provisions of this Affiliation Agreement shall remain in full force and effect and shall be enforceable in accordance with its terms.

11.11 Cost of Transaction. Except as is otherwise provided in Sections 5.5 and 10.3, each Party shall pay the fees, expenses and disbursements of its own agents, representatives, accountants and counsel incurred in connection with the subject matter hereof and any amendments hereto.

11.12 Confidentiality. The Parties agree that any information submitted to or compiled by a Party in connection with this Agreement, including without limitation, which involves future plans or intentions, budgetary information, personnel records, patient records, marketing plans, financial statements, trade secrets, research concepts, methods or products or proprietary information belonging to or provided by third parties (the "***Confidential Information***") shall be confidential, except to the extent (i) the person or entity who provided such information consents to its disclosure or disclosure is required by law; (ii) is now or subsequently becomes generally available to the public through no fault of either Party; or (iii) can be demonstrated by either Party to be rightfully in its possession prior to receipt from the other Party in connection with the Affiliation. Each Party agrees that it shall maintain the confidentiality of all such Confidential Information delivered to it by the other Party or its agents in connection with the negotiation of this Affiliation Agreement or in compliance with the terms, conditions and covenants hereof and shall only disclose such Confidential Information to its duly authorized officers, members, trustees, directors, representatives and agents. For the avoidance of doubt, each Party's respective obligations with respect to any Confidential Information delivered to it by the other Party shall terminate as of the Closing; provided however, that each Party further agrees that if the transactions contemplated hereby are not consummated, it shall return all such Confidential Information and all copies thereof in its possession to the other Party to this Affiliation Agreement, each party shall instruct its agents and representatives to return or destroy any such material in its possession, and neither Party shall use the Confidential Information for its own benefit or the benefit of others except as specifically contemplated herein. Nothing in this Section, however, shall prohibit the use of such Confidential Information for such governmental filings as in the opinion of the counsel for a Party are (i) required by law or governmental regulations or (ii) otherwise appropriate. Each Party shall cause its Subsidiaries and its and their directors, trustees, officers, employees and agents to comply with this Section 11.12.

11.13 Public Announcements. The Parties mutually agree that they shall jointly develop a plan of communications concerning the transactions herein contemplated, and further that neither Party shall release, publish or otherwise make available to the public in any manner whatsoever any information or announcement regarding the transactions herein contemplated without the prior consent of the other Party, except for information or filings reasonably necessary to be directed to Governmental Authorities to fully and lawfully effect the transactions herein contemplated or required in connection with Applicable Laws. Nothing herein shall prohibit either Party from responding to questions presented by the press or media without first obtaining prior consent of the other Party hereto provided such responses are made in accordance with previously agreed upon communications.

11.14 Survival. The provisions of Article 10 and Article 11 (other than Section 11.12 and Section 11.13) shall survive the Closing and any termination of this Affiliation Agreement. If the Closing shall occur, the provisions of Article 2 and Section 5.5 shall survive the Closing for a period equal to the Initial Period (provided that (i) the second sentence of Section 2.1.3, other than the proviso thereof, shall survive until the sixth anniversary of the Closing Date, as expressly contemplated thereby and (ii) the provisions of Section 2.13 shall survive for so long as the YSM Affiliation Agreement remains in effect).

[Signature page follows.]

IN WITNESS WHEREOF, the Parties have executed this Affiliation Agreement as of the Effective Date set forth above.

LAWRENCE + MEMORIAL CORPORATION

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

IN WITNESS WHEREOF, the Parties have executed this Affiliation Agreement as of the Effective Date set forth above.

LAWRENCE + MEMORIAL CORPORATION

By:_____
Name: Bruce Cummings
Title: President and Chief Executive Officer

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: Marna P. Bo
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

EXHIBIT 1

Definitions

"***Affiliate***" means, as to the entity in question and at the time of reference thereto, any Person that directly or indirectly controls, is controlled by, or is under common control with, the entity in question; and the term "control" means possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of an entity whether through ownership of voting securities, membership interests, by contract, the power to appoint directors or trustees or otherwise.

"***Affiliation***" has the meaning set forth in the introductory paragraph.

"***Affiliation Agreement***" has the meaning set forth in the introductory paragraph.

"***Applicable L+M Budgets***" means, in the case of an expenditure that is made, or a transaction entered into, by an L+M Affiliate during a given fiscal year, the capital and/or operating budget (as applicable) for such L+M Affiliate for such fiscal year described in Section 5.1.15.

"***Applicable Law***" means any constitution, law, ordinance, principle of common law, code, statute, act, treaty or order of general applicability of any Governmental Authority, including the rules and regulations promulgated thereunder.

"***Associated Specialists***" means Associated Specialists of Southeastern Connecticut, Inc., a Connecticut non-stock corporation.

"***Closing***" has the meaning set forth in Section 9.1.

"***Closing Date***" has the meaning set forth in Section 9.1.

"***CMS***" mans the Centers for Medicare and Medicaid Services.

"***Code***" means the Internal Revenue Code of 1986, as amended.

"***Collective Bargaining Agreement***" has the meaning set forth in Section 3.16.1.

"***Commercially Reasonable Best Efforts***" means that the applicable Party will exert every reasonable effort and expend material amounts of resources in order to accomplish an objective, that the level of such efforts and expenditures shall be such as would be expended to achieve a fundamental business objective and shall be over and above the level that would be expended to achieve an ordinary course of business; provided however that Commercially Reasonable Best Efforts shall not require a Party to (i) expend extraordinary resources, (ii) agree to change its fundamental business organization, practices or relationships (such as, but not limited to, divesting of any material business activities or undertaking material restrictive covenants), or (iii) undertake adminisrative proceedings, judicial action or litigation in order to achieve an objective.

"***CON Filing***" means the filings, application and process by and pursuant to which Certificate of Need authorization is requested from OHCA and any other Governmental Authority with respect to this Affiliation Agreement and the transactions contemplated hereunder.

"***Confidential Information***" has the meaning set forth in Section 11.12.

"***Consents and Approvals***" means the consent to or approval of the Affiliation by any Governmental Authorities and other third parties.

"***Contract(s)***" means all rights, benefits and interests of any Person in, to and under all contracts relating to the conduct of their respective businesses, including, without limitation, physician agreements, agreements with third party payors, joint venture or partnership agreements, supply purchase agreements, employment agreements, equipment leases, equipment maintenance agreements, agreements with municipalities and labor organizations, settlement agreements, loan agreements, bonds, mortgages, liens or other security agreements, but excluding the Leases.

"***Cost Reports***" means all cost and other reports related to any Person filed within the last three years pursuant to the requirements of the Government Payer programs for cost-based payments or reimbursement due to or claimed by such Person from the Government Reimbursement Programs or their fiscal intermediaries or payor agents, including all cost report receivables or payables and all related appeals and appeal rights and other forms or claims filed or submitted by such Person to the Government Payer programs or their fiscal intermediaries or payor agents for payment or reimbursement due to or claimed by such Person on a fee-for-service, prospective payment, fee schedule or other similar basis.

"***Covered Person***" means a current or former employee, officer, director or consultant of an L+M Affiliate.

"***Covered Transaction***" means any (i) acquisition or disposition by any L+M Affiliate of a material line of business or of the equity or assets of such L+M Affiliate to or with an entity that is not an L+M Affiliate as of the date of this Affiliation Agreement, in each case other than acquisitions of physician practices, which shall be governed by item (ii) below; (ii) acquisition of a physician practice by an L+M Affiliate that involves more than eight (8) employed physicians; (iii) contracting with an unrelated third party for the management of all or substantially all of the assets or operations of an L+M Affiliate; (iv) entering into a contract for the management of a clinical service line of any L+M Affiliate if (A) such L+M Affiliate does not contract with the manager of such clinical service line for the management of such clinical service line as of the Effective Date or (B) the non-cancellable term of such contract is more than three (3) years; or (v) any new relationships or agreements for graduate medical education or any material amendments to or terminations of existing agreements for graduate medical education programs.

"***DEEP***" means the Connecticut Department of Energy and Environmental Protection.

"***Disclosure Schedule***" means the disclosure schedule, dated as of the date hereof, that is attached hereto and incorporated in and made a part of this Affiliation Agreement, as updated by any Schedule Supplement.

"***DPH***" means the Connecticut Department of Public Health.

"***Due Diligence Information***" means the information disclosed by YNHHSC to L+M and the information disclosed by L+M to YNHHSC pursuant to due diligence request lists provided by each Party to the other Party prior to the date of this Affiliation Agreement.

"***Effective Date***" has the meaning set forth in the introductory paragraph.

"***Employee Benefit Plan***" means any "employee benefit plan" (as such term is defined in ERISA §3(3)) and any other employee benefit plan, program or arrangement.

"***Environmental Claim***" means with respect to any party, any claim, action, cause of action, investigation or notice (written or oral) by any Governmental Authority or third party alleging potential Liability (including, without limitation, potential Liability for investigatory costs, cleanup costs, governmental response costs, natural resources damages, property damages, personal injuries or penalties) against such party arising out of, based on or resulting from (a) the presence, or release into the environment, of any Hazardous Substances at any location, owned, occupied or operated by such party at any time, or (b) any violation, or alleged violation, of any Environmental, Health or Safety Requirement by such party.

"***Environmental Condition***" means (i) the presence of, spills of, leaks of, emissions of, disposal of, discharge of, release of or threatened release to the environment, prior to the Closing Date, of Hazardous Substances on, in, under, originating from or emanating from the Owned Real Property or the Leased Real Property in violation of Environmental, Health, and Safety Requirements, including any migration of those Hazardous Substances through the air, soil or groundwater, and (ii) any claim, prior to the Closing Date, for injury to, destruction of, damage to or loss of natural resources, including reasonable costs of assessing such injury, destruction or loss relating to the acts or omissions of the L+M Affiliates prior to or on the Closing Date.

"***Environmental, Health, and Safety Requirements***" means all applicable federal, state, local, and foreign statutes, laws, rules, regulations, codes, ordinances, standards, guidelines, authorizations and orders of any federal, state or local public agency or authority that deal with Solid Waste, toxic or hazardous waste, wastewater discharges, water quality, drinking water, air emissions, air quality, lead-based paint or employee health, safety or community right-to-know, or otherwise concerning public health and safety, worker health and safety, pollution, or protection of the environment, including all those relating to the presence, use, production, generation, handling, transportation, treatment, storage, disposal, distribution, labeling, testing, processing, discharge, release, threatened release, control, or cleanup of any Hazardous Substances (including Medical Hazards), as such requirements are enacted and in effect on or prior to the Closing Date, provided that Environmental Health and Safety Requirements shall not include Health Care Laws.

"***ERISA***" means the Employee Retirement Income Security Act of 1974, as amended.

"***ERISA Affiliate***" means a trade or business, whether or not incorporated, which is deemed to be in common control or affiliated with L+M within the meaning of Section 414(b)(c)(m) or (o) of the Code.

"***GAAP***" means generally accepted accounting principles in the United States.

"***Government Reimbursement Programs***" means the Medicare program, the Connecticut Medicaid program, the federal TRICARE program, and any other, similar or successor federal, state or local health care payment programs with or sponsored by Governmental Authorities, including without limitation, current federal and Connecticut disproportionate share "DSH" reimbursement or adjustments applicable to any Person, and federal reimbursement or adjustments for or related to any of the Parties graduate medical education programs.

"***Governmental Authority***" means any federal, state, local or any foreign governmental unit, agency, commission or authority.

"***Governmental Payer***" means any Governmental Authority that provides reimbursement for health care services, including but not limited to Medicare, Medicaid, CHAMPUS, TRICARE and other federal, state and local reimbursement and payment programs.

"***Guarantee***" by any Person means any obligation, contingent or otherwise, of such Person directly or indirectly guaranteeing or otherwise supporting in whole or in part the payment of any Indebtedness or other obligation of any other Person and, without limiting the generality of the foregoing, any obligation, direct or indirect, contingent or otherwise, of such Person (a) to purchase or pay (or advance or supply funds for the purchase or payment of) such Indebtedness or other obligation of such other Person (whether arising by virtue of partnership arrangements, by agreements to keep well, to purchase assets, goods, securities or services, to take or pay, or to maintain financial statement conditions or otherwise) or (b) entered into for the purpose of assuring in any other manner the obligee of such Indebtedness or other obligations of the payment of such Indebtedness or to protect such obligee against loss in respect of such Indebtedness (in whole or in part). The term "Guarantee" used as a verb has a correlative meaning.

"***Hart-Scott-Rodino Act***" means the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the rules and regulations promulgated thereunder.

"***Hazardous Substances***" means asbestos, radioactive substances, radon, PCBs, petroleum, Medical Hazards and any chemical, substance or material that is listed or regulated under Environmental, Health, and Safety Requirements as a hazardous or toxic substance, material, chemical substance, pollutant, waste, pesticide or fungicide or that under Environmental, Health, and Safety Requirements requires special handling or notification of any federal, state or local governmental agency or authority in its collection, storage, treatment, recycling or disposal.

"***Health Care Fraud and Abuse Laws***" has the meaning set forth in Section 3.9.1.

"***Health Care Laws***" means, collectively, any and all federal, state or local statutes, rules, regulations and administrative manuals, orders, guidelines and requirements of law of any Governmental Authority governing the licensure of or regulating healthcare providers, professionals, facilities or payors or otherwise governing or regulating the provision of, or payment for, healthcare services, the sale of controlled substances or other pharmaceuticals, medical devices or supplies and the like. Without limiting the generality of the foregoing, Health

Care Laws include, without limitation, state corporate practice of medicine laws, statutes and regulations, Section 1128B(b) of the Social Security Act, as amended, 42 U.S.C. Section 1320a 7(b) (Criminal Penalties Involving Medicare or State Health Care Programs), commonly referred to as the "Federal Anti-Kickback Statute," Section 1877 of the Social Security Act, as amended, 42 U.S.C. Section 1395nn and related regulations (Prohibition Against Certain Referrals), commonly referred to as "Stark Law," the federal False Claims Act, 31 U.S.C. Section 3729 et seq., corresponding state laws and other state and federal fraud and abuse laws.

"***Health Information Laws***" has the meaning set forth in Section 3.24.1.

"***HIPAA Regulations***" has the meaning set forth in Section 3.24.1.

"***Hospital Members***" shall mean each acute care hospital that is a YNHHSC Obligated Group Member.

"***Indebtedness***" of any Person means either (a) any liability of such Person (i) for borrowed money (including the current portion thereof), (ii) under any reimbursement obligation relating to a letter of credit, bankers' acceptance or note purchase facility, (iii) evidenced by a bond, note, debenture or similar instrument (including a purchase money obligation), (iv) for the payment of money relating to any lease that is required to be classified as a capitalized lease obligation in accordance with GAAP, (v) for all or any part of the deferred purchase price of property or services (other than trade or accounts payables), including any "earnout" or similar payments or any noncompete payments, (vi) under interest rate swap, hedging or similar agreements or (vii) for any credit card payables with respect to charges having a transaction date of thirty (30) days or more prior to the Closing Date or related to non-business related activities; or (b) any liability of others described in the preceding clause (a) that such Person has Guaranteed, that is recourse to such Person or any of its assets or that is otherwise its legal liability or that is secured in whole or in part by the assets of such Person.

"***Initial Period***" means the period from the Closing Date to the fifth anniversary of the Closing Date.

"***Intellectual Property***" means all intellectual property rights of any kind, throughout the world, all rights of privacy and rights to personal information, all telephone numbers and Internet protocol addresses, all documentation and media constituting, describing or relating to the above, including memoranda, manuals, technical specifications and other records wherever created throughout the world, all rights in the foregoing and in other similar intangible assets, and all rights and remedies (including the right to sue for and recover damages, profits and any other remedy for past, present, or future infringement, misappropriation or other violation relating to any of the foregoing.

"***IRB***" has the meaning set forth in Section 3.30.

"***IRS List of Exempt Organizations***" has the meaning set forth in Section 3.10.7.

"***Joint Commission***" has the meaning set forth in Section 3.9.5(b).

"***Key Financial Metrics***" means the metrics set forth on Exhibit 2.11 as the targets associated with such metrics are revised and updated in a mutually agreed-upon manner at Closing based upon the development of mutually-agreed upon investment business plans, the five-year strategic plan referred to in Section 2.12 and the financial condition and results of operations of the L+M Affiliates as of the Closing Date.

"***Knowledge***" shall, with respect to the particular provision it qualifies, mean (a) with respect to an L+M Affiliate, the actual knowledge of the president and/or chief executive officer or the chief financial officer of L+M, including, with respect to each, what he or she knows or should know in the exercise of his or her duties in the course of employment with L+M or a L+M Affiliate or as the result of due inquiry of the president and/or chief executive officer and chief financial officer of each L+M Subsidiary, or (b) with respect to YNHHSC, the actual knowledge of the president and chief executive officer or the chief financial officer of YNHHSC, including, with respect to each, what he or she knows or should know in the exercise of his or her duties in the course of employment with YNHHSC or as the result of due inquiry of the president and/or chief executive officer and chief financial officer of each YNHHSC Subsidiary.

"***L+M***" has the meaning set forth in the introductory paragraph.

"***L+M 2014 Audited Financial Statements***" has the meaning set forth in Section 3.7.

"***L+M Activities***" means the business of each applicable L+M Affiliate, as the context may require.

"***L+M Affiliates***" means L+M and each L+M Subsidiary, including without limitation, LMH, LMW, LMMG, L+M Systems, Inc., VNA of Southeastern Connecticut, L+M HealthCare, Inc. and L&M Indemnity Company Ltd.

"***L+M Amended Bylaws***" has the meaning set forth in Section 2.1.1.

"***L+M Amended Certificate of Incorporation***" has the meaning set forth in Section 2.1.1.

"***L+M Bondholders***" means the holders of the L+M Tax-Exempt Bonds.

"***L+M Corporate Transaction***" has the meaning set forth in Section 5.1.11.

"***L+M Determination Letters***" has the meaning set forth in Section 3.10.7.

"***L+M Financial Statements***" has the meaning set forth in Section 3.7.

"***L+M Interim Financial Statements***" has the meaning set forth in Section 3.7.

"***L+M Leased Real Property***" has the meaning set forth in Section 3.5.2.

"***L+M Master Trust Indenture***" means that certain Master Trust Indenture, dated as of February 1, 1990, by and between the L+M Obligated Group and U.S Bank National Association, as successor master trustee, as amended and supplemented from time to time.

"***L+M Material Adverse Effect***" means any occurrence, condition, change, development, circumstance, effect, event or fact, occurring after the Effective Date (a "Matter"), that individually or in the aggregate, would be reasonably expected to have a monetary effect on L+M and the L+M Affiliates taken as a whole that would exceed the L+M Materiality Threshold, or such an effect that prevents L+M or any L+M Affiliate from performing its material obligations under, or from consummating the transactions contemplated by, this Affiliation Agreement. Notwithstanding anything herein to the contrary, "L+M Material Adverse Effect" shall be deemed not to include, and a L+M Material Adverse Effect shall not be deemed to have resulted from or arisen out of: (i) any reduction in the rates of reimbursement or payment received by L+M or any L+M Affiliate under any Government Reimbursement Program that affects similarly situated providers similarly, (ii) any Matter specifically disclosed on the Disclosure Schedules at the Effective Date; (iii) [reserved]; (iv) the public announcement of this Affiliation Agreement, compliance with terms of this Affiliation Agreement or the consummation of the Affiliation; (v) any Matter, to the extent affecting (A) global or national or regional economic, business, regulatory, market or political conditions or national financial markets, (B) the healthcare industry generally or such industry in Connecticut or Rhode Island, or (C) the hospital business generally or in Connecticut or Rhode Island; (vi) any changes or any proposed changes in law or governmental programs after the Effective Date that are not directed at L+M or YNHHSC, in each instance to the exclusion of others; (vii) [reserved]; (viii) any increase in competitive activity by other health care providers in L+M's service area; (ix) [reserved]; or (x) any action taken by L+M at the direction of, or with the prior written consent of, YNHHSC.

"***L+M Materiality Threshold***" means a dollar amount equal to $50,000,000 (Fifty Million Dollars).

"***L+M Obligated Group***" means the obligated group consisting of L+M and LMH.

"***L+M Permits***" has the meaning set forth in Section 3.9.5.1.

"***L+M Plans***" has the meaning set forth in Section 3.17.1.

"***L+M Provider Subsidiaries***" means the L+M Subsidiaries that are licensed providers of clinical services (individually or collectively as the context shall require).

"***L+M Real Property***" means the Owned Real Property and the L+M Leased Real Property.

"***L+M Real Property Leases***" has the meaning set forth in Section 3.5.2.

"***L+M Subsidiaries Amended Bylaws***" has the meaning set forth in Section 2.1.5.

"***L+M Subsidiaries Amended Certificates of Incorporation***" has the meaning set forth in Section 2.1.5.

"***L+M Tax-Exempt Bonds***" means the State of Connecticut Health and Educational Facilities Authority Revenue Bonds Lawrence + Memorial Issue, Series F, Series G and Series H.

"***L+M Subsidiary***" means each Subsidiary of L+M and each direct or indirect Subsidiary of any such Subsidiary.

"***Leases***" means all rights, benefits and interests of L+M or any L+M Affiliate, as the case may be, as the lessor, lessee or sublessee, as the case may be, in, to or under any lease or sublease relating to real property.

"***Liability***" or "***Liabilities***" means debts, obligations, contracts or other liabilities of any kind, character or description, accrued, absolute, contingent, determined, determinable or otherwise, whether presently in existence or arising hereafter.

"***Lien***" **or** "***Encumbrance***" means any lien, pledge, claim, liability, interest, restriction or other encumbrance.

"***Litigation or Proceedings***" has the meaning set forth in Section 3.15.1.

"***LMH***" means Lawrence + Memorial Hospital, Inc., a Connecticut non-stock corporation.

"***LMH Amended Bylaws***" has the meaning set forth in Section 2.1.5(a).

"***LMH Amended Certificate of Incorporation***" has the meaning set forth in Section 2.1.5(a).

"***LMH Medical Staff Bylaws***" has the meaning set forth in Section 2.6.

"***LMI***" means L&M Indemnity Company Ltd., a Cayman Island company limited by shares.

"***LMI Insurance Regulatory Agency***" means Cayman Islands Monetary Authority.

"***LMMG***" means L+M Physician Association Inc., a Connecticut non-stock medical foundation doing business as L+M Medical Group.

"***LMMG-NEMG Agreement and Plan of Merger***" has the meaning set forth in Section 2.1.4.

"***LMW***" means LMW Healthcare, Inc., a Rhode Island nonprofit corporation doing business as Westerly Hospital.

"***LMW Acquisition Related Obligations***" means those specific obligations undertaken by Lawrence + Memorial Corporation, LMW Healthcare, Inc. and LMW Physicians, Inc., a Rhode Island nonprofit corporation ("***LMW Physicians***") that expressly relate to the management and operation of The Westerly Hospital and Related Entities, as such term is defined in those provisions of the following documents under which LMW has ongoing obligations:

i. As set forth in that certain Asset Purchase Agreement, as amended, made as of June 20, 2012, by and among W. Mark Russo, Esq., solely in his capacity as the court-appointed

Special Master (the "***Special Master***") for Westerly Hospital Healthcare, Inc., The Westerly Hospital, Atlantic Medical Group, Inc., Ocean Myst, MSO, LLC, Women's Health of Westerly, LLC, and North Stonington Health Center, Inc. and LMW Healthcare, Inc., a Rhode Island nonprofit corporation, and LMW Physicians, Inc., a Rhode Island nonprofit corporation (the "***Westerly Agreement***").

ii. As set forth in the Order Approving the Sale of Assets of The Westerly Hospital and The Related Entities Free and Clear of Liens and Liabilities in the case of *Charles S. Kinney, Chief Executive and Trustee v. Westerly Hospital Healthcare, Inc., The Westerly Hospital, Atlantic Medical Group, Inc., Ocean Myst, MSO LLC, Women's Health of Westerly, LLC and North Stonington Health Center, Inc.*, C.A. No, 2011-0781, dated as of September 10, 2012.

iii. As set forth in the Decision of the State of Rhode Island Department of Attorney General, dated as of April 17, 2013, *In Re: Expedited Review Hospital Conversion Initial Application of Westerly Hospital Healthcare, Inc., The Westerly Hospital, LMW Healthcare Inc., LMW Physicians, Inc., and Lawrence + Memorial Corporation.*

iv. As set forth in the Report of the Committee of the Health Services Council on the application of Lawrence & Memorial Corporation for change in effective control of The Westerly Hospital, dated as of April 9, 2013.

v. As set forth in the Amended Decision with Conditions regarding the Affiliation of Westerly Hospital Health Care Inc., The Westerly Hospital and Lawrence + Memorial Corporation, LMW Healthcare, Inc., and LMW Physicians, Inc. Under the Hospital Conversion Act of Rhode Island by the Rhode Island Department of Health, dated as of April 16, 2013.

vi. As set forth in the Consent Order Regarding Post-Closing Items in the case of *Charles S. Kinney, Chief Executive and Trustee v. Westerly Hospital Healthcare, Inc., The Westerly Hospital, Atlantic Medical Group, Inc., Ocean Myst, MSO LLC, Women's Health of Westerly, LLC and North Stonington Health Center, Inc.*, C.A. No, 2011-0781, dated as of May 23, 2014.

"***LMW Amended Bylaws***" has the meaning set forth in Section 2.1.5(b).

"***LMW Amended Certificate of Incorporation***" has the meaning set forth in Section 2.1.5(b).

"***LMW Medical Staff Bylaws***" has the meaning set forth in Section 2.6.

"***LMW Physicians***" has the meaning set forth in the definition of LMW Acquisition-Related Obligations.

"***Material Adverse Effect***" means an L+M Material Adverse Effect or a YNHHSC Material Adverse Effect, as the context shall require.

"***Material Contracts***" means, any Contract of a Party or a direct or indirect Subsidiary of a Party that is a:

a) Contract under which debt for borrowed money has been or can be incurred in excess of $500,000 (other than contracts described in the L+M 2014 Audited Financial Statements or the YNHHSC 2014 Audited Financial Statements, as applicable, true, correct and complete copies of which have been delivered by the applicable Party to the other Party);

b) Capital lease for real property or equipment under which the annual obligations payable by the lessee exceed (i) $500,000 in the case of L+M or any L+M Subsidiary or (ii) $3,500,000 in the case of YNHHSC or any YNHHSC Subsidiary;

c) Contract with a third party payor under which during the last full fiscal year of such Party payments were made by the third party payor in excess of (i) $2,000,000 in the case of L+M or any L+M Subsidiary or (ii) $14,000,000 in the case of YNHHSC or any YNHHSC Subsidiary;

d) Academic or clinical affiliation agreement (other than agreements with Yale University) for medical education for residents, fellows, medical students and/or physician's assistants at the undergraduate or graduate level;

e) Grant agreement under which during the last full fiscal year of such Party such Party or such Subsidiary of a Party received payments in excess of (i) $1,000,000 in the case of L+M or any L+M Subsidiary or (ii) $7,000,000 in the case of YNHHSC or any YNHHSC Subsidiary;

f) Contract under which such Party or such Subsidiary guarantees the performance or payment obligations of a third party (i.e. a Person other than such Party or a Subsidiary thereof);

g) Contract that limits the freedom of such Party or such Subsidiary to conduct business;

h) Contract (other than a contract for the purchase of supplies, equipment, or software) under which the value of the obligations of such Party and its Subsidiaries, taken as a whole, exceeds (i) $2,000,000 annually in the case of L+M or any L+M Subsidiary or (ii) $14,000,000 annually in the case of YNHHSC or any YNHHSC Subsidiary; or

i) Any primary or excess professional or general liability insurance policy.

"***Medical Hazards***" means all biological and chemical materials that under applicable Environmental, Health, and Safety Requirements or industry standards are required to be handled in accordance with certain procedures, and all other materials that may contain or be contaminated with such biological or chemical materials, and all devices or materials that could puncture or cut the skin (including, without limitation, those commonly known as "sharps").

"***NEMG***" means Northeast Medical Group Inc., a Connecticut nonstock corporation of which YNHHSC is the sole member.

"***OHCA***" means the Office of Health Care Access of the State of Connecticut.

"***OHRP***" has the meaning set forth in Section 3.30.

"***Owned Real Property***" means any real property in which any L+M Affiliate owns a fee interest.

"***Party***" and "***Parties***" have the meanings set forth in the introductory paragraph.

"***Payer Programs***" means collectively, Third Party Payers and Governmental Payers.

"***Permits***" means any licenses, approvals, permits, orders, registrations, certificates, variances, and similar rights obtained from any Governmental Authority.

"***Permitted Encumbrances***" means (a) Liens or Encumbrances created by YNHHSC, (b) Liens or Encumbrances for Taxes, assessments or other similar governmental charges which are not due and payable as of the Closing Date, (c) as to real property, Liens, Encumbrances, covenants, restrictions, utility easements and agreements of record, and encroachments that do not render title unmarketable or materially and adversely affect the applicable owner's ability to use such Real Property for its current use, (d) Liens and Encumbrances set forth on Schedule 3.5.1 hereof, (e) Liens and Encumbrances which shall be satisfied in full and discharged of record by L+M on or prior to the Closing, (f) the Leases and Contracts that exist as of the date hereof and such Leases and Contracts that are entered into, modified or renewed after the date hereof not in violation of this Affiliation Agreement; (g) all violations of building, fire, sanitary, environmental, housing and such other laws, regulations and ordinances; (h) all matters of record superior to the Leases pursuant to which an L+M Affiliate is a tenant; and (i) all laws, regulations and ordinances including, without limitation, all environmental, building and zoning restrictions affecting the Owned Real Property or the ownership, use or operation thereof adopted by any governmental authority having jurisdiction over the Owned Real Property or the ownership, use or operation thereof, and all amendments or additions thereto now in effect or which may be in force or effect on the Closing Date.

"***Person***" means any individual, sole proprietorship, partnership, corporation, limited liability company, limited partnership, joint venture, unincorporated society or association, trust, estate or other entity or organization, or any division of such Person.

"***Personal Property***" means tangible personal property (including, without limitation, equipment, fixtures, vehicles, furniture, tools, furnishings, machinery, instruments, spare parts, supplies, pharmacueticals and inventory).

"***Physician***" means any licensed doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry or chiropractor, or any group, partnership, corporation, of whatever form, made up of one more such persons.

"***Principal Properties***" shall have the meaning assigned to that term in Section 3.5.

"***Protected Health Information***" shall have the meaning assigned to that term in Section 103 of 45 C.F.R. Part 160.

"Rating Agencies" means Standard & Poor's Ratings Services, a division of The McGraw-Hill Companies, Inc., Moody's Investors Service, Inc., Fitch Inc., their successor and assigns, and such other nationally recognized securities rating agency as shall have awarded a rating to the Obligations (as defined in the YNHHSC Master Trust Indenture).

"***Reimbursement Claims***" has the meaning set forth in Section 3.28.

"***Remediation***" means any or all of the following activities to the extent they relate to or arise from the presence of Hazardous Substances or any Environmental Condition: (1) the monitoring, investigation, assessment, treatment, cleanup, containment, removal, mitigation, response or restoration work; (2) obtaining any Permits, consents, approvals or authorizations of any Governmental Authority necessary to conduct any such activity; (3) preparing and implementing any plans or studies for any such activity; (4) obtaining a written notice from a Governmental Authority with jurisdiction over the Hazardous Substances or Environmental Condition under the Environmental, Health, and Safety Requirements that no additional work is required by such Governmental Authority; and (5) any other activities reasonably determined by a Person to be necessary or appropriate or required under the Environmental, Health, and Safety Requirements to address the presence of Hazardous Substances or the Environmental Condition.

"RIDOH" means the Department of Health, Office of Health Systems Development, of the State of Rhode Island.

"***Safe Harbor Management Contract***" means a contract or arrangement that satisfies the "safe harbors" set forth in IRS Rev. Proc. 97-13, as amended or supplemented.

"***Schedule Supplement***" has the meaning set forth in Section 5.3.

"***Secretary of State***" means the Secretary of the State of the State of Connecticut or Rhode Island, as the context may require.

"***Solid Waste***" means any substance deemed under any applicable federal or state law or regulations as waste.

"***Solvent***" or "***Solvency***" means, with respect to either Party: (a) the fair value of entity's assets exceeds the fair value of the entity's liabilities, including contingent liabilities; (b) neither Party has, and is not incurring debts or liabilities beyond its respective ability to pay as such debts and liabilities mature; (c) each Party is generally able to pay its debts as they become due and payable and are, in fact, paying such debts as they become due and payable; and (d) neither Party is engaged in a business or transaction, and is not about to engage in a business or transaction, for which either Party's property would constitute unreasonably small capital to carry on its businesses as it is then conducted. The amount of contingent liabilities at any time shall be computed as the amount that, in light of all the facts and circumstances existing at the time, represents the amount that can reasonably be expected to become an actual or matured liability. If at any time in the future a Party projects that it will be in non-payment default with respect to debt for borrowed money, it shall be assumed that such non-payment default will not result in the acceleration of such debt.

"***Special Master***" has the meaning set forth in the definition of LMW Acquisition-Related Obligations.

"***Subsidiary***" means at the time of reference thereto (i) any corporation with respect to which a specified Person owns a majority of the common stock or membership rights or has the power to vote or direct the voting of sufficient securities or membership rights to elect a majority of the directors (or Persons performing similar functions), (ii) any corporation with respect to which a specified Person is a member and has the right to exercise reserved power or authorities, (iii) any corporation a majority of the governing board of which is made up of persons who are also members of the governing board of the specified Person and (iv) any entity of which a specified Person is a 50% or more beneficial owner.

"***Tax***" or "***Taxes***" means all taxes, fees, levies or other assessments imposed by the United States or any state, country, local or foreign government or subdivision or agency thereof, including, without limitation, income, gross receipts, excise, real and personal property, premiums, municipal, capital, value-added, goods and services, consumption, sales, transfer, license, payroll and franchise taxes, and such term shall include any interest, penalties or additions to tax attributable to such taxes, fees, levies or other assessments.

"***Tax-Exempt Organization***" means a Person organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code and exempt from federal income taxes under Section 501(a) of the Code.

"***Tax Returns***" means any report, return or other information required to be supplied to any federal, state or local taxing authority in connection with Taxes.

"***Third Party Expenses***" has the meaning set forth in Section 10.3.

"***Third Party Payer***" means any commercial or non-profit entity that provides reimbursement for health care services, including but not limited to, health maintenance organizations, preferred provider organizations, accountable care organizations, health benefit plans, insurers, health insurance plans, third party administrators, workers' compensation, auto insurance and other third party reimbursement and payment programs.

"***Transfer Act***" means the Transfer Act of the State of Connecticut, Conn. Gen. Stat. §§22a-134 *et seq.*

"VNA of Southeastern Connecticut" means Visiting Nurse Association of Southeastern Connecticut Inc., a Connecticut non-stock corporation.

"***VNA of Southeastern Connecticut Amended Bylaws***" has the meaning set forth in Section 2.1.5(c).

"***VNA of Southeastern Connecticut Amended Certificate of Incorporation***" has the meaning set forth in Section 2.1.5(c).

"***Westerly Agreement***" has the meaning set forth in the definition of LMW Acquisition-Related Obligations.

"***Yale New Haven Health System***" means the health system comprised of YNHHSC and the YNHHSC Subsidiaries.

"***YNHHSC***" has the meaning set forth in the introductory paragraph.

"***YNHHSC 2014 Bond Disclosure Documents***" means (i) the official statement, dated May 29, 2014, of the State of Connecticut Health and Education Facilities Authority with respect to the YNHHSC Tax-Exempt Bonds, (ii) the private placement memorandum, dated May 29, 2014, of YNHHSC with respect to its Taxable Bonds, Series 2014, and (iii) the continuing disclosure notifications filed on behalf of YNHHSC pursuant to the Electronic Municipal Market Access system administered by the Municipal Securities Rulemaking Board.

"***YNHHSC 2014 Audited Financial Statements***" has the meaning set forth in Section 4.7.

"***YNHHSC Activities***" means the business activities of each of the YNHHSC Affiliates, as the context may require.

"***YNHHSC Affiliates***" means YNHHSC and all of its Subsidiaries.

"***YNHHSC Amended Bylaws***" has the meaning set forth in Section 2.1.3.

"***YNHHSC Amended Certificate of Incorporation***" has the meaning set forth in Section 2.1.3.

"***YNHHSC Change of Control***" means any transaction as a result of which (i) any entity other than Yale University and the Hospital Members has the right to appoint a majority of the board of trustees of YNHHSC or (ii) any entity or entities other than Yale University or one or more YNHHSC Affiliates becomes a corporate member of YNHHSC.

"***YNHHSC Determination Letters***" has the meaning set forth in Section 4.10.7.

"***YNHHSC Financial Statements***" has the meaning set forth in Section 4.7.

"***YNHHS Interim Financial Statements***" has the meaning set forth in Section 4.7.

"***YNHHSC Leased Real Property***" has the meaning set forth in Section 4.5.3.

"YNHHSC Master Trust Indenture" means that certain Master Trust Indenture (Security Agreement), dated as of February 1, 2013 and effective on June 23, 2014 among the YNHHSC Obligated Group and U.S. Bank National Association, as Master Trustee, as it may be supplemented from time to time.

"***YNHHSC Material Adverse Effect***" means any occurrence, condition, change, development, circumstance, effect, event or fact, occurring after the Effective Date (a "***Matter***"), that individually or in the aggregate, would be reasonably expected to have a monetary effect on YNHHSC and the YNHHSC Obligated Group members, taken as a whole, that would exceed the YNHHSC Materiality Threshold, or such an effect that prevents YNHHSC or on the YNHHSC

Obligated Group from performing its material obligations under, or from consummating the transactions contemplated by, this Affiliation Agreement. Notwithstanding anything herein to the contrary, "YNHHSC Material Adverse Effect" shall be deemed not to include, and a YNHHSC Material Adverse Effect shall not be deemed to have resulted from or arisen out of (i) any reduction in the rates of reimbursement or payment received by YNHHSC or any YNHHSC Obligated Group Member under any Government Reimbursement Program that affects similarly situated providers similarly; (ii) any Matter specifically disclosed on the Disclosure Schedules at the Effective Date; (iii) [reserved]; (iv) the public announcement of this Affiliation Agreement, compliance with terms of this Affiliation Agreement or the consummation of the Affiliation; (v) any Matter, to the extent affecting (A) global or national or regional economic, business, regulatory, market or political conditions or national financial markets, (B) the healthcare industry generally or such industry in Connecticut, or (C) the hospital business generally or in Connecticut; (vi) any changes or any proposed changes in law after the Effective Date that are not directed at L+M or YNHHSC, in each instance to the exclusion of others; (vii) [reserved]; or (viii) [reserved].

"***YNHHSC Materiality Threshold***" means a dollar amount equal to $350,000,000 (Three Hundred Fifty Million Dollars).

"***YNHHSC Obligated Group***" means the members, as of a given date, of the Obligated Group (as such term is defined in the YNHHSC Master Trust Indenture) pursuant to the YNHHSC Master Trust Indenture.

"***YNHHSC Obligated Group Agreement***" means the obligated group agreement, dated as of June 23, 2014 by and among YNHHSC and the other members of the YNHHSC Obligated Group.

"***YNHHSC Obligated Group Bonds***" means the YNHHSC Tax-Exempt Bonds and the Yale New Haven Health Taxable Bonds Series 2014.

"***YNHHSC Obligated Group Member***" means each member, as of the date of reference thereto, of the YNHHSC Obligated Group.

"***YNHHSC Obligated Group Policies***" has the meaning ascribed to the term "OGA Policies" in the YNHHSC Obligated Group Agreement.

"***YNHHSC Owned Real Property***" has the meaning set forth in Section 4.5.2.

"***YNHHSC Permits***" has the meaning set forth in Section 4.9.5(a).

"***YNHHSC Plans***" has the meaning set forth in Section 4.15.

"***YNHHSC Real Property***" has the meaning set forth in Section 4.5.3.

"***YNHH Real Property Leases***" has the meaning set forth in Section 4.5.3.

"***YNHHSC Subsidiary***" means each Subsidiary of YNHHSC and each direct or indirect Subsidiary of any such Subsidiary.

"***YNHHSC Tax Exempt Bonds***" means the State of Connecticut Health and Educational Facilities Authority Revenue Bonds, Yale New Haven Health Issue, Series A, Series B, Series C, Series D and Series E.

"***YSM Affiliation Agreement***" means the Affiliation Agreement, dated as of June 25, 1999, by and between Yale University and YNHHSC, as the same may be amended from time to time.

Exhibit 2.1.1(A)

L+M Amended Certificate of Incorporation

Amended and Restated

Certificate of Incorporation

of

Lawrence + Memorial Corporation

Section 1. The name of the corporation is Lawrence + Memorial Corporation (the "Corporation").

Section 2. The Corporation is organized and shall be operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time, and the corresponding provisions of any future United States Internal Revenue Law (the "Code"). The Corporation shall serve as the parent corporation of a network of health care affiliates in southeastern Connecticut and Rhode Island (the "L+M Network"), and the nature of the activities to be conducted, or the purposes to be promoted or carried out by the Corporation are as follows:

(a) To benefit, perform the functions of, carry out the purposes of, and uphold, promote, develop and further the welfare, programs and activities of the entities affiliated with the L+M Network (the "L+M Entities"), including the following:

(i) initiating, developing, recommending and carrying out for the L+M Entities goals and priorities for new or expanded programs for the benefit of the L+M Network and the communities served by the L+M Network;

(ii) continuously reevaluating, maintaining and revising a master plan for the programs and facilities of the L+M Network;

(iii) considering and recommending the acquisition of properties or the construction of facilities by or for the use of the L+M Entities;

(iv) planning for the acquisition and placement of new facilities and equipment by or for the use of the L+M Entities; and

(v) performing public relations work on behalf of the L+M Network, and soliciting and receiving subscriptions and gifts for the exclusively charitable purposes of the L+M Entities.

(b) To initiate, develop, operate and maintain, for the L+M Network and for other hospitals and health care facilities which are not part of the L+M Network, programs directed toward improving the efficiency of utilization of health care facilities and services in the States of Connecticut and Rhode Island, and in New

London County and surrounding areas in particular, and reducing the cost of health care to the public while maintaining a high quality of such care;

(c) To initiate, develop, operate and maintain educational programs for health professionals and for the public, including programs of nursing education, continuing medical education, residency training and community health education;

(d) To initiate, develop and maintain, in cooperation with the L+M Entities and with other hospitals and health care facilities, and operate directly or through one or more separate corporations, programs for the delivery of health care services to persons other than hospital patients;

(e) To acquire, improve, hold and lease to the L+M Entities and to other hospitals and health care facilities any real or personal property useful to the accomplishment of the purposes of this Corporation, the L+M Entities or such other hospitals or health care facilities;

(f) To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of the Corporation;

(g) Generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein; and

(h) To engage in any lawful act or activity for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act, as the same may be amended from time to time, and the corresponding provisions of any future Connecticut nonstock corporation law.

In furtherance of the foregoing, the Corporation shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the Corporation's charitable purposes and the charitable purposes of all System affiliates.

Section 3. The Corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

Section 4. The Corporation shall have but one member, Yale-New Haven Health Services Corporation, which shall have the rights, powers and privileges provided in the Bylaws

and by the State of Connecticut, including certain expressly reserved powers and retained rights described in the Bylaws.

Section 5. Subject to the rights, powers and privileges accorded to Yale-New Haven Health Services Corporation under the Bylaws and by the State of Connecticut, the Corporation shall be governed by its Board of Trustees. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio trustees who may vote and be counted in determining a quorum. As may be further provided in the Bylaws of the Corporation, the terms of elected trustees may be staggered by dividing the trustees into groups so that approximately an equal number of such trustees have terms that expire each year.

Section 6. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's trustees, officers or other private persons, except that the Corporation, subject to the provisions of the Bylaws, shall be authorized and empowered to pay reasonable compensation for services rendered. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

Section 7. Upon any dissolution of the Corporation, all of its property and assets shall, after payment of the lawful debts of the Corporation and the expenses of its dissolution, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Yale-New Haven Health Services Corporation, as long as it is at that time an organization that qualifies as an exempt organization under Section 501(c)(3) of the Code, or, if at the time of the dissolution or termination of existence of the Corporation, Yale-New Haven Health Services Corporation is not in existence or does not qualify as an exempt organization under Section 501(c)(3) of the Code, to one or more charitable, scientific or education organizations located in the State of Connecticut and qualified as exempt organizations under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

Section 8. In addition to, and not in derogation of, any other rights conferred by law, a trustee shall not be personally liable for monetary damages for breach of duty as a trustee in an amount greater than the compensation received by such trustee for serving the Corporation during the year of such breach if such breach does not (A) involve a knowing and culpable violation of law by such trustee, (B) enable such trustee or an associate (as defined in Section 33-840 of the Connecticut General Statutes), to receive an improper personal economic gain, (C) show a lack of good faith and conscious disregard for the duty of such trustee to the Corporation

under circumstances in which such trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (D) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of such trustee's duty to the Corporation. Any lawful repeal or modification of this Section 8 or the adoption of any provision inconsistent herewith by the Board of Trustees or member of the Corporation shall not, with respect to a person who is or was a trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a trustee provided for in this Section 8 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

Section 9. The Corporation shall provide its trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act and shall advance expenses to trustees consistent with Section 33-1119 of the Connecticut General Statutes. In furtherance of the foregoing, the Corporation shall indemnify its trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statutes to any person for any action taken, or any failure to take any action, as a trustee, except liability that (A) involves a knowing and culpable violation of law by such trustee, (B) enables such trustee or an associate (as defined in Section 33-840 of the Connecticut General Statutes), to receive an improper personal economic gain, (C) shows a lack of good faith and conscious disregard for the duty of such trustee to the Corporation under circumstances in which such trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (D) constitutes a sustained and unexcused pattern of inattention that amounted to an abdication of such trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a trustee, or who is a trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

Section 10. The Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Board of Trustees and the member.

Exhibit 2.1.1(B)

L+M Amended Bylaws

LAWRENCE + MEMORIAL CORPORATION

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

LAWRENCE + MEMORIAL CORPORATION
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 **Name**. The name of the corporation is **Lawrence + Memorial Corporation** (the "Corporation").

Section 1.2 **General Purposes**. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 **Member**. The Corporation shall have a single member, Yale-New Haven Health Services Corporation (the "Member").

Section 2.2 **Rights, Powers and Privileges**. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act as may be amended from time to time (the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), without the prior approval of the Member. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the Member, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the approval rights reserved to the Member set forth in Exhibit A, the Member expressly retains the rights to take the actions set forth in Exhibit B on behalf of and in the name of the Corporation, directly and without the approval of the Board of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 Liability and Reimbursement of Expenses. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. Subject to the powers retained by, conferred upon, or reserved to the Member by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances and in a manner he or she reasonably believes to be in the best interests of the Corporation.

Section 3.2 Composition. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees.** Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees.** In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President/Chief Executive Officer of the Member (or his or her designee);

(ii) the President of the Corporation;

(iii) the Chair of the Board of Lawrence + Memorial Hospital, Inc. ("L+M Hospital");

(iv) the Chair of the Board of LMW Healthcare, Inc., doing business as Westerly Hospital ("Westerly Hospital"); and

(v) the Chair of the Board of Visiting Nurse Association of Southeastern Connecticut, Inc. ("VNASC").

Ex Officio Trustees shall be counted in determining the presence of a quorum and shall have the right to vote on all matters that come before the Board.

Section 3.3 Number. The Board shall consist of no fewer than eight (8) nor more than seventeen (17) Trustees, such number to be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors from among the nominees presented by the Board; provided, however, that in the event the Member does not elect any such nominee, the Board shall present a different nominee to the Member for election; and provided further that in the event any such successor nominee is not elected by the Member within ninety (90) days following the original nomination, the Member may solicit alternative nominees or elect its own nominee. In all events, the Elected Trustees shall be individuals who meet the requirements set forth in Section 3.2(a) of this Article III.

Notwithstanding anything herein to the contrary, the Elected Trustees shall include:

(a) up to three (3) health care providers on the Medical Staffs of L+M Hospital and Westerly Hospital who shall be selected from a group of five (5) candidates proposed to the Nominating and Governance Committee by each of the respective Medical Staffs, provided that at least one (1) such Elected Trustee shall be on the Medical Staff of L+M Hospital and at least one (1) such Elected Trustee shall be on the Medical Staff of Westerly Hospital;

(b) Up to six (6) community members from the L+M Hospital service area; and

(c) Up to three (3) community members from the Westerly Hospital service area.

Section 3.5 Term and Term Limits. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an

additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of Yale-New Haven Health Services Corporation at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of Yale-New Haven Health Services Corporation.

Section 3.6 Resignation. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with or without cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member and may be filled at any time in accordance with the process set forth in Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

Section 3.9 Meetings.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Chair of the Board shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held at least quarterly or more frequently as needed on such dates and at such times and places as the Chair shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the Chair or President and shall be called upon the written request of any three (3) Trustees.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President/Chief Executive Officer of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President/Chief Executive Officer of the Member has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the

Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 Officers. The officers of the Corporation shall consist of a President, a Chair, one or more Vice Chairs, a Secretary, a Treasurer and such other officers as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be selected from among members of the Board of Trustees. The offices of the President, the Chair and the Treasurer shall be held by different individuals.

Section 4.2 Election and Term of Office. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, Vice Chairs, Secretary and Treasurer shall be nominated in consultation with the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 Powers. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President**. The President of the Corporation shall be appointed by the Member, following consultation with the Board. The appointed President shall serve at the pleasure of the Member.

The President shall be a person who in the judgment of the Member has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, the Medical Staffs of L+M Hospital and Westerly Hospital, Corporation personnel and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws. The President shall report to the President/Chief Executive Officer of the Member (or his or her designee) as well as to the Board.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board and shall be a voting member of all committees except the Nominating and Governance Committee.

The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board shall designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s) shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office; shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President of the Corporation may be removed from office by the Member following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board of Trustees for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as are provided for in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees. Every committee of the Board shall include among its members a representative of the Member, who shall be appointed by the President/Chief Executive Officer of the Member and who shall have a vote and be included for purposes of determining a quorum.

Section 5.3 Committee Governance.

(a) **Quorum and Voting**. A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings**. Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) **Executive Committee**. The Executive Committee shall consist of the President, the Chair, the Secretary, the Treasurer, a member of the Board selected by the Member, and any other member of the Board that the Board may choose to appoint. The Chair shall serve as the chair of the Executive Committee. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws, or resolution of the Board.

(b) **Finance Committee**. The Finance Committee shall consist of at least three (3) Trustees, including the Treasurer, a member of the Board selected by the Member, and such other members as are necessary to properly perform the functions of the Finance Committee. The Finance Committee shall have such duties as are established by the Member and set forth in the Finance Committee charter. These duties shall include, but not be limited to, approval of local operating and capital budgets and examination and monitoring of other operating and capital budgets involving the Corporation.

(c) **Nominating and Governance Committee**. The Nominating and Governance Committee shall develop recommended criteria for membership on the Board and on committees of the Board. The Nominating and Governance Committee shall, after

consultation with the President, nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all standing committees. The Nominating and Governance Committee shall also periodically review of Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process. The composition of the Nominating and Governance Committee shall be as set forth in its Charter and shall include a member of the Board selected by the Member.

(d) **Executive Compensation Committee.** The Executive Compensation Committee shall set compensation for executives of the Corporation (other than the President and any other officer whose compensation is set by the Member) who are in a position to exercise substantial influence over the affairs of the Corporation as determined by the Executive Compensation Committee. The Executive Compensation Committee shall obtain and rely upon appropriate comparability data, including from the Member, in making its compensation decisions, and shall ensure that such compensation decisions are in compliance with the laws relating to organizations described in Section 501(c)(3) of the Internal Revenue Code. The composition of the Executive Compensation Committee shall be as set forth in its Charter and shall include a member of the Board selected by the Member.

Section 5.6 Other Committees. The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

Section 5.7 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws. The Executive Committee shall have authority to take actions consistent with these Bylaws; all other committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation, unless expressly authorized by the Board.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with

the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

ARTICLE IX. AMENDMENTS

Subject to approval by the Member, these Bylaws may be amended, altered, or repealed at any meeting of the Board by a majority vote of the Trustees present and voting, a quorum being present. The general nature and purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice. No amendment, alteration or repeal shall take effect until it shall have been approved by the Member.

EXHIBIT A

Actions Requiring Approval of Both the Board and the Member

Notwithstanding anything in these Bylaws to the contrary and except as otherwise provided in Exhibit B relating to the direct authority retained by the Member, the following actions may only be taken with both the prior approval of the Board and the Member:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate or the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the Member;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. The Member shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate, which will comport with the strategic planning processes and strategic plans established by the Member; and

K. Adoption of safety and quality assurance policies not in conformity with policies established by the Member.

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member pursuant to these Bylaws.

EXHIBIT B

Direct Authority Retained by the Member

Notwithstanding anything in these Bylaws to the contrary, the Member retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by the Member in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to the Member or as otherwise directed by the Member;

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate; and

G. Appointment of the President consistent with Section 4.3(a), which requires prior consultation with the Board.

Other Major Activities Requiring the Approval of the Member

A. In addition, the Member shall have the authority, except as otherwise provided by the Member and after consultation with the Board of this Corporation, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that the Member determines to be "major activities."

B. "Major activities" shall be those which the Member by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the Member, and shall refer to this Bylaw provision granting such approval rights to the Member. Notices received pursuant to this

section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation.

Exhibit 2.1.3(A)

YNHHSC Amended Certificate of Incorporation

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

1. The name of the corporation is YALE-NEW HAVEN HEALTH SERVICES CORPORATION.

2. The nature of the activities to be conducted, or the purposes to be promoted or carried out by the corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Code (as defined in paragraph 8 hereof) and shall include the following:

A. To benefit and carry out the purposes of, to perform the functions of, and uphold, promote and further the welfare, programs and activities of an integrated health care delivery system known as the Yale New Haven Health System (the "System") and its affiliates, including Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, Lawrence + Memorial Corporation, Northeast Medical Group, Inc. and such other organizations as may become affiliates of the System from time to time (collectively, the "YNHHS Members");

B. To engage directly in, and collaborate with, the YNHHS Members and Yale University and other hospitals and health care institutions and other organizations in, the initiation, development and maintenance of programs directed toward improving the efficiency and reducing the cost of health care services while maintaining a high quality of such care;

C. To collaborate with Yale University and with other colleges and schools in the initiation, development and maintenance of educational programs for health professionals and for the public, including programs of medical and nursing education, continuing education, graduate medical education and community health education;

D. to collaborate with the YNHHS Members, with Yale University and with other hospitals, health care institutions, colleges and schools in the initiation, development and maintenance of programs of scientific research related to the care of the sick and injured;

E. To initiate, develop, operate and maintain, directly and in collaboration with the YNHHS Members, and with other hospitals and health care institutions and organizations, programs for the delivery of health care services through one or more separate corporations;

F. To acquire, improve, hold and lease any real or personal property useful to the accomplishment of the purposes of this corporation;

G. To own and operate facilities, directly and in collaboration with the YNHHS Members, and with other hospitals and health care institutions and organizations, to achieve the purposes of the corporation;

H. To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of this corporation; and generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein; and

I. To engage in any lawful act or activity for which a corporation may be organized under the Connecticut Revised Nonstock Act in furtherance of the foregoing.

3. The corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

4. The corporation shall have no Members, and the corporation shall be operated under the management of a Board of Trustees.

5. The Board of Trustees shall be composed of two designations of trusteeships, Elected Trustees and Ex Officio Trustees, with the trustees to be elected as provided in the Bylaws. Ex Officio Trustees may be counted in determining a quorum and have the right to vote as shall be provided in the Bylaws. As may be further provided in the Bylaws, the terms of Elected Trustees may be staggered by dividing the Elected Trustees into groups so that approximately an equal number of such Trustees have terms that expire each year.

6. No part of the net earnings of the corporation shall inure to the benefit of or be distributable to the corporation's trustees, officers or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal Income Tax under Section 501(c)(3) of the Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

7. Upon any dissolution or termination of the existence of the corporation, all of its property and assets shall, after payment of the lawful debts of the corporation and the expenses of its dissolution or termination, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, Lawrence + Memorial Corporation, and Northeast Medical Group, Inc., provided they shall then qualify as exempt organizations under Section 501(c)(3) of the Code, in such proportions as the Board of Trustees may deem appropriate consistent with the relative financial and other contributions of each to the corporation, and to such other charitable, scientific or educational organizations qualified as exempt organizations under Section 501(c)(3) of the Code,

in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

8. References to sections of the Code shall be deemed references to the Internal Revenue Code of 1986, as the same may be amended from time to time, and to the corresponding provisions of any future United States Internal Revenue Law.

9. In addition to, and not in derogation of, any other rights conferred by law, a Trustee shall not be personally liable for monetary damages for breach of duty as a Trustee in an amount greater than the compensation received by the Trustee for serving the corporation during the year of the violation if such breach did not (1) involve a knowing and culpable violation of law by the Trustee, (2) enable the Trustee or an associate as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (3) show a lack of good faith and conscious disregard for the duty of the Trustee to the corporation under circumstances in which the Trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the corporation, or (4) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the corporation. Any lawful repeal or modification of this Section 9 or the adoption of any provision inconsistent herewith by the Board of Trustees of the corporation shall not, with respect to a person who is or was a Trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a Trustee provided for in this Section 9 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

Section 10. The corporation shall provide its Trustees with the full amount of indemnification that the corporation is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act and shall advance expenses to Trustees consistent with Section 33-1119 of the Connecticut General Statutes. In furtherance of the foregoing, the corporation shall indemnify its Trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statutes to any person for any action taken, or any failure to take any action, as a trustee, except liability that (1) involved a knowing and culpable violation of law by the Trustee, (2) enabled the Trustee or an associate to receive an improper personal economic gain, (3) showed a lack of good faith and a conscious disregard for the duty of the Trustee to the corporation under circumstances in which the Trustee was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the corporation, or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the corporation.

The corporation may indemnify and advance expenses to each officer, employee or agent of the corporation who is not a Trustee, or who is a Trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the corporation is permitted to provide the same to a Trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

Exhibit 2.1.3(B)

YNHHSC Amended Bylaws

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 Name. The name of the corporation is **Yale-New Haven Health Services Corporation** (the "Corporation").

Section 1.2 General Purposes. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

The Corporation shall have no members and shall be governed by a self-perpetuating Board of Trustees (the "Board") as set forth herein.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. The Board shall have charge, control and management of the affairs, property and funds of the Corporation. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances, and in a manner he or she reasonably believes to be in the best interests of the Corporation.

Section 3.2 Composition. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees**. Elected Trustees shall be the persons elected by the Board for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the communities and geographies served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees**. In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President/Chief Executive Officer of the Corporation;

(ii) the President of Yale University;

(iii) the Chair of the Board of Trustees of Yale-New Haven Hospital,

Inc.;

(iv) the Chair of the Board of Trustees of Bridgeport Hospital;

(v) the Chair of the Board of Trustees of Greenwich Hospital.

Section 3.3 Number. The Board shall consist of up to twenty-one (21) Trustees, inclusive of Ex Officio Trustees.

Section 3.4 Election of Trustees. At the annual meeting of the Board, the Board shall elect successors to the Elected Trustees whose terms are then expiring. The Board shall elect such successors consistent with the following:

(a) Nine (9) of the Trustees, at least one of whom shall, when nominated, be a trustee of Yale-New Haven Hospital, Inc., shall be individuals nominated by the Chair of the Board of Trustees of Yale-New Haven Hospital, Inc.

(b) Three (3) of the Trustees, at least one of whom shall, when nominated, be a trustee of Yale-New Haven Hospital, Inc., shall be individuals nominated by the President of Yale University; provided that (x) no more than two (2) Trustees nominated and elected in accordance with this clause shall be employees of Yale University; and (y) if any Trustee nominated in accordance with this clause is an employee of Yale University, then such Trustee shall hold an officer position at Yale University throughout the term of such individual's service as a Trustee.

(c) All other Elected Trustees shall be elected from among the nominees presented by the Nominating and Governance Committee.

In all events, the Elected Trustees shall be individuals who meet the requirements set forth in Section 3.2(a) of this Article III.

Section 3.5 Term and Term Limits. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Board at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Board at which they were elected or at such later date as may be established by the Board and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if:

(i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or

(ii) the Board determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board.

In the instance of re-election as a Trustee for an additional term as provided in clause (i) above, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided, however, that a Trustee may be re-elected for one or more additional consecutive terms if:

(i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or

(ii) the Board determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms.

In the instance of re-election as a Trustee for an additional term as provided in clause (i) above, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

Section 3.6 Resignation. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with cause by action of the Board. Action to remove an Elected Trustee may be taken at any meeting of the Board, provided that the notice of the meeting at which such action will be voted on shall state that the purpose or one of the purposes, of the meeting is removal of the Trustee.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled by the Board in accordance with Section 3.4 of these Bylaws. If the vacancy results from the death, resignation or removal of a Trustee elected on nomination of Yale-New Haven Hospital, Inc., Bridgeport Hospital, Greenwich Hospital or Yale University, the institution that nominated the Trustee who died, resigned or was removed shall submit a name of a replacement Trustee consistent with Section 3.4. In the event that the remaining Trustees on the Board do not constitute a quorum, a vacancy may be filled by the concurring vote of a majority of such remaining Trustees. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

Section 3.9 Meetings.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Chair or the President/Chief Executive Officer shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held at least quarterly or more frequently as needed on such dates and at such times and places as the Chair or the President/Chief Executive Officer shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the Chair or the President/Chief Executive Officer and shall be called upon the written request of any three (3) Trustees.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees are present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the

Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 Officers. The officers of the Corporation shall consist of a President/Chief Executive Officer, a Chair, a Secretary, a Treasurer and such other officers as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be members of the Board.

Section 4.2 Election and Term of Office. Employees of the Corporation who are designated as officers shall be appointed by the Board and shall hold office at the pleasure of the Board. Officers who are not paid employees of the Corporation shall be nominated by the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 Powers. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President/Chief Executive Officer.** The President/Chief Executive Officer shall be the chief executive officer of the Corporation.

The President/Chief Executive Officer shall be a person who in the judgment of the Board has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, employees and the community.

The President/Chief Executive Officer shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President/Chief Executive Officer shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President/Chief Executive Officer shall be defined in a written statement adopted by the Board.

The President/Chief Executive Officer shall be a voting member of all standing committees except as otherwise specified in these Bylaws. In the absence of the Chair and the Vice Chair, or if there be no Chair or Vice Chair, the President/Chief Executive Officer shall preside at all meetings of the Board.

The President/Chief Executive Officer shall serve, as long as he or she is appointed by the Board of Yale-New Haven Hospital, Inc., as the chief executive officer of Yale-New Haven Hospital, Inc.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board and shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board shall designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s) shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office, shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, the vacancy may be filled by the Board for the unexpired term.

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as are provided for in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members

and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. All committees shall have the power to choose their own secretaries. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees. Each committee shall be chaired by a member of the Board.

Section 5.3 Committee Governance.

(a) **Quorum and Voting**. A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings**. Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) **Finance Committee**. The Finance Committee shall consist of such members as may be appointed by the Board on nomination of the Nominating and Governance Committee and shall include at least one (1) representative from each of the founding hospital members of the obligated group led by the Corporation. Notwithstanding anything herein to the contrary, (i) at least one member of the Finance Committee shall have financial expertise, as determined by the Board; and (ii) a majority of the members of the Finance Committee shall be Trustees. The Finance Committee shall have such duties as are established by the Board and set forth in the Finance Committee charter. These duties shall include, but not be limited to, fact-finding for the Board on matters relating to the financial administration of the Corporation and its affiliates, examination and analysis of financial reports of the Corporation and its affiliates, and preparation of annual operating and capital budgets for presentation to the Board that take into account the financial plans for the Corporation and its affiliates.

(b) **Audit Committee**. The Audit Committee shall consist of such members as may be appointed by the Board on nomination of the Nominating and Governance Committee. Notwithstanding anything herein to the contrary, (i) at least one member of the Audit Committee shall have financial expertise, as determined by the Board; (ii) a majority of the members of the Audit Committee shall be Trustees; and (iii) no member of the Audit Committee shall have any material business relationship (including but not limited to an employment relationship) with the Corporation or any of its affiliates. The Audit Committee shall have such duties as are established by the Board and set forth in the Audit Committee charter. These duties shall include, but not be limited to, monitoring the integrity of the financial statements of the Corporation and its affiliates; recommending to the Board an independent auditor for the Corporation and its affiliates; reviewing the outside auditor's independence, qualifications and

performance; meeting with the independent auditor from time to time to review financial results and controls of the Corporation and its affiliates; overseeing the effectiveness of internal controls of the Corporation and its affiliates.

(c) **Nominating and Governance Committee**. The Nominating and Governance Committee shall consist of not fewer than five (5) nor more than eight (8) members of whom the following shall be Ex Officio members: (i) the Chair of the Board of Yale-New Haven Hospital; (ii) the President of Yale University; (iii) the President/Chief Executive Officer of the Corporation; (iv) the Chair of the Board of Bridgeport Hospital; and (v) the Chair of the Board of Greenwich Hospital. Ex Officio members shall be counted in determining a quorum and shall have full voting rights. All other members shall be elected by the Board subject to the consent of the Chair of the Board of Yale-New Haven Hospital and at least one of such additional members shall be a member of the Board of Trustees of Yale-New Haven Hospital, Inc. The Nominating and Governance Committee shall nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all other standing committees. The Nominating and Governance Committee shall also review Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process.

(d) **System Investment Committee**. The System Investment Committee shall consist of such members as may be appointed by the Board on nomination of the Nominating and Governance Committee and shall include one (1) representative from each of the founding hospital members of the obligated group led by the Corporation. At all times, a majority of the members of the System Investment Committee shall be Trustees. The System Investment Committee shall have such duties as are delegated to it by the Board. These duties include oversight of investment activities of the Corporation.

Section 5.6 Other Committees. The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

Section 5.7 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Connecticut Revised Nonstick Corporation Act, as such act may be amended from time to time (the "Nonstock Act") related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President/Chief Executive Officer or such other officers or officers as may be specified by the Board or authorized by the President/Chief Executive Officer.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President/Chief Executive Officer or such officer or officers of the Corporation as the Board may specify from time to time.

Section 8.4 **Related Corporations**. The Corporation is nonprofit and shall not engage directly in activities for profit. It may, however, from time to time organize and control, through stock ownership or otherwise, one or more corporations organized and operated for profit. In considering the appropriateness of organizing or controlling corporations organized and operated for profit, the Corporation shall give principal consideration to corporations engaged in activities which relate to health care or which directly or indirectly support, advance or contribute to the purposes and objectives of the Corporation and its affiliates that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time. The Board shall establish guidelines, consistent with the provisions of this Section, for consideration of activities which might suitably be developed through for profit corporations controlled by the Corporation.

ARTICLE IX. AMENDMENTS

These Bylaws may be amended, altered, or repealed at any meeting of the Board by a two-thirds vote of the Trustees present and voting, a quorum being present, provided that the general nature and

purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice.

Notwithstanding anything herein to the contrary:

(i) any amendment to reduce or alter the number, conditions of office, or terms of Trustees who either (x) are required to be trustees of Yale-New Haven Hospital, Inc. or (y) are nominated for election by the Chair of the Board of Yale-New Haven Hospital, Inc., shall be subject to approval by at least a majority of the following Trustees: the Chair of the Board of Yale-New Haven Hospital, Inc. and all Trustees nominated by the Chair of the Board of Yale-New Haven Hospital, Inc.

(ii) any amendment to reduce or alter (x) the number, conditions of office, or terms of Trustees who serve Ex Officio by virtue of his or her position with Bridgeport Hospital or Greenwich Hospital or (y) the rights of Bridgeport Hospital or Greenwich Hospital to have a representative on certain enumerated committees of the Board, shall be subject to approval by a two-thirds vote of the Trustees present and voting, a quorum being present, and to approval by the Ex Officio Trustee representing the affected hospital(s).

(iii) any amendment, alteration or repeal of these Bylaws shall be consistent with the Affiliation Agreement between the Corporation and Yale University dated June 25, 1999 and any amendments thereto.

Exhibit 2.1.4(A)

LMMG-NEMG Agreement and Plan of Merger

AGREEMENT AND PLAN OF MERGER

of

L&M PHYSICIAN ASSOCIATION, INC.
a Connecticut medical foundation

with and into

NORTHEAST MEDICAL GROUP, INC.,
a Connecticut medical foundation

ARTICLE I
PARTIES

The parties to the merger (the "Merger") are L&M Physician Association, Inc., a Connecticut medical foundation (the "Merging Corporation"), and Northeast Medical Group, Inc., a Connecticut medical foundation (the "Surviving Corporation" and, together with the Merging Corporation, the "Constituent Corporations"). The Merging Corporation shall merge with and into the Surviving Corporation in accordance with the Connecticut Medical Foundations Law and the Connecticut Revised Nonstock Corporation Act (together, the "Act").

ARTICLE II
SURVIVING CORPORATION, NAME

Northeast Medical Group, Inc. shall be the surviving corporation of the Merger. The Constituent Corporations shall cause an appropriate Certificate of Merger (the "Certificate of Merger") reflecting the Merger to be filed with the Secretary of the State of the State of Connecticut. Upon the Effective Time (as defined below) of the Merger, the name of the Surviving Corporation shall continue to be Northeast Medical Group, Inc.

ARTICLE III
EFFECTIVE TIME AND DATE

The Constituent Corporations shall do all acts and things as shall be necessary or desirable to effect the Merger. The effective time and date of the Merger provided for herein shall be the time and date on which the Certificate of Merger is filed with the Secretary of the State of the State of Connecticut (the "Effective Time").

ARTICLE IV
PURPOSES OF THE PLAN OF MERGER

(a) L&M Physician Association, Inc. is a corporation without capital stock organized and existing under the Act. Northeast Medical Group, Inc. is a corporation without capital stock organized and existing under the Act.

(b) This Agreement and Plan of Merger (the "Plan") is intended to accomplish the merger of L&M Physician Association, Inc. with and into Northeast Medical Group, Inc., with Northeast Medical Group, Inc. as the surviving corporation, in the manner stated in this Plan and in accordance with the provisions of the Act.

ARTICLE V
MEMBERSHIP, CERTIFICATE OF INCORPORATION, BYLAWS, OFFICERS AND TRUSTEES

At the Effective Time, the following shall happen automatically and immediately, without the need for any other action by the board of directors of the Merging Corporation, the board of trustees of the Surviving Corporation, or the respective members of either of the Constituent Corporations, and without any filing other than the filing of the Certificate of Merger:

(a) As of the Effective Time, the separate existence of the Merging Corporation shall cease, and the membership of the Merging Corporation shall not convert into membership of the Surviving Corporation.

(b) The Certificate of Incorporation and the Bylaws of Northeast Medical Group, Inc. shall each be amended and restated at the Effective Time as a result of the Merger. The Amended and Restated Certificate of Incorporation and the Amended and Restated Bylaws of the Surviving Corporation, are set forth as Exhibit A and Exhibit B, respectively, to this Plan, and shall be effective from and after the Effective Time, until further amended pursuant to the Act and in the manner prescribed therein.

(c) The officers and trustees of Northeast Medical Group, Inc. in office immediately prior to the Effective Time shall be the officers and trustees of the Surviving Corporation until such time as they may be changed in accordance with the Bylaws of the Surviving Corporation and other applicable law.

ARTICLE VI
EFFECT OF MERGER

Upon the Effective Time of the Merger, the separate existence of L&M Physician Association, Inc. shall cease. The effect of the Merger shall be as set forth in §33-1158 of the Act.

ARTICLE VII
OTHER TERMS AND CONDITIONS

If, at any time after the Effective Time, the Surviving Corporation or its successor or assigns determines that any documentation, action or other things are necessary or desirable to further carry out the purposes of this Plan or to vest the Surviving Corporation with all right, title and interest in to and under all of the assets, properties, rights, claims, privileges, immunities, powers, franchises and authority of each of the Constituent Corporations, the officers and directors of the Surviving Corporation shall be authorized to execute and deliver, in the name of and on behalf of any Constituent Corporation or otherwise, all such documentation, and to take and do, in the name and on behalf of any Constituent Corporation or otherwise, all such other actions and things.

END OF PLAN OF MERGER

* * * * * *

[Signature page follows.]

IN WITNESS WHEREOF, each of the Constituent Entities has caused this Agreement and Plan of Merger to be executed on its behalf by its duly authorized officers on this _____ day of _____.

L&M PHYSICIAN ASSOCIATION, INC.

By:_____
Name: Christopher M. Lehrach, M.D.
Title: President

NORTHEAST MEDICAL GROUP, INC.

By:_____
Name: Amit Rastogi, M.D.
Title: Interim President

EXHIBIT A
to
AGREEMENT AND PLAN OF MERGER

Amended and Restated Certificate of Incorporation
of
Northeast Medical Group, Inc.

EXHIBIT B
to
AGREEMENT AND PLAN OF MERGER

Amended and Restated Bylaws
of
Northeast Medical Group, Inc.

Exhibit 2.1.4(B)

Amended and Restated Bylaws of NEMG

NORTHEAST MEDICAL GROUP, INC.

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

NORTHEAST MEDICAL GROUP, INC.
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 **Name**. The name of the corporation is **Northeast Medical Group, Inc.** (the "Corporation").

Section 1.2 **General Purposes**. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 **Member**. The Corporation shall have a single member, Yale-New Haven Health Services Corporation (the "Member"), a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes.

Section 2.2 **Rights, Powers and Privileges**. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a medical foundation under the Chapter 594b of the Connecticut General Statutes (as it may be amended from time to time, the "Foundation Act") and of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act (as it may be amended from time to time, the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), without the prior approval of the Member. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the Member, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the approval rights reserved to the Member set forth in Exhibit A, the Member expressly retains the rights to take the actions set forth in Exhibit B on

behalf of and in the name of the Corporation, directly and without the approval of the Board of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 Liability and Reimbursement of Expenses. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. Subject to the powers retained by, conferred upon, or reserved to the Member by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances, and in a manner he or she reasonably believes to be in the best interests of the Corporation.

Section 3.2 Composition. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees.** Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees.** In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President of the Corporation; and

(ii) the President of each Affiliated Delivery Network, or his or her designee.

For purposes hereof, "Affiliated Delivery Network" shall mean Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with the Yale New Haven System in the future, as designated by the Member.

Section 3.3 Number. The Board shall consist of no fewer than thirteen (13) nor more

than twenty-four (24) Trustees, inclusive of Ex Officio Trustees. The number of Trustees within the range set forth in the preceding sentence shall be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors consistent with the following Board composition:

(a) two (2) representatives of senior management of the Member (each, a "YNHHSC Board Member");

(b) one (1) representative from each Affiliated Delivery Network other than Lawrence + Memorial Corporation (in addition to the President, or his or her designee, who shall serve Ex Officio as set forth in Section 3.2(b));

(c) two (2) physicians employed by the Corporation, each of whom is a member in good standing on the medical staff of Lawrence + Memorial Hospital or Westerly Hospital;

(d) up to eight (8) individuals, each of whom is either (1) nominated by a majority vote of the Board and approved by the Member; or (2) self-nominated and appointed by the Member; provided, however, that each such individual, whether nominated by a majority vote of the Board or self-nominated, shall be a Provider (as defined in the Foundation Act) employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Delivery Network;

(e) two (2) representatives of Yale School of Medicine;

(f) such other individuals nominated Yale School of Medicine and approved by the Member; provided, however, that each such other individual shall be a Provider employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Deliver Network.

Notwithstanding anything herein to the contrary: (x) in accordance with the Foundation Act, the number of Trustees on the Board who are Providers shall equal or exceed the number of Trustees on the Board who are nonprovider employees of the Member; and (y) the number of Trustees appointed to the Board as representatives of, or on the nomination of, Yale School of Medicine shall constitute twenty-five percent (25%) of the total number of Trustees on the Board.

Section 3.5 Term and Term Limits. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of Yale-New Haven Health Services Corporation at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of Yale-New Haven Health Services Corporation.

Section 3.6 Resignation. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

Section 3.9 Meetings.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Board or the President shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held on such dates and at such times and places as the Board or President shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the President and shall be called by the President upon the written request of the Member or any Trustee.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board and the Member in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President/Chief Executive Officer of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President/Chief Executive Officer of the Member has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided

that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 **Officers**. The officers of the Corporation shall consist of a Chair, a President, a Secretary, a Treasurer and such other officers, including Vice Chairs, as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be members of the Board.

Section 4.2 **Election and Term of Office**. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, any Vice Chairs, the Secretary and the Treasurer shall be nominated by the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 **Powers**. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President**. The President of the Corporation shall be appointed by the Member, following consultation with the Board. The appointed President shall serve at the pleasure of the Member.

The President shall be a person who in the judgment of the Member has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, employees and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board may designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s), if any, shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office, shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President may be removed from office by the Member following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as may be provided for, from time to time, in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in

these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. All committees shall have the power to choose their own secretaries. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

Section 5.3 Committee Governance.

(a) **Quorum and Voting.** A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings.** Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) **Executive Committee.** The Executive Committee shall consist of the Chair, who shall act as chair of the committee, the President, the Treasurer, and any other member of the Board that the Board may choose to appoint. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws or resolution of the Board.

(b) **Nominating and Governance Committee.** The Nominating and Governance Committee shall consist of Trustees elected by the Board. The Nominating and Governance Committee shall, after consultation with the President and other Trustees, nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all standing committees. The Nominating and Governance Committee shall also review Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process.

(c) **Finance Committee.** The Finance Committee shall have such duties as are established by the Member and set forth in the Finance Committee charter. These duties shall include, but not be limited to, approval of local operating and capital budgets and examination and monitoring of other operating and capital budgets involving the Corporation.

Section 5.6 **Other Committees**. The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

Section 5.7 **Powers of Committees**. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Member, Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

ARTICLE IX. AMENDMENTS

Subject to approval by the Member, these Bylaws may be amended, altered, or repealed at any meeting of the Board by a majority vote of the Trustees present and voting, a quorum being present. The general nature and purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice. No amendment, alteration or repeal shall take effect until it shall have been approved by the Member.

EXHIBIT A

Actions Requiring Approval of the Member

Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of the Corporation may take any of the following actions, or approve an Affiliate taking any of the following actions, without the prior approval of the Member:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate and the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the Member;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. The Member shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate;

K. Adoption of safety and quality assurance policies not in conformity with policies established by the Member; and

L. Adoption of any polices relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation.

Other Major Activities

A. In addition, the Member shall have the authority, except as otherwise provided by the Member and after consultation with this Corporation, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that the Member determines to be "major activities."

B. "Major activities" shall be those which the Member by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the Member, and shall refer to this Bylaw provision granting such approval rights to the Member. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation.

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member pursuant to these Bylaws and the Bylaws of the Member.

EXHIBIT B

Actions Direct Authority Retained by the Member

Notwithstanding anything in these Bylaws to the contrary, the Member retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by the Member in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to the Member or as otherwise directed by the Member;

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate; and

G. Appointment of the President consistent with Section 4.3(a).

Exhibit 2.1.4(C)

Amended and Restated Certificate of Incorporation of NEMG

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

NORTHEAST MEDICAL GROUP, INC.

§1. Name. The name of the Corporation shall hereafter be: NORTHEAST MEDICAL GROUP, INC. (the "Corporation").

§2. Purposes. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and shall include the following:

(a) to operate and maintain one or more offices or facilities for the study, diagnosis and treatment of human ailments and injuries by licensed persons;

(b) to render medical and surgical treatment, consultation or advice by duly licensed employees or agents of the Corporation to patients without regard to race, color, creed, sex, age or ability to pay for such care and services;

(c) to promote, enhance, improve, and develop medical, surgical and scientific research at providers affiliated with Yale-New Haven Health Services Corporation, including, for so long as such providers are affiliated with Yale-New Haven Health Services Corporation, Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with Yale-New Haven Health Services Corporation in the future (the "Affiliated Delivery Networks") and throughout the communities they serve;

(d) to promote, enhance, improve and augment the quality of medical and clinical education and patient care at Affiliated Delivery Networks and at any other sites determined by the Corporation;

(e) to promote and enhance a high quality of medical care and other human services for the benefit of all persons in the communities it serves;

(f) to augment the planning process for the promotion of the general well-being and human health needs of the communities it serves;

(g) to solicit, accept, hold, invest, reinvest, and administer any contributions, grants, donations, gifts, bequests, devises, benefits of trusts (but not to act as trustee of any trust), and property of any sort, without limitation as to amount or value, and to use, disperse or donate the income or principal thereof for exclusively charitable and educational purposes in such manner as, in the judgment of the Board of Trustees and the member of the Corporation, will best promote the purposes of the Corporation;

(h) to contract for, purchase, receive, own, manage, operate or lease property, real, personal and mixed, wheresoever situated, as may be necessary to promote and further the purposes and objectives of the Corporation; and

(i) to engage in any lawful act or activity for which a medical foundation may be organized under Chapter 594b of the General Statutes of Connecticut or for which a nonstock corporation may be organized under Chapter 602 of the General Statutes of Connecticut.

The member of the Corporation has elected to bring the Corporation within the provisions of Chapter 594b of the General Statutes of Connecticut.

In furtherance of the purposes set forth herein, the Corporation shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through the corporation and its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the corporation's charitable purposes and the charitable purposes of all System affiliates.

§3. Nonprofit. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

§4. Member. The Corporation shall have but one voting member. The member shall be Yale-New Haven Health Services Corporation, a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes. The member shall have the rights, powers and privileges provided in the Corporation's Bylaws and by Connecticut law, including certain expressly reserved powers and retained rights described in the Bylaws.

§5. Duration. The duration of the Corporation shall be perpetual.

§6. Board of Trustees. Subject to the rights, powers and privileges of the member, the Corporation shall operate under the management of its Board of Trustees. The Bylaws may provide that certain persons occupying certain positions within or without the Corporation shall be ex-officio trustees, who may be counted in determining a quorum and may have the right to vote as may be provided in the Bylaws. As may be further provided in the Bylaws, the terms of elected trustees may be staggered by dividing the elected trustees into up to three groups so that approximately an equal number of such trustees have terms that expire each year. Trustees may be removed by the member for cause as set forth in the Bylaws.

§7. Restrictions. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, the Corporation's trustees, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Section 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of "statements")

any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

§8. Dissolution. Upon the dissolution or termination of the existence of the Corporation, all of its property and assets, after payment of the lawful debts of the Corporation and the expenses of its dissolution or termination, shall be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Yale-New Haven Health Services Corporation, or, if at the time of the dissolution or termination of the existence of the Corporation, Yale-New Haven Health Services Corporation is not in existence or does not qualify as exempt under Section 501(c)(3) of the Code, to any organization (or organizations) that qualifies as an organization exempt under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

§9. Limitation of Liability of Trustees. In addition to and not in derogation of any other rights conferred by law, a Trustee shall not be personally liable for monetary damages for breach of duty as a Trustee in an amount greater than the amount of compensation received by the Trustee for serving the Corporation during the year of the violation, provided that such breach did not (a) involve a knowing and culpable violation of law by the Trustee, (b) enable the Trustee or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the Trustee to the Corporation under circumstances in which the Trustee was aware that his/her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the Corporation. Any lawful repeal or modification of this Section 9 or the adoption of any provision inconsistent herewith by the Board of Trustees or member of the Corporation shall not, with respect to a person who is or was a Trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a Trustee provided for in this Section 9 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

§10. Indemnification. The Corporation shall provide its Trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act. In furtherance of the foregoing, the Corporation shall indemnify its Trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statues to any person for any action taken, or any failure to take any action, as a Trustee, except liability that (1) involved a knowing and culpable violation of law by the Trustee, (2) enabled the Trustee or an associate to receive an improper personal economic gain, (3) showed a lack of good faith and a conscious disregard for the duty of the Trustee to the Corporation under circumstances in which the Trustee was aware that his or her conduct or omission created an

unjustifiable risk of serious injury to the Corporation, or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the Trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a Trustee, or who is a Trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a Trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any Trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

§11. Amendment of Bylaws. The Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Board of Trustees and the member.

Exhibit 2.1.5(a)(1)

LMH Amended Certificate of Incorporation

Amended and Restated

Certificate of Incorporation

of

Lawrence + Memorial Hospital, Inc.

Sec. 1. The name of the corporation is Lawrence + Memorial Hospital, Inc. (the "Hospital").

Sec. 2. The nature of the activities to be conducted, and the purposes to be promoted or carried out by the Hospital, shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time, and the corresponding provisions of any future United States Internal Revenue Law (the "Code") and shall include the following:

(a) To establish, maintain and carry on an institution with permanent facilities for inpatients and ambulatory patients, with medical services to provide diagnosis and treatment, to carry on all associated services, and to assure that there is no unlawful discrimination under any program or in any facility of the Hospital;

(b) To participate, so far as circumstances may warrant, in any activity designed and carried on to promote the general health needs of the community;

(c) To conduct and participate in educational and scientific research activities related to providing care to the sick and injured, to the promotion of health, or to the development of personnel in the health professions or occupations, which, in the opinion of the Board of Trustees may be justified and supported by the facilities, personnel, funds or other requirements that are or can be made available; and

(d) To engage in any lawful act or activity for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act, as the same may be amended from time to time, and the corresponding provisions of any future Connecticut nonstock corporation law.

In furtherance of the foregoing, the Hospital shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the Hospital's charitable purposes and the charitable purposes of all System affiliates.

Sec. 3. The Hospital is nonprofit and shall not have or issue shares of stock or pay dividends.

Sec. 4. The Hospital shall have but one member, Lawrence + Memorial Corporation (the "Sole Member"), which shall have the rights, powers and privileges provided in the Bylaws and by the State of Connecticut, including the right to exercise, on behalf of and as directed by its sole member, Yale-New Haven Health Services Corporation ("YNHHSC"), certain expressly reserved powers and retained rights described in the Bylaws.

Sec. 5. Subject to the rights, powers and privileges accorded to the Sole Member and to YNHHSC under the Bylaws and by the State of Connecticut, the Hospital shall be governed by its Board of Trustees. The Bylaws may provide that persons occupying certain positions within or without the Hospital shall be ex-officio trustees who may vote and be counted in determining a quorum. As may be further provided in the Bylaws of the Hospital, the terms of elected trustees may be staggered by dividing the trustees into groups so that approximately an equal number of such trustees have terms that expire each year.

Sec. 6. No part of the net earnings of the Hospital shall inure to the benefit of or be distributable to the Hospital's trustees, officers or other private persons, except that the Hospital, subject to the provisions of the Bylaws, shall be authorized and empowered to pay reasonable compensation for services rendered. No substantial part of the activities of the Hospital shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Hospital shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Hospital shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

Sec. 7. Upon any dissolution of the Hospital, all of its property and assets shall, after payment of the lawful debts of the Hospital and the expenses of its dissolution, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Lawrence + Memorial Corporation, so long as it is at that time an organization that qualifies as an exempt organization under Section 501(c)(3) of the Code, or, if at the time of the dissolution of the Hospital, Lawrence + Memorial Corporation is not in existence or does not so qualify, to one or more charitable, scientific or educational organizations located in the State of Connecticut and qualified as exempt organizations under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

Sec. 8. In addition to, and not in derogation of, any other rights conferred by law, a trustee of the Hospital shall not be personally liable for monetary damages for breach of duty as a trustee in an amount greater than the compensation received by the trustee for serving the Hospital during the year of such breach if such breach does not (A) involve a knowing and culpable violation of law by such trustee, (B) enable such trustee or an associate (as defined in

Section 33-840 of the Connecticut General Statutes) to receive an improper personal economic gain, (C) show a lack of good faith and conscious disregard for the duty of such trustee to the Hospital under circumstances in which such trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the Hospital, or (D) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of such trustee's duty to the Hospital. Any lawful repeal or modification of this Section 8 or the adoption of any provision inconsistent herewith by the Board of Trustees or the Sole Member of the Hospital shall not, with respect to a person who is or was a trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a trustee provided for in this Section 8 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

Sec. 9. The Hospital shall provide its trustees with the full amount of indemnification that the Hospital is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act and shall advance expenses to trustees consistent with Section 33-1119 of the Connecticut General Statutes. In furtherance of the foregoing, the Hospital shall indemnify its trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statutes to any person for any action taken, or any failure to take any action, as a trustee, except liability that (A) involves a knowing and culpable violation of law by such trustee, (B) enables such trustee or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal economic gain, (C) shows a lack of good faith and conscious disregard for the duty of such trustee to the Hospital under circumstances in which such trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the Hospital, or (D) constitutes a sustained and unexcused pattern of inattention that amounted to an abdication of such trustee's duty to the Hospital.

The Hospital may indemnify and advance expenses to each officer, employee or agent of the Hospital who is not a trustee, or who is a trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Hospital is permitted to provide the same to a trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Hospital shall not indemnify any trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

Sec. 10. This Certificate of Incorporation and the Bylaws of the Hospital may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Sole Member and YNHHSC.

Exhibit 2.1.5(a)(2)

LMH Amended Bylaws

LAWRENCE + MEMORIAL HOSPITAL, INC.

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

LAWRENCE + MEMORIAL HOSPITAL, INC.
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 Name. The name of the corporation is **Lawrence + Memorial Hospital, Inc.** (the "Corporation").

Section 1.2 General Purposes. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 Member. The Corporation shall have a single member, Lawrence + Memorial Corporation (the "Member").

Section 2.2 Rights, Powers and Privileges. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act as may be amended from time to time (the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws. If and to the extent that actions by the Member cannot be taken without the approval of the sole member of the Member, Yale-New Haven Health Services Corporation ("YNHHSC"), or actions have been reserved to YNHHSC, the Member may take such actions only as directed by YNHHSC.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A or Exhibit B of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), except that, with respect to the actions on Exhibit A, the Board's recommendation may be requested by the Member and YNHHSC consistent with Section 3.1(a) below. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the YNHHSC, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the rights reserved to the Member and YNHHSC to take the actions set forth in Exhibit A on behalf of and in the name of the Corporation, directly and without

the approval or the recommendation of the Board, YNHHSC (or the Member, acting on the direction of YNHHSC) expressly retains the rights to take the actions set forth in Exhibit B on behalf of and in the name of the Corporation, directly and without the approval or the recommendation of the Board or the Member of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member and YNHHSC any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 Liability and Reimbursement of Expenses. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. Subject to the powers retained by, conferred upon, or reserved to the Member or YNHHSC by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances and in a manner he or she reasonably believes to be in the best interests of the Corporation.

The Board shall have among its duties those duties required to be exercised by the governing body by applicable regulatory, licensing or accreditation agencies. Without limiting the generality of the foregoing, the Board shall be responsible for the appointment, organization and activities of the Medical Staff (the "Medical Staff"), shall hold the Medical Staff responsible for recommendations concerning medical matters, and shall make decisions regarding initial staff appointments, reappointments, terminations of appointments, and the granting, termination, curtailment or revision of clinical privileges (directly or as delegated by the Board to the Patient Safety and Clinical Quality Committee in accordance with Section 5.4(b) of these Bylaws).

Further without limiting the generality of the foregoing, and subject to Section 2.2 and Exhibit A and Exhibit B of these Bylaws, the Board may:

(a) Make the following recommendations to the Member and YNHHSC:

(i) Recommend to the Member and YNHHSC the philosophy, mission and values of the Hospital and any changes thereto;

(ii) Recommend to the Member and YNHHSC the Corporation's strategic plans;

(iii) Recommend to the Member and YNHHSC the Corporation's annual operating and financial targets, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(iv) Recommend to the Member and YNHHSC the sale, transfer or substantial change in use of all or substantially all of the assets, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any Affiliate;

(v) Recommend to the Member and YNHHSC the formation or acquisition by the Corporation of any Affiliates or any other new direct or indirect subsidiaries, joint ventures or affiliations;

(vi) Recommend to the Member and YNHHSC the introduction or termination of any services to be offered by the Corporation not otherwise included in an approved budget or a strategic or financial plan; and

(vii) Recommend to the Member and YNHHSC changes to the Corporation's Certificate of Incorporation and Bylaws.

(b) Make the following recommendations to the Member:

(i) Recommend to the Member approval of any consent decree or settlements from state and federal authorities;

(ii) Recommend to the Member nominations for and removal of Trustees of the Corporation; and

(iii) Recommend to the Member the appointment and evaluation of the President of the Corporation.

(c) Take the following actions:

(i) Annually assess the Corporation's performance against approved budgets, initiatives and strategic plans adopted by the Member and YNHHSC;

(ii) Except for the President of the Corporation, elect officers of the Board (following consultation with the Member's Nominating and Governance Committee in accordance with Section 4.2 of these Bylaws) and remove from office any officer (except for the President of the Corporation) with or without cause (in accordance with Section 4.4(b) of these Bylaws);

(iii) Approve any business transaction or contract that is not otherwise included in an approved budget or a strategic or financial plan, except for long-term or material agreements that require the approval of the Member and YNHHSC in accordance with Exhibit A;

(iv) Periodically assess the Corporation's Quality Initiatives, including tracking and reporting on the Hospital's performance under quality measures, quality and patient safety programs and initiatives, patient satisfaction and cultural competence initiatives;

(v) Periodically assess the Corporation's Development Plans and its Planned Giving Plans;

(vi) Periodically assess the Corporation's Community Relations Initiatives and Community Outreach Programs;

(vii) Approve actions with respect to the privileges and credentials of members of the Corporation's medical staff in accordance with state and federal law, applicable accreditation standards, the Corporation's Medical Staff Bylaws and any System guidelines established by the Member, subject to the Board's delegation of authority to the Board Patient Safety and Clinical Quality Committee; and

(viii) Evaluate the Board's performance.

Section 3.2 Composition. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees**. Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of

demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees**. In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President/Chief Executive Officer of YNHHSC (or his or her designee);

(ii) the President of the Member (if such person is not also concurrently serving as the President of the Corporation);

(iii) the President of the Corporation (if such person is not also concurrently serving as the President of the Member);

(iv) the President of the Medical Staff; and

(v) the Vice President of the Medical Staff.

Ex Officio Trustees shall be counted in determining the presence of a quorum and shall have the right to vote on all matters that come before the Board.

(c) **Other Board Participants**. Any present or former Trustee who has served with unusual distinction, or faithfully over a number of years, shall be eligible for election by the Board as a Trustee Emeritus. A Trustee Emeritus shall have the privilege of attending meetings of the Board and shall have the privilege of the floor, but shall have no vote at meetings of the Board and shall not be counted in determined a quorum thereof.

Section 3.3 Number. The Board shall consist of no fewer than six (6) nor more than twelve (12) Trustees, such number to be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors from among the nominees presented by the Board; provided, however, that in the event the Member does not elect any such nominee, the Board shall present a different nominee to the Member for election; and provided further that in the event any such successor nominee is not elected by the Member within ninety (90) days following the original nomination, the Member may solicit alternative nominees or elect its own nominee. In all events, the Elected Trustees shall be individuals who meet the requirements set forth in Section 3.2(a) of this Article III and who are satisfactory to YNHHSC.

Notwithstanding anything herein to the contrary, the Elected Trustees shall include one (1) physician on the Medical Staff who has previously held the position of President of the Medical Staff.

Section 3.5 Term and Term Limits. There shall be three (3) classes of Elected

Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of YNHHSC at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of YNHHSC.

Section 3.6 Resignation. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board

with or without cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board. The Member shall remove an Elected Trustee at the direction of YNHHSC.

Section 3.8 **Vacancies**. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the trustee replaced.

Section 3.9 **Meetings**.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Chair of the Board shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held at least quarterly or more frequently as needed on such dates and at such times and places as the Chair shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the Chair or President and shall be called upon the written request of any three (3) Trustees.

Section 3.10 **Notice of Meetings**. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President of the Member has consented to receive notice.

Section 3.11 **Waiver of Notice**. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 **Action by Unanimous Written Consent**. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 Officers. The officers of the Corporation shall consist of a President, a Chair, one or more Vice Chairs, a Secretary, a Treasurer and such other officers as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be selected from among members of the Board of Trustees. The offices of the President, the Chair and the Treasurer shall be held by different individuals.

Section 4.2 Election and Term of Office. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, Vice Chairs, Secretary and Treasurer shall be nominated in consultation with the Nominating and Governance Committee of the Member and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 Powers. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President.** The President of the Corporation shall be appointed by the Member, following consultation with the Board and with the approval of YNHHSC. The appointed President shall serve at the pleasure of the Member and YNHHSC.

The President shall be a person who in the judgment of the Member and YNHHSC has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, the Medical Staff, Corporation personnel, YNHHSC and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to

such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board and with the approval of YNHHSC.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws. The President shall report to the President of the Member (or his or her designee) as well as to the Board.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board and shall be a voting member of all committees except the Governance Committee. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board shall designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s) shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office; shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President of the Corporation may be removed from office by the Member at the direction of YNHHSC following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board of Trustees for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 **Other Officers**. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 **Classification**. There shall be such standing committees as are provided for in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 **Appointment of Committee Members**. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

Section 5.3 **Committee Governance**.

(a) **Quorum and Voting**. A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings**. Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 **Standing Committees**.

(a) **Executive Committee**. The Executive Committee shall consist of the President, the Chair, the Secretary, the Treasurer, the President of the Member (if such person is not also concurrently serving as the President of the Corporation), a member of the Board selected by YNHHSC, and any other member of the Board that the Board may choose to appoint. The Chair shall serve as the chair of the Executive Committee. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws, or resolution of the Board.

(b) **Patient Safety and Clinical Quality Committee**. The Patient Safety and Clinical Quality Committee shall have such duties as are delegated to it by the Board. These duties include authority to render decisions in cases of uncontested medical staff appointments, reappointments, and renewals or modifications of clinical privileges. The Patient Safety and Clinical Quality Committee shall also periodically review patient safety and clinical quality metrics to ensure the provision of high quality, effective care. Other delegated duties may be set forth in the Medical Staff Bylaws. The Patient Safety and Clinical Quality Committee shall serve as a liaison for communication between the Board, the Medical Staff and hospital administration. To the extent that such committee engages in peer review activity, such committee shall function as a "peer review committee" within the meaning of that term as set forth in Chapter 368a of the Connecticut General Statutes, as amended from time to time.

Section 5.5 Other Committees. The Board may establish and appoint ad-hoc committees from time to time as the Board may deem necessary to carry out special fund raising events or other initiatives of the Board. Such committees may not exercise the authority of the Board, and any acts taken by them shall be solely advisory in nature. The members and chairs of each such committee shall be appointed by the Board, and each such committee shall consist of at least one (1) Trustee and two (2) other individuals who may or may not be Trustees. Each such committee shall be chaired by a Trustee of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

Section 5.6 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws. The Executive Committee shall have authority to take actions consistent with these Bylaws; all other committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation, unless expressly authorized by the Board.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer

than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

Section 8.4 **Auxiliary**. There may be an auxiliary organized to further the purposes and interests of the Corporation (the "Auxiliary"). The Auxiliary shall have the authority, subject to the review and approval of the Board, to adopt and amend bylaws for its operations which shall state its purpose, duties and organization.

Section 8.5 **Department Chairs**. The Corporation shall consult with YNHHSC regarding the recruitment and selection of all Department Chairs or other comparable positions at the Corporation and/or any of its Affiliates.

ARTICLE IX. AMENDMENTS

Except as otherwise provided by the Certificate of Incorporation or by law, and subject to approval by YNHHSC, these Bylaws may be amended, altered, or repealed by the Member.

EXHIBIT A

Actions Requiring Approval of the Member and YNHHSC

Notwithstanding anything in these Bylaws to the contrary, the following actions may only be taken upon the approval of the Member and YNHHSC, without the approval of the Board of this Corporation:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate or the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by YNHHSC to adopt such budgets within parameters established by YNHHSC);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by YNHHSC to adopt such budgets within parameters established by YNHHSC);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by YNHHSC by a specified dollar amount to be determined from time to time by YNHHSC;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by YNHHSC, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. YNHHSC shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate;

K. Adoption of safety and quality assurance policies not in conformity with policies established by YNHHSC;

L. Oversee the Corporation's management and investment of its permanent and temporarily restricted funds;

M. Approve any voluntary change to the federal income tax exemption granted by the IRS to the Corporation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended;

N. Initiate or consent to any form of insolvency proceeding undertaken by the Corporation or any direct or indirect subsidiary of the Corporation;

O. Approve any change in the name of the Corporation, and establish advertising, marketing and promotional policies applicable to the Corporation; and

P. Appointment of the President of this Corporation consistent with Section 4.3(a).

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member or YNHHSC pursuant to these Bylaws and the Bylaws of the Member and of YNHHSC.

EXHIBIT B

Direct Authority Retained by YNHHSC

Notwithstanding anything in these Bylaws to the contrary, YNHHSC (or, where required by law, the Member acting at the direction of YNHHSC) retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by YNHHSC in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to YNHHSC or as otherwise directed by YNHHSC; and

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate,

Other Major Activities

A. In addition, YNHHSC shall have the authority, except as otherwise provided by YNHHSC and after consultation with the Member, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that YNHHSC determines to be "major activities."

B. "Major activities" shall be those which YNHHSC by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to the Member, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of YNHHSC, and shall refer to this Bylaw provision granting such approval rights to YNHHSC. Notices received pursuant to this section shall be recorded in the minutes of the Member and of this Corporation, and shall be filed with the minutes of the Member and of this Corporation.

Exhibit 2.1.5(b)(1)

LMW Amended Certificate of Incorporation

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Office of the Secretary of State
Corporations Division
148 W. River Street
Providence, Rhode Island 02904-2615
(401) 222-3040

INSTRUCTIONS FOR FILING ARTICLES OF AMENDMENT TO THE ARTICLES OF INCORPORATION OF A DOMESTIC NON-PROFIT CORPORATION

Section 7-6-40 of the General Laws of Rhode Island, 1956, as amended

The attached form is designed to meet minimal statutory filing requirements pursuant to the relevant statutory provision. This form and the information provided are not substitutes for the advice and services of an attorney and/or tax specialist.

1. In order to procure a Certificate of Amendment, a non-profit corporation must file Articles of Amendment to the Articles of Incorporation (Form No. 201) with the Office of the Secretary of State, Corporations Division, at the above address. When the Articles are properly completed, signed and submitted with the correct filing fee, a Certificate of Amendment, shall be issued.

2. Upon filing the Articles, the corporation must be in good standing and current with the filing of its annual reports and the maintenance of its registered agent and its registered office in this state.

3. The filing fee for the Articles of Amendment is $10.00, and payment should be made payable to the Rhode Island Secretary of State.

4. A corporation may amend its articles of incorporation, from time to time, in any and as many respects as may be desired, so long as its articles of incorporation as amended contain only such provisions as are lawful under this chapter. The following instructions apply if the corporation is changing its corporate name, and/or changing, enlarging or diminishing its corporate purpose.

   (a) The name of any non-profit corporation must be "distinguishable upon the records of the secretary of state." This means the Office of the Secretary of State will deny a request for a name if such name is identical to or not distinguishable from any entity, name reservation, or registration on file with the Business Section of the Corporations Division. A preliminary name availability check can be made by checking the Name Availability Database on our website, or by phoning us at the above telephone number. This preliminary check is not statutorily required, is not binding upon the Secretary of State, and does not ensure that the name will be available upon filing the Articles of Incorporation. It is suggested that you do not make any financial expenditures or execute documents utilizing the name based upon a preliminary name availability check. The final determination as to availability of the name will be made when the documents are submitted for filing.

   (b) The specific purpose or purposes of the corporation must be stated. General statements such as "any lawful purpose" or "any lawful business" will not be accepted.

5. The Articles must be signed by the corporation's president or vice president and secretary or assistant secretary. A signature must appear on each line even if the same person holds both offices.

If you have any questions, please call us at (401) 222-3040, Monday through Friday, between 8:30 a.m. and 4:30 p.m.

Filing Fee: $10.00 **ID Number: 790650**

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Office of the Secretary of State
Corporations Division
148 W. River Street
Providence, Rhode Island 02904-2615

NON-PROFIT CORPORATION

ARTICLES OF AMENDMENT TO ARTICLES OF INCORPORATION

Pursuant to the provisions of Section 7-6-40 of the General Laws of Rhode Island, 1956, as amended, the undersigned corporation adopts the following Articles of Amendment to its Articles of Incorporation:

1. The name of the corporation is **LMW Healthcare, Inc.**

2. The following amendment to the Articles of Incorporation was adopted by the corporation:

[Insert Amendment]

Please see amendment attached.

Form No. 201
Revised: 12/05

3. The amendment was adopted in the following manner:

(check one box only)

☑ The amendment was adopted at a meeting of the members held on _____, at which meeting a quorum was present, and the amendment received at least a majority of the votes which members present or represented by proxy at such meeting were entitled to cast.

☐ The amendment was adopted by a consent in writing on _____, signed by all members entitled to vote with respect thereto.

☐ The amendment was adopted at a meeting of the Board of Directors held on _____ and received the vote of a majority of the directors in office, there being no members entitled to vote with respect thereto.

4. Date when amendment is to become effective _____
(not prior to, nor more than 30 days after, the filing of these Articles of Amendment)

Under penalty of perjury, we declare and affirm that we have examined these Articles of Amendment to the Articles of Incorporation, including any accompanying attachments, and that all statements contained herein are true and correct.

Date: _____

LMW Healthcare, Inc.
Print Corporate Name

By _____

☐ President or ☐ Vice President (check one)

AND

By _____

☐ Secretary or ☐ Assistant Secretary (check one)

Attachment to

Articles of Amendment to

Articles of Incorporation for:

LMW Healthcare, Inc.

Section 3 shall be amended to add thereto:

In furtherance of the foregoing, the Corporation shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the Corporation's charitable purposes and the charitable purposes of all System affiliates.

Exhibit 2.1.5(b)(2)

LMW Amended Bylaws

LMW HEALTHCARE, INC. D/B/A THE WESTERLY HOSPITAL

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

LMW HEALTHCARE, INC. D/B/A THE WESTERLY HOSPITAL
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 Name. The name of the corporation is **LMW Healthcare, Inc.** (the "Corporation"). The Corporation shall conduct business under the name "The Westerly Hospital."

Section 1.2 General Purposes. The purposes of the Corporation shall be as set forth in the Corporation's Articles of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Articles of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 Member. The Corporation shall have a single member, Lawrence + Memorial Corporation (the "Member").

Section 2.2 Rights, Powers and Privileges. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a Rhode Island nonprofit corporation under the Rhode Island Nonprofit Corporation Act as may be amended from time to time (the "Act") and not conferred thereby or by the Articles of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws. If and to the extent that actions by the Member cannot be taken without the approval of the sole member of the Member, Yale-New Haven Health Services Corporation ("YNHHSC"), or actions have been reserved to YNHHSC, the Member may take such actions only as directed by YNHHSC.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A or Exhibit B of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), except that, with respect to the actions on Exhibit A, the Board's recommendation may be requested by the Member and YNHHSC consistent with Section 3.1(a) below. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the YNHHSC, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the rights reserved to the Member and YNHHSC to take the actions set forth in Exhibit A on behalf of and in the name of the Corporation, directly and without the approval or the recommendation of the Board, YNHHSC (or the Member, acting on the direction of YNHHSC) expressly retains the rights to take the actions set forth in Exhibit B on behalf of and in the name of the Corporation, directly and without the approval or the recommendation of the Board or the Member of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member and YNHHSC any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 Liability and Reimbursement of Expenses. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. Subject to the powers retained by, conferred upon, or reserved to the Member or YNHHSC by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances and in a manner he or she reasonably believes to be in the best interests of the Corporation.

The Board shall have among its duties those duties required to be exercised by the governing body by applicable regulatory, licensing or accreditation agencies. Without limiting the generality of the foregoing, the Board shall be responsible for the appointment, organization and activities of the Medical Staff (the "Medical Staff"), shall hold the Medical Staff responsible for recommendations concerning medical matters, and shall make decisions regarding initial staff appointments, reappointments, terminations of appointments, and the granting, termination, curtailment or revision of clinical privileges (directly or as delegated by the Board to the Patient Safety and Clinical Quality Committee in accordance with Section 5.4(b) of these Bylaws).

Further without limiting the generality of the foregoing, and subject to Section 2.2 and Exhibit A and Exhibit B of these Bylaws, the Board may:

(a) Make the following recommendations to the Member and YNHHSC:

(i) Recommend to the Member and YNHHSC the philosophy, mission and values of the Corporation and any changes thereto;

(ii) Recommend to the Member and YNHHSC the Corporation's strategic plans;

(iii) Recommend to the Member and YNHHSC the Corporation's annual operating and financial targets, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(iv) Recommend to the Member and YNHHSC the sale, transfer or substantial change in use of all or substantially all of the assets, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any Affiliate;

(v) Recommend to the Member and YNHHSC the formation or acquisition by the Corporation of any Affiliates or any other new direct or indirect subsidiaries, joint ventures or affiliations;

(vi) Recommend to the Member and YNHHSC the introduction or termination of any services to be offered by the Corporation not otherwise included in an approved budget or a strategic or financial plan; and

(vii) Recommend to the Member and YNHHSC changes to the Corporation's Certificate of Incorporation and Bylaws.

(b) Make the following recommendations to the Member:

(i) Recommend to the Member approval of any consent decree or settlements from state and federal authorities;

(ii) Recommend to the Member nominations for and removal of Trustees of the Corporation; and

(iii) Recommend to the Member the appointment and evaluation of the President of the Corporation.

(c) Take the following actions:

(i) Annually assess the Corporation's performance against approved budgets, initiatives and strategic plans adopted by the Member and YNHHSC;

(ii) Except for the President of the Corporation, elect officers of the Board (following consultation with the Member's Nominating and Governance Committee in accordance with Section 4.2 of these Bylaws) and remove from office any officer (except for the President of the Corporation) with or without cause (in accordance with Section 4.4(b) of these Bylaws);

(iii) Approve any business transaction or contract that is not otherwise included in an approved budget or a strategic or financial plan, except for long-term or material agreements that require the approval of the Member and YNHHSC in accordance with Exhibit A;

(iv) Periodically assess the Corporation's Quality Initiatives, including tracking and reporting on the Corporation's performance under quality measures, quality and patient safety programs and initiatives, patient satisfaction and cultural competence initiatives;

(v) Periodically assess the Corporation's Development Plans and its Planned Giving Plans;

(vi) Periodically assess the Corporation's Community Relations Initiatives and Community Outreach Programs;

(vii) Approve actions with respect to the privileges and credentials of members of the Corporation's medical staff in accordance with state and federal law, applicable accreditation standards, the Corporation's Medical Staff Bylaws and any System guidelines established by the Member, subject to the Board's delegation of authority to the Board Patient Safety and Clinical Quality Committee; and

(viii) Evaluate the Board's performance.

Section 3.2 **Composition**. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees**. Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees**. In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President/Chief Executive Officer of YNHHSC (or his or her designee);

(ii) the President of the Member (if such person is not also concurrently serving as the President of the Corporation);

(iii) the President of the Corporation (if such person is not also concurrently serving as the President of the Member);

(iv) the President of the Medical Staff; and

(v) the Vice President of the Medical Staff.

Ex Officio Trustees shall be counted in determining the presence of a quorum and shall have the right to vote on all matters that come before the Board.

(c) **Other Board Participants**. Any present or former Trustee who has served with unusual distinction, or faithfully over a number of years, shall be eligible for election by the Board as a Trustee Emeritus. A Trustee Emeritus shall have the privilege of attending meetings of the Board and shall have the privilege of the floor, but shall have no vote at meetings of the Board and shall not be counted in determined a quorum thereof.

Section 3.3 Number. The Board shall consist of no fewer than eleven (11) nor more than fifteen (15) Trustees, such number to be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors from among the nominees presented by the Board; provided, however, that in the event the Member does not elect any such nominee, the Board shall present a different nominee to the Member for election; and provided further that in the event any such successor nominee is not elected by the Member within ninety (90) days following the original nomination, the Member may solicit alternative nominees or elect its own nominee. In all events, the Elected Trustees shall be individuals who meet the requirements set forth in Section 3.2(a) of this Article III and who are satisfactory to YNHHSC.

Notwithstanding anything herein to the contrary, the Elected Trustees shall include:

(a) One (1) physician on the Medical Staff who has previously held the position of President of the Medical Staff; and

(b) At least six (6) individuals who work or reside in the service area of the Corporation and who (i) are independent of and not employed by or affiliated with the Member or its Affiliates; and (ii) are not elected officials of or otherwise subject to the Rhode Island Code of Ethics.

Section 3.5 Term and Term Limits. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of YNHHSC at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of YNHHSC.

Section 3.6 Resignation. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with or without cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board. The Member shall remove an Elected Trustee at the direction of YNHHSC.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the trustee replaced.

Section 3.9 Meetings.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Chair of the Board shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held at least quarterly or more frequently as needed on such dates and at such times and places as the Chair shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the Chair or President and shall be called upon the written request of any three (3) Trustees.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President of the Member has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 **Officers**. The officers of the Corporation shall consist of a President, a Chair, one or more Vice Chairs, a Secretary, a Treasurer and such other officers as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be selected from among members of the Board of Trustees. The offices of the President, the Chair and the Treasurer shall be held by different individuals.

Section 4.2 **Election and Term of Office**. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, Vice Chairs, Secretary and Treasurer shall be nominated in consultation with the Nominating and Governance Committee of the Member and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 **Powers**. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President**. The President of the Corporation shall be appointed by the Member, following consultation with the Board and with the approval of YNHHSC. The appointed President shall serve at the pleasure of the Member and YNHHSC.

The President shall be a person who in the judgment of the Member and YNHHSC has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, the Medical Staff, Corporation personnel, YNHHSC and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board and with the approval of YNHHSC.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws. The President shall report to the President of the Member (or his or her designee) as well as to the Board.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board and shall be a voting member of all committees except the Governance Committee. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board shall designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s) shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the

Corporation pertaining to the Secretary's office; shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President of the Corporation may be removed from office by the Member at the direction of YNHHSC following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board of Trustees for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as are provided for in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be

approved by a majority of the committee members who are Trustees.

Section 5.3 Committee Governance.

(a) **Quorum and Voting**. A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings**. Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) **Executive Committee**. The Executive Committee shall consist of the President, the Chair, the Secretary, the Treasurer, the President of the Member (if such person is not also concurrently serving as the President of the Corporation), a member of the Board selected by YNHHSC, and any other member of the Board that the Board may choose to appoint. The Chair shall serve as the chair of the Executive Committee. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws, or resolution of the Board.

(b) **Patient Safety and Clinical Quality Committee**. The Patient Safety and Clinical Quality Committee shall have such duties as are delegated to it by the Board. These duties include authority to render decisions in cases of uncontested medical staff appointments, reappointments, and renewals or modifications of clinical privileges. The Patient Safety and Clinical Quality Committee shall also periodically review patient safety and clinical quality metrics to ensure the provision of high quality, effective care. Other delegated duties may be set forth in the Medical Staff Bylaws. The Patient Safety and Clinical Quality Committee shall serve as a liaison for communication between the Board, the Medical Staff and hospital administration. To the extent that such committee engages in peer review activity, such committee shall function as a "peer review board" for the purposes set forth in R.I. Gen. Laws § 23-17-25(a), as amended from time to time.

Section 5.5 Other Committees. The Board may establish and appoint ad-hoc committees from time to time as the Board may deem necessary to carry out special fund raising events or other initiatives of the Board. Such committees may not exercise the authority of the Board, and any acts taken by them shall be solely advisory in nature. The members and chairs of each such committee shall be appointed by the Board, and each such committee shall consist of at least one (1) Trustee and two (2) other individuals who may or may not be Trustees. Each such committee shall be chaired by a Trustee of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

Section 5.6 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of

Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws. The Executive Committee shall have authority to take actions consistent with these Bylaws; all other committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation, unless expressly authorized by the Board.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Trustees, officers and employees to the full extent permitted by law.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Act related to disclosure and approval of transactions that present a conflict of interest.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

Section 8.4 **Auxiliary**. There may be an auxiliary organized to further the purposes and interests of the Corporation (the "Auxiliary"). The Auxiliary shall have the authority, subject to the review and approval of the Board, to adopt and amend bylaws for its operations which shall state its purpose, duties and organization.

Section 8.5 **Department Chairs**. The Corporation shall consult with YNHHSC regarding the recruitment and selection of all Department Chairs or other comparable positions at the Corporation and/or any of its Affiliates.

ARTICLE IX. AMENDMENTS

Except as otherwise provided by the Articles of Incorporation or by law, and subject to approval by YNHHSC, these Bylaws may be amended, altered, or repealed by the Member.

EXHIBIT A

Actions Requiring Approval of the Member and YNHHSC

Notwithstanding anything in these Bylaws to the contrary, the following actions may only be taken upon the approval of the Member and YNHHSC, without the approval of the Board of this Corporation:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate or the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by YNHHSC to adopt such budgets within parameters established by YNHHSC);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by YNHHSC to adopt such budgets within parameters established by YNHHSC);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by YNHHSC by a specified dollar amount to be determined from time to time by YNHHSC;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by YNHHSC, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. YNHHSC shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate;

K. Adoption of safety and quality assurance policies not in conformity with policies established by YNHHSC;

L. Oversee the Corporation's management and investment of its permanent and temporarily restricted funds;

M. Approve any voluntary change to the federal income tax exemption granted by the IRS to the Corporation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended;

N. Initiate or consent to any form of insolvency proceeding undertaken by the Corporation or any direct or indirect subsidiary of the Corporation;

O. Approve any change in the name of the Corporation, and establish advertising, marketing and promotional policies applicable to the Corporation; and

P. Appointment of the President of this Corporation consistent with Section 4.3(a).

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member or YNHHSC pursuant to these Bylaws and the Bylaws of the Member and of YNHHSC.

EXHIBIT B

Direct Authority Retained by YNHHSC

Notwithstanding anything in these Bylaws to the contrary, YNHHSC (or, where required by law, the Member acting at the direction of YNHHSC) retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by YNHHSC in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to YNHHSC or as otherwise directed by YNHHSC; and

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate.

Other Major Activities

A. In addition, YNHHSC shall have the authority, except as otherwise provided by YNHHSC and after consultation with the Member, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that YNHHSC determines to be "major activities."

B. "Major activities" shall be those which YNHHSC by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to the Member, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of YNHHSC, and shall refer to this Bylaw provision granting such approval rights to YNHHSC. Notices received pursuant to this section shall be recorded in the minutes of the Member and of this Corporation, and shall be filed with the minutes of the Member and of this Corporation.

Exhibit 2.1.5(c)(1)

VNA of Southeastern Connecticut Amended Certificate of Incorporation

AMENDED AND RESTATED CERTIFICATE OF INCORPORATION

VISITING NURSE ASSOCIATION OF SOUTHEASTERN CONNECTICUT, INC.

1. The name of the corporation is Visiting Nurse Association of Southeastern Connecticut, Inc. (the "Corporation").

2. The nature of the activities to be conducted, and the purposes to be promoted or carried out by the Corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time, and the corresponding provisions of any future United States Internal Revenue Law (the "Internal Revenue Code") and shall include the following:

(a) The promotion and maintenance of health;

(b) The prevention of disease and disability;

(c) Provision and coordination of vital health and support services for those in need of preventative, acute, maintenance, and/or terminal care at home and in the communities served based on current community needs;

(d) Collaboration and coordination with other groups in developing and implementing community health programs;

(e) Contribution to knowledge supporting improvements in community health practice; and

(f) Any other lawful act or activity for which a corporation may be organized under the Connecticut Revised Nonstock Corporation Act, as the same may be amended from time to time, and the corresponding provisions of any future Connecticut nonstock corporation law.

In furtherance of the foregoing, the Corporation shall (i) participate as an integral part of the integrated health care delivery system known as the Yale New Haven Health System (the "System"), which System provides, through its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the Corporation's charitable purposes and the charitable purposes of all System affiliates.

3. The Corporation shall have but one member, Lawrence + Memorial Corporation (the "Sole Member"), which shall have the rights, powers and privileges provided in the Bylaws and by the State of Connecticut, including the right to exercise, on behalf of and as directed by its sole member, Yale-New Haven Health Services Corporation ("YNHHSC"), certain expressly reserved powers and retained rights described in the Bylaws.

4. Subject to the rights, powers and privileges accorded to the Sole Member and to YNHHSC under the Bylaws and by the State of Connecticut, the Corporation shall be governed by its Board of Trustees. The Bylaws may provide that persons occupying certain positions within or without the Corporation shall be ex-officio trustees who may vote and be counted in determining a quorum. As may be further provided in the Bylaws of the Corporation, the terms of elected trustees may be staggered by dividing the trustees into groups so that approximately an equal number of such trustees have terms that expire each year.

5. The Corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

6. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

7. No part of the net earnings of the Corporation shall inure to the benefit of or be distributable to the Corporation's trustees, officers or other private persons, except that the Corporation, subject to the provisions of the Bylaws, shall be authorized and empowered to pay reasonable compensation for services rendered. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in or intervene in (including the publishing or distribution of statements) any political campaign on behalf of (or in opposition to) any candidate for public office.

8. Upon dissolution of the Corporation and subject to any restrictions imposed by any applicable will, deed, agreement or other governing document, the Board of Trustees shall dispose of and distribute the assets remaining after payment of all liabilities to Lawrence + Memorial Corporation, so long as it is at that time an organization that qualifies as an exempt organization under Section 501(c)(3) of the Internal Revenue Code, or, if at the time of the dissolution of the Corporation, Lawrence + Memorial Corporation is not in existence or does not so qualify, to one or more charitable, scientific or educational organizations located in the State of Connecticut and qualified as exempt organizations under Section 501(c)(3) of the Internal Revenue Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

9. In addition to, and not in derogation of, any other rights conferred by law, a trustee of the Corporation shall not be personally liable for monetary damages for breach of duty as a trustee in an amount greater than the compensation received by the trustee for serving the Corporation during the year of such breach if such breach does not (A) involve a knowing and culpable violation of law by such trustee, (B) enable such trustee or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal economic gain, (C) show a lack of good faith and conscious disregard for the duty of such trustee to the Corporation under circumstances in which such trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (D) constitute a sustained and

unexcused pattern of inattention that amounted to an abdication of such trustee's duty to the Corporation. Any lawful repeal or modification of this Section 9 or the adoption of any provision inconsistent herewith by the Board of Trustees or Sole Member of the Corporation shall not, with respect to a person who is or was a trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a trustee provided for in this Section 9 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

10. The Corporation shall provide its trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Connecticut Revised Nonstock Corporation Act and shall advance expenses to trustees consistent with Section 33-1119 of the Connecticut General Statutes. In furtherance of the foregoing, the Corporation shall indemnify its trustees against liability as defined in Section 33-1116(4) of the Connecticut General Statutes to any person for any action taken, or any failure to take any action, as a trustee, except liability that (A) involves a knowing and culpable violation of law by such trustee, (B) enables such trustee or an associate (as defined in Section 33-840 of the Connecticut General Statutes) to receive an improper personal economic gain, (C) shows a lack of good faith and conscious disregard for the duty of such trustee to the Corporation under circumstances in which such trustee was aware that his conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (D) constitutes a sustained and unexcused pattern of inattention that amounted to an abdication of such trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a trustee, or who is a trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Connecticut General Statutes.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Internal Revenue Code.

11. The Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Sole Member and YNHHSC.

Exhibit 2.1.5(c)(2)

VNA of Southeastern Connecticut Amended Bylaws

VISITING NURSE ASSOCIATION OF SOUTHEASTERN CONNECTICUT, INC.

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

VISITING NURSE ASSOCIATION OF SOUTHEASTERN CONNECTICUT, INC.
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 Name. The name of the corporation is **Visiting Nurse Association of Southeastern Connecticut, Inc.** (the "Corporation").

Section 1.2 General Purposes. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 Member. The Corporation shall have a single member, Lawrence + Memorial Corporation (the "Member").

Section 2.2 Rights, Powers and Privileges. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act as may be amended from time to time (the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws. If and to the extent that actions by the Member cannot be taken without the approval of the sole member of the Member, Yale-New Haven Health Services Corporation ("YNHHSC"), or actions have been reserved to YNHHSC, the Member may take such actions only as directed by YNHHSC.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A or Exhibit B of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), except that, with respect to the actions on Exhibit A, the Board's recommendation may be requested by the Member and YNHHSC consistent with Section 3.1(a) below. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the YNHHSC, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the rights reserved to the Member and YNHHSC to take the actions set forth in Exhibit A on behalf of and in the name of the Corporation, directly and without

the approval or the recommendation of the Board, YNHHSC (or the Member, acting on the direction of YNHHSC) expressly retains the rights to take the actions set forth in Exhibit B on behalf of and in the name of the Corporation, directly and without the approval or the recommendation of the Board or the Member of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member and YNHHSC any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 Liability and Reimbursement of Expenses. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. Subject to the powers retained by, conferred upon, or reserved to the Member or YNHHSC by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances and in a manner he or she reasonably believes to be in the best interests of the Corporation.

The Board shall have among its duties those duties required to be exercised by the governing body by applicable regulatory, licensing or accreditation agencies, including the duties set forth in Section 19-13-D67 of the Regulations of Connecticut State Agencies.

Without limiting the generality of the foregoing, and subject to Section 2.2 and Exhibit A and Exhibit B of these Bylaws, the Board may:

(a) Make the following recommendations to the Member and YNHHSC:

(i) Recommend to the Member and YNHHSC the philosophy, mission and values of the Corporation and any changes thereto;

(ii) Recommend to the Member and YNHHSC the Corporation's strategic plans;

(iii) Recommend to the Member and YNHHSC the Corporation's annual operating and financial targets, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(iv) Recommend to the Member and YNHHSC the sale, transfer or substantial change in use of all or substantially all of the assets, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any Affiliate;

(v) Recommend to the Member and YNHHSC the formation or acquisition by the Corporation of any Affiliates or any other new direct or indirect subsidiaries, joint ventures or affiliations;

(vi) Recommend to the Member and YNHHSC the introduction or termination of any services to be offered by the Corporation not otherwise included in an approved budget or a strategic or financial plan; and

(vii) Recommend to the Member and YNHHSC changes to the Corporation's Certificate of Incorporation and Bylaws.

(b) Make the following recommendations to the Member:

(i) Recommend to the Member approval of any consent decree or settlements from state and federal authorities;

(ii) Recommend to the Member nominations for and removal of Trustees of the Corporation; and

(iii) Recommend to the Member the appointment and evaluation of the President of the Corporation.

(c) Take the following actions:

(i) Annually assess the Corporation's performance against approved budgets, initiatives and strategic plans adopted by the Member and YNHHSC;

(ii) Except for the President of the Corporation, elect officers of the Board (following consultation with the Member's Nominating and Governance Committee in accordance with Section 4.2 of these Bylaws) and remove from office any officer (except for the President of the Corporation) with or without cause (in accordance with Section 4.4(b) of these Bylaws);

(iii) Approve any business transaction or contract that is not otherwise included in an approved budget or a strategic or financial plan, except for long-term or material agreements that require the approval of the Member and YNHHSC in accordance with Exhibit A;

(iv) Periodically assess the Corporation's Quality Initiatives, including tracking and reporting on the Corporation's performance under quality measures, quality and patient safety programs and initiatives, patient satisfaction and cultural competence initiatives;

(v) Periodically assess the Corporation's Development Plans and its Planned Giving Plans;

(vi) Periodically assess the Corporation's Community Relations Initiatives and Community Outreach Programs; and

(vii) Evaluate the Board's performance.

Section 3.2 Composition. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees**. Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees**. In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President/Chief Executive Officer of YNHHSC (or his or her designee);

(ii) the President of the Member; and

(iii) the President of the Corporation.

Ex Officio Trustees shall be counted in determining the presence of a quorum and shall have the right to vote on all matters that come before the Board.

Section 3.3 Number. The Board shall consist of no fewer than six (6) nor more than ten (10) Trustees, such number to be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors from among the nominees presented by the Board; provided, however, that in the event the Member does not elect any such nominee, the Board shall present a different nominee to the Member for election; and provided further that in the event any such successor nominee is not elected by the Member within ninety (90) days following the original nomination, the Member may solicit alternative nominees or elect its own nominee. In all events, the Elected Trustees shall be individuals who meet the requirements set forth in Section 3.2(a) of this Article III and who are satisfactory to YNHHSC.

Section 3.5 Term and Term Limits. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of YNHHSC at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of YNHHSC.

Section 3.6 Resignation. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with or without cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board. The Member shall remove an Elected Trustee at the direction of YNHHSC.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of

the term of the trustee replaced.

Section 3.9 Meetings.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Chair of the Board shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held at least quarterly or more frequently as needed on such dates and at such times and places as the Chair shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the Chair or President and shall be called upon the written request of any three (3) Trustees.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President of the Member has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 Officers. The officers of the Corporation shall consist of a President, a Chair, one or more Vice Chairs, a Secretary, a Treasurer and such other officers as may be appointed from time to time consistent with Section 4.6. The Chair, any Vice Chair, the Secretary and the Treasurer shall be selected from among members of the Board of Trustees.

Section 4.2 Election and Term of Office. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, Vice Chairs, Secretary and Treasurer shall be nominated in consultation with the Nominating and Governance Committee of the Member and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 Powers. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President**. The President of the Corporation shall be appointed by the Member, following consultation with the Board and with the approval of YNHHSC. The appointed President shall serve at the pleasure of the Member and YNHHSC.

The President shall be a person who in the judgment of the Member and YNHHSC has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, Corporation personnel, YNHHSC and the community.

The President shall serve as the Administrator of the home health care agency operated by the Corporation and shall possess the qualifications specified in any applicable laws and regulations for the administrator of a home health care agency. The Administrator shall have full authority and responsibility to plan, staff, direct and implement the programs and manage the clinical affairs of the corporation and such other duties and responsibilities as are specified by the Public Health Code.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some

other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board and with the approval of YNHHSC.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws. The President shall report to the President of the Member (or his or her designee) as well as to the Board.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board and shall be a voting member of all committees except the Governance Committee. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board shall designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s) shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office; shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President of the Corporation may be removed from office by the Member at the direction of YNHHSC following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board of Trustees for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as are provided for in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

Section 5.3 Committee Governance.

(a) **Quorum and Voting.** A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings.** Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) **Executive Committee.** The Corporation shall not have an Executive Committee.

(b) **Professional Advisory Committee.** The Professional Advisory Committee shall consist of the President (or his or her designee), a member of the Board approved by YNHHSC, the Health Director of one or more of the communities served by the Corporation, a representative designated by the Member, and at least the following (the "Professional Members"): one public health nurse, one physician, one social worker and one representative from one of the skilled therapy services offered by the Corporation. All Professional Members must be actively engaged in their professions or have been so engaged within the previous five (5) years. The President (or his or her designee) and the representative designated by the Member shall serve as non-voting members of the committee. The representative designated by the Member shall serve as the chairperson and

the President (or his or her designee) shall serve as the secretary of the committee. Additional members may be appointed by the Board from time to time. Members appointed by the Board shall serve for terms of two (2) years. In order to provide continuity within the committee, terms may be staggered as the Board deems appropriate. The committee shall hold at least two (2) meetings annually. Written minutes of each meeting shall be recorded and presented to the Board at its next regular meeting. No members of the Professional Advisory Committee shall be an employee of the Corporation or related to an employee, including by marriage, unless, in the case of an employee, the employee serves ex-officio without the right to vote. All proceedings of the Professional Advisory Committee shall be made available upon request to the Commissioner of the State of Connecticut Department of Public Health.

The Professional Advisory Committee shall:

(1) Participate in the Corporation's Quality Assurance Program to the extent defined in that Program's policies;

(2) Recommend and at least annually review Corporation policies on the scope of services offered and discharge criteria; medical and dental supervision and plans of treatment; clinical records; personnel qualifications; quality assurance activities; standards of care and professional issues relating to the delivery of services and the findings of the Quality Assurance Program; and

(3) Perform such other duties as the Board may assign to it from time to time.

Section 5.5 Other Committees. The Board may establish and appoint ad-hoc committees from time to time as the Board may deem necessary to carry out special fund raising events or other initiatives of the Board. Such committees may not exercise the authority of the Board, and any acts taken by them shall be solely advisory in nature. The members and chairs of each such committee shall be appointed by the Board, and each such committee shall consist of at least one (1) Trustee and two (2) other individuals who may or may not be Trustees. Each such committee shall be chaired by a Trustee of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

Section 5.6 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation, unless expressly authorized by the Board.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

ARTICLE IX. AMENDMENTS

Except as otherwise provided by the Certificate of Incorporation or by law, and subject to approval by YNHHSC, these Bylaws may be amended, altered, or repealed by the Member.

EXHIBIT A

Actions Requiring Approval of the Member and YNHHSC

Notwithstanding anything in these Bylaws to the contrary, the following actions may only be taken on the approval of the Member and YNHHSC, without the approval of the Board of this Corporation:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate or the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by YNHHSC to adopt such budgets within parameters established by YNHHSC);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by YNHHSC to adopt such budgets within parameters established by YNHHSC);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by YNHHSC by a specified dollar amount to be determined from time to time by YNHHSC;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by YNHHSC, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. YNHHSC shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate;

K. Adoption of safety and quality assurance policies not in conformity with policies established by YNHHSC;

L. Oversee the Corporation's management and investment of its permanent and temporarily restricted funds;

M. Approve any voluntary change to the federal income tax exemption granted by the IRS to the Corporation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended;

N. Initiate or consent to any form of insolvency proceeding undertaken by the Corporation or any direct or indirect subsidiary of the Corporation;

O. Approve any change in the name of the Corporation, and establish advertising, marketing and promotional policies applicable to the Corporation; and

P. Appointment of the President of this Corporation consistent with Section 4.3(a).

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member of YNHHSC pursuant to these Bylaws and the Bylaws of the Member and of YNHHSC.

EXHIBIT B

Direct Authority Retained by YNHHSC

Notwithstanding anything in these Bylaws to the contrary, YNHHSC (or, where required by law, the Member acting at the direction of YNHHSC) retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by YNHHSC in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to YNHHSC or as otherwise directed by YNHHSC; and

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate.

Other Major Activities

A. In addition, YNHHSC shall have the authority, except as otherwise provided by YNHHSC and after consultation with the Member, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that YNHHSC determines to be "major activities."

B. "Major activities" shall be those which YNHHSC by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to the Member, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of YNHHSC, and shall refer to this Bylaw provision granting such approval rights to YNHHSC. Notices received pursuant to this section shall be recorded in the minutes of the Member and of this Corporation, and shall be filed with the minutes of the Member and of this Corporation.

Exhibit 2.11

Key Financial Metrics

Key Financial Metrics

($ in thousands)

	Projected FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	Total FY2016-2020
L+M as a Yale New Haven Health System Member *							
Operating Margin	-2.2%	-1.3%	2.6%	3.4%	2.9%	3.5%	
Investments	$ 24,200	$ 53,912	$ 28,950	$ 29,950	$ 31,788	$ 32,000	$ 176,600
Days Cash on Hand	155	151	167	182	193	207	
Pension Funding %	70%	74%	78%	81%	84%	87%	

* Metrics incorporate the initial YNHHS investment of approximately $41 million.

Exhibit 5.1.18

Consent Communications

All communications requesting YNHHSC consent, as set forth in Section 5.1.18, shall be sent to:

Gayle Capozzalo
Executive Vice President and Chief Strategy Officer
Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519
Phone: (203) 688-2605
E-mail: gayle.capozzalo@ynhh.org

with a copy to:

William J. Aseltyne, Esq.
Senior Vice President and General Counsel
Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519
Phone: (203) 688-2291
E-mail: bill.aseltyne@ynhh.org

Exhibit 5.5

Allocation of Certain Costs and Expenses

Consultant	L+M	YNHHSC
1. Charles River Associates	50% of fees (up to total fees of $250,000, such that L+M maximum obligation shall not exceeds $125,000)	50% of fees (up to total fees of $250,000) plus 100% of any fees in excess of $250,000
2. Deloitte Corporate Finance LLC	50% of fees incurred prior to receiving a Second Request, if any, from the Federal Trade Commission, the Department of Justice or any other Governmental Authority with respect to the Hart-Scott-Rodino Filing process or any other applicable Competition Laws; and 0% of fees incurred from and after receiving such Second Request	50% of fees incurred prior to receiving a Second Request, if any, from the Federal Trade Commission, the Department of Justice or any other Governmental Authority with respect to the Hart-Scott-Rodino Filing process or any other applicable Competition Laws; and 100% of fees incurred from and after receiving such Second Request
3. Deloitte Consulting LLP	0% of fees accrued during the period after the Effective Date	100% of fees accrued during the period after the Effective Date
4. Other Jointly Retained Consultants	0% of fees	100% of fees
5. Attorneys' Fees	Except as provided in item 6 of this Exhibit 5.5, each party will be responsible for its own legal fees. However, as mutually agreed upon, YNHHSC will assume responsibility for any legal fees associated with jointly retained counsel.	Except as provided in item 6 of this Exhibit 5.5, each party will be responsible for its own legal fees. However, as mutually agreed upon, YNHHSC will assume responsibility for any legal fees associated with jointly retained counsel.
6. Attorneys' Fees if certain closing conditions are not satisfied at termination under	If the Affiliation Agreement is terminated pursuant to Section 8.1(b) due to a condition of closing under	YNHHSC will be responsible for its own third party professional fees (except as otherwise contemplated by

Section 8.1(b)	Section 6.5 or Section 7.5 not being satisfied despite the compliance by L+M with its covenants in Section 5.1.8, then notwithstanding items 5 of this Exhibit 5.5, YNHHSC will reimburse L+M for its third party professional fees accrued during the period after the Effective Date up to a maximum amount of $2,000,000 (Two Million Dollars).	items 1 and 2 of this Exhibit 5.5).

L+M SCHEDULES
TO THE
AFFILIATION AGREEMENT

by and between

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

LAWRENCE + MEMORIAL CORPORATION

July 17, 2015

Introduction

Reference is made to the Affiliation Agreement (the "Affiliation Agreement"), entered into as of July 17, 2015, by and between Yale-New Haven Health Services Corporation ("***YNHHSC***") and Lawrence + Memorial Corporation ("***L+M***"). This document constitutes the Disclosure Schedule of L+M pursuant to the Affiliation Agreement. Each of YNHHSC and L+M is referred to herein as a "Party" and collectively as the "Parties." All capitalized terms used, but not defined, herein shall have the meaning ascribed to such term in the Affiliation Agreement.

Section and sub-section numbers and letters used herein correspond to the section and sub-section numbers and letters in the Affiliation Agreement, unless otherwise noted, and any information disclosed in any section or sub-section herein shall be deemed to be disclosed to YNHHSC for all purposes of the Affiliation Agreement so long as such disclosure's relevance to the applicable section(s) of the Affiliation Agreement is reasonably apparent on its face. The captions of each Schedule are included for convenience only and are not intended to limit the scope of such part, paragraph or section of the Disclosure Schedule as set forth in the Affiliation Agreement.

No disclosure made herein constitutes an admission of any liability or obligation of any L+M Affiliate, an admission against any interest of any L+M Affiliate or a concession as to any defense available to any L+M Affiliate. Unless the Affiliation Agreement specifically provides otherwise, the disclosure of a specific item herein shall not be deemed to constitute an admission that such item is not in the ordinary course of business. To the extent that any representation or warranty contained in the Affiliation Agreement is limited or qualified by the materiality of the matters to which the representation or warranty is given, the inclusion of any matter in this Disclosure Schedule does not constitute an admission that such matters are material or will have a L+M Material Adverse Effect. Certain information set forth herein is included solely for informational purposes and may not be required to be disclosed pursuant to the Affiliation Agreement.

If there is any inconsistency between any provision or statement in the Affiliation Agreement and any provision or statement in the Disclosure Schedule (other than an exception in any section or subsection to a specific representation or warranty), then the provision or statement in the Affiliation Agreement shall control.

Schedule 3.1.1

L+M Subsidiaries

Direct Subsidiaries of Lawrence + Memorial Corporation:

- Lawrence + Memorial Hospital, Inc.*
- LMW Healthcare, Inc.*
- L&M Physician Association, Inc.*
- L & M Systems, Inc.
- Visiting Nurse Association of Southeastern Connecticut Inc.*
- [L & M Health Care, Inc.]
- L+M Indemnity Company Ltd.
- [Lawrence and Memorial Foundation, Inc.]*
- [Southeastern Connecticut Health Partners, Inc.]
- [LMW Physicians, Inc.]

Direct Subsidiaries of Lawrence + Memorial Hospital, Inc.:

- Associated Specialists of Southeastern Connecticut, Inc.*
- [Southeastern Connecticut Imaging Center, LLC]

Direct Subsidiaries of LMW Healthcare, Inc.:

- The Westerly Hospital Foundation, Inc.*
- Westerly Hospital Energy Company, LLC
- The Westerly Hospital Auxiliary, Inc.*

Direct Subsidiaries of L & M Systems, Inc.:

- L&M Home Care Services, Inc.
- L & M Home Medical Equipment, LLC

Other Entities in which any L+M Affiliate has an interest:

- DVA Healthcare of New London, LLC
- Connecticut Hospital Laboratory Network, LLC
- Value Care Alliance, LLC
- Northeast Purchasing Coalition, LLC

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* Tax-Exempt Organization

[ ] Inactive Entity

___ L+M Determination Letter has been received

Schedule 3.5.1

Owned Real Property

List of Owned Real Property:

Owner	Street	City/Town	State
LMH	365 Montauk Ave	New London	CT
LMH	436-441 Ocean Ave	New London	CT
LMH	48R Minor Lane	Waterford	CT
LMH	900 Bank Street	New London	CT
LMH	230 Waterford Parkway South	Waterford	CT
LMH	194 Howard Street	New London	CT
LMH (the "Pequot Property")*	52 Hazelnut Hill Road	Groton	CT
LMH	412 Ocean Ave	New London	CT
LMH 7/8 interest; Bank of America 1/8 interest (in trust on behalf of Elizabeth Stamm Estate) (the "Beach Property")^	Pequot Ave	New London	CT
LMW	1 Rhody Drive	Westerly	RI
LMW	65 Wells Street	Westerly	RI
LMW	11 Wells Street Unit 6	Westerly	RI
LMW	45 East Avenue	Westerly	RI
LMW	3 Rhody Drive	Westerly	RI
LMW	26 Wells Street	Westerly	RI
LMW	45 Wells Street, Unit 101	Westerly	RI
LMW	45 Wells Street, Unit 201	Westerly	RI
LMW	25 Wells Street	Westerly	RI
LMW	81 Beach Street	Westerly	RI
Visiting Nurse Association of Southeastern Connecticut Inc.	403 N Frontage Rd	Waterford	CT
LMH	One Huntley Road	Old Lyme	CT
L+M	230 Waterford Parkway South (land)	Waterford	CT
LMH	230 Waterford Parkway South (building)	Waterford	CT

*The fee interest in the land on which the Pequot Property is situated is not owned by an L+M Affiliate, but is leased by LMH from the City of Groton, CT, pursuant to a Ground Lease, dated May 1, 1991.

^LMH owns a 7/8 interest in the Beach Property (a beach located in New London, CT for the use of L+M employees and their families). The remaining 1/8 interest in the Beach Property is held by Bank of America, in trust, on behalf of the Elizabeth Stamm Estate.

Encumbrances or Liens on Principal Properties:

230 Waterford Parkway, Waterford Connecticut (Cancer Center)

1. Assessment & Connecticut Fee Lien in favor of the Town of Waterford in the amount of $84,636.12 recorded in Volume 1315 at Page 352 of the Waterford Land Records.

2. Waiver and relinquishment of rights of access as set forth in a deed dated November 13, 1947 and recorded in Volume 61 at Page 458 of the Waterford Land Records.

3. Easement in favor of the American Telephone and Telegraph Company dated October 10, 1942 and recorded in Volume 65 at Page 481 of the Waterford Land Records.

4. Rights in favor of the State of Connecticut as set forth in a Certificate of Taking dated November 21, 1961 and recorded in Volume 138 at Page 206 of the Waterford Land Records.

5. Rights of way as set forth in a deed dated July 22, 1974 and recorded in Volume 211 at Page 662 and in a deed dated June 11, 1978 and recorded in Volume 224 at Page 394, both of the Waterford Land Records.

6. Easement in favor of the Southern New England Telephone Company dated October 9, 1974 and recorded in Volume 213 at Page 179 of the Waterford Land Records.

7. Rights, agreements, reservations and conditions as set forth in a deed dated March 30, 1983 and recorded in Volume 270 at Page 889 of the Waterford Land Records.

8. Easements and rights in favor of the State of Connecticut as set forth in an Easement dated November 27, 2001 and recorded in Volume 540 at Page 47 of the Waterford Land Records.

9. Easements, notations, zone lines, rights of way, notes, facts and conditions as shown on Maps Nos. 1893 and 1894, both on file in the Office of the Waterford Town Clerk.

10. Riparian rights of others in and to any watercourse on, flowing through and/or abutting the subject premises.

11. Water Line Easement in favor of the Town of Waterford dated May 24, 2012 and recorded in Volume 1247 at Page 129 of the Waterford Land Records.

12. Electric Distribution Easement in favor of The Connecticut Light and Power Company dated September 11, 2012 and recorded in Volume 1270 at Page 155 of the Waterford Land Records.

365 Montauk Avenue, New London, Connecticut (Main Campus)

1. Covenants and Restrictions affecting lots shown on map "Plan of Building Lots, New London, Conn., F.B. Brandegee and T.M. Waller, 1895, Scale: 40 feet to the inch, surveyed and drawn by Daboll and Crandall" which map is on file in the New London Town Clerk's Office in Map Volume 1 Map 73, reference is made to Warranty Deed from Frank B. Brandegee to The Joseph Lawrence Free Public Hospital dated November 19, 1918 and recorded in Volume 135 at Page 170 of the New London Land Records.

2. Restrictions and conditions set forth in a Deed of T.M. Waller and F. B. Brandegee to Mary E. Esler dated October 18, 1911 and recorded in Volume 118 at Page 159 of the New London Land Records.

3. Covenants, reservations and restrictions set forth in a Warranty Deed from Frank B. Brandegee to Thomas G. Haney dated September 26, 1917 and recorded in Volume 131 at page 229 of the New London Land Records.

4. Restrictions or reservations referred to in the Deed of Georgie A. Fields to C. Graham Chapin dated June 23, 1926 and recorded in Volume 163 at Page 158 of the New London Land Records.

5. Reservations as contained in Quit Claim Deed from the United States of America to The Lawrence and Memorial Associated Hospitals dated January 22, 1952 and recorded in Volume 254 at Page 418 of the New London Land Records.

6. Agreement by and between Lawrence and Memorial Hospitals, The Joseph Lawrence Free Public Hospital, The Manwaring Memorial Hospital and the State of Connecticut Health & Educational Facilities Authority dated July 21, 1969 and recorded in Volume 336 at Page 96 of the New London Land Records.

7. Lease by and among the State of Connecticut Health and Educational Facilities Authority and Lawrence and Memorial Hospitals, The Joseph Lawrence Free Public Hospital and The Manwaring Memorial Hospital dated July 21, 1969 and recorded in Volume 336 at Page 107 of the New London Land Records.

8. Easement from Lawrence and Memorial Hospitals to the State of Connecticut dated June 25, 1979 and recorded in Volume 468 at Page 270 of the New London Land Records.

9. Variance to L&IV1 Hospitals granted by- The City of New London Zoning Board of Appeals dated November 17, 1983 and recorded in Volume 560 at Page 162 of the New London Land Records.

10. Conditions of Special Permit to L& M Hospitals granted by The City of New London Zoning Commission dated November 17, 1983 and recorded in Volume 560 at Page 164 of the New London Land Records.

11. Special Permit to Lawrence and Memorial Hospitals granted by The City of New London Zoning Commission dated December 1, 1986 and recorded in Volume 625 at Page 9 of the New London Land Records.

12. Variance to Lawrence & Memorial Hospital granted by The City of New London Zoning Board of Appeals dated August 25, 1988 and recorded in Volume 714 at Page 237 of the New London Land Records.

13. Special Permit to Lawrence & Memorial Hospital granted by The City of New London Zoning Board of Appeals dated February 10, 1989 and recorded in Volume 735 at Page 306 of the New London Land Records.

14. Certificate of Acceptance of Merger by the State of Connecticut dated July 11, 1957 and recorded April 5, 1989 in Volume 740 at Page 340 of the New London Land Records.

15. Variance to Lawrence & Memorial Hospital granted by City of New London Zoning Board of Appeal dated June 13, 1989 and recorded in Volume 750 at Page 14 of the New London Land Records.

16. Terms and conditions in a Lease and Right of First Refusal from Lawrence & Memorial Hospital, Inc., to 345 Montauk Avenue, LLC dated June 27, 1997 and recorded in Volume 1011 at Page 155 of the New London Land Records

17. Notice of Agreement between Lawrence & Memorial Hospital (Owner) and Message Center Management, Inc., (Manager) dated September 15, 1999 and recorded in Volume 1148 at Page 232 of the New London Land Records, Amended by Amendment to Notice of Agreement dated February 14, 2003 and March 21, 2003 and recorded July 23, 2003 in Volume 1366 at Page 36 of the New London Land Records.

18. Conditions of Notice of Grant of Special Use Permit to Lawrence & Memorial Hospital by the City of New London Planning & Zoning Commission dated September 8, 2003 and recorded in Volume 1381 at Page 291 of the New London Land Records.

19. Conditions of Notice of Grant of Special Use Permit to Lawrence and Memorial Hospital by the City of New London Zoning Board of Appeals dated November 3, 2009 and recorded in Volume 1857 at Page 61 of the New London Land Records.

20. Memorandum of License Agreement by and between Lawrence and Memorial Hospital (Licensor) and Message Center Management, Inc. (Managing Agent) and MetroPCS Massachusetts (Licensee) dated September 29, 2010 and recorded in Volume 1910 at Page 4 of the New London Land Records.

25 Wells Street, Westerly Rhode Island (Westerly Hospital)

1. Easement from The Westerly Hospital to The Narragansett Electric Company recorded in Book 525 at Page 15 in the Westerly Land Evidence Records.

2. Rights and easements as set forth in that Warranty Deed recorded in Book 656 at Page 52; as amended in Book 697 at Page 69 in the Westerly Land Evidence Records.

3. Lease by and between The Westerly Hospital, as Lessor, and Metro Mobile CTS of Providence, Inc., as Lessee, dated March 16, 1995 and evidenced and affected by Assignment of Lease by and between Metro Mobile CTS of Providence, Inc., as Assignor, and SNET Cellular, Inc., as Assignee recorded in Book 562 at Page 161 in the Westerly Land Evidence Records.

4. Rights and easements as set forth in that Warranty Deed recorded in Book 625 at Page 102 in the Westerly Land Evidence Records.

5. Memorandum of Agreement by and between The Westerly Hospital and CoxCom, Inc. d/b/a Cox Communications New England recorded in Book 871 at Page 269 in the Westerly Land Evidence Records.

6. Grant of Easement from The Westerly Hospital to The Narragansett Electric Company recorded in Book 916 at Page 122 in the Westerly Land Evidence Records.

7. Lease by and between The Westerly Hospital, as Lessor, and Celico Partnership d/b/a Verizon Wireless, as Lessee dated July 22, 2002 and evidenced by Memorandum of Lease recorded in Book 1043 at Page 99 in the Westerly Land Evidence Records.

8. Memorandum of Agreement by and between Westerly Hospital (Owner) and Cox TMI Wireless, LLC (Tenant) recorded in Book 1836 at Page 159.

9. A title company may require the recording of a certified copy of the Order Granting the Special Master's Petition to Sell Real Estate Free and Clear of Liens in connection with the issuance of a title policy.

Schedule 3.5.2

L+M Leased Real Property

(1) Lease Agreement, dated as of May 1, 2015, by and between LMH and LMMG for certain medical office space located in the building at 194 Howard Street, New London, Connecticut and for the use of certain parking areas located at 194 Howard Street and 210 Howard Street, New London, Connecticut.

(2) (a) Lease Agreement (the "Radiology Lease"), dated as of July 20, 2004, between Waterford Real Estate Holdings, LLC ("Waterford Real Estate") and Ocean Radiology Associates, P.C. ("Ocean Radiology") for medical office space located at 196 Waterford Parkway South, Waterford, Connecticut (subsequently assigned to LMH pursuant to that certain Assignment, Consent and Termination Agreement, dated as of February 26, 2010, by and among Ocean Radiology, LMH, Southeastern Connecticut Imaging Center, LLC and Waterford Real Estate), as amended by First Amendment to Lease Agreement, dated as of December 15, 2005, and Second Amendment to Lease Agreement, dated as of April 30, 2015, (b) Lease Agreement (the "Cardiology Lease" and, together with the Radiology Lease, the "Waterford Leases"), dated as of July 20, 2004, between Waterford Real Estate and Eastern Connecticut Cardiology Group, P.C. ("ECCG") for medical office space located at 196 Waterford Parkway South, Waterford, Connecticut (subsequently assigned to LMH pursuant to that certain Assignment and Assumption of Lease, dated as of May 1, 2012, by and between Waterford Cardiology Realty Group, LLC, ECCG and LMH), as amended by First Amendment to Lease Agreement, dated as of November 1, 2005, Second Amendment to Lease Agreement, dated as of July 31, 2014 and Third Amendment to Lease Agreement, dated as of April 30, 2015, and (c) Sublease Agreement by and between LMH and LMMG, dated as of May 1, 2012, for the property subject to the Cardiology Lease.

Schedule 3.5.3

Flood Hazard Areas

The property on which the L+M Cancer Center is located is partially located within a Special Flood Hazard Area. The existing structure, however, is not affected and is not in the floodplain.

Schedule 3.5.4

Conditions Affecting Assets

None.

Schedule 3.8

Subsequent Events

(a) None.

(b) *Integrated Leave Program* - Effective April 1, 2015, LMH adopted a new integrated leave program for Directors and Managers and Vice Presidents that are paid biweekly (impacting 120 employees), which includes LMH paid short term disability (self-insured) and long term disability (fully insured) insurance through Unum (plan SPD not yet available). The plan also moves affected employees to an "All Time" bank for days off rather than Separate Paid Time Off ("PTO") and Sick banks and provides for a 2015 PTO cash out of up to 5 days (with 10 days permitted to be kept in the PTO bank) and eliminates Sick day cash out for new employees (current employees may maintain up to 100 days in frozen Sick bank until used for short term disability paid at 75% and L+M has promised to pay each applicable employee for any hours in excess of 800 in their respective Sick banks at such employee's current base rate (up to $10,000). No PTO cash out will be permitted in 2016.

(c) None.

(d)

(1) LMH has purchased an Aptio Equipment Lab from Siemens on June 4, 2015 for $570,000 and a Hematology Analyzer from Sysmex on June 3, 2015 for $426,364. On July 9, 2015, LMH made an 80% payment on a Magnetic Resonance Imaging (MRI) machine from General Electric.

(2) As of April 30, 2015, LMH entered into a Third Amendment to the Cardiology Lease and a Second Amendment to the Radiology Lease Among other things, the amendments to the Cardiology Lease and the Radiology Lease each contain a cross-default provision that provides that a default by LMH under either Waterford Lease constitutes a default under the other Waterford Lease.

(e) None.

(f) None.

(g) Letter Agreement, dated as of June 23, 2014, by and among Teijin Holdings USA, Inc.; L & M Systems, Inc. and L&M Home Medical Equipment, LLC.

(h) None.

(i) None.

(j) None.

(k) None.

(l) None.

(m) None.

Schedule 3.10.2

Tax Deficiencies and Assessments

None.

Schedule 3.10.6

Real Property Certiorari Proceedings

None.

Schedule 3.10.14

L+M Non-Hospital Bonds

$5.4 million of the Series F L+M Tax-Exempt Bonds constitute L+M Non-Hospital Bonds.

Schedule 3.12

Intellectual Property

Filing #, Type, Date & Time	Debtor exactly as listed on UCC	Secured Party (Assignee, if any)	Notes
201514890510 03/17/2015 @ 3:11 pm Original Financing Statement	LMW Healthcare, Inc.	Cardinal Health	All business assets, including but not limited to, goods, equipment, inventory, accounts, accounts receivable, chattel paper, instruments, investment property and all general intangibles, books and records, computer programs and records, and other personal property, tangible or intangible, related to any of the foregoing; all accessions and additions to, substitutions for, and replacements of any of the foregoing; all proceeds or products of any of the foregoing and all rights to payments under any insurance or warranty, guaranty, or indemnity payable with respect to any of the foregoing
201312705070 07/03/2013 @ 9:55 am Original Financing Statement	Westerly Hospital	Sysco Boston, LLC	Customer hereby grants to SYSCO and each SYSCO-related company a continuing security interest in all presently owned or hereafter acquired property of customer consisting of goods, inventory, instruments, chattel paper, documents, accounts, accounts receivable, general intangibles, payment intangibles and any proceeds and all support obligations of any of the foregoing. The collateral secures customer's liabilities and obligations to SYSCO and each SYSCO - related company, whether now existing or hereafter arising.#687945020800062XXXX, dated March 14, 2012, and all of Lessee's rights, title and interest in and to use any software and services financed under and described in the Account, along with any additions, financed amounts, modifications or supplements to the Account and all substitutions, additions, accessions and replacements to the Equipment and Software.

License rights of licensors of third party software and other licensed intellectual property.

Schedule 3.13

Transactions with Affiliates

(1) Affiliate Management Agreement, dated as of May 1, 2010, by and between Sound Medical Associates, P.C.*, a Connecticut professional corporation ("Sound Medical") and LMMG.

(2) Leased Physician Agreement, dated as of January 1, 2010, by and between Sound Medical and LMMG, as amended by Amendment No. 1 to Leased Physician Agreement, dated as of May 1, 2010.

(3) Stock Transfer Restriction Agreement, dated as of September 2007, by and among Sound Medical, LMH and Daniel M. Rissi, M.D.

(4) L & M Systems, Inc. is a Participating Employer in the frozen Sound Medical Associates, P.C. Profit Sharing Plan, originally effective on January 1, 1995, restated on January 1, 2009 and frozen effective December 31, 2009.

(5) L+M is in the process of negotiating a Medical Office Lease to be by and between L+M and The New London Medical Arts Group, LLC (an entity partially owned by Ross J. Sanfilippo, D.M.D., a member of the L+M Board of Directors) for property located at 4 Shaw's Cove, New London CT.

(6) Lease, dated April 1, 2015, between LMW and Shoreline Pulmonary Associates, LLC (owned all, or in part, by Niall J. Duhig, MD).

(7) Letter Agreement, dated January 1, 2015, between Niall J. Duhig, MD and LMH (for Dr. Duhig's services as the LMH Medical Staff Vice President).

(8) Professional Services Agreement for Pulmonary Critical Care Services, dated as of June 1, 2008, by and between The Westerly Hospital and Niall Duhig, M.D. and continued with LMW pursuant to that certain Letter Agreement, dated May 20, 2013, by and between LMW and Niall Duhig, M.D. (entered into in connection with the acquisition of the assets of The Westerly Hospital by LMW).

(9) Letter Agreement, dated January 1, 2014, between Donald J. Felitto, MD and LMH (for Dr. Felitto's services as the LMH Medical Staff Immediate Past President).

(10) Letter Agreement, dated January 5, 2015, between Rachel McCormick, M.D. and LMW (for Dr. McCormick's services as LMW Medical Staff President-Elect).

(11) Letter Agreement, dated January 5, 2015, between William Conlin, MD and LMW (for Dr. Conlin's services as the LMW Medical Staff Immediate Past President).

(12) Letter Agreement, dated January 5, 2015, between Dr. Adrian Hamburger and LMW (for Dr. Hamburger's services as LMW Medical Staff President).

(13) Letter Agreement, dated January 1, 2014, between David F. Reisfeld, MD and LMH (for Dr. Reisfeld's services of LMH Medical Staff President)

*The sole member of Sound Medical is Daniel Rissi, M.D., the Vice President and Chief Medical and Clinical Operations Officer of L+M.

Schedule 3.16.1

Collective Bargaining Matters

(1) Agreement by and between LMH and Lawrence + Memorial Hospital Healthcare Workers Union, Local 5123, AFT-CT, AFT, AFL-CIO ("Local 5123"), dated as of June 1, 2012, including certain Memoranda of Agreement and Understanding by and between LMH and Local 5123, dated as of January 31, 2008, July 3, 2012, September 5, 2012, September 10, 2012, January 22, 2014, October 1, 2013, March 31, 2014, April 2, 2014, April 3, 2014, May 15, 2014, August 8, 2014, January 8, 2015, and also including that certain Memorandum of Agreement by and between LMH and Locals 5049, 5123, and 5051, dated as of June 12, 2008, and also including that certain Memorandum of Agreement by and between LMH and Locals 5049, 5051 and 5123, dated as of April 30, 2014.

(2) Agreement by and between LMH and AFT-CT, AFT Healthcare, AFL-CIO, Local 5051 ("Local 5051"), dated as of December 19, 2013, including that certain Memorandum of Agreement by and between LMH and Local 5049, Local 5123, and Local 5051 dated as of June 12, 2008, and also including that certain Memorandum of Agreement by and between LMH and Locals 5049, 5051 and 5123, dated as of April 30, 2014.

(3) Agreement by and between LMH and AFT-CT, AFT Healthcare, AFL-CIO, Local 5049 ("Local 5049"), dated as of December 19, 2013, including that certain Memorandum of Agreement by and between LMH and Local 5049, Local 5123, and Local 5051, dated as of June 12, 2008, and also including that certain Memorandum of Agreement by and between LMH and Locals 5049, 5051 and 5123, dated as of April 30, 2014.

(4) Agreement by and between LMH and International Union, Security, Police and Fire Professionals of America, dated as of February 4, 2015.

(5) Agreement by and between LMW and The Westerly United Nurses and Allied Professionals, Local 5104 ("Local 5104"), dated as of July 1, 2014, including that certain Memorandum of Agreement by and between LMH Local 5075 and 5104, undated.

(6) Agreement by and between LMW and the Westerly United Nurses and Allied Professionals, Local 5075 ("Local 5075"), dated as of July 1, 2014, including certain Memoranda of Understanding by and between LMW and Local 5075, dated as of January 15, 1991, May 8, 1992, April 27, 1994, February 15, 2001, and also including that certain Memorandum of Agreement by and between LMH and Locals 5075 and 5104, undated, and also including certain Memoranda of Agreement by and between LMW and Local 5075, undated.

(7) Collective Bargaining Agreement by and between Visiting Nurse Association of Southeastern Connecticut, Inc. and the Visiting Nurses Association of Southeastern Connecticut Federation of Registered Nurses and Home Health Aides, Local 5119, AFT-CT, AFT, ACL-CIO, dated as of October 1, 2014 (RNs).

(8) Collective Bargaining Agreement by and between Visiting Nurse Association of Southeastern Connecticut, Inc. and the Visiting Nurse Association of Southeastern Connecticut Federation of Registered Nurses and Home Health Aides, Local 5119, AFT-CT, AFT, AFL-CIO, dated as of October 1, 2014 (Home Health Aides).

(9) The National Labor Relations Board scheduled a union election at the Medical Office Building location of LMMG on November 25, 2014. The union, AFT-Connecticut, was seeking to represent

LPNs, medical assistants, patient coordinators, patient care navigators and surgical schedulers. The election resulted in a no vote for AFT-Connecticut representation.

Schedule 3.16.2

Certain Labor-Related Claims

None.

Schedule 3.16.4

Violation of Certain Agreements

None.

Schedule 3.17.1

L+M Plans

(1) LMH §403(b) Plan, as amended and restated effective as of January 1, 2009, as amended by that certain First Amendment to the LMH §403(b) Plan, effective as of October 1, 2010.

(2) LMH §457(b) Plan for Select Management Employees, effective as of October 28, 2002, as amended by that certain First Amendment to the LMH § 457(b) Plan, effective as of October 1, 2010.

(3) LMH 401(k) Plan, originally effective as of July 1, 1999, as amended by that certain First Amendment to the LMH 401(k) Plan, effective as of January 1, 2004 and further amended as of January 4, 2010.

(4) LMH Pension Plan, effective as of January 1, 2014.

(5) LMH CEO 457(f) Retirement Plan, effective as of January 1, 2006.

(6) LMH 457(f) Supplemental Retirement Plan, effective as of January 1, 2011.

(7) Group Basic Dependent Life, Basic Term Life, Supplemental Term Life, Basic Accidental Death and Dismemberment, Supplemental Accidental Death and Dismemberment, Policy Number GL-033240 for Employees of L+M and Provided by Hartford Life and Accident Insurance Company, effective as of October 1, 1991, as amended by certain Amendatory Riders effective as of March 1, 2014 and May 1, 2014.

(8) Group Long Term Disability Plan, Policy Number 301778011, provided by Unum Life Insurance Company of America for Employees of L+M, as amended.

(9) Group Long Term Disability Plan, Policy Number 521870011, provided by Unum Life Insurance Company of America for Employees of L&M Corporation, effective as of December 1, 1997, as amended.

(10) CIGNA Dental Preferred Provider Insurance to Employees of LMH, effective as of January 1, 2010.

(11) LMH Section 125 Plan, Plan Number 501, effective as of October 1, 2010.

(12) LMH Lumenos Health Savings Account, Provided by Anthem Blue Cross and Blue Shield, effective as of January 1, 2012.

(13) Fully Insured Anthem Medicare Supplement to Retirees of LMH.

(14) LMH offered a VERP in 1993 under which LMH pays a portion of the Medicare Supplement.

(15) LMH Medical Insurance Provided by Anthem BCBS and Century Preferred PPO.

(16) Vision Service Plan to Employees of LMMG.

(17) Hyatt Legal Plan to Employees of LMMG.

(18) 529 College Savings Plan to Employees of LMMG.

(19) Professional Liability Insurance to Employees of LMMG.

(20) Visiting Nurse Association of Southeastern Connecticut, Inc. Flexible Benefits Plan, Plan Number 501, effective as of October 1, 2005.

(21) Visiting Nurse Association of Southeastern Connecticut, Inc. Anthem Blue Cross (PPO and HSA) Medical Insurance Plan.

(22) Visiting Nurse Association of Southeastern Connecticut, Inc. CIGNA Dental Insurance Plan.

(23) Visiting Nurse Association of Southeastern Connecticut, Inc. Dependent Care Assistance Plan.

(24) Visiting Nurse Association of Southeastern Connecticut, Inc. Health Care Expense Reimbursement Plan, effective as of October 1, 2005.

(25) Visiting Nurse Association of Southeastern Connecticut, Inc. Vision Plan.

(26) Visiting Nurse Association of Southeastern Connecticut, Inc. Tuition Reimbursement Plan.

(27) Basic Group Term Life Insurance, Basic Accidental Death and Dismemberment Insurance, Short and Long Term Disability Insurance Provided by Anthem Life Insurance Company, Policy Number AL00003237 Sponsored by Visiting Nurse Association of Southeastern Connecticut, Inc.

(28) Defined Contribution Pension Plan for Employees of Visiting Nurse Association of Southeastern Connecticut, Inc. provided by Mutual of America Life Insurance Company, effective as of July 1, 1988.

(29) Tax-Deferred Annuity Plan for Employees of Visiting Nurse Association of Southeastern Connecticut, Inc., Provided by Mutual of America Life Insurance Company, effective as of January 1, 2009.

(30) Group Long Term Disability Plan, Policy Number 213795001, provided by Unum Life Insurance Company of America for Employees of LMW, effective as of January 1, 2013, and amended by that certain Amendment No. 1, dated as of May 1, 2014.

(31) Integrated Leave Program for Biweekly Directors and Managers, including long term and short term disability insurance provided by Unum Life Insurance Company of America, effective as of April 1, 2015 (separately set forth below).

(32) Employment Agreement (the "CEO Employment Agreement"), dated October 31, 2005, between LMH and Bruce D. Cummings (the "CEO").

(33) LMH leases vehicles for the CEO (pursuant to the CEO Employment Agreement) and for Christopher Lehrach, M.D.

(34) LMH maintains a life insurance policy with Canada Life Assurance Company (Policy No. 2380459) on behalf of John F. Mirabito, the former Chief Executive Officer of L+M. The 2015 Annual Premium for the policy is $4,115.00.

(35) Group Short Term Disability Insurance, Policy Number 640639-C, provided by Standard Insurance Company for Employees of L&M Corporation, effective as of November 1, 2000.

(36) Long Term Disability Insurance Plan, Policy Number 468882001, provided by Unum Life Insurance Company of America to Employees of L&M Corporation, effective as of April 1, 2015.

(37) Sound Medical Associates, P.C. Profit Sharing Plan, amended and restated effective as of January 1, 2009, as amended by that certain Amendatory Agreement, effective as of December 31, 2009, as further amended by that certain Amendment to Sound Medical Associates Profit Sharing Plan, effective as of February 24, 2015.

(38) Unum Administrative Services Agreement for Self-Insured Short Term Income Protection or Salary Continuation Plan, Policy Number 468881, provided by Unum Life Insurance Company of America to Employees of L&M Corporation, effective as of April 1, 2015.

Schedule 3.17.4

Benefits Triggered by Agreements

L+M is currently considering adopting retention bonuses for certain select individuals in connection with the consummation of the transactions contemplated by the Affiliation Agreement.

Schedule 3.26.1

Deficiencies Asserted by Governmental Authorities

None.

Schedule 3.27

Consents and Approvals

(1) See Schedule 7.5

(2) Cancer Center Services Agreement by and among L+M, Associated Specialists of Southeastern Connecticut, Inc. and Dana-Farber Cancer Institute, Inc., dated as of April 1, 2011, as amended by that certain Amendment to the Cancer Center Services Agreement, dated as of October 1, 2013, as further amended by that certain Second Amendment to Cancer Center Services Agreement, dated as of December 1, 2014, as further amended by that certain Third Amendment to Cancer Center Services Agreement, dated as of May 27, 2015.

(3) Respironics Somnolyzer 24x7 Hosting Agreement by and between Respironics, Inc. and LMMG, dated as of October 22, 2014.

(4) Operating Agreement of Value Care Alliance, LLC, dated as of December 23, 2013, by and among Griffin Hospital, LMH and Middlesex Hospital.

(5) Travelers Casualty and Surety Company of America, Fiduciary Liability Policy No. 1050763618.

(6) Appointment of YNHHSC as the ultimate parent of LMI may require approval of the Cayman Island Monetary Authority under Section 12 of the Cayman Island Insurance Law.

Schedule 3.28.2

Cost Report Periods

Government Payer Program	Last Three Complete Report Periods
Medicare	10/1/2011 - 9/30/2012
	10/1/2012 - 9/30/2013
	10/1/2013 - 9/30/2014
Medicaid	10/1/2010 - 9/30/2011
	10/1/2011 - 9/30/2012
	10/1/2012 - 9/30/2013

Schedule 7.5

Third Party Approvals

(1) The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

(2) The appointment of YNHHSC as the sole corporate member of L+M will require Certificate of Need approval from OHCA.

(3) The merger of LMMG with and into NEMG will require notice to OHCA of LMMG Board approval of the merger and Certificate of Need approval from OHCA, and thirty (30) days prior to consummating the merger and closing the aforementioned transaction, notice must be filed with the Connecticut Attorney General.

(4) The appointment of YNHHSC as the ultimate corporate parent of LMW must be approved by both RIDOH and the Rhode Island Attorney General through a Hospital Conversion Act application. The change in control effected by the appointment of YNHHSC as the ultimate parent of LMW must also be approved by the RIDOH Office of Health Systems Development through a Change in Effective Control application.

(5) Notice of the Affiliation must be given to the Connecticut Attorney General at the same time that premerger notification under the HSR Act is given to the Federal Trade Commission. (7) Consent of Bank of America, N.A. to the consummation of the transactions contemplated by the Affiliation Agreement under Section 7(p), and confirmation of Bank of America, N.A. that the transactions contemplated by the Affiliation Agreement will not contravene Section 7(g), of that certain Continuing Covenants Agreement, dated as of October 13, 2013, by and among L+M and LMH on the one hand and Bank of America, N.A. on the other hand.

(6) Consent of the Connecticut Health and Education Facilities Authority to the consummation of the transactions contemplated by the Affiliation Agreement under Section 6.11 of the Master Trust Indenture, dated as of February 1, 1990, by and among L+M and LMH on the one hand and the Master Trustee named therein on the other hand, as the same has been amended or supplemented from time to time in accordance with its terms.

(7) Notification to TD Bank, National Association pursuant to Section 5.30 of that certain Letter of Credit and Reimbursement Agreement, dated as of November 5, 2013, by and among L+M and LMH on the one hand and TD Bank, National Association, on the other hand.

YNHHSC SCHEDULES
TO THE
AFFILIATION AGREEMENT

by and between

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

LAWRENCE + MEMORIAL CORPORATION

July 17, 2015

Introduction

Reference is made to the Affiliation Agreement (the "Affiliation Agreement"), entered into as of July 17, 2015, by and between Yale-New Haven Health Services Corporation ("***YNHHSC***") and Lawrence + Memorial Corporation ("***L+M***"). This document constitutes the Disclosure Schedule of YNHHSC pursuant to the Affiliation Agreement. Each of YNHHSC and L+M is referred to herein as a "Party" and collectively as the "Parties." All capitalized terms used, but not defined, herein shall have the meaning ascribed to such term in the Affiliation Agreement.

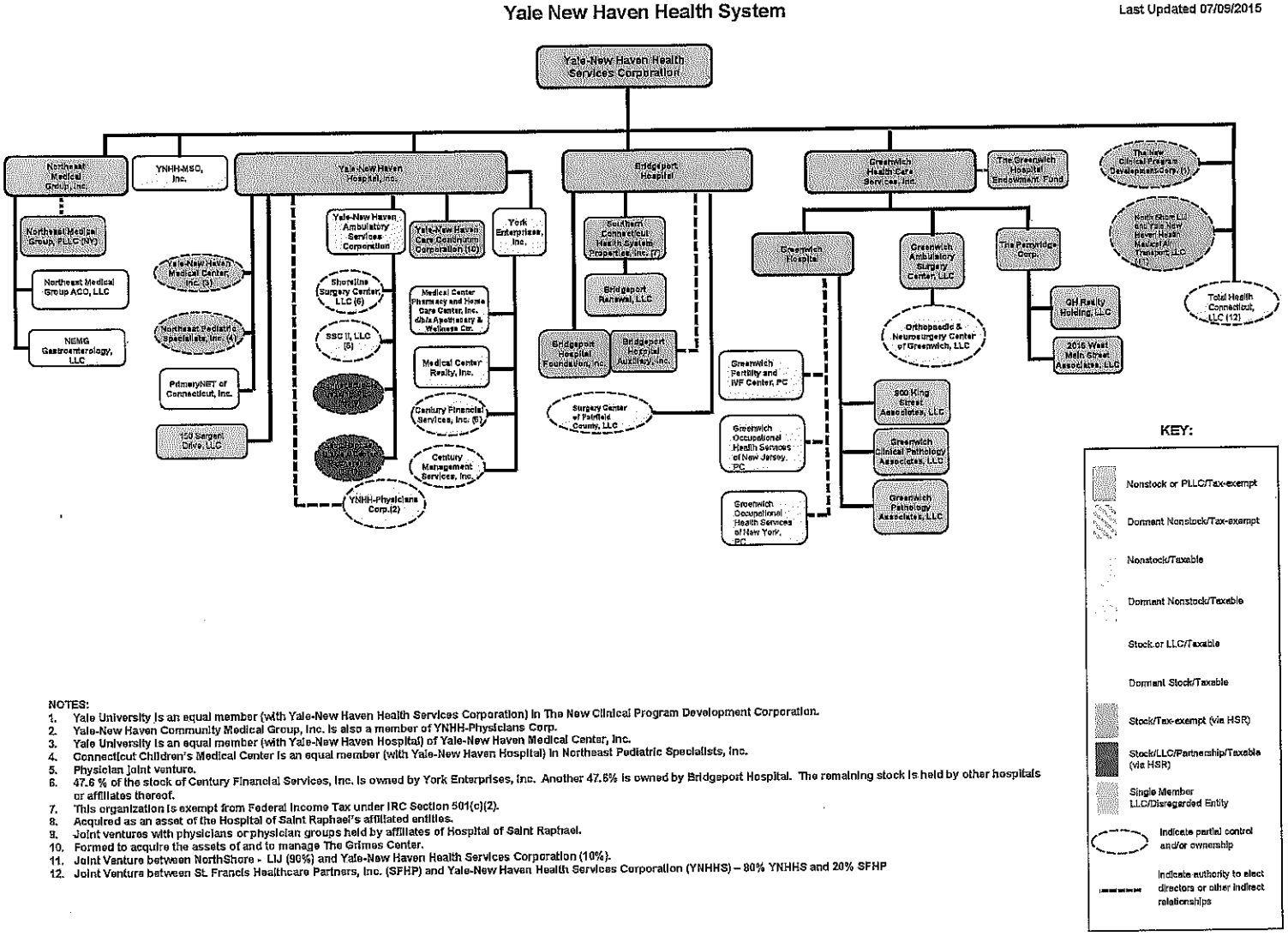
Section and sub-section numbers and letters used herein correspond to the section and sub-section numbers and letters in the Affiliation Agreement, unless otherwise noted, and any information disclosed in any section or sub-section herein shall be deemed to be disclosed to L+M for all purposes of the Affiliation Agreement so long as such disclosure's relevance to the applicable section(s) of the Affiliation Agreement is reasonably apparent on its face. The captions of each Schedule are included for convenience only and are not intended to limit the scope of such part, paragraph or section of the Disclosure Schedule as set forth in the Affiliation Agreement.

No disclosure made herein constitutes an admission of any liability or obligation of any YNHHSC Affiliate, an admission against any interest of any YNHHSC Affiliate or a concession as to any defense available to any YNHHSC Affiliate. Unless the Affiliation Agreement specifically provides otherwise, the disclosure of a specific item herein shall not be deemed to constitute an admission that such item is not in the ordinary course of business. To the extent that any representation or warranty contained in the Affiliation Agreement is limited or qualified by the materiality of the matters to which the representation or warranty is given, the inclusion of any matter in this Disclosure Schedule does not constitute an admission that such matters are material or will have a YNHHSC Material Adverse Effect. Certain information set forth herein is included solely for informational purposes and may not be required to be disclosed pursuant to the Affiliation Agreement.

If there is any inconsistency between any provision or statement in the Affiliation Agreement and any provision or statement in the Disclosure Schedule (other than an exception in any section or subsection to a specific representation or warranty), then the provision or statement in the Affiliation Agreement shall control.

Schedule 4.1.1

YNHHSC Subsidiaries



NOTES:

1. Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
2. Yale-New Haven Community Medical Group, Inc. is also a member of YNHH-Physicians Corp.
3. Yale University is an equal member (with Yale-New Haven Hospital) of Yale-New Haven Medical Center, Inc.
4. Connecticut Children's Medical Center is an equal member (with Yale-New Haven Hospital) in Northeast Pediatric Specialists, Inc.
5. Physician joint venture.
6. 47.6 % of the stock of Century Financial Services, Inc. is owned by York Enterprises, Inc. Another 47.6% is owned by Bridgeport Hospital. The remaining stock is held by other hospitals or affiliates thereof.
7. This organization is exempt from Federal Income Tax under IRC Section 501(c)(2).
8. Acquired as an asset of the Hospital of Saint Raphael's affiliated entities.
9. Joint ventures with physicians or physician groups held by affiliates of Hospital of Saint Raphael.
10. Formed to acquire the assets of and to manage The Grimes Center.
11. Joint Venture between NorthShore - LIJ (90%) and Yale-New Haven Health Services Corporation (10%).
12. Joint Venture between St. Francis Healthcare Partners, Inc. (SFHP) and Yale-New Haven Health Services Corporation (YNHHS) – 80% YNHHS and 20% SFHP

Schedule 4.8

Subsequent Events

In June 2015, the State of Connecticut passed a budget that included increases to the hospital tax and cuts to hospital funding that disproportionally impact YNHHSC Affiliates. The net tax impact on all Yale New Haven Health System hospitals for FY 2016, taking into account the supplemental pool distributions hospitals receive to offset the cost of providing services to Medicaid and uninsured patients, is $300,309,281 (the hospitals will pay $556,267,268 in taxes, but get only $241,119,999 back from the supplemental pool). Overall, the net tax burden on hospitals in the state in FY 2016 will be $60,082,014 more than it was in FY 2015, which is tantamount to a cut in funding to hospitals by $60 million. Yale New Haven Health System as a whole will shoulder 84.3% of that cut in funding (approximately $51M).

In addition, Yale New Haven Health System appears to have been specifically targeted for property tax increases in the budget implementer bill. That legislation will subject to taxation certain property acquired by health systems on and after October 1, 2015, but only if the health system had, for the fiscal year ending September 30, 2013, net patient revenue from facilities located within the state of $1.5 billion or more. Yale New Haven Health System and Hartford Health Care appear to be the only two health systems impacted

Schedule 4.10.2

Tax Deficiencies and Assessments

NONE

Schedule 4.12

Intellectual Property

License rights of licensors of third party software and other licensed intellectual property.

Schedule 4.16.1

Collective Bargaining Matters

- Collective Bargaining Agreement between Yale-New Haven Hospital and New England Health Care Employees Union, District 1199, SEIU, expiring December 31, 2018
- Collective Bargaining Agreement between Yale-New Haven Hospital Saint Raphael Campus and Teamsters Local Union 443, effective September 12, 2012 through September 12, 2015
- Collective Bargaining Agreement between Yale New Haven Care Continuum Corporation d/b/a Grimes Center and Teamsters Local Union 443, effective September 12, 2012 through September 12, 2015
- Representation election petition dated January 13, 2012 filed by International Union of Operating Engineers Local 30, AFL-CIO. Employer – Greenwich Hospital. Letter approving withdrawal request dated January 20, 2012.

Schedule 4.16.2

Certain Labor-Related Claims

NONE

Schedule 4.16.4

Violation of Certain Agreements

NONE

Schedule 4.26

Deficiencies Asserted by Governmental Authorities

NONE

Schedule 4.27

Consents and Approvals

1. The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

2. The appointment of YNHHSC as the sole corporate member of L+M will require Certificate of Need approval from OHCA.

3. The merger of LMMG with and into NEMG will require notice to OHCA of LMMG Board approval of the merger and Certificate of Need approval from OHCA, and thirty (30) days prior to consummating the merger and closing the aforementioned transaction, notice must be filed with the Connecticut Attorney General.

4. The appointment of YNHHSC as the ultimate corporate parent of LMW must be approved by both RIDOH and the Rhode Island Attorney General through a Hospital Conversion Act application. The change in control effected by the appointment of YNHHSC as the ultimate parent of LMW must also be approved by the RIDOH Office of Health Systems Development through a Change in Effective Control application.

5. Notice of the Affiliation must be given to the Connecticut Attorney General at the same time that premerger notification under the HSR Act is given to the Federal Trade Commission.

6. A Transaction Test certificate is required to be delivered as a condition to the merger of LMMG with and into NEMG in satisfaction of the requirements of Section 408 of the YNHHSC Master Trust Indenture; Section 6.27 of that certain Reimbursement Agreement by and between YNHHSC and Bank of America, N.A., dated as of June 1, 2014; and each of the three International Swap Dealers Association, Inc. Master Agreements, each dated as of June 23, 2014, by and between YNHHSC and the following counterparties respectively: (i) Barclays Bank PLC; (ii) JPMorgan Chase Bank, N.A. ("***JPMC***"); and (iii) Goldman Sachs Bank USA.

7. The written consent of Wells Fargo Bank, National Association ("***Wells Fargo***") is required to be obtained as a condition of the merger of LMMG with and into NEMG, pursuant to Section 7.6(b) of that certain Amended and Restated Letter of Credit and Reimbursement Agreement by and among Wells Fargo, Yale-New Haven Hospital, Inc. and YNHHSC, dated as of June 23, 2014.

8. The written consent of JPMC is required to be obtained as a condition of the merger of LMMG with and into NEMG, pursuant to Section 15(d) of that certain Letter of Credit and Reimbursement Agreement by and between YNHHSC and JPMC, dated as of June 1, 2014.

9. The 1999 Affiliation Agreement between Yale University and YNHHSC, as amended

(the "***1999 Affiliation Agreement***") requires that if a health care provider becomes a member of Yale New Haven Health System, YNHHSC must promptly notify the Yale School of Medicine ("***YSM***") and, if such new system member has medical education affiliation agreements with medical schools other than YSM, YNHHSC must give notice of the expiration date and material program terms of such medical education affiliation agreements.

Schedule 6.5

YNHHSC Third Party Approvals

1. The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

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ATTACHMENT IV

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #180

October 2014

Overview of Hospital Stays in the United States, 2012

Audrey J. Weiss, Ph.D. and Anne Elixhauser, Ph.D.

Introduction

Hospital inpatient care constitutes almost one-third of all health care expenditures in the United States.[1] Overall, hospitalizations affect a large proportion of Americans directly and represent a significant impact to the U.S economy. Although general population growth and a higher prevalence of chronic health conditions suggest that hospital utilization may increase over time, particularly among some groups, greater use of chronic disease management programs and emphasis on outpatient treatment may result in a declining trend in hospital stays.

This Statistical Brief presents data from the Healthcare Cost and Utilization Project (HCUP) on characteristics of inpatient stays in U.S. community hospitals in 2012. The distribution of type of hospital stay (surgical, medical, and maternal or neonatal) is presented for different characteristics (patient age, primary payer, and hospital region). Changes in hospital utilization and costs from 2003 to 2012 are provided, along with changes in hospital utilization by primary payer and patient age. All differences between mean estimates noted in the text are statistically significant at the 0.0005 level or better. Differences between proportions noted in the text differ by at least 10 percent.

Highlights

- In 2012, there were 36.5 million hospital stays in the United States, with an average length of stay of 4.5 days and an average cost of $10,400 per stay.
- The rate of hospitalization decreased by an average of 0.3 percent per year from 2003 to 2008 and by an average of 1.9 percent per year from 2008 to 2012. Between 2003 and 2012, average inflation-adjusted hospital costs increased by 1.8 percent per year.
- About 56 percent of hospital stays in 2012 were medical, 21.8 percent were surgical, and 22.2 percent were maternal or neonatal.
- Females had a higher rate of hospitalization in 2012 than did males, but males had a longer average length of stay and higher average cost per stay.
- In 2012, patients residing in low income communities had a higher rate of hospitalization, a longer length of stay, and lower average hospital costs compared with patients in higher income communities.
- The rate of hospital stays in 2012 was lower in the Pacific and Mountain divisions than in the other Census divisions. Patients hospitalized in the Northeast had the longest length of stay and patients in the West had the highest average hospital costs.
- From 2003 to 2012, the share of hospital stays billed to private insurance decreased from 36.6 to 30.6 percent.

[1] Gonzalez JM. National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2011. MEPS Statistical Brief No. 425. Rockville, MD: Agency for Healthcare Research and Quality, 2013. http://meps.ahrq.gov/data_files/publications/st425/stat425.pdf. Accessed March 28, 2014.

Findings

Characteristics of hospital stays, 2012
Table 1 presents utilization and cost data for hospital inpatient stays in 2012 by selected patient and hospital characteristics.

Table 1. Number and rate of hospital stays, length of stay, and costs by patient, payer, community income, and hospital characteristics, 2012

Characteristic	Hospital stays			Mean length of stay, days	Costs	
	Number, thousands	Percent	Rate per 1,000 population		Mean cost per stay, $	Aggregate, millions $
All hospital stays	36,500	100	116.2	4.5	10,400	377,455
Patient age, years						
< 1	4,300	11.7	1,070.9	3.8	5,000	21,101
1–17	1,500	4.0	21.1	3.9	9,900	14,635
18–44	9,000	24.7	78.9	3.6	7,600	68,425
45–64	9,000	24.7	108.8	4.9	12,900	116,075
65–84	9,700	26.7	260.9	5.2	13,000	126,573
85+	3,000	8.2	502.0	5.2	10,200	30,512
Patient sex						
Male	15,400	42.3	99.9	4.8	11,700	180,587
Female	21,000	57.7	132.0	4.3	9,400	196,833
Primary payer[a]						
Medicare	14,300	39.1	n/a	5.2	12,200	174,609
Medicaid	7,600	20.9	n/a	4.3	8,100	61,679
Private insurance	11,200	30.6	n/a	3.8	9,700	107,807
Uninsured	2,000	5.6	n/a	4.0	8,800	18,056
Community income[b]						
Low	10,900	30.0	136.8	4.6	9,700	105,981
Not low	24,700	67.8	106.1	4.4	10,600	262,789
Hospital region						
Northeast	7,000	19.1	125.2	4.9	10,800	75,146
Midwest	8,200	22.6	122.4	4.3	10,200	84,140
South	14,100	38.7	120.4	4.5	9,300	131,635
West	7,200	19.6	97.2	4.2	12,300	86,533

[a] Population rates are not available by primary payer.

[b] Patients in the first quartile are designated as *low* income, and patients in the upper three quartiles are designated as *not low* income.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2012

- **In 2012, there were about 36.5 million hospital stays with an average length of stay of 4.5 days and an average cost of $10,400 per stay.**

  In 2012, there were approximately 36.5 million hospital stays in the United States, representing a hospitalization rate of 116.2 stays per 1,000 population. Across all types of stays, the average length of a hospital stay was 4.5 days. Aggregate hospital costs were $377.5 billion, and the average cost per stay was $10,400.

- **Hospital utilization and costs varied substantially in relationship to patient and hospital characteristics.**

The rate of hospitalization was highest among infants, which included hospital births (newborns), at 1,070.9 stays per 1,000 population. With the exception of infants, the hospitalization rate increased with age from 21.1 stays per 1,000 population among 1–17 year olds to 502.0 stays per 1,000 population among those aged 85 years and older.

Adults aged 18–44 years had the shortest average length of stay (3.6 days), followed by infants and children up to 17 years of age (3.8 to 3.9 days). Among adults, lengths of stay were longer as patient age increased, with adults aged 65 years and older having the longest average length of stay (5.2 days). Average cost per stay was lowest for infants ($5,000) and highest for adults aged 45–84 years ($12,900 to $13,000).

Females had a higher rate of hospitalization (132.0 stays per 1,000 population) than males (99.9 stays per 1,000 population). The average length of a hospital stay was shorter for females than for males (4.3 vs. 4.8 days), and the average cost of a hospital stay was lower for females than for males ($9,400 vs. $11,700). It is important to note that maternal stays for females admitted for pregnancy and delivery were included in this analysis. Analyses excluding maternal and neonatal (newborn) stays showed the same relative differences between males and females (data not shown). Excluding maternal and neonatal conditions and compared with males, females had a higher rate of hospitalization (93.9 vs. 86.9 stays per 1,000 population), a shorter average length of stay (4.8 vs. 5.0 days), and lower average cost per stay ($11,400 vs. $12,800).

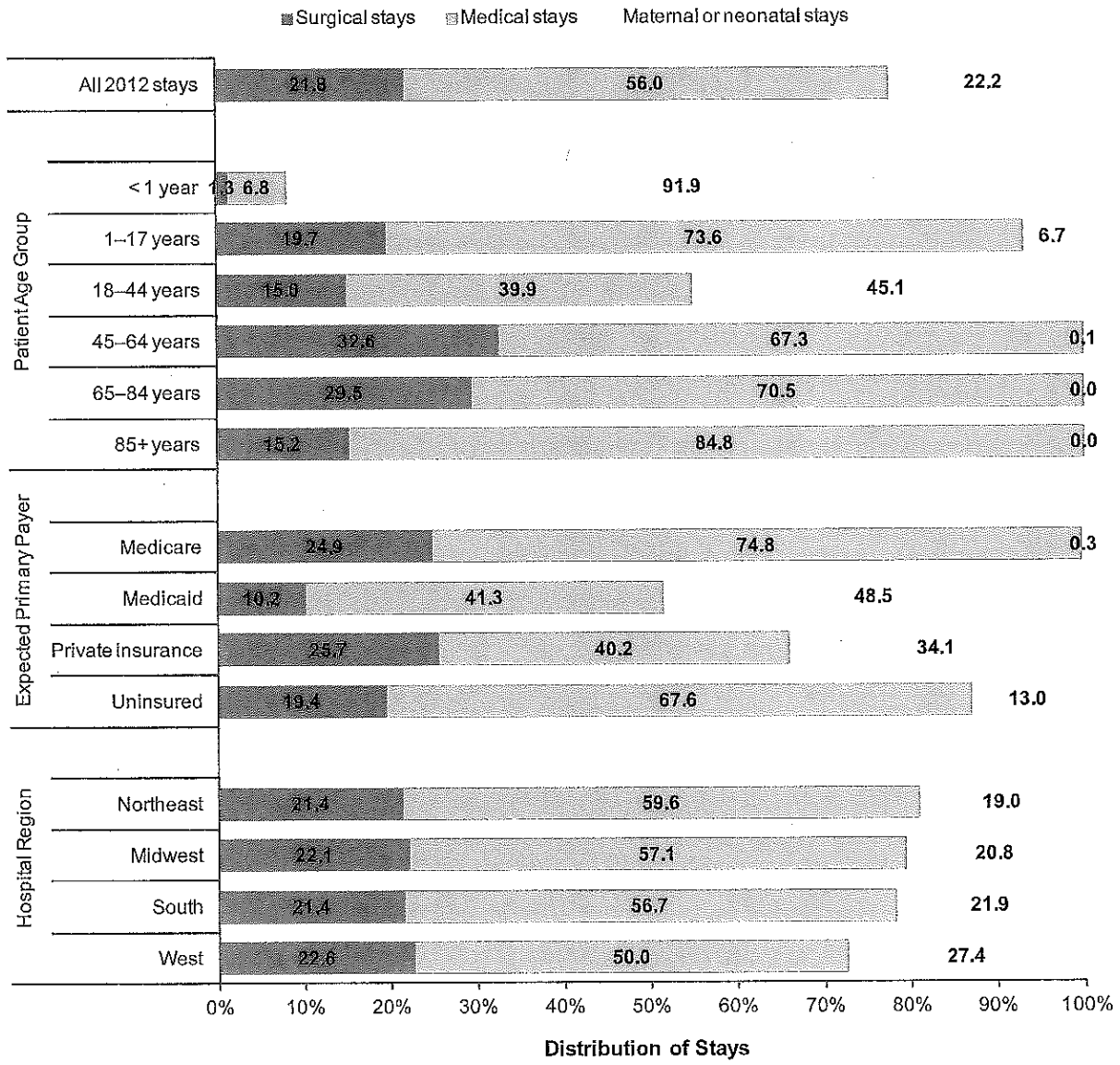
Medicare paid for the largest number of hospitalizations (14.3 million stays), followed by private insurance (11.2 million stays) and Medicaid (7.6 million stays). About 2 million hospital stays were for patients without insurance. Patients covered by Medicare experienced the longest average length of stay (5.2 days), and privately insured patients had the shortest average length of stay (3.8 days). Average cost per stay was highest for Medicare hospitalizations ($12,200) and lowest for Medicaid hospital stays ($8,100).

Communities with low income levels had a higher rate of hospitalization than did communities with higher income levels (136.8 vs. 106.1 stays per 1,000 population). Compared with patients from higher income communities, patients from low income communities had a longer average length of stay (4.6 vs. 4.4 days) and lower average hospital costs ($9,700 vs. $10,600).

The West had a lower rate of hospitalization (97.2 stays per 1,000 population) compared with the other regions (range: 120.4 to 125.2 stays per 1,000 population). The Northeast had the longest average length of stay at 4.9 days, and the West and Midwest had the shortest average lengths of stay (4.2 and 4.3 days, respectively). The West had the highest average hospital cost ($12,300) and the South had the lowest average hospital cost ($9,300).

Figure 1 provides the distribution of hospital stays by patient age, primary payer, and hospital region, comparing each subgroup by type of stay—surgical, medical, and maternal or neonatal.

Figure 1. Distribution of inpatient stays by patient age group, primary payer, hospital region, and type of stay, 2012



Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2012

- **Medical stays constituted the largest proportion of hospitalizations.**

  Overall, medical stays constituted the largest proportion of hospital stays, representing 56.0 percent of all hospitalizations. Maternal/neonatal stays and surgical stays each constituted approximately 22 percent of hospitalizations. More than two-thirds of hospitalizations were medical stays for the second youngest and three oldest age groups: 1–17 years (73.6 percent), 45–64 years (67.3 percent), 65–84 years (70.5 percent), and 85+ years (84.8 percent). Medical stays also constituted a high proportion of stays among patients covered by Medicare (74.8 percent) and among the uninsured (67.6 percent).

- **Maternal or neonatal stays constituted the largest proportion of hospitalizations among infants, younger adults, and patients covered by Medicaid.**

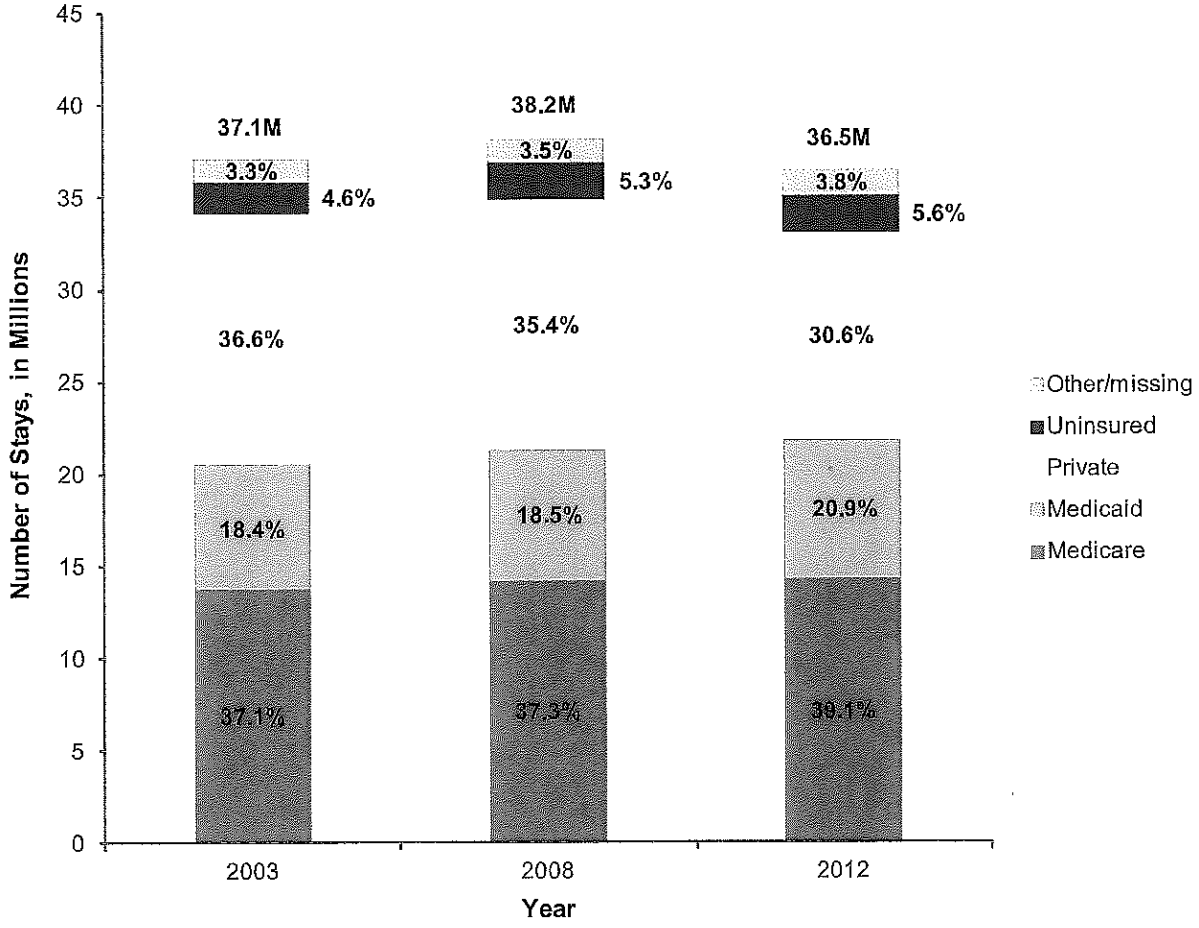
  Neonatal stays constituted 91.9 percent of hospital stays among infants aged < 1 year. Nearly half of stays among patients aged 18–44 years (45.1 percent) and those covered by Medicaid (48.5 percent) were for maternal conditions.

- **In the West, the proportion of maternal or neonatal stays was higher and the proportion of medical stays lower relative to the distribution within other U.S. regions.**

  In the West maternal or neonatal stays accounted for more than one-quarter of all hospitalizations (27.4 percent) versus around 20 percent for the other regions (range: 19.0–21.9 percent). In addition, the West had a lower proportion of medical stays (50.0 percent) compared with the other regions (range: 56.7–59.6 percent).

Figure 2 presents the distribution of hospital stays by primary payer for 2012 and for 2 prior years (2003 and 2008), covering a 10-year time period.

Figure 2. Distribution of inpatient stays by primary payer, 2003, 2008, and 2012



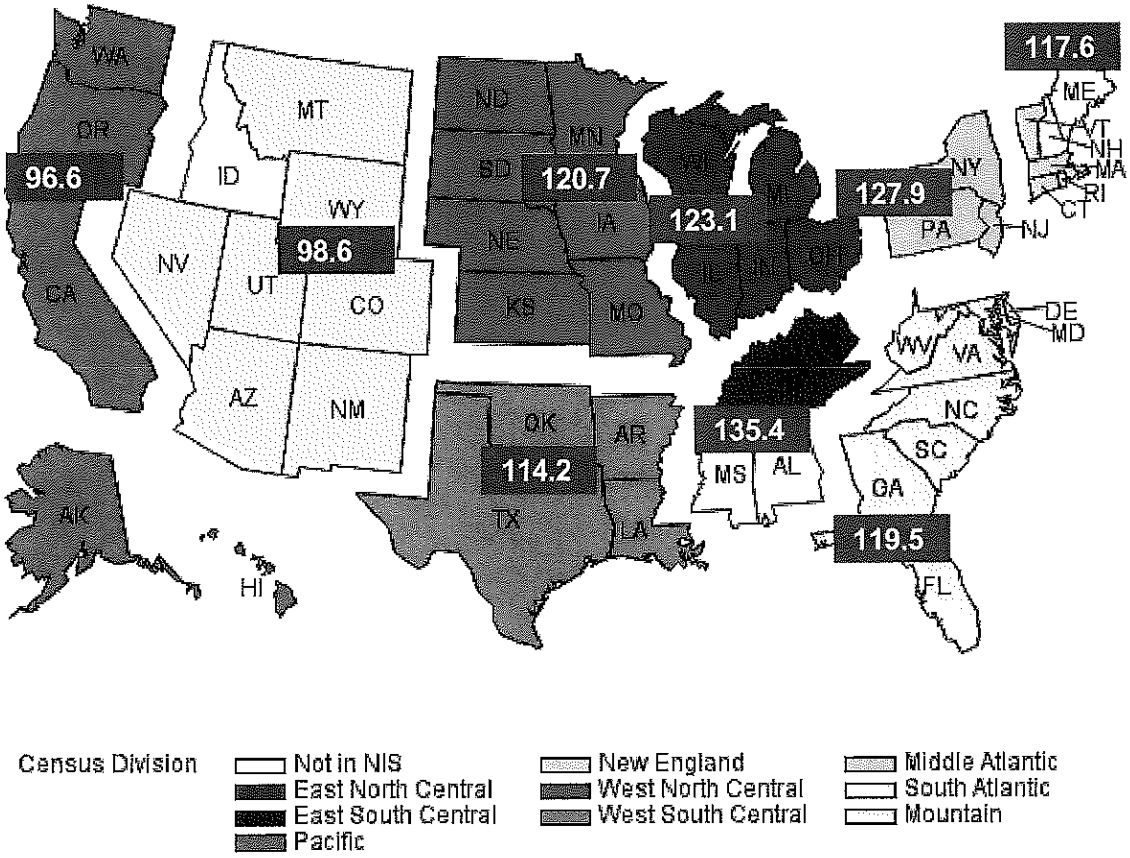
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, 2012

- **The share of hospital costs billed to private insurance decreased between 2003 and 2012.**

  Between 2003 and 2012, the number of hospital stays billed to private insurance decreased from 13.6 to 11.2 million stays, representing a decrease from 36.6 to 30.6 percent of all hospitalizations. During this same time period, the share of stays billed to Medicaid increased from 6.8 to 7.6 million stays (an increase from 18.4 percent to 20.9 percent of all hospitalizations).

Figure 3 presents the rate of hospital inpatient stays across the nine U.S. Census divisions in 2012.

Figure 3. Rate of inpatient stays per 1,000 population by U.S. Census division, 2012



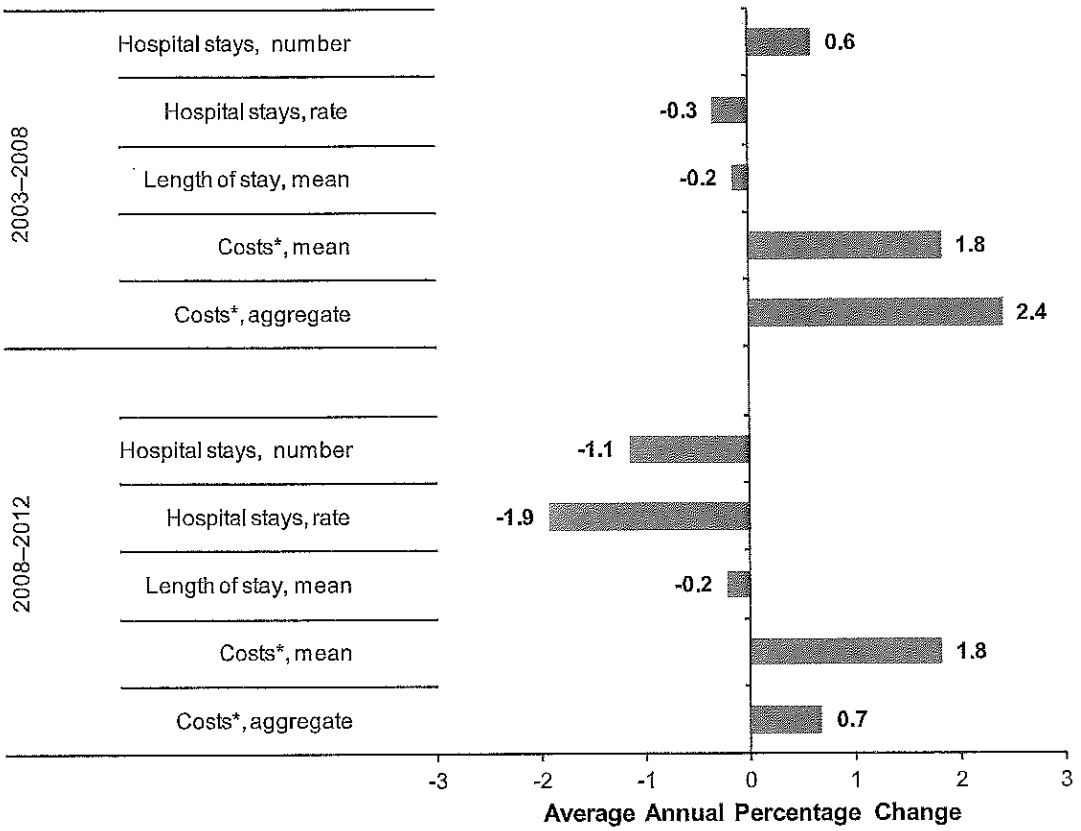
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2012

- **The Pacific and Mountain divisions had the lowest rates of inpatient stays.**

  The lowest hospitalization rates were in the Pacific and Mountain divisions (96.6 and 98.6 stays per 1,000 population, respectively). The West South Central division had a lower hospitalization rate (114.2 stays per 1,000 population) than did the East South Central and Middle Atlantic divisions (135.4 and 127.9 stays per 1,000 population, respectively).

Changes in utilization and costs of hospital stays, 2003–2012
Figure 4 presents overall changes in utilization and costs associated with hospital inpatient stays.

Figure 4. Average annual percentage change in hospital inpatient utilization and inflation-adjusted costs, 2003–2008 and 2008–2012



* Growth in mean and aggregate hospital costs was calculated using inflation-adjusted costs.

Note: Data from 2008 were used as end points in both the 2003–2008 and the 2008–2012 analyses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, 2012

- **Hospital costs increased while the rate of hospitalization and mean length of stay decreased over the decade from 2003 to 2012.**

  The number of hospital stays increased 0.6 percent annually from 2003 to 2008, whereas the number of stays decreased an average of 1.1 percent annually between 2008 and 2012.

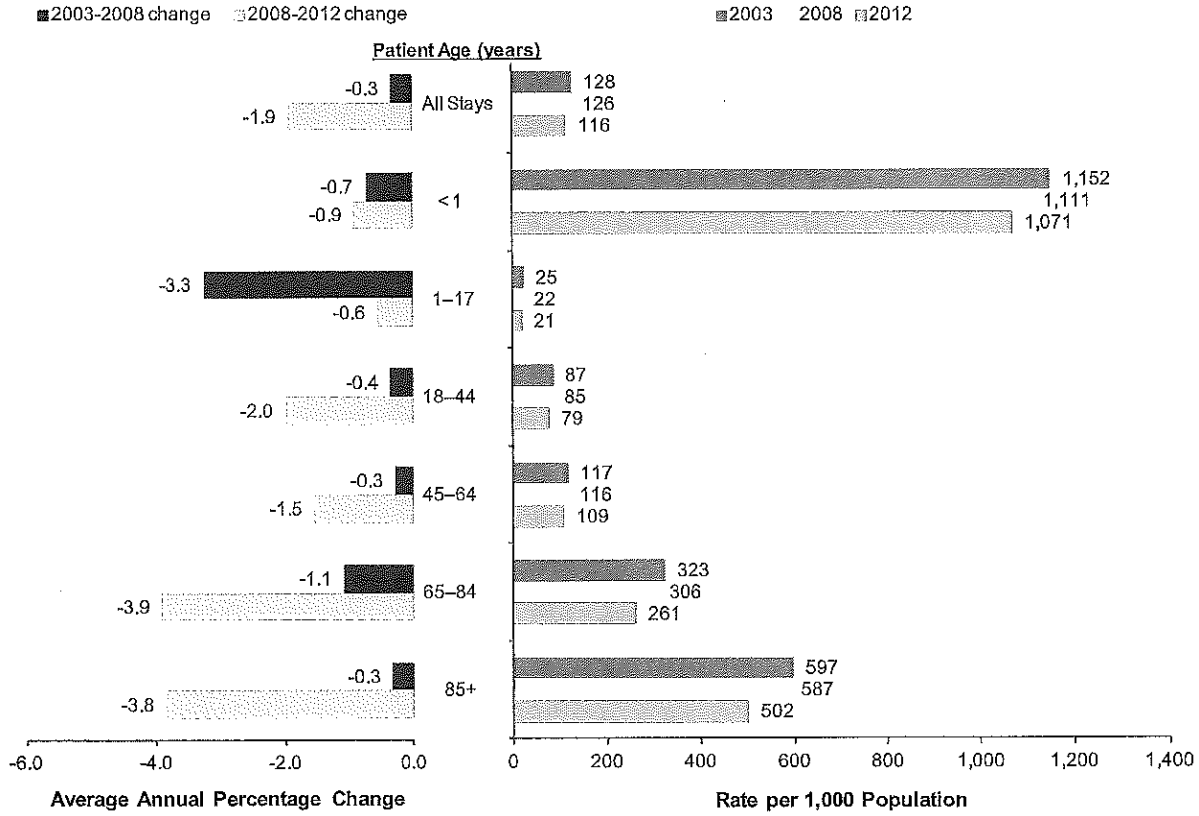
  The overall rate of hospitalization decreased over time, with an average annual decrease of 0.3 percent between 2003 and 2008 and an average annual decrease of 1.9 percent between 2008 and 2012.

  The length of a hospital stay decreased on average 0.2 percent per year between 2003 and 2012.

  Finally, mean inflation-adjusted hospital costs grew at a relatively steady rate, averaging 1.8 percent per year during both time periods. Aggregate inflation-adjusted hospital costs grew an average of 2.4 percent per year between 2003 and 2008 but slowed to a 0.7 percent average increase per year between 2008 and 2012.

Figure 5 presents the rate of stays by patient age for 2003, 2008, and 2012, along with the average annual percentage change for two consecutive 5-year time periods (2003–2008 and 2008–2012).

Figure 5. Rate of inpatient stays and change over time by patient age, 2003–2012



Note: Data from 2008 were used as end points in both the 2003–2008 and the 2008–2012 analyses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, 2012

- **The rate of hospitalization decreased between 2003 and 2012 overall and across patient subgroups.**

  Between 2003 and 2012 the rate of hospitalization decreased from 128 stays per 1,000 population in 2003 to 116 stays per population in 2012. This decrease in the hospitalization rate occurred for all age groups. The rate of decrease was generally greater from 2008 to 2012 than from 2003 to 2008, with the exception of patients aged 1–17 years, who experienced a faster decline in hospitalization rate from 2003 to 2008.

  From 2008 through 2012, the rate of hospitalization decreased at the highest rate—almost 4 percent per year—for those aged 65 years and older.

Data Source

The estimates in this Statistical Brief are based upon data from the Healthcare Cost and Utilization Project (HCUP) 2012 National Inpatient Sample (NIS). Historical data were drawn from the 2003 and 2008 Nationwide Inpatient Sample (NIS). The statistics were generated from HCUPnet, a free, online query system that provides users with *immediate access* to the largest set of publicly available, all-payer national, regional, and State-level hospital care databases from HCUP.[2]

The 2012 NIS was redesigned to optimize national estimates. The redesign incorporates two critical changes:

- Revisions to the sample design—the NIS is now a *sample of discharge records from all HCUP-participating hospitals*, rather than a sample of hospitals from which all discharges were retained.
- Revisions to how hospitals are defined—the NIS now uses the *definition of hospitals and discharges supplied by the statewide data organizations* that contribute to HCUP, rather than the definitions used by the American Hospital Association (AHA) Annual Survey of Hospitals.

The new sampling strategy is expected to result in more precise estimates than did the previous NIS design by reducing sampling error: for many estimates, confidence intervals under the new design are about half the length of confidence intervals under the previous design. The change in sample design for 2012 necessitates recomputation of prior years' NIS data to enable analysis of trends that uses the same definitions of discharges and hospitals.

This is the first Statistical Brief that reports data from the 2012 NIS.

Many hypothesis tests were conducted for this Statistical Brief. Thus, to decrease the number of false-positive results, we reduced the significance level to 0.0005 for individual tests.

Definitions

Diagnoses, ICD-9-CM, major diagnostic categories (MDCs), and diagnosis-related groups (DRGs)
The *principal diagnosis* is that condition established after study to be chiefly responsible for the patient's admission to the hospital. *Secondary diagnoses* are concomitant conditions that coexist at the time of admission or develop during the stay.

ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses and procedures. There are approximately 14,000 ICD-9-CM diagnosis codes and approximately 4,000 ICD-9-CM procedure codes.

MDCs assign ICD-9-CM principal diagnosis codes to one of 25 general diagnosis categories. For this report, maternal hospital stays were identified using MDC 14 (pregnancy, childbirth, and the puerperium) and neonatal hospital stays were identified using MDC 15 (newborns and other neonates with conditions originating during the perinatal period).

DRGs comprise a patient classification system that categorizes patients into groups that are clinically coherent and homogeneous with respect to resource use. DRGs group patients according to diagnosis, type of treatment (procedure), age, and other relevant criteria. Each hospital stay has one assigned DRG. For this report, surgical stays were defined as *valid O.R. procedures* on the basis of DRG coding principles. Stays other than maternal/neonatal stays or surgical stays were considered medical stays.

Types of hospitals included in the HCUP National (Nationwide) Inpatient Sample
The National (Nationwide) Inpatient Sample (NIS) is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). The NIS includes obstetrics and gynecology, otolaryngology, orthopedic,

[2] Agency for Healthcare Research and Quality. HCUPnet Web site. http://hcupnet.ahrq.gov/. Accessed September 11, 2014.

cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Beginning in 2012, long-term acute care hospitals are also excluded. However, if a patient received long-term care, rehabilitation, or treatment for psychiatric or chemical dependency conditions in a community hospital, the discharge record for that stay will be included in the NIS.

Unit of analysis
The unit of analysis is the hospital discharge (i.e., the hospital stay), not a person or patient. This means that a person who is admitted to the hospital multiple times in 1 year will be counted each time as a separate discharge from the hospital.

Costs and charges
Total hospital charges were converted to costs using HCUP Cost-to-Charge Ratios based on hospital accounting reports from the Centers for Medicare & Medicaid Services (CMS).[3] *Costs* reflect the actual expenses incurred in the production of hospital services, such as wages, supplies, and utility costs; *charges* represent the amount a hospital billed for the case. For each hospital, a hospital-wide cost-to-charge ratio is used. Hospital charges reflect the amount the hospital billed for the entire hospital stay and do not include professional (physician) fees. For the purposes of this Statistical Brief, costs are reported to the nearest hundred.

Annual costs were inflation adjusted using the Gross Domestic Product (GDP) from the U.S. Department of Commerce, Bureau of Economic Analysis (BEA), with 2012 as the index base.[4] That is, all costs are expressed in 2012 dollars.

Average annual percentage change
Average annual percentage change is calculated using the following formula:

$$\text{Average annual percentage change} = \left[\left(\frac{\text{End value}}{\text{Beginning value}}\right)^{\frac{1}{\text{change in years}}} - 1\right] \times 100.$$

Median community-level income
Median community-level income is the median household income of the patient's ZIP Code of residence. Income levels are separated into quartiles with cut-offs determined using ZIP Code demographic data obtained from the Nielsen Company. Patients in the first quartile are designated as having *low* income, and patients in the upper three quartiles are designated as having *not low* income. The income quartile is missing for patients who are homeless or foreign.

Payer
Payer is the expected primary payer for the hospital stay. To make coding uniform across all HCUP data sources, payer combines detailed categories into general groups:

- Medicare: includes patients covered by fee-for-service and managed care Medicare
- Medicaid: includes patients covered by fee-for-service and managed care Medicaid
- Private Insurance: includes Blue Cross, commercial carriers, and private health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
- Uninsured: includes an insurance status of *self-pay* and *no charge*
- Other: includes Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs

Hospital stays billed to the State Children's Health Insurance Program (SCHIP) may be classified as Medicaid, Private Insurance, or Other, depending on the structure of the State program. Because most

[3] Agency for Healthcare Research and Quality. HCUP Cost-to-Charge Ratio (CCR) Files. Healthcare Cost and Utilization Project (HCUP). 2001–2011. Rockville, MD: Agency for Healthcare Research and Quality. Updated August 2014. http://www.hcup-us.ahrq.gov/db/state/costtocharge.jsp. Accessed September 11, 2014.

[4] U.S. Bureau of Economic Analysis. National Income and Product Account Tables, Table 1.1.4 Price Indexes for Gross Domestic Product. http://www.bea.gov/iTable/iTable.cfm?ReqID=9&step=1#reqid=9&step=1&isuri=1. Accessed March 20, 2014.

State data do not identify patients in SCHIP specifically, it is not possible to present this information separately.

When more than one payer is listed for a hospital discharge, the first-listed payer is used.

Region
Region is one of the four regions defined by the U.S. Census Bureau:

- Northeast: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania
- Midwest: Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas
- South: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas
- West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska, and Hawaii

About HCUP

The Healthcare Cost and Utilization Project (HCUP, pronounced "H-Cup") is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of encounter-level health care data (HCUP Partners). HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

Alaska State Hospital and Nursing Home Association
Arizona Department of Health Services
Arkansas Department of Health
California Office of Statewide Health Planning and Development
Colorado Hospital Association
Connecticut Hospital Association
Florida Agency for Health Care Administration
Georgia Hospital Association
Hawaii Health Information Corporation
Illinois Department of Public Health
Indiana Hospital Association
Iowa Hospital Association
Kansas Hospital Association
Kentucky Cabinet for Health and Family Services
Louisiana Department of Health and Hospitals
Maine Health Data Organization
Maryland Health Services Cost Review Commission
Massachusetts Center for Health Information and Analysis
Michigan Health & Hospital Association
Minnesota Hospital Association
Mississippi Department of Health
Missouri Hospital Industry Data Institute
Montana MHA - An Association of Montana Health Care Providers
Nebraska Hospital Association

Nevada Department of Health and Human Services
New Hampshire Department of Health & Human Services
New Jersey Department of Health
New Mexico Department of Health
New York State Department of Health
North Carolina Department of Health and Human Services
North Dakota (data provided by the Minnesota Hospital Association)
Ohio Hospital Association
Oklahoma State Department of Health
Oregon Association of Hospitals and Health Systems
Oregon Health Policy and Research
Pennsylvania Health Care Cost Containment Council
Rhode Island Department of Health
South Carolina Revenue and Fiscal Affairs Office
South Dakota Association of Healthcare Organizations
Tennessee Hospital Association
Texas Department of State Health Services
Utah Department of Health
Vermont Association of Hospitals and Health Systems
Virginia Health Information
Washington State Department of Health
West Virginia Health Care Authority
Wisconsin Department of Health Services
Wyoming Hospital Association

About Statistical Briefs

HCUP Statistical Briefs are descriptive summary reports presenting statistics on hospital inpatient and emergency department use and costs, quality of care, access to care, medical conditions, procedures, patient populations, and other topics. The reports use HCUP administrative health care data.

About the NIS

The HCUP National (Nationwide) Inpatient Sample (NIS) is a national (nationwide) database of hospital inpatient stays. The NIS is nationally representative of all community hospitals (i.e., short-term, non-Federal, nonrehabilitation hospitals). The NIS is a sample of hospitals and includes all patients from each hospital, regardless of payer. It is drawn from a sampling frame that contains hospitals comprising more than 95 percent of all discharges in the United States. The vast size of the NIS allows the study of topics at the national and regional levels for specific subgroups of patients. In addition, NIS data are standardized across years to facilitate ease of use.

About HCUPnet

HCUPnet is an online query system that offers instant access to the largest set of all-payer health care databases that are publicly available. HCUPnet has an easy step-by-step query system that creates tables and graphs of national and regional statistics as well as data trends for community hospitals in the United States. HCUPnet generates statistics using data from HCUP's National (Nationwide) Inpatient Sample (NIS), the Kids' Inpatient Database (KID), the Nationwide Emergency Department Sample (NEDS), the State Inpatient Databases (SID), and the State Emergency Department Databases (SEDD).

For More Information

For more information about HCUP, visit http://www.hcup-us.ahrq.gov/.

For additional HCUP statistics, visit HCUPnet, our interactive query system, at http://hcupnet.ahrq.gov/.

For information on other hospitalizations in the United States, refer to the following HCUP Statistical Briefs located at http://www.hcup-us.ahrq.gov/reports/statbriefs/statbriefs.jsp:

- Statistical Brief #168, Costs for Hospital Stays in the United States, 2011
- Statistical Brief #162, Most Frequent Conditions in U.S. Hospitals, 2011
- Statistical Brief #165, Most Frequent Procedures Performed in U.S. Hospitals, 2011

For a detailed description of HCUP and more information on the design of the National (Nationwide) Inpatient Sample (NIS), please refer to the following database documentation:

Agency for Healthcare Research and Quality. Overview of the National (Nationwide) Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality. Updated July 2014. http://www.hcup-us.ahrq.gov/nisoverview.jsp. Accessed September 11, 2014.

Suggested Citation

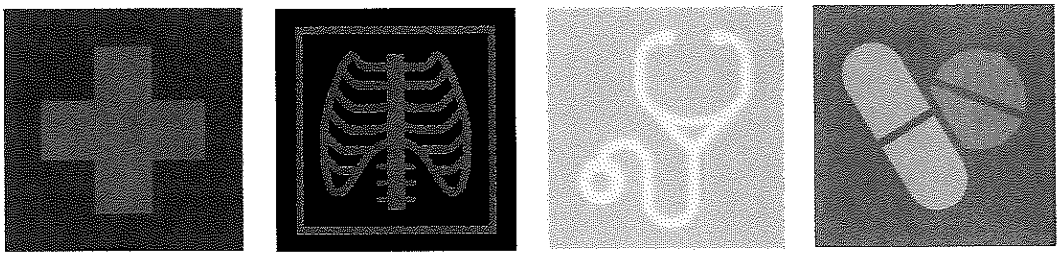
Weiss AJ (Truven Health Analytics), Elixhauser A (AHRQ). Overview of Hospital Stays in the United States, 2012. HCUP Statistical Brief #180. October 2014. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb180-Hospitalizations-United-States-2012.pdf.

* * *

AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at hcup@ahrq.gov or send a letter to the address below:

Irene Fraser, Ph.D., Director
Center for Delivery, Organization, and Markets
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

HEALTH CARE COST INSTITUTE



2013 Health Care Cost and Utilization Report

October 2014

www.healthcostinstitute.org

Letter from the Executive Director

The Health Care Cost Institute (HCCI) is pleased to release the 2013 *Health Care Cost and Utilization Report.* This report is the first examination of 2013 data, and it details the health care cost and utilization trends for Americans younger than age 65 and covered by employer sponsored insurance (ESI).

In 2013, health care spending for the national ESI population grew 3.9%. This growth rate was similar to the rates observed in 2011 (4.0%) and 2012 (3.7%). Spending growth for 2013 was driven mainly by rising prices rather than by utilization, as use of many services declined. As in previous years, this growth in spending was not consistent across various ESI population groups. For this report, HCCI detailed the health care cost and utilization trends across age, gender, and geographic sub-populations. We hope that you find the report informative.

In reviewing the last year, HCCI has engaged in numerous efforts we want to make sure you are aware of.

- *Medicare data*: The Centers for Medicare & Medicaid Services (CMS) certified HCCI as the first national Qualified Entity, granting HCCI access to use for quality reporting Medicare Parts A, B, and D data for the entire country.

- *APCD collaboration*: HCCI's ongoing partnership with Vermont yielded the first HCCI-produced public report for the state's all payer claims database (APCD). This report, the 2007-2011 *Vermont Health Care Cost and Utilization Report,* described health care cost and use trends for Vermonters covered by ESI and compared these trends to the national ESI population for the years 2007 through 2011.

- *Academic research*: The HCCI dataset is being validated as a recognized data source for academic research. In the October 2013 issue of *Health Affairs*, HCCI published an article examining the longitudinal health care trends of the ESI population. The August 2014 issue of *Health Affairs* included the first article published by academic researchers using HCCI's dataset, "Health Spending Slowdown is Mostly Due to Economic Factors, Not Structural Change in the Health Care Sector."

- *Dataset access*: HCCI created the Academic Research Partnership program to expand access by academic researchers to HCCI-held claims data. The initial partners included major public and private universities, two actuarial associations, and two government agencies.

- *State health reform grants:* HCCI and the National Academy for State Health Policy (NASHP), with funding from the Laura and John Arnold Foundation, launched a grant program designed to promote academic research of state health reform efforts.

- *Transparency initiative:* HCCI has partnered with our data contributors and other stakeholders to develop a free Web-based portal to provide health care price and quality information to the public.

More information can be found on the HCCI Website (www.healthcostinstitute.org).

In addition to these activities, HCCI continues to be a source of public reporting on spending and utilization trends of the ESI population younger than age 65. Along with this report, HCCI recently produced the *Children's Health Spending:* 2009-2012 report and an issue brief on the medical health care trends for young adults (ages 19–25).

Our work over the last year would not have been possible without ongoing support from our stakeholders and partners. We look forward to continue working with them on our expanding agenda of activities in 2015.

David Newman
Executive Director, HCCI

Executive Summary

This report, 2013 *Health Care Costs and Utilization*, is the fourth in a series of annual reports by the Health Care Cost Institute (HCCI) on the health care activity of individuals who are younger than age 65 and covered by employer-sponsored health insurance (ESI). The report's study period (2011 -2013) covers the years after passage of the Affordable Care Act (ACA) and prior to the opening of health insurance exchanges. As in previous years, the report details the levels and changes in per capita expenditures ("spending"), utilization ("use"), and prices of medical and prescription services used by the ESI population. Also, for the first time, it details patterns of spending and service use by age-gender groups of the ESI population.

In 2013, spending for the national ESI population grew 3.9% (Table 1). Spending was driven up by rising prices of medical services and brand prescriptions (see "Key definitions"), while use of inpatient and outpatient services and brand prescriptions fell (Table 2). Separately, the use of filled days of generic prescriptions grew 4.5%, while the average price fell by 0.5%.

Despite uneven growth among ESI sub-populations, national trend remained stable

In 2013, ESI health care expenditures increased by 3.9% ($183 per capita) to $4,864 per insured (Table 1). Since 2010, per capita ESI health spending grew by an average 3.9% per year. This health care spending trend is considerably slower than historical expenditure growth for the ESI population.

A number of spending trends from 2011 and 2012 continued in 2013. The Northeast region of the county continued to have the highest per capita expenditures ($5,037 per insured) and the highest rate of spending growth (4.8%). The West continued to have the lowest expenditures ($4,542 per insured) and lowest growth rate (3.0%). Children (ages 0–18) and young adults (ages 19–25) continued to have the lowest per capita expenditures ($2,574 and $2,676, respectively) and the fastest expenditure growth (4.6% and 4.5%). [1,2]

A number of earlier trends, however, did not persist in 2013. Spending in the West grew faster in 2013 than in previous years. Spending growth in the South experienced the highest rate in 2012 but slowed to 3.6% in 2013, the second lowest growth rate. For young adults and intermediate adults (ages 26–44), spending growth also slowed by more than a percentage point, whereas spending growth for pre-Medicare adults (ages 55–64) grew faster than in 2012 by nearly two percentage points. Per capita health care spending for women ($5,403) remained higher than spending for men ($4,305), but the growth rate for men accelerated while the rate for women slowed.

Spending on medical services and prescriptions continued to rise in 2013

Spending trends in 2013 were similar to those observed in 2011 and 2012, with 20% of expenditures on acute

BY THE NUMBERS: 2013

3.9%

The increase in per capita health care spending per insured.

-0.5% & 5.8%

The decline in utilization and increase in price paid for outpatient services.

-15.5% & 21.2%

The decline in utilization and increase in price paid for brand prescriptions.

4.5% & -0.5%

The increase in utilization and decline in prices paid for generic prescriptions.

0.8% & 2.5%

The increase in utilization and increase in price paid for professional services.

8.0%

The increase in utilization of specialist office visits.

inpatient admissions, 28% of expenditures on outpatient care, 34% of expenditures on professional services, and the remaining 17% of expenditures on prescriptions. Spending on acute inpatient care (3.9%) and professional procedures (3.3%) grew faster in 2013 than in 2012 (1.7% and 2.9%, respectively). Outpatient services continued to be the fastest-growing medical service category in terms of spending, but between 2012 and 2013, growth slowed from 6.3% to 5.2%. Prescriptions spending rose by 3.1%, with a spending growth faster on generic (3.9%) than on brand (2.4%) prescriptions.

Professional service and generic prescription use rose

In 2013, professional service use rose 0.8% (Table 3), due to rising utilization of commonly used services, such as office visits to specialists (1,493 services per 1,000 insureds; Appendix Table A5) and laboratory and pathology (lab/path) services (4,719 services per 1,000 insureds). Office visits to specialists grew by 8.0%, and use of lab/path services increased by 1.9%. Increases in the use of these detailed categories offset declining use in other professional detailed service categories, such as office visits to primary care providers (-3.8%).

Also in 2013, generic prescriptions use increased by 4.5% (Table 3), the lowest growth rate observed since 2011. Generics accounted for 83.3% of prescription filled days in 2013. The four mostly commonly filled detailed categories of generic prescriptions were central nervous system (CNS) agents, cardiovascular drugs, hormones and synthetic substitutes, and anti-infective agents (Appendix Table A5). Of these prescriptions, only use of anti-infective agents declined (-1.8%).

Inpatient, outpatient, and brand prescription use fell

In 2013, medical service use fell for acute inpatient admissions, outpatient visits, and outpatient-other services (Table 3). Acute inpatient admissions per 1,000 declined 2.3% due to lower medical (-5.1%) and surgical (-3.7%) admissions per 1,000 insureds (Appendix Table A5). Driving the decline in the number of outpatient visits (-0.8%, or 3 visits per 1,000 insureds; Table 2) were declines in outpatient surgery and emergency room visits (Appendix Table A5). Use of outpatient-other services declined by 0.5% (Table 3) due to fewer ancillary and lab/path (Appendix Table A5) services used.

Also in 2013, use of brand prescriptions fell sharply by 15.5% (Table 3). Continuing a multiyear trend, use declined for the most commonly filled detailed categories (see "Key definitions") of brand prescriptions (hormones and synthetic substitutes, cardiovascular drugs, CNS, and gastrointestinal drugs; Appendix Table A5).

Rising prices pushed up medical and brand prescription spending

In our annual analyses of ESI health care spending, HCCI examines changes in utilization rates and prices paid for care. Our findings for 2013 spending are consistent with those for 2011 and 2012: that rising prices, rather than utilization, were the primary drivers of spending growth for all medical service categories and brand prescriptions (Table 2 and Table 3). For acute inpatient, outpatient, and brand prescriptions, expenditures rose owing to rising prices and that growth was moderated by falling utilization. Exceptions to this trend were professional services and generic prescriptions. Professional services showed increases in both average price and utilization, whereas higher use of generic prescriptions offset the effects of a lower average price.2013

Notable trends: use of services by age-gender groups; emergency room spending; brand prescription spending; CNS agents; demographics of generic prescription use

Utilization by adult women higher than that of men until age 55.

In 2013 adult women (ages 19–54) had levels of outpatient and professional service use higher than those of adult men (Appendix Table A10a). In particular, use of outpatient and professional lab/path and radiology services was higher for women than for men within the same age group. After age 54, pre-Medicare adult men and women used these services at relatively similar rates.

Spending levels for emergency room visits similar across adult age groups, despite differences in use.

In 2013, spending on emergency room (ER) visits for young adults was $310 per capita and $314 per capita for pre-Medicare adults. Overall, ER use rates declined with age; however, the average price paid by older adults was higher than that paid by young adults, due to both higher prices and higher intensity of care for older adults.

Brand spending highest for antirheumatic agents.

In 2013, the top four classes of brand prescriptions, by per capita spending, were antirheumatic agents, biologic response modifiers, insulins, and antiretrovirals (Table 4). Spending on brand antirheumatic agents was $49 per capita. Collectively, spending on

these drugs was $154 per insured, totaling 28% of ESI spending on brand prescriptions.

CNS prescriptions dominated generic usage.

In 2013, spending per insured on CNS agents, drugs that affect the brain and spinal column, was $90 (Appendix Table A4). CNS agents accounted for 31.4% of generic drug spending per capita and 27.1% of the generic filled days (Appendix Table A5). Antidepressants were the most commonly filled class of CNS generic prescriptions (Table 6) and the most used generic drug class for young adult men, intermediate adult men, middle age adult women, and pre-Medicare adult women (Tables 9–12). For girls, young adult women, and intermediate adult women the most commonly used class of generics was contraceptives.

Conclusions

Differences in spending and use across these groups are relevant not only to the insureds, but also to employers and policymakers interested in health care trends during this pre-exchange period. For 2013, HCCI found that utilization rose for some services and populations affected by the ACA, including preventive visits and contraception, but these services generally contributed little to overall spending. ESI spending increased, at a rate similar to those in 2011 and 2012. In each of those years, rising medical and brand prescription prices led to spending growth. However, unlike in 2011 and 2012, declining utilization in 2013 offset price increases, keeping expenditure growth historically slow.

KEY DEFINITIONS

What is per capita spending?

Per capita spending in this report is the estimate of total expenditures paid divided by the employer-sponsored insured population.

What are medical service, subservice, and detailed categories?

Three medical service categories are identified: inpatient facility, outpatient facility, and professional procedures. HCCI also reports on three facility subservice categories: acute inpatient, which includes labor and delivery, medical, mental health and substance use, newborn, and surgery claims; outpatient visits; and outpatient-other services.[7] These are further classified into "detailed service" categories.

What are prescription service, subservice, detailed service categories, and subclasses?

HCCI analyzes prescription drug and device claims from pharmacies. The prescription service category is further classified by brand and generic drug subservice categories. These are further classified into "detailed service" categories, and further into subclasses.[7]

What is intensity?

Intensity is a measure of the complexity of a service, including the length of time, the severity of the illness addressed, and the amount of resources required for treatment. Many factors can account for changes in the intensity of services, including new and better forms of treatment, the health status of the population receiving services, and reimbursement system modifications that either encourage or discourage one form of treatment over another. HCCI does not currently calculate intensity of prescriptions.

What is an intensity-adjusted price?

Isolating the effect of intensity on the price paid per service allows for the calculation of an intensity-adjusted price. The patient never sees this price directly. In metrics, intensity equal to 1 would lead to no difference between prices paid and intensity-adjusted prices. Intensity greater than 1 would lead to intensity-adjusted prices being higher than prices paid; and an intensity-level less than 1 would mean that intensity-adjusted prices were less than the prices paid.

Annual Health Care Expenditures Per Capita

In this report, annual health care expenditures per capita consist of the spending on medical and pharmacy claims by individuals covered by ESI. Per capita expenditures were calculated for the national ESI population, across detailed sub-populations (including regions, genders, age groups, age-gender groups), and across broad and detailed service categories (see "Key definitions").

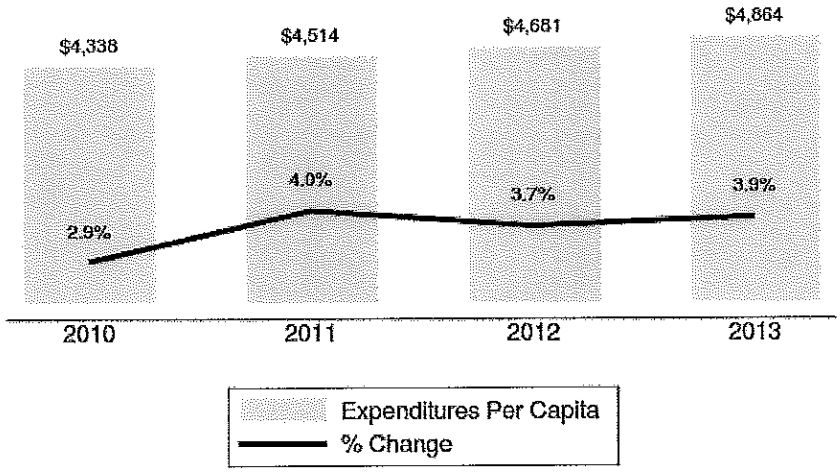
For third year, national expenditures growth remained stable

For the three years of the study period, per capita health spending by the ESI population grew at rates faster than those in 2010 but slower than rates between 2007 and 2009. This report does not investigate the reasons for that slower growth, but other research suggests many factors influencing this trend, including slower economic growth, changing benefit designs, and health system reform.[3,4,5]

Between 2012 and 2013, per capita expenditures for people age 65 or younger and covered by ESI rose $183 per person to $4,864 (Table 1 and Figure 1). This reflects a growth rate of 3.9%, similar to the rats observed in 2011 and 2012.

Although the annual spending growth rate was similar across these years, the underlying trends for those years were quite different. As shown in Table 1, 2013 health care expenditures per capita grew for all sub-populations examined (regions, age groups, and genders), but at rates different from those in 2011 and 2012.

Figure 1
ESI Expenditures Per Capita on Insureds, Younger than Age 65: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than age 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

KEY FINDINGS: 2013

Growth rate remained stable

Growth in per capita spending was 3.9%, a similar rate to 2011 (4.0%) and 2012 (3.7%).

$4,864

The spending per capita for the national ESI population

$2,574 & 4.6%

The spending per capita and growth rate for children, the lowest per capita spending and highest growth rate of any age group.

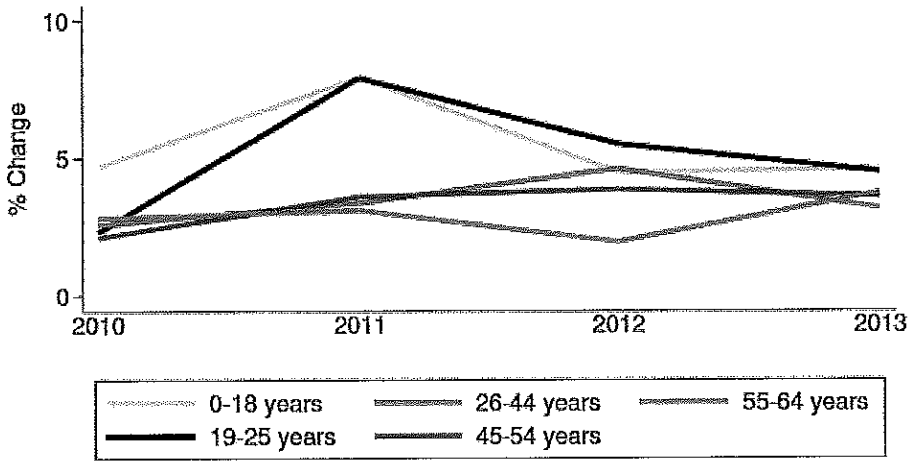
$5,037 & 4.8%

The spending per capita and growth rate for the Northeast, the highest regional per capita spending and growth rate.

$849 & 5.5%

The spending per capita and growth rate for outpatient visits, the highest service category growth rate.

Figure 2
Annual Percentage Changes in Expenditures Per Capita by Age Group: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Health care expenditures grew fastest for men, children, and young adult men

Spending per capita in 2013 was more than $1,000 higher for women than for men ($5,403 versus $4,305), consistent with prior years. Per capita spending rose $173 for men and $192 for women. However, per capita spending for men (4.2%) grew faster as compared with the rate for women (3.7%), which was also true in 2011.

In 2013, pre-Medicare adults had the highest expenditures per capita ($9,232) and the largest dollar increase per capita ($334; Table 1). They also had a growth rate higher than that in 2012: 3.7% versus 2.0% (Figure 2). Middle age adults experienced the second highest spending at $6,314 per capita and a $220 increase (3.6%) over 2012.

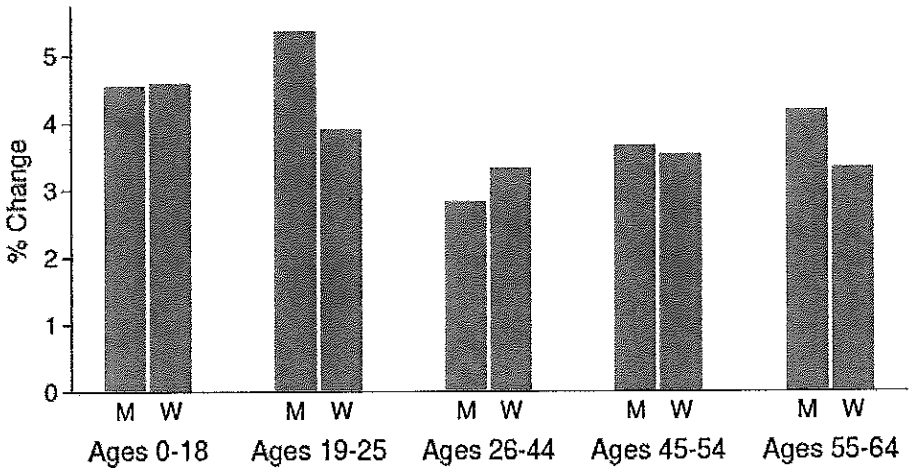
The increases in per capita spending for the youngest age groups (children and young adults) were $113 and $115, respectively. These age groups experienced the highest per capita spending growth rates (4.6% for children and 4.5% for young adults) but the lowest per capita spending levels. Per capita expenditure growth was the slowest for intermediate adults (3.2%); spending for this group rose $131 to $4,258.

Within each age group in 2013, spending growth rates also varied by gender (Figure 3). Spending for young adult men grew more quickly than spending for any other subpopulations, followed by spending for girls and boys. Conversely, spending for intermediate adult men grew the slowest of the age-gender groups studied, followed by intermediate adult women.

Between 2012 and 2013, per capita spending increased in every region (Table 1). However, during this time, spending growth slowed considerably in the South (from 4.6% to 3.6%), and sped up by more than a percentage point in the West (from 1.7% in 2012 to 3.0%).

For the third consecutive year, the Northeast had the highest regional per capita expenditures ($5,037) and the fastest spending growth (4.8%). The West continued to have the lowest regional per capita expenditures ($4,542) and the slowest expenditures growth (3.0%). Between 2012 and 2013, per capita spending in the South increased by $173 to $4,964. Per capita spending in the Midwest increased 4.2% to $4,871, a $196 increase.

Figure 3
Change in Expenditures Per Capita by Gender and Age Group: 2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Per capita expenditures rose slowest for brand prescriptions

Per capita spending in 2013 increased across all service categories. The distribution of per capita spending on these categories was similar to that of the previous two years (Table 1). Professional procedures continued to account for the largest share of spending, approximately 34% of the total. Acute inpatient admissions remained at 20% of expenditures, while outpatient services and prescriptions accounted for the remaining 28% and 17% of expenditures, respectively.

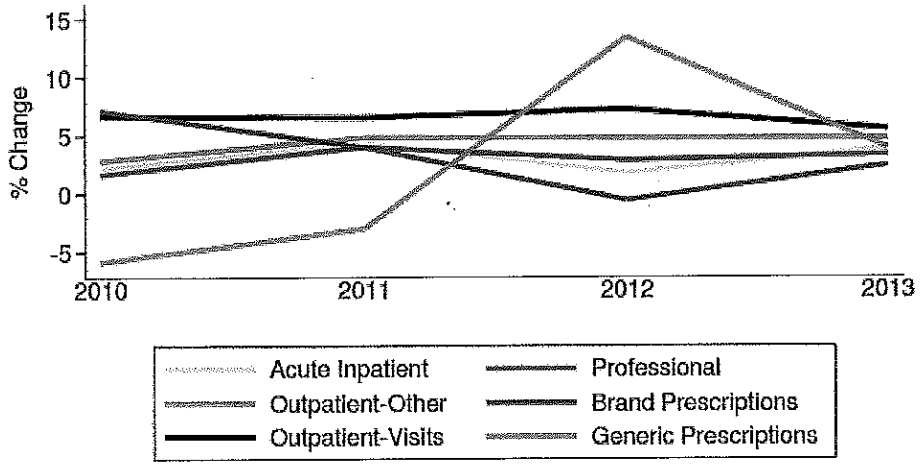
Between 2012 and 2013, spending on acute inpatient admissions grew from 1.7% to 3.9% (Table 1 and Figure 4). The spending increase in this category was $37 per capita, more than twice the $16 increase seen between 2011 and 2012.

Between 2012 and 2013, per capita spending on outpatient services slowed, including on both outpatient visits and outpatient-other services. In 2013, expenditures per capita for all outpatient services increased $68, 66% of which was on outpatient visits, with the rest on outpatient-other services.

Per capita expenditures on professional procedures increased $53 and grew more rapidly than in the previous year (3.3% versus 2.9%). Consistent with the previous two years, professional procedures also accounted for the most per capita dollars spent in 2013 ($1,651).

Per capita spending on prescriptions grew somewhat more slowly in 2013 as compared with 2012 (3.1% versus 3.8%), following substantially slower growth in 2011 (1.7%). In 2013, per capita spending on brand prescriptions grew $13 to $550, a 2.4% increase, following a 0.6% decrease in 2012. Brand prescriptions had the lowest growth rate in 2013 of any subservice category. Expenditures on generic prescriptions grew 3.9%, after spending declined in 2011 (-3.0%) and grew 13.4% in 2012. Per capita expenditures on generics ($287) were about half that of brand prescription expenditures ($550) in 2013.

Figure 4
Annual Percentage Changes in Expenditures Per Capita by Subservice Category: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Per capita spending generally higher for adult women than adult men

In 2013, per capita spending for every service category was higher for boys than for girls, with the largest spending differential for brand prescriptions (an $81 difference) and the smallest for outpatient-other services (a $2 difference; Appendix Tables A9a and A9b). However, girls had higher growth rates for most services. Only on acute inpatient admissions did spending for boys (7.1%) grow faster than spending for girls (4.6%). Despite faster spending growth for girls, the overall spending differential between boys and girls widened in 2013.

Across all service categories in 2013, per capita expenditures were notably higher for young adult and intermediate adult women than for men in the same age groups. Per capita spending on acute inpatient services for young adult women was $642 and $1,088 for intermediate adult women as compared to $390 for young adult men and $485 for intermediate adult men. These represented gender differences of $252 for young adults and $603 for intermediate adults.

Per capita spending on most service categories was higher for middle age adult women and pre-Medicare adult women than for men in those age groups. Spending for middle age adult and pre-Medicare men was higher on acute inpatient admissions than for women, and spending on admissions grew more rapidly for the men. The differences in spending between men and women were smaller for these age groups than for intermediate adults.

Summary

Between 2012 and 2013, growth in total ESI spending persisted at a rate similar to that of the two previous years, rising 3.9%. These expenditures rose across all regions, age groups, and genders. The Northeast continued to have the highest spending levels and growth, while the West continued to have the lowest spending levels and growth.

Among the different age groups in 2013, children experienced the fastest expenditure growth but the lowest per capita spending levels. Pre-Medicare adults had the highest per capita spending but, unlike spending in 2011 and 2012, the spending growth rate for this age group was not the lowest. Women's per capita spending remained higher than men's, but men's expenditures grew more quickly. Spending tended to increase with age, but the gender differentials in the older adult age groups were generally smaller than those in the younger age groups.

Consistent with findings in other HCCI reports, this report found that spending levels and growth rates varied across age and gender.[3] In 2013, spending for children was higher for boys than for girls, and was lower for men ages 19 to 54 than for women in those age groups. For the oldest age group, spending was similar for pre-Medicare and women.

HCCI AGE GROUPS

Children

Ages 0 through 18.

Young Adults

Ages 19 through 25.

Intermediate Adults

Ages 26 through 44.

Middle-Age Adults

Ages 45 through 54.

Pre-Medicare Adults

Ages 55 through 64.

Table 1: Annual Expenditures Per Capita (2011–2013)

	2011	2012	2013	Percent Change 2010 / 2011	Percent Change 2011 / 2012	Percent Change 2012 / 2013
Per Capita	$4,514	$4,681	$4,864	4.0%	3.7%	3.9%
Per Capita by Region						
Northeast	$4,601	$4,805	$5,037	4.5%	4.4%	4.8%
Midwest	$4,512	$4,675	$4,871	4.0%	3.6%	4.2%
South	$4,581	$4,791	$4,964	4.2%	4.6%	3.6%
West	$4,337	$4,409	$4,542	3.5%	1.7%	3.0%
Per Capita by Age						
18 and Younger	$2,356	$2,461	$2,574	7.9%	4.5%	4.6%
19-25	$2,427	$2,561	$2,676	7.9%	5.5%	4.5%
26-44	$3,945	$4,127	$4,258	3.4%	4.6%	3.2%
45-54	$5,867	$6,094	$6,314	3.6%	3.9%	3.6%
55-64	$8,727	$8,898	$9,232	3.1%	2.0%	3.7%
Per Capita by Gender						
Men	$3,997	$4,132	$4,305	4.6%	3.4%	4.2%
Women	$5,011	$5,211	$5,403	3.6%	4.0%	3.7%
Per Capita by Service Category						
Inpatient	$947	$962	$999	3.7%	1.6%	3.8%
Acute Inpatient	$933	$949	$986	4.3%	1.7%	3.9%
Outpatient	$1,230	$1,308	$1,376	5.9%	6.3%	5.2%
Visits	$750	$804	$849	6.5%	7.2%	5.5%
Other	$481	$504	$528	4.8%	4.8%	4.7%
Professional Procedures	$1,553	$1,598	$1,651	4.0%	2.9%	3.3%
Prescriptions	$783	$813	$838	1.7%	3.8%	3.1%
Brands	$540	$537	$550	4.0%	-0.6%	2.4%
Generics	$243	$276	$287	-3.0%	13.4%	3.9%

Source: HCCI, 2014.
Notes: Data represents the population of insureds 0-64 covered by ESI. Actuarial completion was performed on data from 2012 and 2013. All per capita dollars calculated from allowed amounts. All figures rounded. Skilled nursing facility (SNF), hospice, and ungroupable claims were excluded from analysis of acute inpatient trends due to the lack of claims in this population.

Drivers of Spending Growth

Health care cost growth is the result of changes in the number of services provided ("utilization") and the prices paid by insurers for those services. Because changes in price or utilization might reflect changes in how care is delivered, HCCI's analyses also consider a third factor – changes in service intensity – the complexity of services used to provide care. Intensity is used to adjust utilization metrics (see "Key definitions") or to adjust prices paid to a base price that all patients would pay for a given service ("intensity-adjusted price"). HCCI uses intensity-adjusted prices to determine whether prices changed owing to differences in service intensity (the resources used to treat patients) or to changes in other factors.

In the following sections of the report, HCCI analyzes how the different components of spending affected health care trends for each of the subservice categories. For 2013, HCCI found that prices grew for all medical subservice categories, while utilization declined for these categories, except for a small increase in use of professional services (0.8%; Table 2). While the spending growth rate for 2013 (3.9%) was very similar to the growth rate in 2012 (3.7%), the components of the 2013 trend – specifically, use of medical services – differed from those in 2012.

Table 2: Decomposition of Spending Changes (2013)

	2013 Expenditures Per Capita	Components of 2013 Expenditures Trend		Components of 2013 Price Trend	
		Utilization	Prices Paid	Intensity	Unit Price
Inpatient	3.8%	-2.7%	6.7%	N/A	N/A
Acute Inpatient	3.9%	-2.3%	6.3%	1.7%	4.5%
Outpatient	5.2%	-0.5%	5.8%	0.2%	5.5%
Visits	5.5%	-0.8%	6.4%	-0.5%	6.9%
Other	4.7%	-0.5%	5.2%	1.8%	3.4%
Professional Procedures	3.3%	0.8%	2.5%	1.8%	0.7%
Prescriptions - Filled Days	3.1%	0.7%	2.3%	N/A	N/A
Brands	2.4%	-15.5%	21.2%	N/A	N/A
Generics	3.9%	4.5%	-0.5%	N/A	N/A

Source: HCCI, 2014.
Notes: Data represents the population of insureds 0-64 covered by ESI. Actuarial completion was performed on data from 2012 and 2013. All per capita dollars calculated from allowed amounts. All figures rounded. Skilled nursing facility (SNF), hospice, and ungroupable claims were excluded from analysis of acute inpatient trends due to the lack of claims in this population.

Acute Inpatient Services

Inpatient facility claims are submitted for facility charges associated with a hospital admission.[7] In this section, HCCI analyzed trends for acute inpatient admissions (labor and delivery, medical, mental health and substance use, newborns, and surgery). For information about the non-acute inpatient admissions (hospice and skilled nursing facility), see "Non-acute inpatient services".[8]

Acute inpatient spending grew faster in 2013

Between 2012 and 2013, spending on acute inpatient admissions increased 3.9% to $986 per capita (Table 1). This $37 per capita increase accounted for 20% of the ESI population's total spending increase. The increases in the spending level and growth rate for acute inpatient admissions were higher for 2013 as compared with 2011 and 2012.

Use continued to decline for most insureds

Consistent with previous years' trends, acute inpatient utilization declined in 2013, falling by 2.3% (Table 3 and Figure 5). This decrease in admissions is equivalent to fewer admissions per 1,000 insureds, which declined from 56 admissions per 1,000 in 2012 to 55 per 1,000 in 2013.

In 2013, acute admission rates declined for most age groups and for both genders (Appendix Tables A10a and A10b). The largest decline in admissions was for middle age and pre-Medicare women, whose use decreased by 4 admissions per 1,000 insured. However, girls experienced an increase of 1 admission per 1,000.

Prices jumped in 2013 due to rising intensity of care

In contrast to the falling utilization rate, the average price per acute inpatient admission rose for the third consecutive year, to $18,030 in 2013 (Table 3). This increase was $1,067 over 2012. Acute inpatient prices rose in 2013 at a rate (6.3%) faster than in 2011 (5.9%) or 2012 (5.5%). Rising prices offset the fall in utilization, which led to the faster spending growth in 2013 compared to the two prior years.

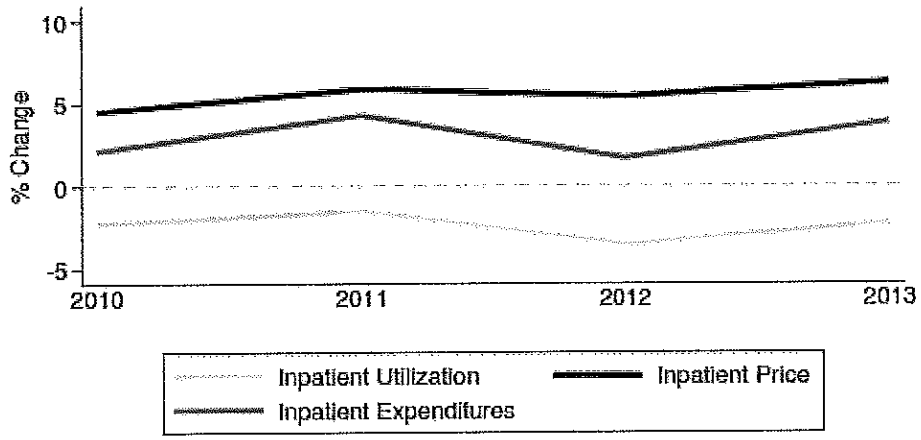
The faster growth in prices was driven in part by rising intensity of care. In 2013, the average intensity (see "Key definitions" and "Drivers of spending growth") rose 1.7%, suggesting that the resources used to treat patients in an acute inpatient setting increased. This followed two years of decreased resource use; in 2011, there was a 4.4% decrease in intensity, and that intensity level persisted through 2012. In 2013, the average intensity-adjusted price increased by $594 (4.5%) to $13,812.

Medical and surgical admissions declined; prices and intensity increased

In 2013, about 62% of acute inpatient admissions were for medical and surgery services (Appendix Table A5 and Figure 5). Since 2011, however, utilization of medical and surgical admissions decreased (Figure 6). Between 2011 and 2013, medical admissions dropped from 21 medical admissions per 1,000 insureds to 19 admissions per 1,000. Similarly during this period, surgery admissions dropped from 16 per 1,000 insureds to 15 per 1,000.

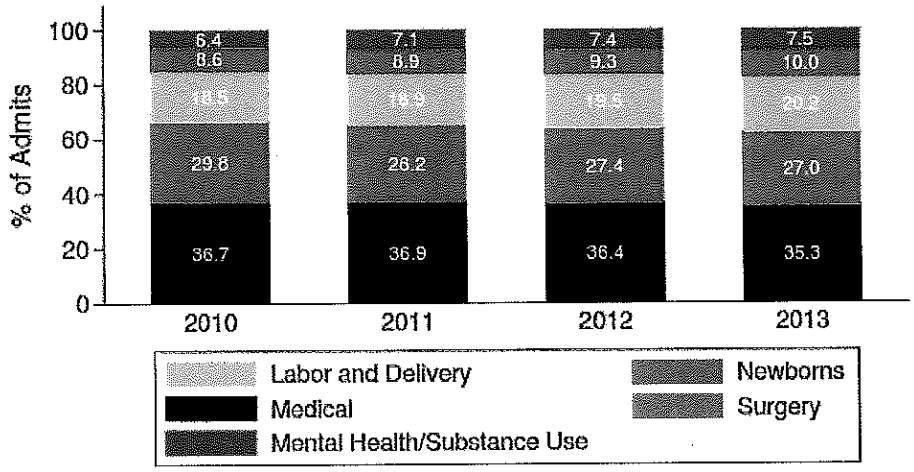
Although medical and surgery admissions decreased, the average prices for those services rose (Appendix Table A6). In 2013, the average price of an inpatient surgery admission rose 8.5% ($2,720) to $34,583. The average price

Figure 5
Annual Percentage Changes in Acute Inpatient Expenditures, Utilization per 1,000 Insureds, and Price: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than age 65 ESI population.
Data from 2012 and 2013 substantially completed.

Figure 6
Percentage of Admissions per 1,000 Insureds by Acute Inpatient Detailed Service Category: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

of a medical admission rose 7.4% ($1,059) to $15,413. The medical and surgical service categories also accounted for the largest increases in acute inpatient intensity, at 2.4% and 3.3%, respectively (Appendix Table A7). Thus, after accounting for service intensity, the average intensity-adjusted prices for medical and surgery admissions also rose (4.9% and 5.1%, respectively; Appendix Table A8).

Little change in labor, delivery, newborn, and behavioral health admission rates

For the third year in a row, admissions for labor and delivery (LD), newborns, and mental health and substance use (MHSU) remained constant (Appendix Table A5). Additionally, in 2013, average prices for LD and newborn admissions rose (4.6% and 4.0%, respectively) at rates much slower than those in the previous two years (Appendix Table A6). The average price for a MHSU admission rose very slightly (0.4%). Intensity of care remained constant for LD admissions since 2011 (Appendix Table A7), while intensity increased slightly for MHSU and newborn admissions, which contributed slightly to the increase in prices paid for those services.

Summary

In 2013, utilization of acute inpatient services declined (Table 3). This overall decrease was observed for most age-gender groups, whereas girls had an increase of 1 admission per 1,000 (Appendix Table A10a). While utilization declined, the average price per acute inpatient admission rose 6.3% (Table 3). Accompanying the rise in prices was a rise in the average intensity of resource use. As a result, in 2013, the fastest acute inpatient spending growth was observed during the study period.

Across the study period, trends for the detailed categories of admissions remained nearly the same for most types of admissions. Most of the decline in utilization and increase in prices in 2013 came from the most commonly used admissions: medical and surgery (Appendix Table A5). Prices and intensity for these services rose, driving the rise in prices and intensity for the overall acute inpatient service category (Appendix Tables A6 and A7).

NON-ACUTE INPATIENT SERVICES

Skilled nursing facility (SNF) and hospice inpatient admissions differ in scope from the acute inpatient detailed categories. Inpatient SNF care includes claims for skilled professional care such as skilled nursing and rehabilitation. Inpatient hospice claims are for palliative care to terminally ill individuals. Hospice services can also be provided within an individual's home, but those services are not included in the HCCI hospice inpatient category.

These two categories had consistently low per capita expenditures over time (Appendix Table A5). During the study period, per capita annual expenditures were $7 for SNF admissions and $2 for hospice admissions. One reason for these comparatively low spending levels was low utilization. SNF and hospice admissions accounted for very few admissions in the younger than 65 ESI population. Combined, these two categories accounted for 2 admissions per 1,000 insureds in each year studied (Appendix Table A6).

Table 3: Changes in Utilization, Prices, Intensity, and Intensity-Adjusted Prices by Service Category (2011–2013)

	2011	2012	2013	Percent Change 2010 / 2011	Percent Change 2011 / 2012	Percent Change 2012 / 2013
Utilization per 1,000 insureds by Service Category						
Inpatient	61	59	57	-1.7%	-3.5%	-2.7%
Acute Inpatient	58	56	55	-1.5%	-3.5%	-2.3%
Outpatient	2,936	2,948	2,933	1.0%	0.4%	-0.5%
Visits	324	328	325	1.6%	1.3%	-0.8%
Other	2,612	2,620	2,608	0.9%	0.3%	-0.5%
Professional Procedures	16,133	16,452	16,579	1.1%	2.0%	0.8%
Prescriptions - Filled Days	278,316	279,959	282,012	0.1%	0.6%	0.7%
Brands	69,484	55,028	46,497	-12.0%	-20.8%	-15.5%
Generics	208,802	224,883	235,017	4.9%	7.7%	4.5%
Average Price Paid per Service by Service Category						
Inpatient	$15,627	$16,452	$17,553	5.5%	5.3%	6.7%
Acute Inpatient	$16,086	$16,963	$18,030	5.9%	5.5%	6.3%
Outpatient	$419	$444	$469	4.8%	5.8%	5.8%
Visits	$2,315	$2,450	$2,607	4.8%	5.8%	6.4%
Other	$184	$192	$202	3.9%	4.4%	5.2%
Professional Procedures	$96	$97	$100	2.9%	0.9%	2.5%
Prescriptions - Filled Days	$3	$3	$3	1.6%	3.2%	2.3%
Brands	$8	$10	$12	18.2%	25.6%	21.2%
Generics	$1	$1	$1	-7.5%	5.3%	-0.5%
Average Intensity per Service by Service Category						
Acute Inpatient	1.28	1.28	1.31	-4.4%	-0.1%	1.7%
Outpatient	2.96	2.90	2.91	-1.2%	-1.9%	0.2%
Visits	16.79	16.07	16.00	-2.9%	-4.2%	-0.5%
Other	1.24	1.25	1.27	0.9%	0.6%	1.8%
Professional Procedures	1.91	1.89	1.93	0.1%	-0.9%	1.8%
Average Intensity-Adjusted Price per Service by Service Category						
Acute Inpatient	$12,528	$13,218	$13,812	10.8%	5.5%	4.5%
Outpatient	$142	$153	$161	6.1%	7.9%	5.5%
Visits	$138	$152	$163	8.0%	10.5%	6.9%
Other	$148	$154	$159	3.0%	3.8%	3.4%
Professional Procedures	$50	$51	$52	2.8%	1.8%	0.7%

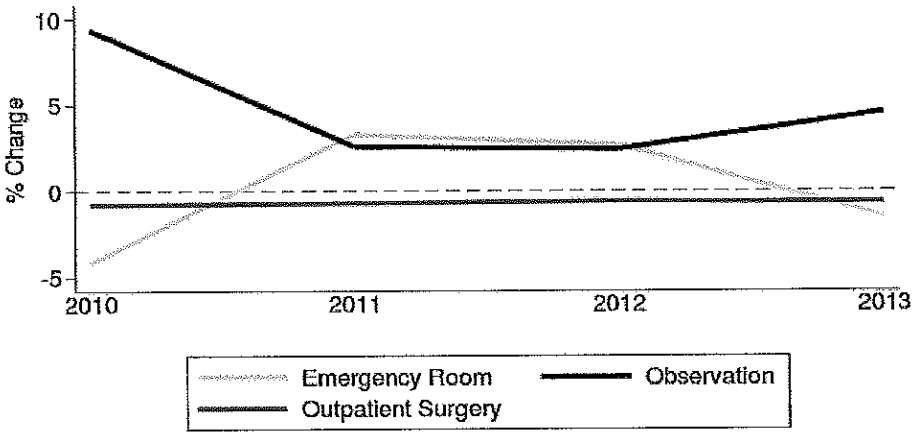
Source: HCCI, 2014.
Notes: Data represents the population of insureds 0-64 covered by ESI. Actuarial completion was performed on data from 2012 and 2013. All per capita dollars calculated from allowed amounts. All figures rounded. Skilled nursing facility (SNF), hospice, and ungroupable claims were excluded from analysis of acute inpatient trends due to the lack of claims in this population.

Outpatient Visits

Between 2012 and 2013, per capita spending on outpatient visits (emergency rooms, observation, and outpatient surgery) rose by $45 to $849, a 5.5% increase (Table 1). As in 2012, outpatient visits had the highest spending growth rate of any of the service categories. In 2013, per capita spending on outpatient visits accounted for 17.5% of total per capita spending, a small increase over 2012 and nearly 25% of the rise in per capita spending.

Between 2012 and 2013, per capita expenditures grew for the three detailed service categories (ER visits, observation, and outpatient surgery; Appendix Table A4). Per capita spending on observation visits rose at the fastest rate, 9.3%, compared with that of emergency room (ER) visits (5.9%) and surgical visits (5.0%). In contrast, observation visits remained a very small share of overall outpatient visit spending at 4.8% ($41 per capita), compared with the share of surgery visits at 61.9% ($526 per capita) and the share of ER visits at 33.1% ($281 per capita).

Figure 7
Annual Percentage Changes in Utilization per 1,000 Insureds by Outpatient Visit Detailed Service Category: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Outpatient prices continued to rise

The average price for an outpatient visit rose 6.4% between 2012 and 2013 (Table 3), from $2,450 to $2,607. The average price (unadjusted for intensity of care) for ER visits grew by 7.6% to $1,595 (Appendix Table A6); for outpatient surgery visits by 5.7% to $4,107; and for observation visits by 4.5% to $1,945.

Outpatient visits fell slightly in 2013

Between 2012 and 2013, the number of outpatient visits declined (-0.8%), falling from 328 visits per 1,000 insureds to 325 (Table 3). This was the first year in the study period in which the number of visits declined.

There were fewer ER and outpatient surgery visits in 2013. ER visits fell by 3 visits per 1,000 insureds (-1.6%) to 176, while outpatient surgeries fell by 1 visit to 128 per 1,000 insureds (-0.7%; Appendix Table A5 and Figure 7). In contrast, observation visits rose by 1 visit (4.6%) to 21 per 1,000 insureds.

Visits rose with age, but use differed by gender

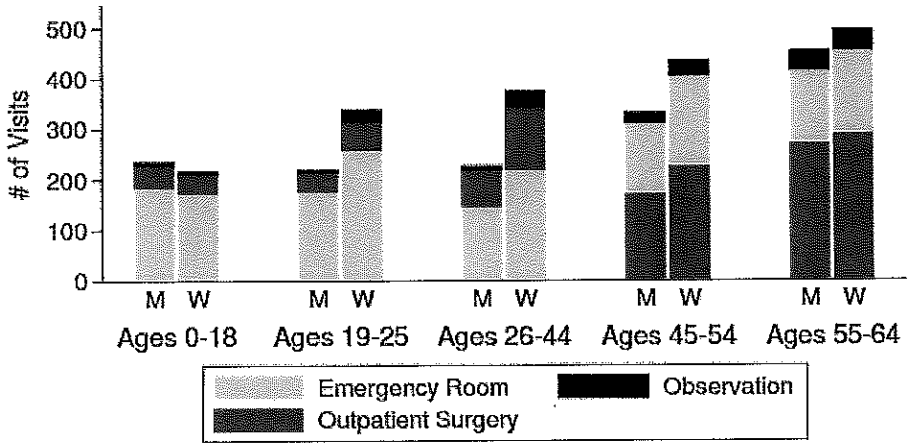
In 2013, the number of outpatient visits generally increased with age, but the number of services used differed by gender, as adult women had more visits than did men (Figure 8). Girls had the lowest use of outpatient visits (219 per 1,000), followed by young adult men (220 visits per 1,000; Appendix Table A10a). Use of outpatient visits was higher for pre-Medicare women (496 visits per 1,000) than for pre-Medicare men (454 visits per 1,000).

ER visits accounted for most of the outpatient visits among children, young adults, and intermediate adult men and women (Appendix Tables A16a-A18a). Men and women over age 44 had fewer ER visits relative to those of younger ages, while surgery visits dominated older adults' outpatient visit usage (Appendix Tables A19a and A20a).

Overall, use of observation services rose with age. Between 2012 and 2013, use increased for both men and women in the two oldest age groups. Use increased by 3 visits to 40 visits per 1,000 for pre-Medicare men and by 3 visits to 41 visits per 1,000 for pre-Medicare women. Use increased by 1 visit to 21 visits per 1,000 for middle age men and by 2 visits to 29 visits per 1,000 for middle age women. Use among the other groups remained constant at the levels observed in 2012.

Between 2012 and 2013, outpatient surgery use levels also increased with age, while declining slightly for the national ESI population (-0.7%; Appendix Table A5). The younger groups (younger than age 45) had the lowest rates of outpatient surgery use and larger reductions

Figure 8
Number of Visits per 1,000 Insureds by Outpatient Visit Detailed Service Category, Gender, and Age Group: 2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

in use. Outpatient surgery use increased for the pre-Medicare adults (3 visits per 1,000 pre-Medicare men and 1 visit per 1,000 pre-Medicare women) and was stable for middle age adult men.

Although spending on ER visits was similar across age groups, spending does not fully reflect utilization trends. In 2013, use of ER visits decreased with age, and the number of visits differed by gender. ER visits accounted for nearly 80% of the outpatient visits for children and young adults (Appendix Tables A16a and A17a) and for about 60% of the visits for intermediate adults ages (Appendix Table A18a). In contrast, ER visits accounted for about 40% of the visits for middle age adults (Appendix Table A19a) and for about 30% of visits for pre-Medicare adults (Appendix Table A20a). Young adult women had the highest number of ER visits (258 per 1,000 young adult women; Appendix Table A17a), while pre-Medicare adult men had the lowest number (143 per 1,000 men; Appendix Table A20a).

ER visits accounted for most of the outpatient visits among children, young adults, and intermediate adult men and women (Appendix Tables A16a-A18a). Men and women over age 44 had fewer ER visits relative to those of younger ages, while surgery visits dominated older adults' outpatient visit usage (Appendix Tables A19a and A20a).

Summary

Outpatient visits (ER, outpatient surgery, and observation visits) constituted the fastest growing category of medical spending for all three study years and totaled 17.5% of ESI per capita health care spending in 2013 (Table 1). At 6.4% growth in 2013, prices for these services rose faster than in 2011 or 2012 (Table 3). However, for the first time in the study period, in 2013 the number of visits per 1,000 fell. As in 2011 and 2012, relatively few outpatient visits were for observation stays in 2013 (Appendix Table A5). Among people younger than age 45, ER visits accounted for 60% of outpatient visits, whereas for those age 45 and older, outpatient surgeries made up the most of the outpatient visit use (Appendix Tables A16a-A20a).

Outpatient visits use varied by gender within age groups. Adult women, generally, used more outpatient services than adult men in the same age cohort. For observation and outpatient surgeries, spending reflected these differences in use by gender and age. However, per capita spending on adult ER visits was similar across adult age groups despite differences in utilization.

WHY IS ER SPENDING HIGH FOR OLDER ADULTS WHEN ITS USE BY THIS AGE GROUP IS RELATIVELY LOW?

In 2013, ER spending for the oldest adults was similar to that for the youngest adults – $326 per pre-Medicare woman as compared to $374 per young adult woman and it was $302 per pre-Medicare man and $246 per young adult man (Appendix Tables A12a and A15a). However, young adult women had 95 visits per 1,000 insureds more than pre-Medicare women; young adult men had 34 visits per 1,000 more than pre-Medicare men (Appendix Tables A18a and A20a).

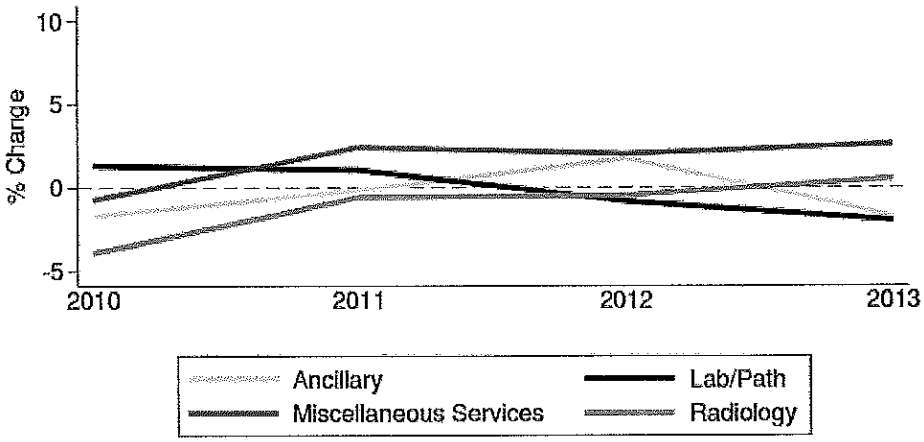
Health care spending rises and falls as prices and utilization rise and fall, which helps explain the levels of ER use. The average intensity-adjusted prices for ER visits for the oldest adults and young adults was similar ($263 per visits as compared to $269 per visit; data not shown), but the intensity of care was different. ER visit service intensity (resources used) for pre-Medicare adults was 47% higher than that for young adults. Because of the higher intensity, the average ER price paid for young adults was $628 lower than the average price paid for the oldest adults.

Outpatient Other Services

In 2013, per capita spending for outpatient-other services (ancillary, lab/path, radiology services, and miscellaneous outpatient services) accounted for 10.9% of total per capita ESI spending (Table 1). Between 2012 and 2013, per capita spending on outpatient-other services rose by $24 to $528. Spending for this service category grew 4.7% ($24), accounting for 13.1% of total per capita ESI spending growth.

Per capita spending grew in 2013 for all four outpatient-other detailed service categories (Appendix Table A4). Ancillary services spending per insured grew by 3.7% to $80, and lab/path services spending per insured rose by 2.3% to $72. Together, these two categories made up 28.8% of outpatient-other spending. Miscellaneous services (e.g., outpatient dialysis services, rehabilitation, and mental health and substance use services) made up 33.7% ($178 per capita) of outpatient-other spending per insured. The largest share of spending was on radiology services ($198 per capita). Although radiology made up 37.5% of per capita spending for outpatient-other services, spending on radiology services grew relatively slowly (2.7%).

Figure 9
Annual Percentage Changes in Utilization Per Capita by Outpatient Other Services Detailed Service Category: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Outpatient prices continued to rise

The average price across all outpatient-other services rose 5.2% (Table 3). Average prices grew most rapidly for ancillary services (5.5%) and miscellaneous services (5.9%; Appendix Table A6). Prices for radiology services also grew, by 2.2% to $501, while the average price for lab/path services grew by 4.4% to $62.

Outpatient-other services use fell

Between 2012 and 2013, outpatient-other service use fell by -0.5% from 2,620 services per 1,000 insureds to 2,608 services per 1,000 insureds (Table 3). The 2013 decline in outpatient-other services was due to declines in use of ancillary and lab/path services (Appendix Table A5). Ancillary service use fell by 1.7% (7 fewer services per 1,000 insureds), while lab/path use fell by 2.0% (23 fewer services per 1,000 insureds). However, lab/path services were still the most used of any of the outpatient-other services: 1,147 services per 1,000 insureds. At the same time, use of miscellaneous and radiology services increased 2.6% and 0.5%, respectively (Figure 9).

Outpatient-other spending rose with age

In 2013, per capita spending on outpatient-other services was highest for the

REGIONAL VARIATIONS IN OUTPATIENT-OTHER SPENDING

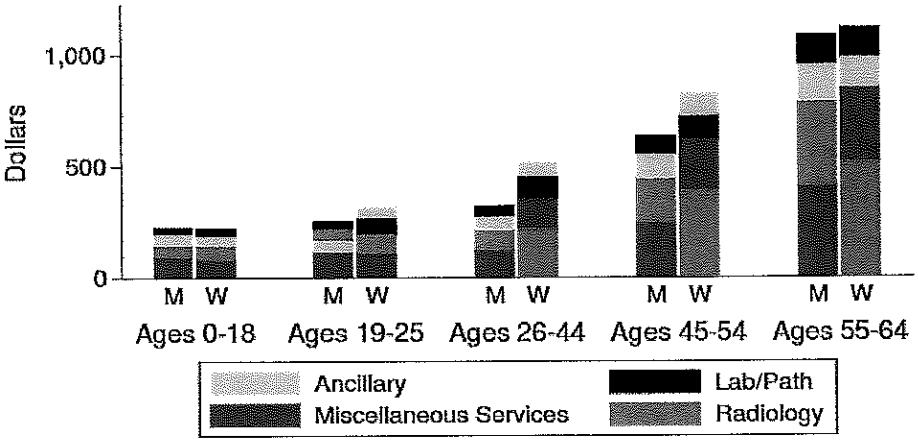
Regionally, over the three-year study period, outpatient-other spending in the West grew the slowest (an average 3.4% per year) and fastest in the Northeast (an average 5.4% per year; Appendix Table A1). The 2013 outpatient-other per capita spending was lowest in the West ($431 per person) and highest in the Midwest ($622 per person).

Changes in spending levels for the West were also low in comparison to the other regions. Between 2011 and 2013, per capita spending on outpatient-other services rose by $59 in the Midwest and the Northeast and by $42 in the South, but rose by $28 in the West.

pre-Medicare group and lowest for children (Appendix Table A2 and Figure 10). Spending growth for young adult men, however, rose the most quickly – by 15.9% –to $255 per young adult man (Appendix Tables A9a and A9b). Spending grew the slowest for intermediate adult women – at 2.8% – to $516 per intermediate adult woman.

For the three oldest age groups (intermediate adults, middle age adults, and pre-Medicare adults), women had the highest per capita spending on radiology services, whereas men had the highest spending on miscellaneous services. Pre-Medicare women experienced the highest per capita spending for any age-gender group on radiology services ($517; Appendix Table A15a). Pre-Medicare men experienced the highest per capita spending on miscellaneous services ($411). For all children and young adults, the highest per capita spending was on miscellaneous services (Appendix Tables A11a and A12a).

Figure 10
Expenditures Per Capita by Outpatient Other Services Detailed Service Category, Gender, and Age Group: 2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Summary

In 2013, outpatient-other services accounted for about 11% of total per capita ESI spending (Table 1). Spending on this category grew 4.7% over spending in 2012. Prices also increased; however, for the first time in the three-year study period, the number of services used per 1,000 decreased (Table 3).

In 2013, lab/path services were the most commonly used outpatient-other services (Appendix Table A5) and were used most by adult women (Appendix Tables A17a-A20a). Radiology services, which had the lowest levels of utilization per 1,000 insureds, were also used most frequently by adult women and at rates much higher than those of adult men. The gender differences in outpatient-other service use drove spending for women on this category to $115 per insured greater than spending for men (Appendix Table A3).

ADULT WOMEN THROUGH AGE 54 HAD RATES OF SERVICE USE HIGHER THAN THOSE OF MEN

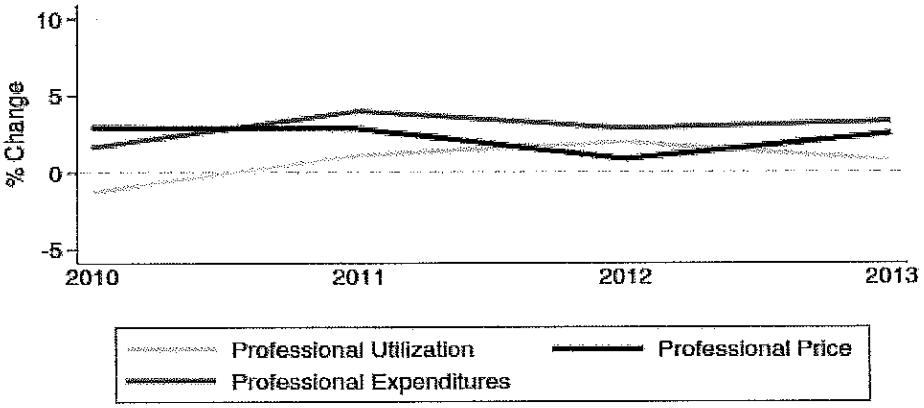
Compared to adult men, adult women through age 54 had higher rates of utilization for most outpatient-other detailed categories.

In 2013, these differences are observable in use of lab/path and radiology services. For young adult women, the use of lab/path services was nearly three times higher than men's use in the same age group (1,020 per 1,000 women versus 346 per 1,000 men; Appendix Table A17a). Similarly, for radiology services, young adult women's use was two times higher than young adult men's use (156 per 1,000 women versus 74 per 1,000 men). These differences in use by gender continued in the older age groups. Intermediate adult women used 2.4 times more lab/path services and nearly 4 times more radiology services than did men in the same age group (Appendix Table A18a). Middle age adult women used 1.3 times more lab/path services and nearly 4 times more radiology services than did men in the same age group (Appendix Table A19a). Women's higher use of radiology services continued, even as they neared Medicare-eligibility, with pre-Medicare women using more than 2.5 times more radiology services than did men in that age group (Appendix Table A20a). However, pre-Medicare women and men used nearly identical rates of lab/path services (2,213 per 1,000 men and 2,235 per 1,000 women).

This study did not investigate which types of lab/path or radiology services drove these patterns or whether the specific services in question were gender-specific.

Professional Procedures

Figure 11
Annual Percentage Changes in Professional Procedure Expenditures, Utilization per 1,000 Insureds, and Price: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than age 65 ESI population.
Data from 2012 and 2013 actuarially completed.

In 2013, per capita spending on professional procedures was $1,651 (Table 1 and Figure 11). Spending increased slightly – by $53 per capita – over 2012, which accounted for 29% of the total ESI spending increase. Professional services grew at the lowest rate (3.3%) of any of the medical service categories

Unlike in 2012, rising prices in 2013 contributed more than did utilization to increased spending on professional services (Table 2). Prices for professional services grew by 2.5% (Table 3). This price growth equaled a $3 increase in the average price per service, which rose to $100. At the same time, use of professional services increased slightly by 127 services (0.8%), to 16,579 services per 1,000 insureds.

Spending on professional services rose 5.1% in Northeast

In 2013, professional services spending rose in all four regions but grew most rapidly in the Northeast, up 5.1% to $1,855 per insured (Appendix Table A1). Spending was about $169 per capita more than the next highest spending region (the South) and grew 1.9 percentage points faster than the next-fastest region (the Midwest). In 2012, the South had the fastest-growing professional services spending (4.0%) and second highest spending per capita ($1,641); in 2013, the South saw spending rise by 2.7% to $1,686 per capita.

Spending for women on professional procedures was nearly $600 more than for men

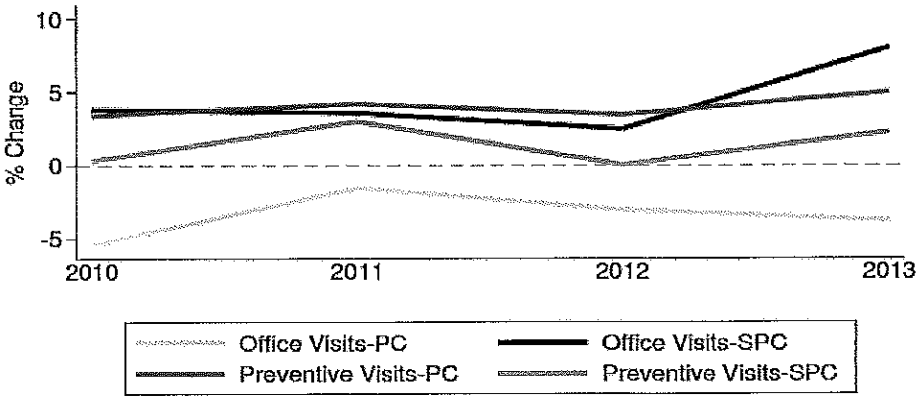
In 2013, both men's and women's spending on professional procedures grew by 3.3% (Appendix Table A3). However, spending for women reached $1,939 per capita, $586 more than per capita spending for men.

Professional services expenditures were highest among pre-Medicare adults, at $2,781 per capita, and lowest among young adults, at $931 per capita (Appendix Table A2). However, spending growth was fastest for young adults (4.2%), whereas it rose 3.4% for pre-Medicare adults.

Highest use of professional procedures by pre-Medicare women

In all age groups, women used more professional services as compared with men (Appendix Table A10a). This gender differential was minimal for children, with 301 per 1,000 more services for girls than for boys. Among young adults and intermediate adults, use by

Figure 12
Annual Percentage Changes in Utilization per 1,000 Insureds by Professional Procedure Primary Care and Specialist Visit Detailed Service Category: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

women was nearly twice the use by men. Use was highest among the pre-Medicare adults, but the gender difference in use in that age group was the smallest of the adult age groups. Pre-Medicare men's utilization was 23,025 services per 1,000, compared to 28,177 services for pre-Medicare women.

Office visits to specialists increased by 8.0%

In 2013, specialist office visits rose 8.0% (an increase of 111 visits per 1,000 insureds) to 1,493 services per 1,000 insureds (Appendix Table A5 and Figure 12); spending on these visits rose by 10.6% to $150 per capita (Appendix Table A4). Conversely, office visits to a primary care provider (PCP) fell by 3.8% to 1,472 per 1,000 insured. This was the first year in which the number of specialists' office visits per 1,000 insureds was higher than the number of PCP office visits. Many factors influence trends in physician visits, including billing practices and patterns, physician supply, and population health.

Of the non-visit detailed categories within the professional procedures category, utilization of three service types declined between 2102 and 2013 (Appendix Table A5): miscellaneous services (-0.3% - the most used professional service); radiology (-1.2%); and surgery (-0.1%). In contrast, use increased for other services, including preventive visits to PCPs (5.0%) and lab/path services (1.9%).

In 2013, lab/path services were the second-most commonly used professional services (4,719 per 1,000 insured). As with office visits, the use of lab/path services varied by age and gender. Among children, per 1,000, boys used fewer lab/path services than did girls (1,524 and 1,996 services, respectively; Appendix Table A16a). Young adult women utilized substantially more lab/path services (5,044 per 1,000) than men did (1,982 per 1,000) in that age group (Appendix Table A17a), and more than children of both genders. The pattern of substantially higher lab/path services use by women within an age group persisted for all of the adult age groups (Appendix Tables A18a-A20a)

Summary

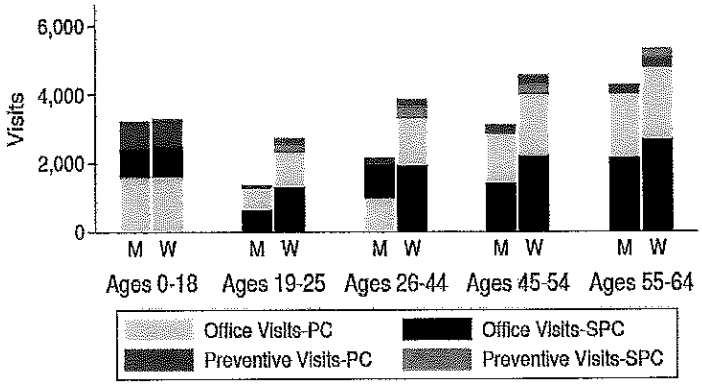
As in prior years, in 2013, the ESI population spent more on professional services per capita than on other medical services (Table 1). Professional procedure spending growth (3.3%) was similar to the growth in 2012 (2.9%), but utilization growth (0.8%) was slower than in 2012 (2.0%; Table 3).

Analysis of professional services trends found distinct utilization differences between women and men. Utilization of lab/path services continued to rise and, within each age group, women used more of these services than did men. Additionally, specialist office visit use increased in 2013, surpassing the use of PCP office visits for the first time in the study period.

VARIATION IN SPECIALIST OFFICE VISITS

From 2012 to 2013, specialist office visits rose by 111 visits per 1,000 insureds, while PCP visits declined by 58 visits per 1,000 insureds (Appendix Table A5). On net, over the study period, the total number of office visits per 1,000 insureds grew by 1.3%, but this overall rate obscures important utilization trends for these services. For example, in 2013, children's office visits to PCPs were more common than were specialist visits (Appendix Table A16a), whereas for adults, specialist office visits were generally more common than PCP visits (Appendix Tables A17a-A20a and Figure 13).

Figure 13
Number of Visits per 1,000 Insureds to Primary Care (PC) Providers and Specialists (SPC) by Gender and Age Group: 2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

PCP office visits are among the most common services used by children, with use rates in 2013 of about 1,600 visits per 1,000 girls or boys – nearly twice as many as specialist visits (Appendix Table A16a). In contrast, for adult women, specialist visits outnumbered PCP office visits. Of all of the adult groups, only intermediate adult men used PCP visits more often than specialist visits (Appendix Table A18a). Use of specialist office visits increased for all age-gender groups more than in previous years in the study period. This report did not examine what factors may have influenced the increase in specialist office visits. Physician billing and coding practices, insurance benefit structures, and patient preferences, among other factors, may have influenced the trends observed in utilization rates.

Brand Prescriptions

In 2013, spending on brand prescriptions rose 2.4% to $550 per capita (Table 1), and made up 11.3% of total per capita ESI spending ($4,864). In 2011 and 2012, spending on brand prescriptions rose 4.0% to $540 per capita and then declined slightly (-0.6%) to $537. Between 2012 and 2013, spending increased by $13 per capita and made up 7.1% of the total spending growth for the national ESI population.

Between 2012 and 2013, the number of filled days of brand prescriptions per 1,000 insureds declined 15.5%, or 8,531 filled days per 1,000 insureds to 46,497 (Table 3). Brand filled days made up only a small percentage (16.5%) of total filled days of prescriptions (282,012 filled days per 1,000 insureds). At the same time, the average price per filled day of brand prescriptions increased 21.2%, to $12.

Spending on hormones continued to rise

HCCI classified brand prescriptions into nine HCCI detailed categories that were further subdivided into subclasses using the *American Hospital Formulary System* (AHFS) classifications. Of the nine detailed brand categories, the four with the highest number of filled days in 2013 are the focus of this section (excluding the "other therapeutic classes" detailed category, which is composed of multiple therapeutic drug types). These four were cardiovascular drugs, hormones and synthetic substitutes ("hormones"), central nervous system (CNS) agents, and gastrointestinal drugs (Appendix Table A5).

In 2013, spending on cardiovascular drugs, hormones, CNS agents, and gastrointestinal drugs made up 50.9% ($280 per capita) of brand prescription spending (Appendix Table A4). Of these four categories, per capita spending was highest for hormones ($100 per insured) and increased by 10.0% (Figure 14). Per capita spending on gastrointestinal brand prescriptions was the lowest ($33 per capita) and rose 7.9%. Conversely, between 2012 and 2013, per capita spending on CNS agents and cardiovascular drugs declined (-2.0% and -10.5%, respectively). Insureds spent $89 per capita on CNS agents and $58 per capita on cardiovascular drugs.

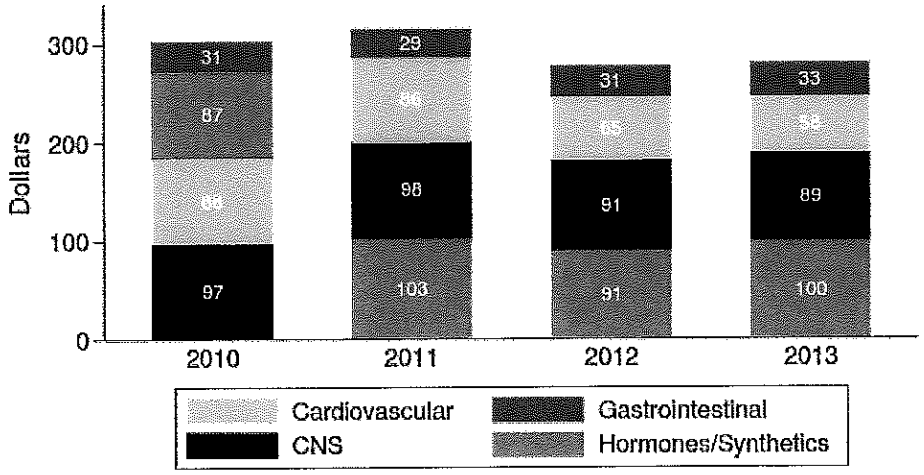
For the first time, HCCI examined subclasses of prescriptions within the detailed categories. Table 4 displays the four subclasses of brand prescriptions with the highest per capita spending for the ESI population in 2013. Of these classes, only insulins is contained in one of the top four detailed categories (hormones). In 2013, spending on the four subclasses made up 28.0% of ESI spending on brand prescriptions.

Use of cardiovascular brand drugs declined 21.2% in 2013

In 2013, the top four brand detailed categories constituted 73.2% of the total filled days per 1,000 insureds of brand prescriptions (Appendix Table A5). However, use of these categories declined. The most filled days was for hormones (11,426 filled days per 1,000 insureds), which declined 6.6%. The largest decline in the number of filled days was for cardiovascular drugs, at 21.2% to 10,763 filled days per 1,000 insureds. Use of CNS agents declined 13.4% to 8,732 filled days per 1,000 insureds. Use of gastrointestinal drugs declined 4.9% to 3,124 filled days.

Table 5 displays the four subclasses of brand prescriptions with the highest number of filled days per 1,000 insureds for the ESI population in 2013.

Figure 14
Expenditures Per Capita by Top 4 by Use Brand Prescription Detailed Service Categories: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Of these subclasses, only corticosteroids is not in one of the top four detailed categories; two of the classes are in the cardiovascular category. Only insulins showed both high per capita spending and high use. Together, the top four used subclasses accounted for 25.4% of total brand filled days by the ESI population.

Brand prescription use varied with age and gender

Generally, prescription use levels rose with age, and use was higher for women. In 2013, however, for the top four brand categories, women's use was only higher than men's use among young adults (a 15,734 filled day difference; Appendix Table A17a) and intermediate adults (an 8,934 filled day difference; Appendix Table A18a and Figure 15).

Among the top four brand categories, the difference in filled days between men and women for young adults and intermediate adults was due largely to women's use of hormones. Young adults' use of the top four categories was 23,535 filled days per 1,000 young adult women compared to 7,801 filled days per 1,000 young adult men (Appendix Table A17a). Intermediate adults' use of the top four categories was 26,427 filled days per 1,000 women and 17,493 filled days per 1,000 men (Appendix Table A18a).

Among children, use of the top four brand categories amounted to 10,442 filled days per 1,000 boys and 7,312 per 1,000 girls (Appendix Table A16a). Nearly 82% of those filled days for boys were CNS agents (8,498 days per 1,000 boys); 12.0% were hormones (1,249 days per 1,000 boys). In contrast, 51.4% of filled days for girls were CNS agents (3,761 days per 1,000 girls), while 40.7% were hormones (2,978 days per 1,000 girls).

In 2013, both middle age adult men and pre-Medicare men used more filled days than did women in the same age groups. Middle age adult men used 50,142 filled days per 1,000 men as compared to 49,437 filled days per 1,000 middle age adult women (Appendix Table A19a). Pre-Medicare men used 89,359 filled days per 1,000 men whereas women in that age group used 88,099 days per 1,000 women (Appendix Table A20a). For men in these two age groups, the most highly used category was cardiovascular drugs (24,856 days per 1,000 middle age adult men and 48,624 days per 1,000 pre-Medicare adult men). For women in these age groups, the highest use was of hormones (17,077 filled days per middle age adult women and 31,262 filled days per pre-Medicare adult women).

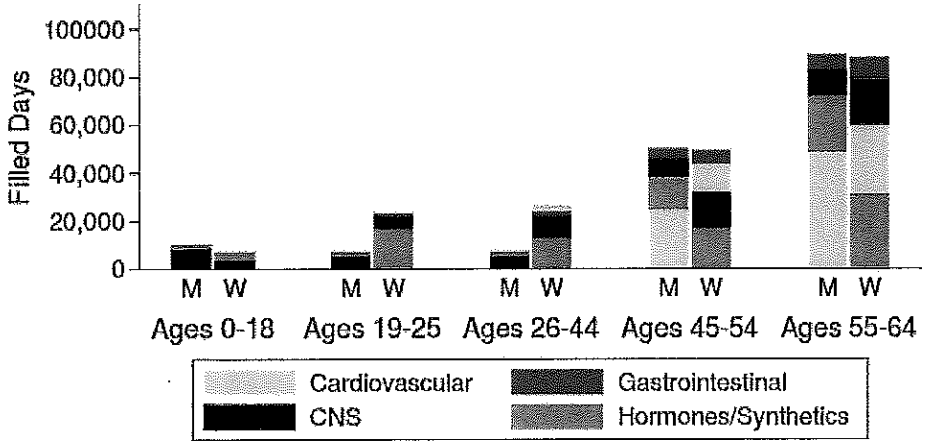
Summary

In 2013, spending on brand prescriptions rose 2.4% to $550 per capita (Table 1), and the average price paid per brand prescription day rose 21.2% (Table 3). Use of brand prescriptions declined for the third consecutive year, down 15.5% to 46,497 filled days per 1,000 insureds.

About 72% of spending on brand prescriptions was accounted for by 4 categories of brand prescriptions (cardiovascular drugs, hormones, CNS agents, and gastrointestinal drugs) and three subclasses (antirheumatic agents, biologics, and antiretrovirals). Similarly, 79% of filled days of brand prescriptions were for the same four categories and the corticosteroids subclass.

Overall, the highest use of brand prescriptions by the ESI population was for hormones; however, this was due mainly to use of this category by young adult and intermediate adult women. The second-most highly used category was cardiovascular drugs, largely owing to use by adult men older than age 25.

Figure 15
Filled Days per 1,000 Insureds by Top 4 by Use Brand Prescription Detailed Service Categories, Gender, and Age Group: 2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Table 4: Top 4 Highest Spending Per Capita Brand Prescription Subclasses: 2013 ESI

Subclass Name (Number)	HCCI Detailed Category	Common Use	Expenditures Per Capita	Filled Days per 1,000 Insureds
Disease-Modifying Antirheumatic Agents (92:36.00)	Other Therapeutic Classes	Various types of arthritis, such as rheumatoid arthritis and psoriatic arthritis	$49.31	543
Biologic Response Modifiers (92:20.00)	Other Therapeutic Classes	Autoimmune conditions, such as multiple sclerosis, rheumatoid arthritis, Crohn's disease	$39.23	250
Insulins (68:20.08)	Hormones and Synthetic Substitutes	Manage blood sugar levels, type 1 and type 2 diabetes	$35.48	3,136
Antiretrovirals (08:18.08)	Anti-Infective Agents	Prescribed for HIV infections and prevention of HIV infection after virus exposure	$29.87	752

Source: HCCI, 2014.

Table 5: Top 4 Brand Prescription Subclasses Used per 1,000 Insureds: 2013 ESI Population

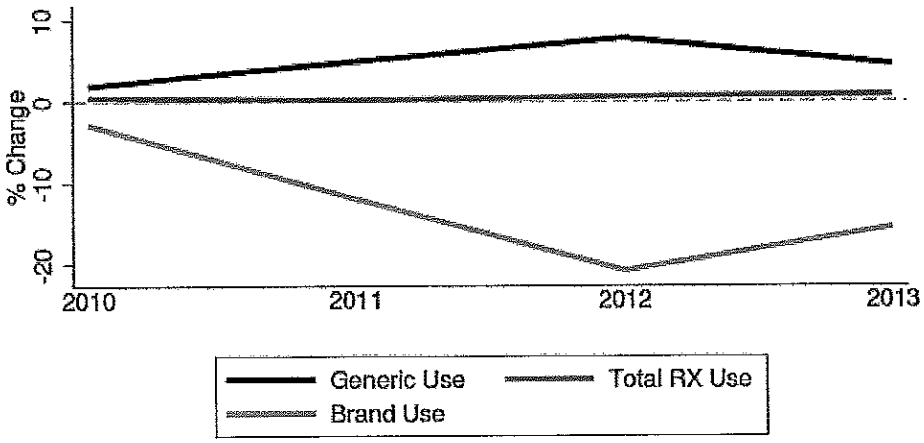
Subclass Name (Number)	HCCI Detailed Category	Common Use	Filled Days per 1,000 Insureds	Expenditures Per Capita
HMG-CoA Reductase Inhibitors (24:06.08)	Cardiovascular Drugs	Management of high cholesterol	3,226	$17.31
Insulins (68:20.08)	Hormones and Synthetic Substitutes	Manage blood sugar levels, type 1 and type 2 diabetes	3,136	$35.48
Corticosteroids (48:10.08)	Respiratory Agents	Reduce inflammation related to respiratory conditions, such as asthma and chronic obstructive pulmonary disorder	2,821	$20.89
Contraceptives (68:12.00)	Hormones and Synthetic Substitutes	Commonly known as "birth control", includes oral, intravaginal, and transdermal forms	2,620	$8.50

Source: HCCI, 2014.

TOTAL PRESCRIPTION FILLED DAY USE IN 2013

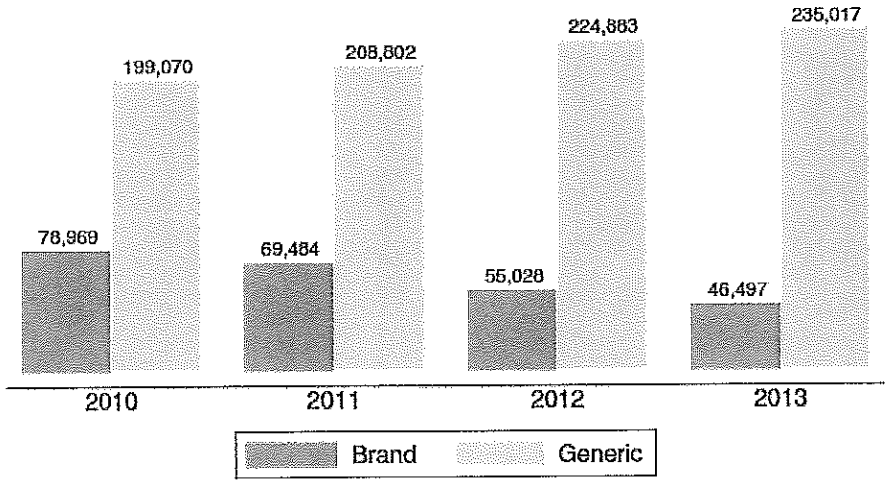
In 2013, use of filled days of prescriptions by the ESI population increased 0.7%, equaling 2,053 more filled days per 1,000 insureds (Figure 16). Use of generic prescription filled days increased 4.5%, equaling 10,134 filled days per 1,000 insureds (Figure 17). Offsetting this increase in generic prescription use was a 15.5% decline in the use of brand prescription filled days. Changes in use of prescriptions between 2012 and 2013 varied by age group and gender (Appendix Table A10b). Use of prescriptions declined for children and for pre-Medicare adults, with the largest decline in filled days use per 1,000 insureds for pre-Medicare adult women (17,059 filled days). The other three age groups – young adults, intermediate adults, and middle age adults – increased their use of prescriptions. The largest increase was for young adult women (6,342 filled days), followed by middle age adult women (3,576 filled days).

Figure 16
Annual Percentage Changes in Brand, Generic, and Total Prescription Filled Days Use per 1,000 Insureds: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Figure 17
Annual Filled Days Use of Generic and Brand Prescriptions per 1,000 Insureds: 2010-2013



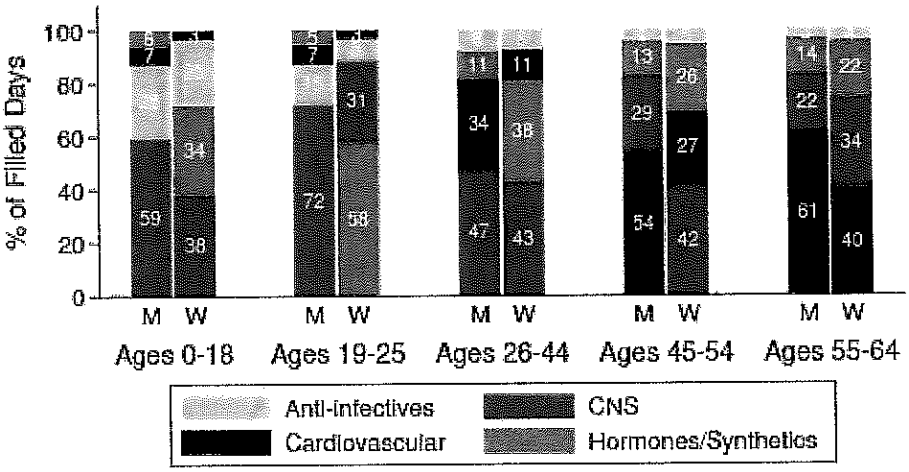
Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Generic Prescriptions

In 2013, national ESI spending on generic prescriptions constituted 5.9% of total per capita ESI spending and 34.2% of total prescription spending (Table 1). Between 2012 and 2013, per capita spending on generic prescriptions grew 3.9%, from $276 to $287, an $11 increase that accounted for 6.0% of the total increase in spending for the national ESI population.

In 2013, about 83% of prescription filled days were for generics (Table 3), up from 75% of filled days in 2011. Over the study period, the number of filled days of generic prescriptions per 1,000 insureds rose in each year, with the largest increase (7.7%) occurring in 2012. In 2013, use of generic prescriptions rose 4.5% to 235,017 filled days per 1,000 insureds. Additionally, the average price per filled day of generic prescriptions rose in 2012 (5.3%) but declined slightly in 2013 (-0.5%). In both years, the average price per day was less than $1.50.

Figure 19
Share of Filled Days by Top 4 by Use Generic Prescription Detailed Service Categories, Gender, and Age Group: 2013

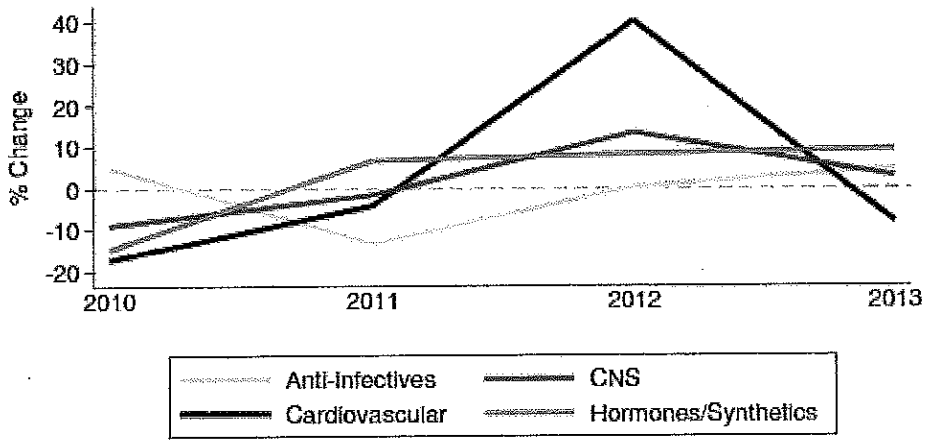


Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

CNS agents accounted for 31% of generic prescription spending in 2013

HCCI classified generic prescriptions into nine detailed prescription categories, and subdivided them into subclasses to better understand the drivers of generic prescription trends. Analysis of generics focused on those four detailed categories having the highest number of filled days per 1,000 insureds in 2013 (excluding the "other therapeutic classes" detailed category). Three of the top four generic prescription categories – cardiovascular drugs, hormones, and CNS agents – were also among the highest used categories of brand prescriptions. The fourth high-use generic category was anti-infective agents (Appendix Table A5).

Figure 18
Annual Percentage Changes in Expenditures Per Capita by Top 4 by Use Generic Prescription Detailed Service Categories: 2010-2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

Spending on the top four categories made up 66.9% of the total per capita spending on generic prescriptions (Appendix Table A4). In 2012 and 2013, spending per capita for three of the top four generic detailed categories increased (Figure 18). The highest per capita spending in 2013 was on CNS agents; spending increased 2.8% to $90 per capita, which accounted for

31.4% of spending on generics. Spending on hormones (9.3%) and anti-infective agents (4.6%) also rose, to $36 and $26 per capita, respectively. Cardiovascular drug spending dropped 8.2% to $40 per capita.

Table 6 displays the four subclasses with the highest per capita spending for the ESI population in 2013. All four subclasses are in the CNS agents category.

The highest per capita spending in 2013 was on antidepressants ($18.48), which also had the highest use of any subclass – 24,223 filled days per 1,000 insureds. This accounted for 10.3% of all generic prescription filled days. The other three subclasses (amphetamines, opiate agonists, and anticonvulsants) had similar per capita spending, between $12 and $13, and lower rates of use as compared to antidepressants.

Generic hormone use rose 5% in 2013

In 2013, the top four detailed categories of generic prescriptions (CNS agents, hormones, cardiovascular drugs, and anti-infectives) made up 75.3% of filled days (Appendix Table A5). Filled days of three of these categories increased, while use of anti-infective agents declined 1.8%, to 11,096 filled days per 1,000 insureds.

ANTIDEPRESSANT USE BY THE ESI POPULATION (2009-2013)

In each of the previous five years (2009-2013), generic antidepressants were the subclass of generic prescriptions most used by the national ESI population. In 2009, generic antidepressant use was 18.1 filled days per person; by 2013, this had increased to 24.2 filled days per person (Table 7). Use of generic prescriptions increased every year during this period, with the largest increase occurring in 2012. During that same period, use of brand antidepressants decreased in every year, with the largest decrease seen in 2012. In 2009, there were 6.4 filled days of brand antidepressants per person; use of declined to 2.3 filled days by 2013. Overall, every year between 2009 and 2013, there was a net increase in the use of antidepressants (combined brand and generic) by the ESI population. In 2009, there were 24.5 filled days per person of antidepressants and 26.6 filled days in 2013. Over that period, antidepressants also made up an increasing share of all prescriptions. In 2009, filled days of antidepressants made up 8.8% of filled days of all prescriptions for the ESI population. By 2013, filled days of antidepressants were nearly 10% of all prescription filled days.

Table 6: Use of brand and generic antidepressants in filled days per 1,000 insureds for the national ESI population: 2009—2013

Antidepressants (28:16.04)	2009	2010	2011	2012	2013
Brand					
Filled Days per 1,000	6,439	6,035	4,918	2,985	2,345
Percent Change in Use	*	-6.3%	-18.5%	-39.3%	-21.4%
Generic					
Filled Days per 1,000	18,058	18,801	20,522	23,138	24,223
Percent Change in Use	*	4.1%	9.2%	12.7%	4.7%
Combined					
Filled Days per 1,000	24,497	24,836	25,440	26,123	26,568
Percent Change in Use	*	1.4%	2.4%	2.7%	1.7%
Difference from Previous Year of Filled Days	*	339	604	683	445
All Prescriptions					
Filled Days per 1,000	276,821	278,065	278,316	279,959	282,012
Antidepressants Share of All Prescriptions	8.8%	8.9%	9.1%	9.3%	9.4%

Source: HCCI, 2014.

The generic category used most was CNS agents, use of which increased 3.5%, to 63,670 filled days per 1,000 insureds. Use of cardiovascular drugs increased 4.9%, to 61,668 filled days, the largest increase in the number of filled days between 2012 and 2013 (2,869 filled days).

Hormone use rose 5.0%, to 40,457 filled days per 1,000 insureds. The most commonly filled subclass was contraceptives, which made up 30.8% of filled days in the hormones category (12,469 filled days per 1,000 insureds; data not shown).

For most common classes of generics, women used more generic drugs than men of the same age

For each of the top four detailed categories of generic prescriptions in 2013, women's filled days were higher than men's for each age group. The difference in use between genders was largest for young adults (97,205 filled days; Appendix Table A17a) and intermediate adults (93,622 filled days; Appendix Table A18a), due mainly to the number of filled days of hormone use among women in those age groups (78,194 filled days per 1,000 young adult women and 70,786 filled days per 1,000 intermediate adult women; Figure 19). The smallest gender difference in generic prescription use was seen between girls and boys – 5,784 more filled days for girls (Appendix Table A16a).

Summary

In 2013, spending on generic prescriptions increased, constituting slightly more than a third of total spending on prescriptions. The relatively low per capita spending on generic prescriptions, however, as compared to brand prescriptions, masks the higher use rates of generics.

Generic prescription use by the ESI population rose every year between 2011 and 2013. At the same time, the average price paid per generic filled day remained below $1.50. CNS agents had the highest per capita spending of the top four categories and included antidepressants, the subclass with the highest per capita spending and highest use.

Table 7: Top 4 Highest Spending Per Capita Generic Prescription Subclasses for ESI Population: 2013

Subclass Name (Number)	HCCI Detailed Category	Common Use	Expenditures Per Capita	Filled Days Per 1,000 Insureds
Antidepressants (28:16.04)	CNS Agents	Management of various conditions including depression, anxiety disorders, obsessive compulsive disorder	$18.48	24,223
Amphetamines (28:20.04)	CNS Agents	Primarily used for narcolepsy and ADHD	$12.96	2,939
Opiate Agonists (28:08.08)	CNS Agents	Pain killers	$12.68	7,227
Anticonvulsants, Miscellaneous (28:12.92)	CNS Agents	Treatment of seizure disorders	$12.07	6,104

Source: HCCI, 2014.

Special Supplement: 2013 Generic Prescription Use by Age and Gender

As part of the 2013 analysis of prescription use by the ESI population, HCCI analyzed filled days of generic prescriptions for men and women by age group. This analysis reflects a growing interest at HCCI in how different age-gender groups covered by ESI used prescriptions in 2013 and whether patterns emerged in prescription use as insureds aged. HCCI did not examine changes in use over time.

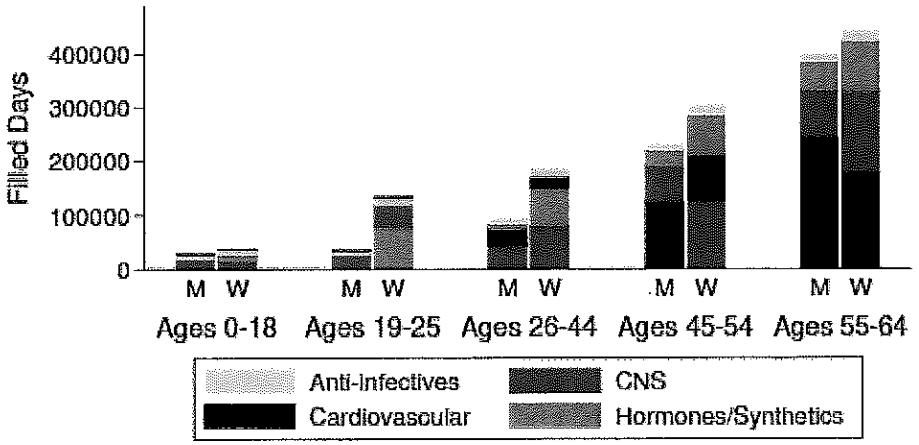
In this supplement, HCCI described for generic prescriptions the four detailed categories and four subclasses used most commonly for each age-gender group. All the statistics in this supplement have been converted from filled days per 1,000 insureds to filled days per person.

Only 13 subclasses made up the prescription classes most commonly used, representing 31% to 62% of generic prescription use by the different age-gender groups.

The 13 subclasses were contained within 5 of HCCI's 9 detailed categories of drugs:

- Anti-infective agents (penicillins);
- Cardiovascular drugs (angiotensin -converting enzyme inhibitors, dihydropyridines, HMG-CoA reductase inhibitors, β-adrenergic blocking agents);
- CNS agents (amphetamines, miscellaneous anticonvulsants, antidepressants, opiate agonists, and respiratory and CNS stimulants);
- Hormones (contraceptives and thyroid agents); and
- Respiratory agents (leukotriene modifiers).

Figure 20
Filled Days per 1,000 Insureds by Top 4 by Use Generic Prescription Detailed Service Categories, Gender, and Age Group: 2013



Source: HCCI, 2014.
Notes: All data weighted to reflect the national younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

CNS agents were the most common drug category used by children

For both boys and girls, the category of drugs used most was CNS agents (18.5 filled days per boy and 14.1 per girl; Appendix Table A16a and Figure 20). For boys, the second most-used category of drugs was anti-infective agents (8.7 filled days per boy). The second most-used category of drugs for girls was hormones (12.4 filled days per girl).

The first and third most used subclass of drugs for boys and second most used for girls were in the CNS agent category (Table 8). For boys, the subclass used most was respiratory and CNS stimulants (5.7 days per boy), which made up 30.8% of the CNS filled days for boys. Filled days of antidepressants constituted 24.3% of CNS use for boys (4.5 days per boy) and 39.7% for girls (5.6 days per girl).

For girls, the subclass used most was contraceptives (9.5 days per girl), which made up 76.6% of girls' hormone use. Penicillins were the third most-used subclass for girls (3.5 days per girl) and fourth most used for boys (3.5 days per boy); this subclass accounted for 38.5% and 40.2% of anti-infective agent use for girls and boys, respectively. Leukotriene modifiers were the second most-used subclass for boys (4.6 days per boy) and fourth most-used for girls (3.2 days per girl).

Young adult women used more prescriptions than young adult men

Young adult women had more filled days of the top four detailed categories

MOST COMMON ON-LABEL USES OF SELECTED AHFS SUBCLASSES[9,10]

Anti-infective agents

Penicillins are a group of antibiotics that treat a large range of bacterial infections, including pneumonia, strep throat, and staph infection.

Respiratory agents

Leukotriene modifiers are a type of respiratory agent taken to control the symptoms of mild-to-severe asthma.

Hormones and synthetic substitutes

Thyroid agents are used to treat both diminished and increased thyroid function.

Cardiovascular drugs

HMG-CoA reductase inhibitors, more commonly known as statins, are one of the primary ways to manage high cholesterol levels. In addition, they may be prescribed to prevent heart disease and heart attack in individuals who have multiple risk factors, such as smoking and age. In 2013, the American Heart Association and the American College of Cardiology revised the recommendations for statin therapy, which increased the importance of physicians considering risk factors (such as age, gender, race, smoking habits, etc.) rather than focusing on cholesterol levels. This revision in the recommendations increased the number of individuals said to benefit from statin therapy to about one-third of Americans.[11]

Angiotensin-converting enzyme inhibitors, more commonly known as ACE inhibitors, are used to treat high blood pressure, often in conjunction with other drugs. These drugs can also be used to treat congestive heart failure and general chest pain that is associated with restricted blood flow to the heart.

CNS agents

Antidepressants are used to treat many conditions, including depression, anxiety disorders, obsessive compulsive disorder, and many others.

Opiate agonists are mainly opiate pain killers, such as codeine and morphine, used to treat mild-to-severe pain.

Amphetamines are a type of stimulant primarily used to treat narcolepsy and attention deficit hyperactivity disorder (ADHD) in adults and children.

Anticonvulsants are primarily used to treat a broad range of seizure disorders; they can also treat agitation or episodes associated with mental health disorders such as schizophrenia or bi-polar disorder.

of generic prescriptions as compared with the number for young adult men. Young adult women had the most filled days of hormones, 78.2 filled days per young adult woman (Appendix Table A17a). Of these filled days of hormones, 69.0 (88.2%) were for contraceptives, the subclass most commonly used by young adult women (Table 9). Use of contraceptives made up 43.7% of filled days of generic prescriptions for young adult women. The most-used detailed category for young adult men and the second most-used detailed category for young adult women were CNS agents (27.0 days per young adult man and 41.4 filled days per young adult woman).

For young adult men, the four subclasses of generic prescriptions used most were all CNS agents. Antidepressants – the subclass used most by young adult men – constituted 31.5% of the CNS filled days for young adult men (8.5 days per man), and 16.5% of total generic prescription days. For young adult women, three of the four most-used subclasses were CNS agents; the most commonly used CNS agent (and second most common subclass) was antidepressants (17.7 days per young adult woman), which made up 42.8% of CNS use.

Antidepressants accounted for nearly 15% of generic filled days for intermediate adult women

Similar to use among young adults, intermediate adult women had higher use of three of the top four detailed categories, while men of this age cohort had higher use of cardiovascular drugs. The highest-used category for both intermediate adult men and women was CNS agents: 43.5 filled days per intermediate adult man and 79.4 days per intermediate adult woman (Appendix Table A18a). For both intermediate adult men and women, the subclass of CNS agent used most was antidepressants (15.0 days per man and 34.2 days per woman; Table 10). Within this age group, use of antidepressants accounted for 34.5% of CNS use by men and 43.1% of CNS use by women. Use of antidepressants made up 14.7% of total filled days of generic prescriptions for intermediate adult women and 12.2% of generic days for intermediate adult men.

The second most-used detailed category of generic prescriptions for intermediate adult women was hormones (70.8 filled days per intermediate adult woman). The most common type of hormone, and the most used subclass, for intermediate adult women was contraceptives (43.3 days per intermediate adult woman), constituting 61.2% of the hormone use for this group.

For intermediate adult men, the second most-used detailed category was cardiovascular drugs (31.4 filled days per man). The most common subclass of cardiovascular drugs for men in this age group was angiotensin-converting enzyme inhibitors ("ACE inhibitors"; 9.0 days per man), which accounted for 28.7% of their cardiovascular use.

Cardiovascular drugs were most common generics for middle age adult men

Middle age adult men used more filled days of cardiovascular drugs than any other category (124.5 per man; Appendix Table A19a); this category contained three of the top four subclasses used by these men (Table 11). The most commonly used subclass for middle age adult men was HMG-CoA reductase inhibitors ("statins"; 37.0 days per man), which made up 29.7% of their cardiovascular filled days. Statins were the third most-used subclass for middle age adult women (21.0 days per woman) and made up 25.4% of their cardiovascular filled days.

CNS agents were the category used most by middle age adult women (126.5 days per woman) and the second most-used category for men of the same age group (66.7 days per man). The most used subclass for middle age adult women was antidepressants (52.2 days per woman), accounting for 41.3% of their CNS use. Antidepressants were also the third most-used class for middle age adult men (21.6 days per man), accounting for 32.4% of their CNS filled days.

The second most-used category for middle age women was hormones, at 77.4 filled days per woman. The most used subclass of hormone by middle age adult women, and the second most used subclass overall for these women, was thyroid agents (33.3 days per woman), which made up 43.0% of their filled days of hormones.

Before Medicare eligibility, cardiovascular generic use rose for group

The category most used by pre-Medicare adult men and women was cardiovascular drugs (244.2 filled days per man and 178.0 filled days per woman; Appendix Table A20a). Likewise, all of the top four subclasses for men in this age cohort were in the cardiovascular category (Table 12). The most common subclass for pre-Medicare adult men, as with middle age adult men, was statins (71.7 days

per man), accounting for 29.4% of cardiovascular filled days for men in this age group. Statins were also the second most used drug class for pre-Medicare adult women (52.9 days per woman), accounting for 29.7% of their cardiovascular filled days.

The second most-used detailed category of generic prescriptions for both pre-Medicare men and women was CNS agents: 87.3 filled days per man and 150.5 filled days per woman. Overall, antidepressants were the most used subclass by pre-Medicare adult women (61.5 days per woman), and it made up 40.9% of CNS filled days for this group. For pre-Medicare women, as with middle age adult women, the subclass of hormones used most commonly was thyroid agents (47.6 days per woman), which constituted 49.6% of their hormone use.

Summary

Thirteen therapeutic subclasses constituted the top four most commonly filled generics for the age-gender groups. These classes were drawn from five of the nine HCCI detailed drug categories: anti-infective agents, cardiovascular drugs, CNS agents, hormones, and respiratory agents.

These findings document how generic prescription use in filled days varied by age and gender among the ESI population. HCCI found several patterns among the detailed categories used most commonly. Subclasses of drugs that were in the respiratory and anti-infective agent categories were commonly used only among boys and girls. Hormone subclasses ranked highest in use for women of each age group but not for men in any age group. CNS agents were in the top four for nearly all age-gender groups. Cardiovascular drugs were common in the adult populations, more predominantly for men.

At the subclass level several other patterns emerged. Antidepressants were in the top four most-used subclasses for nearly all age-gender groups. The only exception was use by pre-Medicare men, whose top four subclasses were all cardiovascular drugs. Within the cardiovascular category, statins and ACE inhibitors were prevalent in the older age groups, for both men and women. Hormone use by women was common in every age group; however, use transitioned from contraceptives before age 45 to thyroid medications after age 25.

Table 8: Top 4 Highest Used per 1,000 Insureds Generic Prescription Subclasses for Children: 2013

Subclass Name (Number)	HCCI Detailed Category	Utilization Filled Days per Boy/Girl	Spending per Boy/Girl
Boys (ages 0-18)			
Respiratory and CNS Stimulants (28:20.32)	CNS Agents	5.68	$25.12
Leukotriene Modifiers (48:10.24)	Respiratory Agents	4.57	$5.52
Antidepressants (28:16.04)	CNS Agents	4.53	$2.92
Penicillins (08:12.16)	Anti-Infective Agents	3.46	$5.27
Girls (ages 0-18)			
Contraceptives (68:12.00)	Hormones	9.51	$8.66
Antidepressants (28:16.04)	CNS Agents	5.56	$3.32
Penicillins (08:12.16)	Anti-Infective Agents	3.49	$5.16
Leukotriene Modifiers (48:10.24)	Respiratory Agents	3.21	$3.79

Source: HCCI, 2014.

Table 9: Top 4 Highest Used per 1,000 Insureds Generic Prescription Subclasses for Young Adults: 2013

Subclass Name (Number)	HCCI Detailed Category	Utilization Filled Days per Man/Woman	Spending per Man/Woman
Men (ages 19-25)			
Antidepressants (28:16.04)	CNS Agents	8.51	$6.52
Amphetamines (28:20.04)	CNS Agents	5.24	$22.25
Anticonvulsants, Miscellaneous (28:12.92)	CNS Agents	3.08	$11.40
Opiate Agonists (28:08.08)	CNS Agents	1.71	$2.99
Women (ages 19-25)			
Contraceptives (68:12.00)	Hormones and Synthetic Substitutes	69.03	$66.35
Antidepressants (28:16.04)	CNS Agents	17.74	$11.49
Amphetamines (28:20.04)	CNS Agents	5.93	$24.39
Anticonvulsants, Miscellaneous (28:12.92)	CNS Agents	4.70	$11.33

Source: HCCI, 2014.

Table 10: Top 4 Highest Used per 1,000 Insureds Generic Prescription Subclasses for Intermediate Adults: 2013

Subclass Name (Number)	HCCI Detailed Category	Utilization Filled Days per Man/Woman	Spending per Man/Woman
Men (ages 26-44)			
Antidepressants (28:16.04)	CNS Agents	15.01	$10.93
Angiotensin-Converting Enzyme Inhibitors (24:32.04)	Cardiovascular Drugs	8.99	$2.40
HMG-CoA Reductase Inhibitors (24:06.08)	Cardiovascular Drugs	8.01	$4.89
Opiate Agonists (28:08.08)	CNS Agents	6.06	$9.97
Women (ages 26-44)			
Contraceptives (68:12.00)	Hormones and Synthetic Substitutes	43.25	$41.76
Antidepressants (28:16.04)	CNS Agents	34.19	$24.88
Thyroid Agents (68:36.04)	Hormones and Synthetic Substitutes	16.35	$7.57
Anticonvulsants, Miscellaneous (28:12.92)	CNS Agents	8.05	$14.42

Source: HCCI, 2014.

Table 11: Top 4 Highest Used per 1,000 Insureds Generic Prescription Subclasses for Middle Age Adults: 2013

Subclass Name (Number)	HCCI Detailed Category	Utilization Filled Days per Man/Woman	Spending per Man/Woman
Men (ages 45-54)			
HMG-CoA Reductase Inhibitors (24:06.08)	Cardiovascular Drugs	36.96	$24.94
Angiotensin-Converting Enzyme Inhibitors (24:32.04)	Cardiovascular Drugs	30.55	$8.58
Antidepressants (28:16.04)	CNS Agents	21.62	$16.54
β-Adrenergic Blocking Agents (24:24.00)	Cardiovascular Drugs	18.53	$9.94
Women (ages 45-54)			
Antidepressants (28:16.04)	CNS Agents	52.20	$41.81
Thyroid Agents (68:36.04)	Hormones and Synthetic Substitutes	33.33	$14.71
HMG-CoA Reductase Inhibitors (24:06.08)	Cardiovascular Drugs	21.02	$12.83
Angiotensin-Converting Enzyme Inhibitors (24:32.04)	Cardiovascular Drugs	18.60	$5.06

Source: HCCI, 2014.

Table 12: Top 4 Highest Used per 1,000 Insureds Generic Prescription Subclasses for Pre-Medicare Adults: 2013

Subclass Name (Number)	HCCI Detailed Category	Utilization Filled Days per Man/Woman	Spending per Man/Woman
Men (ages 55-64)			
HMG-CoA Reductase Inhibitors (24:06.08)	Cardiovascular Drugs	71.68	$53.06
Angiotensin-Converting Enzyme Inhibitors (24:32.04)	Cardiovascular Drugs	53.12	$15.78
β-Adrenergic Blocking Agents (24:24.00)	Cardiovascular Drugs	41.24	$21.81
Dihydropyridines (24:28.08)	Cardiovascular Drugs	27.28	$14.46
Women (ages 55-64)			
Antidepressants (28:16.04)	CNS Agents	61.45	$50.45
HMG-CoA Reductase Inhibitors (24:06.08)	Cardiovascular Drugs	52.90	$35.91
Thyroid Agents (68:36.04)	Hormones and Synthetic Substitutes	47.58	$19.20
Angiotensin-Converting Enzyme Inhibitors (24:32.04)	Cardiovascular Drugs	34.33	$10.08

Source: HCCI, 2014.

Data & Methods

Data

HCCI's dataset contains several billion de-identified commercial health insurance claims for the years 2009 through 2013. Three major health insurers contributed data to HCCI for the purposes of producing a national, multi-payer, commercial health care claims database. These data include claims for individuals covered by group insurance (fully insured and administrative services only), individual insurance, and Medicare Advantage plans. The claims data include prices paid to providers by both insurers and insureds and details about the services used. Furthermore, HCCI's claims data are compliant with the Health Insurance Portability and Accountability Act (HIPAA).

For the 2013 *Health Care Cost and Utilization Report,* HCCI performed analysis on a subset of data for approximately 40 million insureds per year (2009-2013), totaling approximately 5 billion claim lines.[12] This analytic subset consisted of all claims for insureds younger than age 65 and covered by ESI. The data set used for this report represented about 27% of the national ESI population, making this one of the largest datasets on the privately insured ever assembled.

Methods

The analytic subset was weighted using U.S. Census Bureau age-gender-geographic-based estimates of the ESI population to make the analytic subset representative of the national ESI population. Claims in the analytic subset from 2012 and 2013 were actuarially completed to account for claims that had been incurred but not adjudicated. Claims for years 2009 through 2011 were not adjusted and were considered 100% adjudicated.

HCCI used the weighted, actuarially completed dataset to estimate per capita health expenditures, average prices, utilization of services, unit prices, and service intensity for 2009 through 2013. HCCI did not correct dollars for inflation; thus, all reported expenditures and prices were in nominal dollars.

HCCI analyzed four major categories of services, several subservice categories, and detailed service categories. Inpatient facility claims were from hospitals, skilled nursing facilities (SNFs), and hospices where detail was sufficient to identify an overnight stay by an insured. Outpatient facility claims did not entail an overnight stay, and include observation and emergency room services. Both outpatient and inpatient claims consisted of only the facility charges associated with such claims. Professional procedures included claims billed by physicians and non-physicians according to the industry's standard procedure coding practices. Prescription data are prescriptions filled at both retail and mail order pharmacies.

For a more detailed description of HCCI's methodology and dataset, see the Analytic Methodology on HCCI's website.[7]

HCCI recognizes that the terms "heath care spending" and "health spending" could be interpreted differently; however, they were used interchangeably in this report.

Limitations

This report, like all research, had several limitations that affect the generalizability and interpretation of the findings. For this reason, HCCI considers the work a starting point for analysis and research on individuals covered by ESI rather than as a conclusive analysis of the ESI population's effect on health care in the United States.

First, our findings were estimates for the US ESI population ages 0 to 64 based on a sample of approximately 27% of these insureds.

Second, the analysis and results were descriptive, and the findings were not causal and cannot be used to determine causal relationships.

Third, the effect of individual or population health status, such as existence of chronic conditions, was not specifically investigated or discussed in the report.

A note on premiums

HCCI does not report on premiums or their determinants. For more information on health insurance premiums and the multiple factors that affect them (including health care expenditure; beneficiary, group, and market characteristics; benefit design; and the regulatory environment) see Congressional Research Service, *Private Health Insurance Premiums and Rate Reviews, 2011*; American Academy of Actuaries, *Critical Issues in Health Reform: Premium Setting in the Individual Market, 2010*; and Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals, Chapter 3, Factors Affecting Insurance Premiums, 2008.*[13,14,15]

Changes in 2013

HCCI's analytic methodology underwent a number of changes to enhance reporting for the 2013 *Health Care Cost and Utilization Report.* See the methodology document available on HCCI's Website for details on these changes.[7]

Data changes.

In the 2013 report, new data were provided for 2011 through 2013 from the data contributors, resulting in changes in the membership, expenditures, utilization, and prices in all years. This is an unavoidable consequence of updating and refining the dataset over time. As a result, the trends reported in the 2013 report are somewhat different from those in the 2012 report.

The data were adjusted to account for new and revised data for 2013. For the 2013 analytic dataset, 2009 through 2011 data were considered complete, and no actuarial adjustment was performed. The 2012 and 2013 claims were actuarially completed using the new data. The average intensity weights were changed for some of the outpatient and professional procedure subservice categories due to improved imputation for missing weights and the introduction of some new weights in 2013.

Weighting methodology was updated. The weighting methodology was updated to reflect the national ESI population younger than age 65 as measured by the American Community Survey. The methodology was also updated to better account for fluctuations in the population within a year.

Analysis changes. For the 2013 report, HCCI reported on health care trends by age-gender groups, further enhancing the specificity of the analysis. In response to public inquires about the data, HCCI enhanced the reporting on prescriptions by reporting on even more detailed pharmaceutical categories. See the 2013 *Health Care Cost and Utilization Report Methodology* for more information.

Suggested citation for 2013 report:

"2013 Health Care Cost and Utilization Report." Health Care Cost Institute, Inc., Oct. 2014. Web.

Endnotes

[1] Health Care Cost Institute. 2012 Health Care Cost and Utilization Report. HCCI, Sep. 2013. Web.

[2] Herrera, Carolina-Nicole, Martin Gaynor, David Newman, Robert J. Town, and Stephen Parente. "Trends Underlying Employer-Sponsored Health Insurance Growth for Americans Younger Than Age 65." *Health Affairs*. 32.10 (2013): 1715-1722. Print.

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[4] Ryu, Alexander J., et al. "The slowdown in health care spending in 2009–11 reflected factors other than the weak economy and thus may persist." *Health Affairs* 32.5 (2013): 835-840.

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[6] Yamamoto, Dale H. "Health Care Costs - From Birth to Death." Health Care Cost Institute (2013): 1-39. Society of Actuaries. Web.

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[11] American Heart Association. "Doctor Discussion is Key for Cholesterol Treatment." Blog.heart.org. 30 Nov. 2013. Web.

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[13] Congressional Research Service. *Private Health Insurance Premiums and Rate Reviews* [Internet]. Washington (DC): CRS; 2011 Jan. Web.

[14] American Academy of Actuaries. *Critical Issues in Health Reform: Premium Setting in the Individual Market.* Washington (DC): AAA; 2010 March. Web.

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Trend to Watch

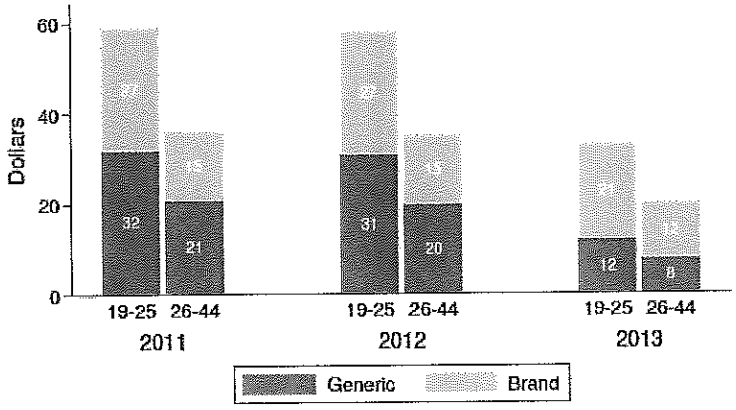
In 2013, there was a notable break in trend for out-of-pocket spending growth for adult women (ages 19–44). Out of pocket spending growth slowed considerably for young adult women (ages 19–25) and intermediate adult women (ages 26–44) compared to the two prior years. For the first time in 2013, HCCI observed that there was no increase in out-of-pocket expenditures for young adult women (0.0% growth). For intermediate adult women, out-of-pocket spending growth slowed considerably, increasing by 3.2% as compared to 6.4% growth the previous year.

Driving these breaks in trends were changes in out-of-pocket spending on contraceptive prescriptions. Out-of-pocket spending per capita by young adult and intermediate adult women on generic contraceptives fell by 61% to $20, and brand contraceptive spending fell by 21% to $33 (Appendix Table A29). At the same time, use of contraceptives increased by 4% for young adult women and 2% for intermediate adult women (Appendix Table A30).

Lower out-of-pocket spending and rising contraceptive use coincided with the first full calendar year of Affordable Care Act (ACA) provisions requiring full coverage (no cost-sharing) of some preventive services, such as contraceptives, prenatal screenings and tests, cervical cancer screenings, diabetes and blood pressure screenings. Although the ACA was likely a large influence on the 2013 per capita out-of-pocket spending trends, other factors also influence spending and use trends. For example, in 2011, changes in out-of-pocket spending on contraceptives were observed following launches of generic versions of brand-name contraceptives, such as Yaz™ and Seasonique™.

Additional details and further discussion of out-of-pocket spending are discussed in *Out-of-Pocket Spending Trends (2013)*.

Out-of-Pocket Spending Per Capita on Contraceptives by Women Ages 19-25 and 26-44: 2011-2013



Source: HCCI 2014.
Notes: All data weighted to reflect the national, younger than 65 ESI population.
Data from 2012 and 2013 adjusted using actuarial completion.

HCCI HEALTH CARE COST INSTITUTE

1310 G Street NW, Suite 720
Washington, DC 20005
202-803-5200

ATTACHMENT V

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0047

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Lawrence and Memorial Hospital, Inc. of New London, CT d/b/a Lawrence and Memorial Hospital is hereby licensed to maintain and operate a General Hospital.

Lawrence and Memorial Hospital is located at 365 Montauk Avenue, New London, CT 06320.

The maximum number of beds shall not exceed at any time:

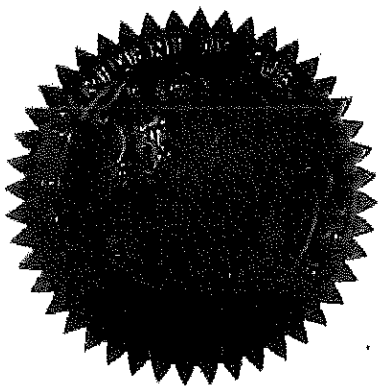
28 Bassinets
280 General Hospital Beds

This license expires **March 31, 2017** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2015. RENEWAL.

Satellites:

Outpatient Surgery Center, 52 Hazelnut Hill Road, 2nd Floor, Groton, CT
Pequot Health Center, 52 Hazelnut Hill Road, 1st Floor, Groton, CT
L&M Cancer Center, 230 Waterford Parkway South, Waterford, CT
Wound & Hyperbaric Center, 40 Boston Post Road, Waterfall Plaza, Waterford, CT



Jewel Mullen, MD, MPH, MPA
Commissioner

ATTACHMENT VI

MARNA PARKE BORGSTROM

Home: 458 Three Mile Course
Guilford, Ct. 06437

(203) 453-8782

Business: Yale-New Haven Health System
789 Howard Avenue
New Haven, CT 06519
(203) 688-2608

EDUCATION

1977-1979 Yale University School of Medicine
Department of Epidemiology and Public Health
Program in Hospital Administration, M.P.H.

1972-1976 Stanford University
Bachelor of Arts in Human Biology awarded June, 1976

EXPERIENCE

2005-Present President and Chief Executive Officer: Yale New Haven Health System

Chief Executive Officer: Yale-New Haven Hospital

Yale New Haven Health System is a regional, integrated health care delivery system composed of three local health care delivery networks, as well as a physician foundation (independent from the Yale University Medical Group). The System operates in the New Haven, Bridgeport and Greenwich regions, and has nearly 2150 inpatient beds, multiple outpatient centers, over 5000 medical staff members, 19,000 employees and 2014 revenues of $3.5 billion. It is anchored by the 1541 bed Yale-New Haven Hospital, which includes the Yale-New Haven Children's Hospital, the Yale-New Haven Psychiatric Hospital and the Smilow Cancer Hospital. Yale-New Haven Hospital serves as the primary teaching hospital for the Yale University School of Medicine. The System is the co-founder of a Statewide, clinically integrated network of providers with Tenet Corporation.

1993-2005 Executive Vice President & Chief Operating Officer: Yale-New Haven Hospital
Executive Vice President and Secretary: Yale-New Haven Health System

Responsible for New Haven Delivery Network operations including Yale-New Haven Hospital operations, finance, human resources and planning and marketing; and Yale-New Haven Ambulatory Services Corporation, which operated two independent surgery centers and a large, full-service radiology business in New Haven and Guilford. Served as the senior Hospital interface for Yale School of Medicine operational issues. Represented the YNHH Delivery Network in all Health System strategic and operational activities.

1970-1993 Various administrative and staff roles at Yale-New Haven Hospital from Administrative Resident to Senior Vice President.

PROFESSIONAL AWARDS:

1992 Up and Comers Award - Sponsored by Modern Healthcare and 3M Health Systems
Women In Leadership Award, 1993 - YWCA
Junior Achievement Hall of Fame, 1998
20 Noteworthy Women, New Haven Business Times, 1999
Gateway Community College Hall of Fame, 2002
Hill Health Center Leadership Award, 2006
Connecticut Women in Leadership, 2009 (Women & Families Center Award)
Girl Scouts of Connecticut Women of Achievement Award, 2010
Anti-Defamation League Torch of Liberty Award, 2010
Business New Haven's Business Person of the Year, 2010
American Hospital Association 2010 Grassroots Champion Award
Doctor of Humane Letters, Quinnipiac University, 2011
Greater New Haven Chamber of Commerce Community Leadership Award, 2012
United Way Alexis de Tocqueville Herbert H. Pearce Award, 2012

MAJOR PROFESSIONAL AFFILIATIONS, BOARDS AND ACTIVITIES:

Yale-New Haven Hospital Board of Trustees (1994 – present)
Yale New Haven Health System Board of Directors (2005 - present)
The Connecticut Hospital Association (2006 – present) Immediate Past Chair, Board of Trustees and member of Executive Committee
VHA, Inc. (Dallas, Texas), Board of Directors 2009 –present (current Chair)
Council of Teaching Hospitals Administrative Board (2008 - present) Chair as of 11/12
Coalition to Protect America's Health Board of Directors, 2011-present (current Chair)
Healthcare Institute Board of Directors (2014-present)
Healthcare Executives Study Society (2006-present)
Fellow – American College of Healthcare Executives

University Appointments

Yale University – Lecturer, Yale School of Public Health, Department of Health Policy and Management.

PERSONAL:
Married: Eric N. Borgstrom (5/27/78)
Children: Christopher (4/14/85) and Peter (8/4/89)

CURRICULUM VITAE

NAME: James M. Staten
BIRTHDATE: September 26, 1958
EDUCATION: 1980 – B.S. – Business / Economics / State University College of NY

Yale New Haven Health System (YNHHS) and Yale-New Haven Hospital (YNHH)

October 2000 - Present

Executive Vice President of Finance and Corporate Services, YNHHS
Senior Vice President and CFO, YNHH

Yale New Haven Health system is a regional, integrated health care system composed of three regional health care delivery networks. The New Haven-based delivery system is anchored by Yale-New Haven Hospital, the Yale-New Haven Children's Hospital, and the Yale-New Haven Psychiatric Hospital, which total 944-beds. The system includes a Bridgeport-based delivery system led by the 425-bed Bridgeport Hospital and Greenwich-based delivery system anchored by 160-bed Greenwich Hospital. The System is also affiliated with the Westerly Hospital in Rhode Island. The Yale New Haven Health System has a formal affiliation with the Yale University School of Medicine, as does Yale-New Haven Hospital which serves as the Medical School's primary teaching hospital. System services include acute care hospitals, ambulatory surgery and outpatient diagnostic imaging centers, as well as primary care centers. In total, the System has 1,500 beds, 74,000 admissions, 10,000 employees, assets of $1.6 billion, and annual net revenues of over $1.4 billion.

Responsible for financial and corporate services of YNHHS including managed care, information systems, materials management, admitting/registration, and medical records, as well as all financial responsibilities such as accounting, budgeting, financial and operational reporting, tax, reimbursement, and treasury.

OTHER EMPLOYMENT

New York-Presbyterian Hospital (NYPH) and New York-Presbyterian Healthcare System (NYPHS)

July 1999 – October 2000 Senior Vice President of Finance

Responsible for assuring the financial viability of a $3 billion Health System, including monitoring financial condition of approximately 15 corporately-controlled Sponsored/Member Hospitals and other healthcare related organizations. Report regularly to the NYPHS Board and NYPH Board Executive Committee on financial performance.

January 1997 - June 1999 Vice President of Financial Planning
June 1993 - December 1996 Director of Financial Planning

Responsible for complete integration of financial planning at all Sponsored Hospital Members including NYPH and leading the financial group of approximately 70 professionals in performing budget, reimbursement, managed care contracting, decision support and business plan development functions.

Ernst & Young

January 1991 - June 1993 Senior Manager - Consulting Services

Directed and coordinated Ernst & Young's New York State Reimbursement Consulting Services.

Pannell Kerr Forster

October 1980 – December 1990 Partner

Elected Partner in June 1990 after working 10 years in the firm's large healthcare practice as a certified public accountant. 11th Largest Public Accounting Firm in United States during late 1980s.

PROFESSIONAL MEMBERSHIPS

American Institute of Certified Public Accountants (1982 – 1998)
New York State Society of Certified Public Accountants (1982 – 1996)
- Healthcare Committee (1988 – 1991)
- Chairman of the Hospital Sub-Committee (1990/1991)

Healthcare Financial Management Association (1984 – 1994)
- Chairman of various Committees (1984 – 1994)
- Trustee (1990/1991)
- President Elect (1993/1994)

Greater New York Hospital Association
- Fiscal Policy Committee (1993 – 2000)
- Managed Care Committee (1995 – 2000)

Connecticut Hospital Association
- Finance Committee (2000 – 2004)
- Special Committee on Medicaid Reimbursement (2000 – 2004)

Blue Ribbon Committee on the Future of Healthcare in Connecticut (2000 – 2003)

OTHER PROFESSIONAL ACTIVITIES

Presenter at New Jersey Health Care Financing Authority on Medicare Payment System
Presenter on Hospital Reimbursement Issues for the NYS Society of CPAs
Presenter on Accounts Receivable Issues for the Connecticut Hospital Association
Guest Speaker at NYU's graduate program in Hospital Administration on Healthcare Financing
Guest speaker at Cornell University's Sloan Program in Health Services on Managed Care
Presenter on Mergers and Acquisitions to New York State Hudson Valley HFMA
Guest speaker at Chicago Municipal Bond Analysts Society on New York State Hospital Deregulation
Guest speaker at Yale's School of Epidemiology and Public Management on Health Systems

GAYLE L. CAPOZZALO, FACHE

ADDRESS

Office: Yale New Haven Health
789 Howard Avenue
New Haven, CT 06519
(203) 688-2605

Home: 110 Lower Road
Guilford, CT 06437
(203) 453-9758

HEALTH SERVICES EXPERIENCE

1997-Present **Executive Vice President / Chief Strategy Officer. Yale New Haven Health System (YNHHS),** New Haven, Connecticut. Major regional multi-hospital system in Connecticut with assets and annual revenues in excess of $3.4 billion. Report to YNHHS President/CEO; a member of the System senior leadership team consisting of: The President/CEO of YNHHS/YNHH, Chief Operating Officer of Yale-New Haven Hospital the CEOs of Greenwich Hospital and Bridgeport Hospital and Chief Financial Officer of YNHHS. Responsible for leading and directing the growth, diversification, clinical and operational integration, strategy, innovation, markenting, communication, government relations, business development performance management and annual performance measurement process for the System.

Direct shared and corporate services, facilities, real estate and plant engineering, supply chain, leadership development, training and education, corporate compliance and privacy, strategy, government relations, emergency preparedness, grant development, marketing, communication and business development.

Member of the following YNHHS Boards of Directors:

- Greenwich Hospital and related corporations, Greenwich, CT
- Bridgeport Hospital and related corporations, Bridgeport, CT
- Ambulatory Services Corporation – provides radiology, surgery and recovery services in southern CT
- Shoreline Surgical Corporation – a joint venture with physicians (chair)
- Physician practice foundation for physician employment (chair)
- Continuing Services -- long term care and rehabilitation

Accomplishments:

- Led team to purchase assets of 500 bed academic medical center
- Established, developed and led non-profit physician foundation to employ physicians across the System
- Created clinical integrated physician network
- Created System to System strategic alliances
- Led the transition of a $40 million Ambulatory Services Corporation through turnaround and restructuring.
- Expanded System by adding hospitals, ambulatory centers and physician practices
- Created and directed the development of statewide service lines in Oncology, Cardiology and Pediatrics
- Facilitated the establishment and strategic direction of Yale-New Haven Hospital service lines in eight specialties
- Led the development of a full-service 80,000 square foot ambulatory care center, including ambulatory surgery, radiation therapy, satellite emergency services, laboratory services, physician offices and radiology services.
- Instrumental in the design and implementation of a Systemwide performance management strategy and structure to enhance clinical quality, patient safety and

operations performance. The strategy included the development of a performance management infrastructure, full-time performance management coordinators, an electronic balanced scorecard to provide managers with timely, detailed information to monitor, communicate and improve performance and an Institute for Excellence to develop leadership for the future. Responsible for directing and managing the effort.

- Created and direct the Institute for Excellence, Systemwide management development, succession planning and corporate leadership, training and education function.
- Led the integration and standardization of clinical service lines (heart, cancer, pediatrics, neurosciences) and administrative services across the System.
- Led the development of a Systemwide three-year standardization project that standardized 365 operational and administrative processes across the System.
- Created and manage Systemwide Office of Emergency Preparedness, Systemwide corporate compliance, Systemwide compensation and benefit management, and Systemwide strategic planning process to enhance collaboration, improve performance and create economies of scale.

1993 – 1997 **Senior Vice President. Organizational Development. Sisters of Charity of the Incarnate Word Health Care System (SCH),** Houston, Texas. Major Catholic multi-hospital system (14th largest health care system - $2 billion in assets) (3932 acute beds, 620 long-term care and residential beds and numerous health businesses and programs). Report to System President/CEO; a member of the senior leadership team of the System; interact regularly with System governance and member of Board Committees. Responsible for leading and directing Systemwide Leadership Development, System Organizational Development, Growth and Diversification of the Ministry, System Managed Care, System Human Resources, System Continuous Quality Improvement and Quality Assurance, System Strategic Planning and System Communications functions including staffs. Responsible for leading the System efforts in the development and operation of integrated community health networks (ICHN) and mergers and acquisitions.

Accomplishments:

- Instrumental in the design and implementation of a regionalization strategy for (SCH), health care centers and services in Southeast Texas.
- Instrumental in the design and implementation of a regionalization strategy for (SCH), health care centers and services in the state of Louisiana.
- Led the transition of the Sisters of Charity of the Incarnate Word to co-sponsorship of Catholic Healthcare West, including the transition of two (SCH), health care centers to CHW.
- Led the development, implementation and governance of a statewide joint venture triple option insurance product in Louisiana with Ochsner Clinic. The HMO grew from 70,000 to 130,000 lives in one year.
- Instrumental in the development, implementation and governance of a $100 million joint venture health network in Houston, Texas between (SCH), and Memorial Health System, the largest not for profit health care system in Houston. The $100 million health network includes physician practices, group practices, management services organization, clinics, home health, wellness services, and a PPO, TPA, HMO and indemnity insurance product
- Led the development, implementation and management of numerous physician hospital organizations (PHO) in Louisiana and Texas.
- Led the development, implementation, governance and management of a Louisiana statewide MSO, employing 75 physicians and managing 35 physician

practices.

- Led the development, implementation, governance and management of a risk insurance joint venture with Arkansas Blue Cross/Blue Shield.
- Directed a 25,000 enrollee Department of Defense HMO until its integration into the Memorial SCH Health Network.
- Member of governing board of two HMOs, PPOs and insurance companies. Member of governing board and officer of a 75-physician management services organization (MSO).
- Instrumental in the development and implementation of the reengineering of (SCH), corporate office resulting in a reduction of hierarchy, initiation of process work teams, reduction of costs and focus on strategic leadership and creating the System's future.
- Initiated and administered Systemwide leadership development program including education, succession planning, competency based behavior performance evaluations, etc.
- Led the development and administration of a systemwide initiative to fast track qualified women to senior leadership.
- Instrumental in the reduction of costs per weighted discharge by 25% in a three-year period.

1982 - 1993 **Strategic Development. SSM Health Care System.** St. Louis, Missouri. Major Catholic multi-hospital system (4,000 acute beds, 500 long term care and residential beds and numerous health businesses and programs).

1986 – 1993 **Senior Vice President** Reported to System President/CEO; a member of the senior leadership of the System; interacted regularly with System governance; directed Corporate Strategic Planning, Corporate Communications, Corporate Managed Care, Physician/Hospital Organization Directors and staffs. Member of Board of Directors for all System for profit corporations. Responsibilities included organizing and directing the System strategic planning process; developing strategic planning policies and marketing strategies for the System; directing research and development function of the System; directing managed care activities of the System; directing networking activities of the System, e.g., collaboration, acquisition and affiliation; directing communication function of the System including advertising and public relations. Instrumental in implementing Clinical Quality Improvement. Responsible for leading System cross functional teams in implementing a new System-wide strategic and financial planning process which incorporates Continuous Quality Improvement principles, implementing patient-focused care, developing integrated delivery networks in specific geographical areas and establishing System-wide customer feedback mechanisms for physicians. Responsible for managing and/or consulting in Continuous Quality Improvement, strategic planning, marketing, delivery system integration and managed care at twenty-four member institutions and programs. Responsibilities also included developing Continuous Quality Improvement implementation plans, curriculum and teaching Continuous Quality Improvement courses throughout the System. Lead the system efforts to regionalize all health care centers and services in the greater St. Louis area

1982 - 1986 **Corporate Director of Planning/Marketing**. Reported to President of the Governing Board of the System. Supervised corporate planning, marketing and managed care staffs. Responsibilities included organizing and directing the first system planning process and development of a new structure for the system. Responsibilities also included directing the marketing research, product development, marketing strategy development and alternative delivery activity of the system.

1981 – 1982 **Principal, Health Studies Institute. Inc.,** Columbia, Missouri. Consultant and Project Director for planning, management and education to health care organizations.

1980 - 1981 **Business Development Staff. St. Louis University Hospital and Clinics,** St. Louis, Missouri. Major responsibility included the development of an education subsidiary corporation. Reported to the Chief Operating Officer of the hospital.

1978 - 1980 **Faculty Member. University of Missouri-Columbia. Graduate Studies in Health Services Management.** Major responsibilities included developing and coordinating a baccalaureate degree program in Health Services Management; developing and teaching courses in health care delivery, management and planning. Other responsibilities included student advisement and curriculum design.

EDUCATION

Post Masters Post-Master studies: St. Louis University, Center for Health Services Education and Research, St. Louis, Missouri, specialized in Health Services Marketing and Administration. Doctoral comprehensive examinations completed.

MSPH Master of Science in Public Health (MSPH) with a concentration in Health Planning; University of Missouri-Columbia, Department of Health Services Management.

BA Bachelor of Arts; University of Maryland, College Park, Maryland.

APPOINTMENTS

Professional

- Immediate Past Chairman, American College of Healthcare Executives (ACHE) (2013-2014)
- Chairman, American College of Healthcare Executives (ACHE) (2012-2013)
- Member, Institute for Healthcare Improvement, Audit and Compliance Committee (2012 - 2013)
- Board Member, VHA New England (2001-Present); Chair (2010 – 2013)
- Board Member, Secretary, Past Chair, Connecticut Association of Healthcare Executives (2004-Present)
- Board Member, Greenwich Health Care Services. (1997-Present)
- Board Member, Bridgeport Hospital & Healthcare Services. (1997–Present)
- Alumni Board, University of Missouri-Columbia (2003–Present)
- American College of Healthcare Executives (ACHE) Regents Advisory Council– CT. (1999-Present)
- Co-Chair, The Leadership Institute (2008–2010)Board Member, Board of Governors, American College to Healthcare Executives (2007-2010)
- Board Member, Board of Overseers, Malcolm Baldrige National Quality Award (2006– 2009)
- Regent, American College of Healthcare Executives (Connecticut) (2004–2007)
- Program Committee, European Forum on Quality Improvement in Health Care. (1995-1999)
- Member, Review Board, Quality Management in Health Care Magazine. (1993-2006)
- Board Member, Institute for Healthcare Improvement. (1993-2001)
- Co-Chair, National Forum on Quality Improvement in Healthcare, sponsored by the Institute for Healthcare Improvement. (1992,1993,1994)
- Vice Chairperson, Executive Committee, Healthcare Quality Management Network, Institute for Healthcare Improvement. (1991-1994)
- Member, Holy Cross Health System, Board of Directors, Mission & Planning Committee (1990-1994)
- President, Catholic Health System Planners and Marketers. (1988-1989)
- Member, Strategic Planning Committee, Society of Healthcare Planning and Marketing (AMA)

(1988-1989)
- Co-Chairperson, Membership Committee, Society of Healthcare Planning and Marketing (19851987)
- Chairperson, St. Louis Association of Women in Health Administration. (1984-1986)
- Vice Chairperson, ACHE Ad Hoc Committee of Women in Health Administration. (1982-1984)

Community
- Board Member, Planned Parenthood of Connecticut (2013-Present)
- Member, Project Advisory Group, Women in Healthcare Leadership, National Center for Healthcare Leadership (2013-Present)
- Board Member/Chair, Connecticut Public Broadcasting. (1999-Present)
- Board Member, International Festival of Arts & Ideas. (2008-2010)
- Board Member/Secretary, New Haven Symphony Orchestra. (1999-2007)
- Member, Executive Committee, National Migrant Worker Council, Inc. (1993-1995)
- Board Member, National Migrant Worker Council, Inc. (1992-1995)

Education Faculty
- Faculty Member, Yale University, Department of Epidemiology and Public Health. (2000-Present)
- Preceptor, University of Missouri-Columbia, Health Services Management (June 2003 – Present)
- Faculty Member, Institute for Healthcare Improvement, Boston, MA. (1992-Present)
- Adjunct Faculty Member, St. Louis University, Center for Health Services Education and Research, St. Louis, MO. (1985-Present)

PROFESSIONAL MEMBERSHIPS
- Fellow, American College of Healthcare Executives (ACHE)
- Member, Society of Healthcare Planning and Marketing (AHA).
- Member, American College of Health Care Marketing.

PRESENTATIONS AND PUBLICATIONS (since 2000)

2014 Capozzalo, Gayle. "Quality, Cost and Accountable Care: Models for the Journey." Healthcare Executive. May/June 2014

Presentation, American College of Healthcare Executives
ACQUISITION & INTEGRATION: LEARNING FROM ONE HOSPITAL'S SUCCESSFUL RESULTS EXPERIENCE

Publication: Contributor to The Transformation Takes Shape: Leadership in the healthcare industry during the next three years: Insights from the Oliver Wyman Healthcare CEO Survey 2014

2013 Presentation, American College of Healthcare Executives
LEADERSHIP FOR THE FUTURE

2012 Capozzalo, Gayle. "Successfully Leading Change: Innovation in Service Delivery." International Hospital Federation. Volume 28, Number 4.

Capozzalo, Gayle. "Challenging Assumptions." Modern Healthcare Magazine March 2012

Presentation, American College of Healthcare Executives
SUCCESSFULLY LEADING CHANGE

Panel, Modern Healthcare Women Leaders in Healthcare
LEADERSHIP IN TIMES OF CHANGE

2011

Presentation, American College of Healthcare Executives
ETHICS: A KEY DRIVER FOR TODAY'S HEALTHCARE ORGANIZATIONS
Presentations, American College of Healthcare Executives
SUCCESSFULLY LEADING CHANGE

Presentation, Long Island University, Westchester Campus
THE HEALTHCARE REFORM FALL-OUT: STRATEGIC CHOICES FOR HEALTHCARE LEADERS
Presentation, American College of Healthcare Executives
FORCES OF CHANGE: NEW LEADERSHIP TO IMPROVE HEALTHCARE IN AMERICA

2010

Presentation, Institute for Healthcare Improvement
ACHIEVING COMPREHENSIVE, SAFE PATIENT FLOW IN AN ACADEMIC MEDICAL CENTER
Presentation, Columbia University
MANAGEMENT CHALLENGES IN THE EVOLVING HEALTHCARE AND INSURANCE SYSTEM
Presentation, the Leadership Institute
YALE NEW HAVEN HEALTH AND EMERGING SOCIAL MEDIA
Presentation, American College of Healthcare Executives
ACHE, NEW JERSEY REGENT BREAKFAST
Presentation, American College of Healthcare Executives Rhode Island Chapter
THE CASE FOR ACHE IN 2010 AND BEYOND

2009

Presentation, the Leadership Institute
PERFORMANCE EXCELLENCE
Presentation, Yale School of Public Health
YALE HEALTHCARE MANAGEMENT PROGRAM
Presentation, Yale University School of Public Health, Class of '54 Reunion
HEALTHCARE REFORM

2008

Presentation, American College of Healthcare Executives
ACHE REFLECTIONS ON LEADERSHIP

2006

Presentation, Institute for Healthcare Improvement
USING MEASUREMENT TO GUIDE IMPROVEMENT

2005

Presentation, Institute for Healthcare Improvement
USING MEASUREMENT TO GUIDE IMPROVEMENT
Presentation, the Leadership Institute
HOSPITALS NOT FOR PROFIT STATUS
Presentation, University of Columbia-Missouri Alumni Meeting
HEALTHCARE IN THE 2000s
Presentation, the Leadership Institute
YALE NEW HAVEN HEALTH HEART INSTITUTE

2004

Presentation, SG2
TECHNOLOGY EVALUATION AND ADOPTION PLANNING
Presentation, Better Management LIVE Worldwide
ACHIEVING PERFORMANCE EXCELLENCE IN A COMPLEX HEALTHCARE DELIVERY SYSTEM
Presentation, the Leadership Institute
STRATEGY ORGANIZATION AND STAFFING: LEADERSHIP INSTITUTE STRATEGISTS' FORUM
Presentation, Institute for Healthcare Improvement National Forum on Quality Management
A PERFORMANCE MANAGEMENT INITIATIVE: YALE NEW HAVEN HEALTH SYSTEM'S STRATEGY

2003

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
STAYING AHEAD OF EMERGING SCIENCE AND TECHNOLOGY

2002

Presentation, National Committee for Quality Healthcare
USING TECHNOLOGY TO DELIVER QUALITY HEALTHCARE
Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
MEDICAL SCIENCE AND TECHNOLOGY: OPPORTUNITY OR THREAT

2001

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
WOMEN EXECUTIVES AND THE GLASS CEILING
Presentation, the Leadership Institute
LEVERAGING CLINICAL DEVELOPMENT TO CREATE AN ENTREPRENEURIAL ENVIRONMENT
Presentation, Modern Healthcare 2001 Healthcare IT Outsourcing Summit
LEVERAGING THE INTERNET TO ENHANCE CUSTOMER RELATIONSHIPS
Presentation, American College of Healthcare Executives
2020 VISION: USING SCIENCE AS THE BASIS FOR HEALTH SYSTEM STRATEGY

2000

Presentation, Institute for Healthcare Improvement National Forum on Quality Improvement
WOMEN IN LEADERSHIP IN THE NEXT CENTURY
Presentation, VHA Northeast
TRENDS IN HEALTH SYSTEM DEVELOPMENT

CHRISTOPHER M. O'CONNOR, FACHE

54 Connelly Hill Road
Hopkinton, MA 01748 oconnor.chris09@gmail.com Tel: (508) 625-1487
Mobile: (203) 444-5789

PROFESSIONAL EXPERIENCE

YALE NEW HAVEN HEALTH SYSTEM, NEW HAVEN, CT
Large academic health system with nearly $3.4 billion in revenue, 2,130 beds and over 19,000 employeess located in southern Connecticut

Executive Vice President, Chief Operating Officer (2012 – present)
Responsible for system operations of this large, academic multihospital integrated delvery system including overseeing the 300+ physician medical foundation.

- Integrated the employee health, occupational medicine and corporate health components into a consolidated and aligned business unit with gains in efficiencies and revenue performance.
- Leading the system's cost and value positioning effort to to improve our annual cost performance by more that $125 million on an ongoing annual basis. Chair of the system implementation steering committee that coordinates the four committees driving this project.
- Coordinating the effort to improve the operations through a system approach in the laboratory, pharmacy, care management, medical staff credentialing – these areas are under system development to meet operational benchmark targets as well as business plan opportunities.
- Leading the "big data" effort across the health system to ensure the capability to manage data and produce information meets the changing needs across the health care spectrum.

SAINT RAPHAEL HEALTHCARE SYSTEM, NEW HAVEN, CT
Large community teaching hospital (511 beds) affiliated with the Yale School of Medicine encompassing over $500 million in revenue, long term care and other ancillary services

President and Chief Executive Officer (2009-2012)
Reporting to the Board, oversaw all aspects of the health care system up to and including the asset sale of the system to Yale-New Haven Hospital in September of 2012.

- Led the team to negotiate and ultimately execute a letter of intent and Asset Purchase Agreement with Yale-New Haven Hospital. This process included a full second request investigation by the Federal Trade Commission as well as a reviews by the Attorney General and the Office of Health Care Access regarding a Certificate of Need process.
- Implemented a broad strategy to investigate an opportunity to affiliate with a system that included national catholic systems, for-profit systems and systems within the state of Connecticut.
- Over the two year period managed to maintain operational focus and performance while managing through the purchase process while uncertain of the approval process.
- Improved profitability of the medical center by implementing widespread redesign and cost improvement targets.

CARITAS ST. ELIZABETH'S MEDICAL CENTER, BOSTON, MA
Flagship tertiary teaching hospital of a six-hospital system affiliated with Tufts School of Medicine, located in eastern Massachusetts with 340 licensed beds and 2,500 employees and nearly $400 million in net revenue.

President ***(2006 – 2009)***
Chief Operating Officer ***(2006)***
Responsible for medical center operations including strategic plan, operational performance and community engagement for this urban tertiary teaching hospital.

- Exceeded budgeted performance, earning progressively larger bottom-lines of 1.1%, 1.5% and 2% during the three fiscal years under my leadership.

- Successfully recruited more than 40 new physicians, including key leadership as well as clinical staff to facilitate clinical activity turnaround.
- Improved patient satisfaction from the 70th percentile to the 90th percentile by linking service, quality and access to leadership performance.
- Through a team approach, worked to improve quality goals in many areas including surgical care infection, cardiac outcomes, infection control and ventilator associated pneumonia. Facilitated the implementation of a transparent patient safety program with non-punitive reporting as well as a thorough root cause analysis process to ensure process improvements.
- Recognized as a Tompson Performance Improvement hospital in both 2007 and 2008 in the large teaching category.
- Improved quality outcomes, including benchmark performance in the surgical care infection program to over 95% compliance, and achieved distinction from the Institute of Healthcare Improvement.
- Facilitated programmatic expansion into hyperbaric wound care, neurosciences and robotic surgery. Oversaw milestone construction projects including: a new emergency department, operating suite renovations, a neuroscience and spine center and a multi-disciplinary wound center.
- Led the implementation of Leadership Development initiative across the system in conjunction with the "Achieving Exceptional Care" program – A Studer Group collaborative for over 600 system-wide leaders that focused on improving leadership tools.

OCHSNER HEALTH SYSTEM, NEW ORLEANS, LA

A non-profit, academic, multi-specialty healthcare delivery system dedicated to patient care, research and education. The system includes seven hospitals, more than 35 healthcare centers and 11,000 employees.

Vice President Clinical Operations (2003 – 2006)

Responsible for specialty clinical services including cardiac, oncology, digestive diseases, musculoskeletal, transplant, surgical and perioperative services. Included within these service lines are both clinic operations and hospital services for areas including infusion therapy, radiation therapy, endoscopy, cardiac cath labs and EP labs, 23 OR suites, 6 OR ASC, and 2 plastic surgical OR suites.

- Hurricane Katrina - Led the organization through its response to this national disaster. Ochsner was one of three hospitals to remain functional throughout the storm and flooding. Facilitated the emergency preparedness and response to this regional catastrophe including countless leadership and staff meetings and briefings for the 2,500 staff, patients and dependants sheltered at Ochsner. Assisted in communicating current operational status with media outlets. Assisted in coordination of assets and security needs with state and local emergency operations centers. Maintained a structured decision making process in the face of failing utilities, flooding, civil unrest and numerous operational and human resource issues.
- Assisted in the acquisition process that resulted in the purchase of three Tenet hospitals in the greater New Orleans region. Finalized planning for new cancer center and heart and vascular institute. Facilitated the operational opening of main campus ASC in January 2004.
- Facilitated the focus on patient satisfaction, patient safety and quality, including implementing quality metrics as well as improving patient satisfaction within the operating room setting by 50% over a 12-month period.
- Upon arrival, addressed significant resource shortage within Anesthesia. Implemented recruitment and retention tactics to increase CRNA staff, recruited a new chair and increased staffed anesthesia locations 20% within a year of implementation.
- Improved endoscopy scheduling by both resource allocation and process improvement that increased procedures from 50 to 70 per day.

HOSPITAL OF SAINT RAPHAEL, NEW HAVEN, CT

A 510 bed tertiary teaching hospital affiliated with the Yale School of Medicine in New Haven, Connecticut. St. Raphael's has more than 3,500 employees with a broad range of clinical programs with over $600 million in net patient revenue.

Vice President, Clinical Operations *(2001 – 2003)*
Administrative Director, Departments of Surgery and Emergency Medicine *(1999 – 2001)*
Administrator, St. Raphael Physician Organization *(1997 – 1999)*

Progressive responsibility focused on operational performance of major clinical departments including surgery, emergency medicine, radiology, pathology, gastroenterology, cardiac and oncology services. Responsible for more than 400 FTE's and $200+ million in net patient service revenue.

- Following 9/11, established the first regional emergency response agreement in Connecticut in collaboration with Yale New.Haven Hospital and other local healthcare providers.
- Improved OR efficiency by both adding supply (from 19 OR suites to 23) and increasing production by $25 million in gross revenue. Improved cost per case by 5%, and increased OR utilization (saving approximately $3 million in both med/surg supplies and implant costs).
- Implemented OR information system (ORSOS) following a difficult period for both scheduling and preference cards.
- Implemented a capitated defibrillator agreement with Medtronic that enabled savings of more than $1.2 million in pacemaker and defibrillator implants in one year.
- Coordinated the integration of additional subspecialties within the practice, increasing gross professional revenue to $1.5 million.

SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD **(1995 – 1997)**

A large acute tertiary teaching hospital with nearly 500 beds and affiliated with the Johns Hopkins School of Medicine. It is the flagship for Lifebridge Health an two-hospital integrated healthcare delivery system.

Coordinator, Emergency Medicine Operations ***(1996 – 1997)***
Administrative Resident ***(1995 – 1996)***

Following post graduate residency, worked with then CEO Warren Green and the senior leadership team. Remained and managed this large emergency department, which at the time was seeing 65,000 patients annually with more than 20 physicians and PA FTE's.

AFFILIATIONS / BOARD MEMBERSHIPS / RECOGNITIONS

CONNECTICUT HOSPITAL ASSOCIATION, **Board Member** (2010-present)
Diversified Network Services, Board Member (2010-present)
Financial Oversight Committee, Member (2010-present)

VHA, NORTHEAST PURCHASING COALITION, **Board Member** (2012-present)

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES, **Fellow**
Member of Article of the Year Committee

AMERICAN HEART ASSOCIATION, Founders Affiliate, **Board Member** (2008)
Chair of the Heart Walk Leadership Committee

SAINT RAPHAEL LEADERSHIP AWARD, (September, 2012)

GOOD SCOUTING LEADERSHIP AWARD (October, 2012)

NEW HAVEN BUSINESS TIMES, **Forty under 40 Award** (September 2000)

EDUCATION

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC - 1996
Masters in Health Service Administration

THE GEORGE WASHINGTON UNIVERSITY, Washington, DC - 1993
Bachelor of Arts, Economics

Curriculum Vitae

Bruce D. Cummings, FACHE
901 Pequot Avenue
New London, Connecticut 06320
Home email: thompsonlake@hotmail.com
Home phone: 860-447-9518

Present Position

Lawrence + Memorial Healthcare – New London, CT
President and Chief Executive Officer — 2005 – Present

Key accomplishments:
- Led acquisition of Westerly Hospital (Westerly, RI) in 2013
- John D. Thompson Award and Community Service Award from the Connecticut Hospital Association
- L+M named one of the state's 20 best places to work by Connecticut Magazine

Previous Positions

Olean General Hospital – Olean, New York
President and Chief Executive Officer — 2002 – 2005

Blue Hill Memorial Hospital – Blue Hill, Maine
Chief Executive Officer — 1990 – 2002

Mid-Maine Medical Center – Waterville, Maine
Vice President, Strategic Planning, Marketing and Corporate Development — 1985 – 1990
Director of Ambulatory Care — 1980 – 1985

City of Danbury – Danbury, Connecticut
Director of Health — 1978 – 1980

Education

M.P.H - Yale University School of Medicine, Department of Epidemiology and Public Health — 1977

B.A. - Colby College — 1973

Professional Affiliations and Associations

American College of Healthcare Executives (Fellow)
Connecticut Hospital Association, Board of Directors, Chair (2014-2016)
Visiting Nurse Association of Southeastern Connecticut, Director
American Hospital Association, Regional (New England) Policy Board, Delegate
Sea Research Foundation, Board of Directors

Daniel Rissi, MD
365 Montauk Avenue
New London, CT 06320
(860) 442-0711

Professional Experience

Febuary 2008 to present; Lawrence & Memorial Healthcare; VP/Chief Medical & Clinical Operations Officer
June 2006 to February 2008; Lawrence and Memorial Hospital; Vice President and Chief Operating Officer
October 2005 to January 2006; Olean General Hospital; Interim President and Chief Executive Officer
January 2003 to June 2006; Olean General Hospital; Vice President for Medical Affairs
March 2002 to August 2002: Blue Hill Memorial Hospital; Interim Chief Executive Officer
1990 to 2002: Blue Hill Memorial Hospital; Medical Director (full time since 1998); Chief of Staff
1996 to 2002: Maine Network for Health; Medical Director (1998-2002)

Additional Professional Activities

2014 to present: CT Hospital Association Committee on Patient Care Quality
2010 to present: CT Medical Examining Board; physician member
2009 to present: Qualidigm; Board member
2003-2006: Olean General Hospital, Olean, New York; active medical staff
1980-2003: Blue Hill Memorial Hospital, Blue Hill, Maine; active medical staff
1980-2003: Eastern Maine Medical Center, Bangor, Maine; affiliate medical staff
1980-1994: Island Medical Center Doctors, Stonington, Maine; physician, managing partner

Education and Training

American Board of Family Medicine; certified 1980, recertified 1986,1992, 1998, 2004, 2013
Certificate of added Qualification in Geriatrics, AAFP; certified 1988; recertified 1998
Medical Review Officer; certified by AAMRO 2003
Aviation Medical Examiner (FAA); certified 1981, recertified 1986, 1991
State of Maine Medical Examiner; certified 1977
1977-1980 Eastern Maine Medical Center; Residency in Family Medicine
1973-1977 Johns Hopkins University School of Medicine; MD
1969-1973 Yale University; BA

Professional Memberships

American College of Physician Executives; member since 1996
American Academy of Family Physicians; member since 1980; Fellowship 1994
National Board of Medical Examiners; diplomate 1977

Curriculum Vitae

Seth Van Essendelft

152 Long Wharf Road
Mystic, Connecticut 06355
Cell (252) 320-2032
Email svanessendelft@lmhosp.org

PRESENT POSITION

Lawrence + Memorial Healthcare– New London, CT & Westerly, RI
Chief Financial Officer/ Vice President of Support Services — 2014 – Present

PREVIOUS POSITIONS

Vidant Health – Greenville, NC
Vice President of Financial Services (Financial Officer), Vidant Medical Center — 2011 – 2014
Vice President of Financial Operations (Financial Shared Services), Vidant Health — 2009 – 2011

Doctors Hospital – Coral Gables, FL
Financial Officer/Controller — 2006 – 2009

CIGNA Corporation –Various Locations
CIGNA Healthcare, Dental & Vision Subsidiary
AVP, Director of Strategic Planning and Control, Plantation, FL — 2005 – 2006

Financial Leadership Program, Hartford, CT — 2000 -- 2005
CIGNA Healthcare Division
Director of Capital Planning — 2003 – 2005
Assistant Director, PPO Product Controller — 2001 – 2003
CIGNA Retirement and Investments Division
Assistant Director, Consolidated Asset Financial Reporting — 2000 – 2001

PREVIOUS MILITARY EXPERIENCE

United States Coast Guard –Various Locations — 1991 -- 2011
Senior Reserve Officer, Coast Guard Sector - Miami, FL — 2005 – 2011
Command Center Operations Controller, First Coast Guard District – Boston, MA — 2000 – 2005
Budget Officer, Pacific Area Command – Alameda, CA — 1998 – 2000
Commanding Officer, Cutter Point Huron – Virginia Beach, VA — 1994 – 1996
Department Head, Cutter Diligence -- Wilmington, NC — 1991 – 1994

EDUCATION

M.B.A
The College of William and Mary, Graduate School of Business – Williamsburg, VA — 1997

B.S., Management
United States Coast Guard Academy – New London, CT — 1991

ATTACHMENT VII

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE KEVIN RYAN
ONE HUNDRED THIRTY NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4000
HARTFORD, CT 06106-1591

HOME: 860-848-0790
CAPITOL: 860-240-8585
TOLL FREE: 1-800-842-8267
E-MAIL: Kevin.Ryan@cga.ct.gov

DEPUTY SPEAKER

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT
PUBLIC HEALTH COMMITTEE

August 4, 2015

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System. As a State Representative in the area, I have many constituents who depend on the existing services of Lawrence & Memorial Hospital. My constituents and the larger community will be much better served by the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health Systems.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale is a great opportunity and the right response for the challenges that face our region. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Sincerely,

Kevin Ryan
Deputy Speaker

State of Connecticut

SENATE

SENATOR ART LINARES
THIRTY–THIRD DISTRICT

LEGISLATIVE OFFICE BUILDING
SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
Capitol: (800) 842-1421
E-mail: Art.Linares@cga.ct.gov
Website: www.SenatorLinares.com

ASSISTANT MINORITY LEADER

RANKING MEMBER
PLANNING AND DEVELOPMENT COMMITTEE

CHAIR
INTERNSHIP COMMITTEE

MEMBER
EDUCATION COMMITTEE
JUDICIARY COMMITTEE

August 13, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As senator of the 33rd district, I am writing to express my support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

L+M's proposed affiliation with Yale makes sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and should expand their accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation, and employees should benefit as well.

If this affiliation supports a higher quality of care at lower cost for a greater number of patients, as indicated in early reports, I strongly encourage you to approve this application.

Sincerely,

Art Linares

Art Linares
State Senate

STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS
OFFICE OF THE SENATE MINORITY LEADER
ROOM 120, STATE HOUSE
PROVIDENCE
02903

DENNIS L. ALGIERE
MINORITY LEADER
401-222-2708

July 30, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P. O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As the Rhode Island Senate Republican Leader, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility—particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

If I can be of any assistance, please feel free to contact me.

Sincerely,

Dennis L. Algiere
SENATE MINORITY LEADER

DLA:plm

August 17, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As elected officials representing the Greenwich region, we are writing to express our strong support for the proposed affiliation of Lawrence + Memorial Health (L&M) with the Yale New Haven Health System (YNHHS).

Greenwich Hospital joined the Yale New Haven Health System as an Affiliate in 1998 to ensure strong, local, full-service health care for residents of lower Fairfield County and Westchester County. The Affiliation provided Greenwich with a collaboration across a broad geographic area while remaining a separate organization with our own local Board of Directors. And, 17 years later, it has proven to be a cost-effective and clinically strong relationship.

We understand that healthcare is changing rapidly and believe that an affiliation between L+M and YNHHS will enhance access to high quality healthcare. As your agency reviews the proposed affiliation, we encourage you to consider the interests of patients in the New London region who will directly benefit from this partnership as do our constituents.

We believe there is exceptional value in this partnership and we urge its approval.

Sincerely,

Scott Frantz
State Senator

Fred Camillo
State Representative

Mike Boechino
State Representative

Livvy Floren
State Representative

City of New London

Office of the City Council
181 State Street • New London, CT 06320 • Phone (860) 447-5202 • Fax (860) 447-1971

August 7, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Ave.
MS#13HCA
PO Box 340308
Hartford, CT 0613400308

Re: L + M Healthcare, Inc. Affiliation With Yale New Haven Health System

Dear Ms. Martone:

As a three term New London City Councilor, and the immediate past president of the City Council, I am writing to support the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

L+M Healthcare is the parent corporation for Lawrence + Memorial Hospital here in New London, along with the Visiting Nurse Association of Southeastern Connecticut, the L+M Medical Group and Westerly Hospital. If L+M joins Yale New Haven Health System our two local hospitals would join Greenwich Hospital, Bridgeport Hospital and Yale New Haven Hospital in the nationally renowned Yale network.

I support this affiliation with the assurance that L+M will remain our community hospital and with the realization that a small independent hospital cannot compete in today's health care world. I support this affiliation with the assurance that L+M will remain nonprofit and continue its tradition of public service, community outreach and charitable care. My support is also based on the understanding that L+M will continue to respect the collective bargaining rights of its employees and based on L+M's pledge to continue to honor all contracts and agreements negotiated with its unions. L+M has also agreed to observe any and all future state laws that require it and/or its affiliates to pay municipal property taxes to the City of New London.

Through the years, L+M Hospital has been a valuable partner with the City and has supported a variety of community events and activities and sponsored a number of programs and services here in New London and throughout its service area. The prospect of L+M's community investment, technology and clinical offerings being strengthened by way of this affiliation is most promising.

With all of that in mind, I hope you will approve this application as quickly as possible.

Respectfully,

Michael Passero

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE CHRISTOPHER ROSARIO
128TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 5006
CAPITOL: (860) 240-8585
E-MAIL: Christopher.Rosario@cga.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
ENERGY COMMITTEE
TRANSPORTATION COMMITTEE

August 20, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express my support for the proposed affiliation of Lawrence + Memorial Health with the Yale New Haven Health System which includes Bridgeport Hospital that is located within our community.

I recognize that healthcare is evolving rapidly and that an affiliation between L+M and YNHHS will drive access to high quality healthcare in the most efficient manner possible. As your agency reviews the proposed affiliation, we encourage you to consider the interests of patients in our region who will directly benefit from this partnership. I view the affiliation of L+M with Yale New Haven Health System as a critically important way to preserve access to services for patients throughout the State. Building upon a long and significant history of collaboration and alignment, we see exceptional value and unique synergies in this partnership.

This affiliation will allow L+M and YNHHS and its affiliated hospitals to continue to manage an extraordinarily complex environment and allow these organizations to deliver exceptional care to the patients in our region. We are confident that a thorough review of this affiliation will reveal the strong benefits of this affiliation and we urge its approval.

Sincerely,

Christopher Rosario
State Representative

August 7, 2015

Ms. Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Dear Ms. Martone:

I am writing as Chairman of the Mohegan Tribe of Indians, which owns – among other entities – the Mohegan Sun Casino in Uncasville, and employs more than 6,000 thousand people there. This letter is in strong support of the proposed L+M Healthcare, Inc./Yale New Haven Health System affiliation that will be considered by the Connecticut Office of Health Care Access in the coming months.

Many of our employees receive their healthcare from L+M affiliates – whether it is New London-based Lawrence + Memorial Hospital, Westerly Hospital in Rhode Island, the Visiting Nurse Association of Southeastern Connecticut and/or a physician from Lawrence + Memorial Medical Group. The quality of care our employees and Tribal members receive is unfailingly compassionate and of high quality.

This affiliation would strengthen both organizations clinically, competitively and financially. This – along with Yale's committed capital investment of $300 million over five years - would help strengthen our economy here in eastern Connecticut.

L+M does business with Mohegan Sun, having held two of its annual Spring Galas here – including the hospital's 100th anniversary celebration, which drew a record sit-down crowd of 2,000 people for the event. We proudly hosted L+M's Well Healed Woman in our same Uncas Ballroom in 2014, when more than 1,200 women heard financial advisor Suze Orman speak to eastern Connecticut's largest and longest running women's health conference. We are excited about the 2015 Well Healed Woman conference, which we expect will draw another large crowd to hear this year's keynote speaker, Rebecca Lobo. Additionally, the Mohegan Tribe actively supports L+M philanthropically in a variety of ways, including, but not limited to the use of our arena's Tribal skybox for popular fundraising events.

For these and so many other reasons, I hope you will look favorably on this application. It will benefit both of these quality healthcare providers and – more important – the hundreds of thousands of patients for whom they provide care each year.

Sincerely,

Kevin P. Brown, "Red Eagle"
Chairman

Mashantucket Pequot Tribal Nation
Rodney A. Butler
Chairman
2 Matt's Path
P.O. Box 3060
Mashantucket, CT 06338-3060
Tel 860 396 6133
Fax 860 396 6139

August 7, 2015

Kimberly R. Martone,
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Chairman of the Mashantucket Pequot Tribal Nation, I am writing to urge you to approve the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

The Mashantucket Pequots, owners of Foxwoods Resort Casino and employer of thousands of employees at the casino, Tribal government and other entities, use L+M Healthcare, Inc., more than any other healthcare system. Many of our employees receive their healthcare from Lawrence + Memorial Hospital in New London, Westerly Hospital just across the border in Rhode Island, physicians associated with the Lawrence & Memorial Medical Group and/or the Visiting Nurse Association of Southeastern Connecticut.

L+M's satellites, including its primary care facility in nearby Pawcatuck and the Pequot Health Center just off Interstate 95 in Groton, make access to quality healthcare that much more convenient for Tribal member, our employees and their families.

Over the years, the Mashantucket Pequot Tribal Nation has been a proud supporter of L+M's Joslin Diabetes Center and of the hospital itself. By the same measure, we have welcomed L+M's support for our annual Drive for Diabetes and Education fundraisers. For the past two years, L+M has held its annual Spring Gala in the ballroom of our fox Tower facility, drawing nearly 1,000 supporters to our property.

If this proposed affiliation is approved, we are also very encouraged by Yale's promise to deliver $300 million to this region in capital investment. As you may know, our economic recovery in eastern Connecticut has lagged somewhat behind the rest of the state, and we are facing even more challenges in the future. Such an infusion will have a very positive impact for a region that needs it.

I hope you will look favorably on this application and approve it after learning that there is very strong support for it among a broadly diverse cross section of people from throughout our region. Thank you.

Sincerely,

Rodney Butler

Rodney A. Butler, Chairman

September 1, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As elected officials representing New Haven, we are writing to express our strong support for the proposed affiliation of Lawrence+ Memorial Health with the Yale New Haven Health System (YNHHS).

We recognize that healthcare is evolving rapidly and that an affiliation between L+M and YNHHS will drive access to high quality healthcare in the most efficient manner possible. As your agency reviews the proposed affiliation, we encourage you to consider the interests of patients in our region who will directly benefit from this partnership.

We view the affiliation of L+M with Yale New Haven Health System as a critically important way to preserve access to services for patients throughout the State. Building upon a long and significant history of collaboration and alignment, we see exceptional value and unique synergies in this partnership.

This affiliation will allow both L+M and YNHHS and its affiliated hospitals to continue to manage an extraordinarily complex environment and allow these organizations to deliver exceptional care to the patients in our region.

We are confident that a thorough review of this affiliation will reveal the strong benefits of this affiliation and we urge its approval.

Sincerely,

Rep. Pat Dillon

Rep. Robert Megna

Rep. Toni Walker

Rep. Juan Candelaria

TOWN OF STONINGTON

SELECTMAN'S OFFICE
GEORGE CROUSE, JR.
FIRST SELECTMAN

152 Elm Street • Stonington, Connecticut 06378
(860) 535-5050 • Fax (860) 535-1046
gcrouse@stonington-ct.gov

August 4, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As First Selectman of the Town of Stonington, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community elected Boards of Directors, that this would be the best outcome for both institutions and the communities they serve. I strongly encourage you to approve this application.

Sincerely,

George Crouse, Jr.
First Selectman

TOWN OF LEDYARD
CONNECTICUT
OFFICE OF THE MAYOR

John A. Rodolico
Mayor

Mark J. Bancroft
Mayoral Assistant

741 Colonel Ledyard Highway
Ledyard, CT 06339-1551
(860) 464-3222
FAX (860) 464-8455

August 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA PO Box 340308
Hartford, Connecticut 06134-0308

Ms. Martone:

As you are aware, L+M Healthcare, Inc, the parent corporation for Lawrence + Memorial Hospital, Westerly Hospital, the Visiting Nurse Association of Southeastern Connecticut and Lawrence + Memorial Medical Group, is pursuing full affiliation with Yale New Haven Health System, parent of Greenwich, Bridgeport and Yale-New Haven hospitals. This letter is written to provide my full support for this affiliation.

The citizens of Ledyard have a long relationship with L&M Hospitals and their affiliates and I have no doubt that this affiliation will insure a continuation of the standard of excellence in health care. This cooperative initiative will also provide access to medical advances at an affordable cost due to the expanded network. The well-being of our Town, our region, and the State of Connecticut will be the ultimate winners in this affiliation.

Please do not hesitate to contact me should you wish to further discuss this matter.

Respectfully

John A. Rodolico
Mayor

SENATOR GAYLE SLOSSBERG
Legislative Office Building
Room 3100
Hartford, CT 06106-1591
Toll-free 1-800-842-1420
Capitol 860-240-0482
Home 203-878-6412

State of Connecticut
SENATE
Fourteenth District

Chair
Education
Vice Chair
Human Services
Member
Appropriations
General Law
Regulation Review

September 15, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As an elected official from Greater New Haven, I am writing to express my support for the proposed affiliation of Lawrence + Memorial Health (L&M) with the Yale New Haven Health System.

I understand that healthcare is evolving rapidly and that an affiliation between L+M and YNHHS will enhance access to high quality healthcare in the most efficient manner possible. As your agency reviews the proposed affiliation, I encourage you to consider the interests of patients in the region who will benefit from this partnership.

The affiliation of L+M with Yale New Haven Health System is an important way to preserve access to services for patients throughout the State. Building upon a long history of collaboration between Yale-New Haven Hospital and L&M, I see value in this partnership.

This affiliation will allow both L+M and YNHHS, and its affiliated hospitals (Bridgeport, Greenwich and Yale-New Haven), to continue to manage an extraordinarily complex environment and allow these organizations to deliver exceptional care to the patients in our region.

I am confident that a thorough review of this affiliation will reveal the strong benefits and urge its approval.

Sincerely,

Gayle Slossberg
State Senator, 14th District

TOWN OF GROTON

OFFICE OF THE MAYOR

RITA M. SCHMIDT
MAYOR
RSCHMIDT@GROTON-CT.GOV

45 FORT HILL ROAD, GROTON, CONNECTICUT 06340
TELEPHONE (860) 441-6630 FAX (860) 441-6638
WWW.GROTON-CT.GOV

August 7, 2015

Kimberly R. Martone Director of Operations
Office of Health Care Access
410 Capitol Avenue MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Mayor of the Town of Groton, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System. In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility — particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Rita M. Schmidt

Rita M. Schmidt
Mayor

OFFICE OF
THE SELECTMEN
(860) 434-7733

August 4, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As First Selectman in the Town of Lyme, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Ralph Eno
First Selectman

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE KATHLEEN M. McCARTY
THIRTY-EIGHTH ASSEMBLY DISTRICT

226 GREAT NECK ROAD
WATERFORD, CT 06385

HOME: (860) 442-2903
CAPITOL: (800) 842-1423
Kathleen.McCarty@housegop.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
EDUCATION COMMITTEE
PUBLIC HEALTH COMMITTEE

August 6, 2015

Ms. Kimberly R. Martone, Director of Operations
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone,

I am in strong support of Lawrence+Memorial Hospital's application to establish an affiliation with Yale New Haven Health System. Hospitals and health care providers are undergoing a rapidly changing regulatory environment as well as uncertainties with the level of reimbursement rates both federal and state.

L+M and YNNHS have an existing partnership in a number of clinical services such as radiation oncology and neonatology. Physicians and clinicians from both health care institutions have worked together to help individuals with their medical needs and having a full affiliation will lead to continuity and lead to long-term stability for both hospital systems. Our region will benefit greatly and our residents from the approval of this application.

I strongly encourage you to approve this application.

Sincerely,

Kathleen M. McCarty

Kathleen M. McCarty
State Representative- 38th District
Waterford, Montville

TOWN OF OLD LYME

OFFICE OF THE SELECTMEN
52 Lyme Street
Old Lyme, CT 06371
www.oldlyme-ct.gov
Tel. (860) 434-1605
Fax (860) 434-1400

August 1, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As First Selectwoman of Old Lyme, I am writing to express my support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at several areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Best regards,

Bonnie A. Reemsnyder

Bonnie A. Reemsnyder
First Selectwoman

OFFICE OF THE MAYOR
CITY OF BRIDGEPORT, CONNECTICUT
MARGARET E. MORTON GOVERNMENT CENTER
999 BROAD STREET
BRIDGEPORT, CONNECTICUT 06604
TELEPHONE (203) 576-7201
FAX (203) 576-3913

BILL FINCH
Mayor

July 27, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Mayor of the City of Bridgeport, I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

I have seen first-hand, the benefits of the affiliation between Bridgeport Hospital and Yale New Haven Health System. Under the proposed affiliation agreement that is before you, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for patients.

As you know, healthcare is undergoing significant change across our country and across our state. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

I encourage you to approve the affiliation. Thank you for the opportunity to offer my support.

Sincerely,

Bill Finch
Mayor

State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

July 30, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

We are writing in enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve.

We applaud L+M for their foresight and efforts and strongly support their affiliation with Yale New Haven Health System. We wholeheartedly encourage you to approve this application.

Sincerely,

John Scott
State Representative, 40th District

Aundre Bumgardner
State Representative, 41st District

State of Connecticut

SENATE

SENATOR PAUL FORMICA
TWENTIETH SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
CAPITOL: (800) 842-1421
E-MAIL: Paul.Formica@cga.ct.gov
WEBSITE: www.SenatorFormica.com

SENATE MINORITY WHIP

RANKING MEMBER
ENERGY & TECHNOLOGY COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
PUBLIC SAFETY COMMITTEE

August 4, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Senator of District 20 which includes Lawrence and Memorial Hospital, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M two years ago.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Best regards,

Paul M. Formica
State Senator 20th District
EAST LYME, MONTVILLE, NEW LONDON, OLD LYME, OLD SAYBROOK, SALEM, WATERFORD

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE DIANA S. URBAN
FORTY THIRD ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4042
HARTFORD, CT 06106-1591
HOME: (860) 535-4868
CAPITOL: 860-240-8710
TOLL FREE: 1-800-842-8267
FAX: (860) 240-0206
E-MAIL: Diana.Urban@cga.ct.gov

CHAIR
COMMITTEE ON CHILDREN
RBA SUBCOMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
ENVIRONMENT COMMITTEE
PROGRAM REVIEW & INVESTIGATIONS COMMITTEE

August 7, 2015

Ms. Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Ave.
MS#13HCA
PO Box 340308
Hartford, CT 0613400308

Dear Ms. Martone:

I am writing as the State Representative whose district includes two of the towns in Lawrence & Memorial Healthcare, Inc.'s primary service area – Stonington and North Stonington. Please include me among the many people from the public and private sectors who are on record in support of L+M's proposed affiliation with Yale New Haven Health System.

While my district is in Connecticut, this affiliation would be doubly beneficial for my constituents, the vast majority of whom receive their care at Westerly Hospital, located just over the Rhode Island border, and/or L+M Hospital, based in New London. L+M also has a primary care facility, conveniently located off Route 2 in the Pawcatuck section of Stonington, and some of my constituents are also patients of another L+M affiliate, the Visiting Nurse Association of Southeastern Connecticut.

L+M and Yale are already clinical partners in five areas of care: cancer, cardiac, stroke, neonatal and pediatric emergency. A full affiliation for L+M with the world-class system that is Yale New Haven is logical, and I hope you will approve the application for full affiliation.

Very truly yours,

Diana

Diana Urban
State Representative - 43rd District

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL

REPRESENTATIVE MIKE FRANCE
FORTY-SECOND ASSEMBLY DISTRICT

17 GARDEN DRIVE
GALES FERRY, CT 06335

HOME: (860) 464-9229
CAPITOL: (800) 842-1423
Mike.France@housegop.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
GOVERNMENT ADMINISTRATION AND ELECTIONS COMMITTEE
PLANNING AND DEVELOPMENT COMMITTEE

August 7, 2015

Ms. Kimberly R. Martone, Director of Operations
Office of Health Care Access
Department of Public Health
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone,

I am writing in strong support of the proposed affiliation between Yale New Haven Health System and L+M Healthcare, Inc., which includes L+M Hospital, Westerly Hospital, Visiting Nurse Association of Southeastern Connecticut and L+M Medical Group. In the rapidly evolving healthcare regulatory environment we are working within, coupled with the increasing fiscal pressures on both the federal and state level on our regional and community hospitals, this is the best avenue to ensure the continued viability of L+M Healthcare and their affiliates in providing services to our residents.

L+M Healthcare already partners with Yale New Haven Health System in a number of clinical areas, including neonatology, pediatric emergency medicine and vascular surgery. Based on this partnership, physicians, clinicians and staff at both hospital systems already have strong professional ties to ensure the highest quality of care and treatment for our residents. With a full affiliation and partnership L+M Healthcare will be in a better position to respond to further changes in both the fiscal and regulatory environments, and draw upon the knowledge and experiences of Yale New Haven Health System to assist residents in Southeastern Connecticut.

I appreciate your favorable consideration and review of their application.

Regards,

Mike France
State Representative, 42nd District
Ledyard, Preston, and Montville

CITY OF NEW HAVEN

TONI N. HARP, MAYOR

165 Church Street
New Haven, Connecticut 06510
T: 203.946.8200 F: 203.946.7683
www.CityofNewHaven.com

SETTLED 1638

All-America City

SINCE 1958

August 10, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care
Access 410 Capitol
Avenue MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Mayor of the City of New Haven, I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

I have seen first-hand, the benefits of the Yale New Haven Health System. Under the proposed affiliation agreement that is before you, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for patients.

As you know, healthcare is undergoing significant change across our country and across our state. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

I encourage you to approve the affiliation. Thank you for the opportunity to offer my support.

Sincerely,

Toni N. Harp
Mayor

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ERNEST HEWETT
THIRTY-NINTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING, ROOM 4040
HARTFORD, CT 06106-1591

HOME: 860-442-9765
CAPITOL: 860-240-8585
TOLL FREE: 800-842-8267
FAX: 860-240-0206
E-MAIL: Ernest.Hewett@cga.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
JUDICIARY COMMITTEE
BANKING COMMITTEE
REGULATION REVIEW COMMITTEE

August 5, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Ave.
MS#13HCA
PO Box 340308
Hartford, CT 0613400308

Dear Ms. Martone:

Having proudly served a decade representing the people of New London in the House of Representatives, six years as a New London City Councilor and one year as Mayor, I am writing to express my strong support for the proposed affiliation between L+M Healthcare, Inc., and Yale New Haven Health System.

Having represented and interacted with the people of New London, having heard of their needs and preferences for many years, I believe I am qualified to determine what is good for our city. I firmly believe that this affiliation, with a promised capital investment by Yale of some $300 million for our region, would be very good indeed. Such an investment will strengthen L+M and Westerly Hospitals and our region's economy.

I would like to make it clear that my support for this affiliation is contingent on two promises:

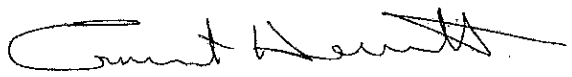
- First, that L+M and its affiliates will comply with any future state law as it pertains to payment of local property taxes to the City of New London, and;
- Will continue to honor and abide by all negotiated contracts with the various unions that represent the dedicated employees of L+M and its affiliates.

Over the years, L+M has been a good corporate citizen, working hard to provide access to care for everyone, including those to whom care is traditionally not readily accessible. It has supported various local charities that are consistent with its mission. The tens of millions of dollars L+M provides annually

in the way of community investment (CBISA – Community Benefit Inventory for Social Accountability) has improved the quality of life for thousands of people in my district and throughout the region.

Please support this proposed affiliation for the benefit of both institutions, but more important, for the many people they will continue to serve.

Very truly yours,



Rep. Ernest Hewett
State Representative, 39th District
New London

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ED JUTILA
37TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 2202
HARTFORD, CT 06106-1591

HOME: 860-739-7730
CAPITOL: 860-842-8267
E-MAIL: Ed.Jutila@cga.ct.gov

CHAIRMAN

GOVERNMENT ADMINISTRATION
AND ELECTIONS COMMITTEE

September 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express my support for the proposed affiliation between Lawrence and Memorial Healthcare, Inc. and Yale New Haven Health System.

With the constantly changing healthcare environment, it becomes increasingly difficult for non-profit community hospitals to remain independent. The proposed merger between Lawrence and Memorial and Yale New Haven makes sense, and would greatly benefit both institutions and patients in our state.

As a New London-based hospital, L&M already partners with Yale in at least five clinical areas:

- radiation oncology,
- neonatology,
- telestroke,
- pediatric emergency medicine,
- and invasive cardiology/angioplasty and vascular surgery.

From this partnership, there has been an established track record of staff from both institutions being able to work productively with each other. A complete merger will allow for both organizations substantially to expand their accessibility, especially to under-served populations. Combining resources will also make it easier to recruit and retain physicians in all areas of care, and perahps most importantly, both organizations will be more financially stable from the affiliation.

For these reasons, I strongly encourage you to act favorably on this application.

Very truly yours,

Ed Jutila

TOWN OF MONTVILLE

Office of the Mayor

310 Norwich-New London Turnpike
Uncasville, Connecticut 06382

August 5, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As the Mayor of Montville, a community served by L+M Healthcare, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree with that conclusion.

I strongly encourage you to approve this application.

Very truly yours,

Ronald McDaniel
Mayor of Montville

FIFTEEN ROPE FERRY ROAD

Town of Waterford

WATERFORD, CT 06385-2886

August 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As the Waterford First Selectman, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree with their recommendation.

I strongly encourage you to approve this application.

Very truly yours,

Daniel Steward
First Selectman, Town of Waterford
(860) 444-5834

Town of East Lyme

Mark C. Nickerson
First Selectman
MNickerson@eltownhall.com

108 Pennsylvania Ave.
P.O. Box 519
Niantic, Connecticut 06357
Phone (860) 691-4110
Fax (860) 739-2851

August 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As First Selectman of the Town of East Lyme, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Mark C. Nickerson, First Selectman

Connecticut Sports Foundation
Helping cancer patients.

www.sportsfoundation.org

July 30, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Executive Director of the Connecticut Sports Foundation, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. It is my understanding that the New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Jane G. Ellis
Executive Director

CHAMBER of COMMERCE
EASTERN CONNECTICUT

914 Hartford Turnpike
Suite 206
Waterford, CT 06385
Phone: (860) 701-9113
Fax: (860) 701-9902
www.ChamberECT.com

August 1, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I write on behalf of the Board of Directors of the Chamber of Commerce of Eastern Connecticut to express our enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve.

The Chamber of Commerce of Eastern Connecticut strongly encourages you to approve this application.

Very truly yours,

Tony Sheridan
President and CEO

About the Chamber of Commerce of Eastern Connecticut:
The Chamber of Commerce of Eastern Connecticut is a collaborative of business and community leaders dedicated to securing and enhancing the economic vitality of eastern Connecticut. The Chamber works to create value for its members and the region by providing forums for business networking, leadership and discussions of issues that affect the region; providing opportunities for members to showcase their products, services and accomplishments; helping small businesses succeed through educational programs; and working to reduce the costs of doing business in Connecticut. For more information, visit www.ChamberECT.com

UCFS
United Community & Family Services

A Legacy of Caring since 1877

34 East Town Street
Norwich, Connecticut 06360-2326

telephone (860) 889-2375
fax (860) 889-3450
www.ucfs.org

July 30, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As President and CEO of United Community and Family Services, Inc., I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Charles Seeman
President & CEO

United Way

GREATER NEW HAVEN CHAMBER
We take care of business.

July 31, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Yale New Haven Health System is a major employer in our region and one of the top five employers in the State of Connecticut. Its investment in Lawrence + Memorial will provide the ongoing ability to drive healthcare costs down since the investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for patients.

I understand that healthcare is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and feature significant investments in clinical programs in both states.

Thank you for the opportunity to offer my support. I believe this affiliation should be approved.

Sincerely,

Anthony P. Rescigno

Anthony Rescigno
President
Greater New Haven Chamber of Commerce

GREATER MYSTIC CHAMBER OF COMMERCE

Bridging Business and Community

July 28th, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone,

As President of the Greater Mystic Chamber of Commerce and on behalf of our Board of Directors I am writing to express our enthusiastic endorsement for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly and ever-changing health care environment, it has become increasingly difficult for not-for-profit community hospitals to remain independent. L+M has sustained their independence for over a century and Westerly Hospital had remained independent as well for over 88 years prior to their acquisition by L+M.

L+M's proposed affiliation with Yale would be very compatible. The New London based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/ angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility- particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve and the Greater Mystic Chamber of Commerce is in complete agreement.

I strongly encourage you to approve this application.

Sincerely,

Tricia Walsh

Greater Mystic Chamber of Commerce
12 Roosevelt Avenue
P.O. Box 143
Mystic, CT 06355-0143

Phone: 860.572.9578
Fax: 860.572.9273
info@mysticchamber.org
www.MysticChamber.org

East End Community Council

1149 Stratford Avenue
Bridgeport, Connecticut 06607
Tel: (203)727-5573

August 5, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. This affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the efficiencies that can be generated through this partnership. This is good for L+M and YNHHS, but more importantly, it is good for patients.

I understand that healthcare is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right answer. The partnership will allow L+M to continue to address community health issues, and significant investments will be made in clinical programs. Additionally, the affiliation would include the installation of the Epic electronic medical record system – another added benefit for patients.

I believe this proposed affiliation should be approved. Thank you for the opportunity to offer my support.

Sincerely,

Ted Meekins, Director EECC

283 Stoddards Wharf Road
P.O. Box 375 • Gales Ferry, CT 06335
Tel 860.464.7281 • Fax 860.464.6362
/w.uwsect.org

United Way
of Southeastern Connecticut

August 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As President and CEO of United Way of Southeastern Connecticut, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Virginia L. Mason

Virginia L. Mason
President and CEO

NEW LONDON ROTARY CLUB

District 7980 Club 303 P.O. Box 654 New London, CT 06320

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

July 31, 2015

Dear Ms. Martone:

As President of the New London Rotary Club and the Hannah Hafkesbrink Professor of Hispanic Studies, Connecticut College, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System. The New London Rotary Club has long enjoyed a successful relationship with the L + M Hospital administration and staff, in addition to a thriving relationship with the VNA of Southeastern Connecticut, and see the proposed affiliation as a positive move for our community.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Julia A. Kushigian-Secor, President

The Greater Westerly-Pawcatuck Area
CHAMBER OF COMMERCE
...serving business, industry, and tourism
in southeastern Connecticut and southwestern Rhode Island
One Chamber Way, Westerly, RI 02891 • 401-596-7761 • Fax 401-596-2190
www.westerlychamber.org • info@westerlychamber.org

August 18, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

For the past 19 years, I have proudly served as Executive Director of the Greater Westerly-Pawcatuck Area Chamber of Commerce, a unique two-state regional business organization. During that time, I have witnessed many exciting new initiatives, industry expansions, and strategic alliances, but none more promising than the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System. Please consider this letter as a pledge of strong support for the proposed affiliation.

As you are no doubt aware, the healthcare landscape is constantly and rapidly shifting, and the challenges faced by independent community hospitals are almost insurmountable. Yet despite the numerous and complex issues threatening our independent hospitals, the residents in our community expect, and deserve, for L+M Hospital and Westerly Hospital to "thrive" rather than just "survive" while meeting the health care needs of the region.

The proposed affiliation between L+M Healthcare and Yale is a prudent partnership that would place our local hospitals in the optimum position to meet the health care needs of our region long into the future. L+M Hospital, located in New London, CT, already enjoys an excellent working affiliation with Yale in at least five clinical areas: telestroke, pediatric emergency medicine, radiation oncology, neonatology, invasive cardiology/angioplasty and vascular surgery. The personnel from both institutions have already established mutual respect, lines of communication and positive interpersonal working relationships with one another. A full affiliation will only improve both organizations and expand their already substantial accessibility, particularly to populations that are traditionally under-served. Additionally, the new affiliation will aid in efforts to recruit and retain physicians in all areas of care, something that has been an ongoing challenge for our local hospitals. Both organizations will be strengthened financially from their affiliation, and the public will be better served.

In the interest of full disclosure, you should know that I have a long standing relationship with L + M Hospital and a somewhat unique perspective. My mother worked in Human Resources for over 20 years and took great pride in the mission of the organization. My first job was at L & M Hospital, in the

Dietary Department, when I was age 16, followed by a clerical position in Outpatient Psychiatric Services. I have given birth at both L+ M Hospital and Westerly Hospital, and said goodbye to my father who was a mere 50 years old, and passed away there after a period of quality, compassionate care. I have served for the last 2 years on the Board of L + M Healthcare. Simply put, the well being of this health care institution matters to the region, and it matters deeply to me personally.

I am confident in the representatives from both organizations that have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I wholeheartedly agree with their recommendation, and strongly encourage you to approve this application.

Best Regards,

Lisa B. Konicki
Executive Director

Leeway

Leaders in AIDS Care

Support Letter for Yale-New Haven Hospital & Yale New Haven Health System
Re: Lawrence & Memorial Hospital Affiliation

August 13th, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As a community partner I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Leeway, with support from Yale New Haven Health, has had a significant impact on the lives of underserved families in our region. Under the proposed affiliation agreement that is before you, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for the communities they serve.

As you know, healthcare is undergoing significant change across our country and across our state. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

I encourage you to approve the affiliation. Thank you for the opportunity to offer my support.

Sincerely,

Heather Aaron
Executive Director

Greenwich chamber of commerce

August 2, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As President and CEO of the Greenwich Chamber of Commerce, I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System (YNHHS). I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to offer the same high-level patient care that it currently offers to its affiliated hospital communities, including Greenwich Hospital. Additionally, many Connecticut residents rely on hospitals for good, stable jobs. The type of affiliation that is proposed with YNHHS and L+M can only help to ensure that residents not only have access to exceptional care, but also to jobs that will remain in the community.

It is evident that the healthcare industry is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will reduce costs, help to manage population health, provide the IT infrastructure to offer seamless care through the implementation of the EPIC electronic medical record system, and will include significant investments in clinical programs.

Thank you for the opportunity to offer my support. I encourage you to approve the affiliation with Yale New Haven Health System and Lawrence + Memorial Healthcare.

Sincerely,

Marcia O'Kane
President and CEO

Habitat for Humanity®
of Coastal Fairfield County

August 10, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express my support for the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. As a leader in the non-profit arena and a significant developer of affordable housing within Coastal Fairfield County and, particularly within the city of Bridgeport, the quality and accessibility of health care is certainly always on the top of our list of concerns. We are confident that this affiliation will enable both of the organizations involved to continue providing access to high quality care in the most efficient and effective manner possible.

As I understand it, the affiliation agreement will lead the Yale New Haven Health System to invest in southeastern Connecticut and western Rhode Island, building upon efficiencies that can be generated through this partnership. I would expect this to be positive for both organizations and, more importantly, for patients.

This is a time of significant change for many aspects of the healthcare systems and I understand that hospitals and others must seek innovative solutions to enhance their capabilities, treat changing and growing populations while continuing to expand and invest in clinical programs. It seems evident that this affiliation will enable YNHHS and L + M to embrace these needed changes will also resulting in IT infrastructure improvements, including the implementation of the Epic electronic medical record system.

I appreciate the opportunity to offer my support and hope that this affiliation will be approved.

Sincerely,

Stuart D. Adelberg
Chief Executive Officer

ANTONINO AUTO GROUP

543 Colman Street • New London, Connecticut 06320 • Phone (203) 447-3141
Route 184 • Groton, Connecticut 06340 • Phone (203) 448-0050

August 4, 2015

Kimberly R.Martone
Director of Operation
410 Capital Ave
MS#13HCA
PO Box 340308
Hartford CT 06134-0308

Dear Kimberly,

I am writing this letter to express my support of the Lawrence and Memorial Hospital and Yale New Haven Hospital's affiliations.

My name is John Antonino, I am the principle of the Antonino Auto Group of Southern Connecticut. I have been in business in Connecticut for 50 years and have had many pleasurable experiences with health needs at Lawrence and Memorial Hospital. My four children and twelve grandchildren were all born at Lawrence and Memorial Hospital. I also have had four occasions with health issues that doctors and staff have helped me though, all with success. Both of my parents were also treated there in the last days of their lives, and always with respectful care.

My business employs 650 people at all skill levels, their extended family member's total over 2000 individuals. Most of our employees have health insurance coverage through us, and all enjoy the benefits of Lawrence and Memorial Hospital.

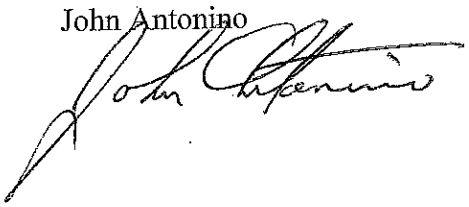
It is apparent to me that Lawrence and Memorial Hospital has always endeavored, though the years, to provide the people of Southeastern Connecticut with the most modern and up to date medical and facilities possible. An affiliation with Yale New Haven Hospital can only improve the reputable status of Lawrence and Memorial Hospital has earned, particularly the Cancer Center which is also state of the art.

It would be an injustice if affiliation of these two fine establishments were not possible. If allowed, the union would quite possibly make them the best in New England.

Thank you for your consideration.

Sincerely,

John Antonino



FROM THE DESK OF

DANIEL BRANNEGAN

July 29, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
MS#13HCA
PO Box 340308
Hartford, Ct 06134-0308

Dear Ms. Martone:

As a Corporator of Lawrence and Memorial (L+M) Hospital, Chair of the L+M Centennial Capital Campaign, and life-long resident of Eastern Connecticut, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

For more than one-hundred years L+M has been a not-for-profit community hospital. Similarly, Westerly Hospital has been one for 88 years before it's recent acquisition by L+M. In the rapidly changing healthcare environment, however, it has become increasingly difficult for such institutions to remain independent. What is necessary is for L+M Healthcare to be strengthened so it can continue to serve the community. I believe the affiliation with Yale New Haven Hospital System fills this need.

L+M's proposed affiliation with Yale makes good sense. Our New London based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with one another. A full affiliation will only improve both organizations and expand their already substantial accessibility - particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be stronger financially from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded that this affiliation would be the best outcome for bother institutions and the communities they serve. I support this conclusion.

I strongly encourage you to approve this application.

Sincerely,

Daniel P. Brannegan

15 GRAVEL STREET, MYSTIC CT 06355

Child & Family Agency of Southeastern Connecticut, Inc.
It's About Children

Sally Crawford
Chairman of the Board

Richard D. Calvert, M.S.W., L.C.S.W.
Chief Executive Officer

August 12, 2015

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue - MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: L+M Healthcare – Yale New Haven Health System application for full affiliation

Dear Ms. Martone:

As CEO for Child and Family Agency, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent. As a major provider of both primary medical care through its school-based health centers, and office-based child guidance, intensive in-home, and school-based behavioral health services, Child and Family Agency (CFA) has perennially relied upon L+M Hospital for caring and well-coordinated services, particularly those at levels of care not directly provided by CFA. Steady, quality continuation of this essential collaborative work between our two organizations depends upon sustainability, fiscal and otherwise, and we are convinced that full affiliation between L+M Healthcare and the Yale New Haven Health System will well serve that end.

Child and Adolescent Psychiatry is a particular service area that warrants special consideration in support of this proposed affiliation. The severe shortage of C & A Psychiatry statewide is a chronic problem that is currently receiving tremendous attention by the relevant State agencies, especially DCF and DMHAS; by the legislatively established Behavioral Health Partnership Oversight Council on which I serve; by the Governor's Sandy Hook Advisory Commission; by the legislature in general; and by consumer groups.

This shortage is chronically felt more severely in Southeastern Connecticut than in any other region of the state. While not-for-profit employers such as L+M and CFA work to attract Psychiatrists by pitching quality of life factors and salaries gauged against cost of living, the lack of a teaching hospital in this region is a major rule-out factor for psychiatrists who typically place high value on collegial contact, professional development, and teaching opportunities. As a result, recruitment, retention and service availability all suffer. Recent initiatives such as the State's funding of Psychiatry Consultation hubs are well-intentioned, but will do nothing to solve the root problem. While it is premature to predict any particular impact of L+M/Yale affiliation on this issue, affiliation will open up a hopeful line of discussion and creative problem solving, since Yale *is* a teaching hospital system, and so there are a host of ways in which this linkage might be advantageous for practicing psychiatrists. As a behavioral health clinician and administrator who has practiced in Southeastern Connecticut since the mid-1980's, this proposed affiliation is the first fundamental sign of hope I have seen for impacting this issue, and so I urge the Office of Health Care Access to approve the L+M/Yale application.

Sincerely,

Richard D. Calvert
Chief Executive Officer
(860) 443-2896, ext. 1404
calvertr@childandfamilyagency.org

51 COLLINS ROAD • STONINGTON • CONNECTICUT 06378

July 30, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As a current corporation member of L+M Healthcare, and a former chairman of L+M Hospital's board of directors, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century, and Westerly Hospital had for 88 years before its acquisition by L+M a couple years ago.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve.

At L+M's recent mid-year corporation meeting I was also persuaded of the benefits of the proposed affiliation during presentations by the current L+M Board Chair and the CEO's of both L+M and Yale, and I strongly encourage your approval.

Sincerely,

Thomas R. Castle

Thomas J. Riley
4 Mayfair Drive
Waterford, CT 06385
tjriley@tcors.com

September 2, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As a resident of Waterford who has received medical care at L + M Hospital, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

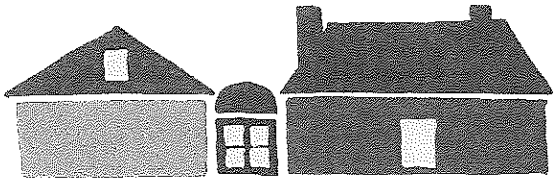
L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Thomas J. Riley



Children's Museum
of Southeastern Connecticut

409 Main Street • Niantic, CT 06357 • Phone: 860-691-1111 • Fax: 860-691-1194
www.cmsect.org

August 1, 2015

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Executive Director of the Children's Museum of Southeastern Connecticut,, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

In addition, as the head of a not-for-profit organization, I know only too well what an important philanthropic role Lawrence and Memorial Hospital plays in our local community. A healthy and successful hospital is vital, not only for the physical health of the population it serves, but also for the financial health of local agencies that rely on its support; the proposed affiliation will help ensure that this support continues.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Holly H. Cheeseman
Executive Director
Children's Museum of Southeastern Connecticut

Community Foundation
of Eastern Connecticut

Maryam Elahi
President & CEO
maryam@cfect.org

August 4, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

I understand that representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Maryam Elahi
President and CEO

BRIDGEPORT
REGIONAL
BUSINESS COUNCIL

July 29, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As President and CEO of the Bridgeport Regional Business Council, I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System (YNHHS). I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to offer the same high-level patient care that it currently offers to its affiliated hospital communities. Oftentimes, a hospital is the largest employer within a host community, and many residents rely on them for good, stable jobs. The type of affiliation that is proposed here can only help to ensure that residents not only have access to exceptional care, but also to jobs that will remain in the community.

It is evident that the healthcare industry is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will reduce costs, enhance capabilities to manage population health, provide the IT infrastructure to offer seamless care, and feature significant investments in clinical programs.

Thank you for the opportunity to offer my support. I believe this affiliation should be approved.

Sincerely,

Paul S. Timpanelli
President and CEO

WEST RIVER NEIGHBORHOOD SERVICES CORPORATION

Stacy R. Spell
Board President
West River Neighborhood Services Corp.
P. O. Box 8401
New Haven, CT 06520-8401

August 21, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Support Letter for Yale-New Haven Hospital & Yale New Haven Health System
Re: Lawrence & Memorial Hospital Affiliation

Dear Ms. Martone:

As a community partner I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare (L+M) with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for the communities they serve. I can attest to this because our organization, the West River Neighborhood Services Corporation (WRNSC), has benefited greatly from our partnership with Yale New Haven Health.

As you know, healthcare is undergoing significant change across our country and across our state. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

I encourage you to approve the affiliation. Thank you for the opportunity to offer my support.

Sincerely,

Stacy R. Spell
WRNSC Board Chair

CONNECTICUT COLLEGE

Ulysses B. Hammond

Vice President for Administration

270 Mohegan Avenue
New London, Connecticut
06320-4196

August 3, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capital Avenue, MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As a citizen of southeastern Connecticut and Vice President for Administration at Connecticut College, I have had the unique experience and pleasure of being involved with Lawrence + Memorial Healthcare, Inc. and its affiliates, staff, administration, medical staff, and operations for nearly all of my 15 years in Connecticut – including 14 years as a Corporator, 12 as a Board member and four as Chair of the Board – I believe I am qualified to write authoritatively on the application for L+M's affiliation with Yale New Haven Health System.

Like other healthcare systems of similar size and capability, L+M faces more fiscal, operational and competitive challenges than at any time in its 103-year history. Reduced Medicare and Medicaid reimbursement, the imposition and raising of taxes, and stepped-up competition from other providers have limited L+M's ability to advance and expand as much as it would like.

In spite of this, L+M has remained remarkably vibrant and competitive and retained its excellent standing in the community. In 2013, my final year as Board Chair, we executed the complex and historic acquisition of Westerly Hospital, just across the Rhode Island border. Despite its fiscal challenges, L+M has continued to support our community with tens of millions of dollars in audited community investments over recent years. Whether helping to sustain New London's regional Homeless Hospitality Center, endowing a nursing faculty position at Three Rivers Community College or funding scholarships for the Dr. Martin Luther King, Jr., Scholarship Trust Fund (of which I am former Board Chair), L+M has never shirked its responsibility as a community pillar.

The prospect of a full affiliation with Yale New Haven, however, offers exciting new possibilities and would strengthen L+M and Yale immeasurably. These two high-quality organizations already partner in a number of clinical areas, demonstrating an interactive chemistry that would make their full affiliation a natural progression.

I strongly encourage you, after your own examination, to approve this application, which will only make both organizations stronger for the patients and communities they serve in so many vital ways.

Respectfully,

Ulysses B. Hammond
Vice President for Administration

860 439-2046 Fax: 860 439-5277 E-mail: ubham@conncoll.edu

Dominion Resources Services, Inc.
P.O. Box 128, Waterford, CT 06385
dom.com

Dominion®

August 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express Dominion's strong support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System. Dominion is one of the nation's largest producers and transporters of energy. In Connecticut, we own and operate the Millstone Power Station in Waterford, the Dominion Bridgeport Fuel Cell facility in Bridgeport and the Somers Solar Center in Somers.

The healthcare industry, like the energy and utilities industry, is experiencing an historic time of change and opportunity. To best serve their patients and customers, both industries need to be financially sound and willing to adapt to current needs. It has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. As you know, L+M already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. A full affiliation will only improve both organizations and expand their already substantial accessibility.

Both organizations will be financially healthier with full affiliation and thus better positioned to serve their patients and communities. This is of particular importance to Dominion because we employ 1100 people in Southeast Connecticut at our Millstone Power Station. Our employees and their families count on a strong L+M for their healthcare needs.

Representatives from both organizations have completed extensive due diligence and concluded, along with their community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. Dominion wholeheartedly agrees.

Dominion strongly encourages you to approve this application.

Very truly yours,

Kevin R. Hennessy
Director – Federal, State & Local Affairs – New England
Dominion Resources, Inc.

CfAL Concepts for Adaptive Learning

"Using technology to help prepare today's children for tomorrow"

CFAL
4 Science Park, Suite A
New Haven, CT 06511
Tel. (203) 410-3679
Fax (203) 272-8451
www.EachChildLearns.org
Info@EachChildLearns.org

July 29, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am honored to have this opportunity to write you in support of the proposed affiliation of Lawrence Memorial Healthcare with Yale New Haven Health System. I firmly think that this affiliation will be positive for the communities these organizations serve, while allowing both to continue providing access to quality healthcare in the most efficient and effective manner possible.

Concepts *for* Adaptive Learning is a non-profit organization based in New Haven. With steadfast support from Yale New Haven Health System, over the past twelve years, our organization has had a significant impact on the academic achievement and quality of life of underserved children and families throughout the Greater New Haven region.

Under the proposed affiliation agreement that is before you, Yale New Haven Health System has committed to investing in the southeastern Connecticut and western Rhode Island regions. This investment is built upon the enormous efficiencies that can be gained through this affiliation. This is positive for both Lawrence Memorial Healthcare and Yale New Haven Health System. But more importantly, it will be positive for the communities they serve.

With the need for quality healthcare expanding and undergoing significant change across our country and our state, innovative solutions to the challenges facing hospitals and healthcare systems are needed and the right course of action. The affiliation will provide Lawrence Memorial Healthcare with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

I encourage you to approve this proposed affiliation. Thank you for hearing from a community partner that understands the benefits this affiliation can achieve for the masses of people they serve.

Sincerely,

Curtis M. Hill
Executive Director Emeritus
Concepts for Adaptive Learning
4 Science Park
New Haven, CT 06511

Greenwood ~ Gilbert ~George~ Orchard Block Watch #311
c/o Prof Jimmy Jones
153 Greenwood Street
New Haven CT 06511
203-376-7189, james.jones@mville.edu

August 13, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for the communities they serve. I can attest to this because our organization, the Greenwood – Gilbert – George – Orchard Blockwatch, has benefited greatly in partnership with Yale New Haven Health.

I understand that healthcare is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and feature significant investments in clinical programs in both states.

Thank you for the opportunity to offer my support. I believe this affiliation should be approved.

Sincerely,

Prof Jimmy Jones
Co-Captain of New Haven Block Watch # 311

Three Rivers
COMMUNITY COLLEGE

574 New London Turnpike • Norwich, CT 06360-6598
860.215.9007 FAX: 860.215.9917

Office of the President

August 4, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As President of Three Rivers Community College and a board member of L+M Hospital, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Sincerely,

Mary Ellen Jukoski

Mary Ellen Jukoski, Ed.D.
President, Three Rivers Community College
L+M Board Member

CHESTER W. KITCHINGS, JR.
P.O. Box 308
Essex, CT 06426

August 7, 2015

Ms. Kimberly R. Martone

Director of Operations

Office of Health Care Access

410 Capitol Ave.

MS#13HCA

PO Box 340308

Hartford, CT 0613400308

Dear Ms. Martone:

I am writing as a second-generation major donor and member of the Board of Directors at Lawrence + Memorial Healthcare, Inc., to express my strong support for L+M's proposed affiliation with Yale New Haven Health System.

My father, Chester W. Kitchings, Sr., served as Chairman of L+M's Board of Directors for three decades from 1954 to 1984. His involvement with the hospital and its affiliates was a true labor of love. Having inherited his passion for L+M, I was elected to the Board in 1999 and served until 2009, chairing the Finance Committee and continuing my family's philanthropic support.

I am still a member of the Finance Committee and, thus, intimately aware of the struggles L+M and other similarly-sized healthcare systems are experiencing as a result of many factors, including, but not limited to increased competition from physicians and other providers, imposition and raising of state taxes, and sharp reductions in Medicare and Medicaid reimbursement. These and other factors have taken an organization that has finished in the black for as long as anyone can remember and landed it in the red at the end of the past two fiscal cycles. A third consecutive year with a negative margin is likely again this year.

Becoming affiliated with Yale will strengthen L+M immeasurably in many ways. It will expand a clinical partnership that is already in place in at least five areas – cardiac, stroke, cancer, neonatal and pediatric emergency care. Yale's commitment to invest in capital, programs and services can only enhance and expand access to healthcare. The affiliation will be beneficial to both organizations, so I hope you will approve it as soon as possible.

Respectfully,

Chester W. Kitchings, Jr.

Kimberly R. Martone

Director of Operations

Office of Health Care Access

410 Capitol Avenue

MS#13HCA

P.O. Box 340308

Hartford, CT 06134-0308

Dear Ms. Martone:

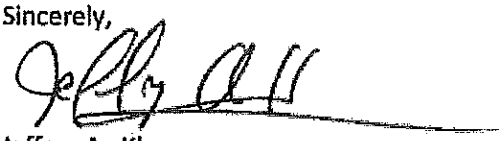
I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for patients.

I understand that healthcare is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and feature significant investments in clinical programs in both states.

Thank you for the opportunity to offer my support. I believe this affiliation should be approved.

Sincerely,



Jeffrey A. Klaus

127 Everit Street

New Haven, CT 06511

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capital Ave, MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to you to indicate my strong endorsement of the proposed affiliation of L+M Healthcare and Yale New Haven Health System. One might expect this in my current role as Board Chair of L+M, but I wished to insure the understanding of my deep belief in the combination of the two institutions.

I hope and also am certain that you will receive much in the way of supporting rationale. I will not dwell on that, but will focus on my experience and tenets. It's all about enhancing the health of the people in the communities that we serve, as well as the future sustainability of our institution.

I have had the good fortune to serve on the board of L+M for about 10 years. During this time I have become convinced that it is the most complex "business" that I have ever been associated with. In this extremely fluctuating environment, but in the simplest of terms, the Board and management of L+M Healthcare have collectively concluded after careful and considerable deliberation, that we are best capable of attaining and maintain our mission and vision by seeking an affiliation with Yale New Haven Health System. We know them well through long standing clinical partnerships and feel we are truly fortunate to have such a world class healthcare organization with which to align.

We greatly anticipate and appreciate your thoughtful consideration and ultimate approval of this application.

Very truly,

Alan Hunter
Chairman of the Board
L+M Healthcare

L+M WESTERLY HOSPITAL

STEPHEN M. GREENE
Chair

email: smg@puccigreene.com
25 Wells Street | Westerly, RI 02891
401.596.1926 | FAX 401.596.9050

August 3, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Board Chair of Westerly Hospital, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M acquired Westerly Hospital just more than two years ago. Westerly, losing as much as $1 million per month in its worst financial times, had gone into receivership, its future was in doubt and our region feared the possibility of losing its valued community hospital. No sooner had the acquisition been completed on June 1, 2013, than Westerly Hospital's financial condition improved dramatically. In fact, with only one exception, our community hospital has finished each of the past 24 months in the black, and our future is bright – particularly if the proposed L+M/Yale affiliation is completed. We are excited about the prospect of becoming part of the Yale New Haven Health System.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

I strongly encourage you to approve this application.

Very truly yours,

Stephen M. Greene
Board Chair

SMG:lll

James C. McGuire
203 Glenwood Avenue
New London, CT 06320
August 5, 2015

Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, Connecticut 06134-0308

Dear Ms. Martone:

As a former board member and chairman of L+M Healthcare, I wish to express my support for the proposed affiliation between L+M and Yale New Haven Health System. I served as chairman of the L+M board from 1984 through 1997 and as a board member from 1980 through 2005. I continue to serve on the finance committee. I have lived in New London all my life and have practiced law here for 42 years. I feel that I know both the hospital and the community well.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century. We have seen other Connecticut hospitals partner to form larger, more stable organizations. Similarly, L+M's acquisition of Westerly Hospital has strengthened that hospital as a community asset.

L+M's proposed affiliation with Yale makes sense. L+M Hospital already partners with Yale in a number of clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. Physicians and other personnel from both institutions know, respect and interact well with each other. A full affiliation will improve both organizations and expand their already substantial accessibility, including to populations that have been traditionally under-served. The affiliation will also make it easier to recruit and retain physicians in our service area. Both organizations should be financially healthier from their affiliation. At the same time, L+M will retain its own local governing board to ensure that the best interests of the community are being met.

After extensive deliberation, the governing boards of both organizations and their administrative staffs have concluded that the affiliation is in the best interest of both institutions and the communities that they serve. I agree.

I urge you to approve this application.

Sincerely,

James C. McGuire

WESTERLY HOSPITAL FOUNDATION

25 Wells Street | Westerly, RI 02891
401.348.2300 | westerlyhospital.org | Tax ID #05-0508064

August 4, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As Westerly Hospital Foundation Board Chair, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

L+M's proposed affiliation with Yale makes great sense. Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility – particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve. I agree.

Our community has embraced this proposed affiliation, and I strongly encourage you to approve the application.

Very truly yours,

Jennifer K. Schwindt
Chairman
Board of Directors

July 29, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I have volunteered in various capacities from candy striper to Vice Chair of the Board of Directors at Lawrence + Memorial Hospital for nearly 70 years, and am writing to express my strong support for L+M Healthcare's proposed affiliation with Yale New Haven Health System.

During seven decades of involvement with L+M, I have seen the hospital evolve from a medium-sized institution that provided virtually all of its care at the main campus in New London to a vast and comprehensive healthcare system with satellites and affiliates that serves hundreds of thousands of residents in eastern Connecticut, western Rhode Island and Fishers Island, NY.

The imposition and raising of taxes, cuts in Medicare and Medicaid funding, and stiffer competition from other healthcare systems and physicians, however, have landed L+M – like so many other independent hospitals – in a challenging financial condition.

Affiliating with Yale will not only bolster our finances, it will bring an infusion of $300 million from Yale into programs, services and technology to our service area – a region that would benefit so much from it and from the ensuing collaboration with this larger, world-class healthcare system.

L+M already enjoys collaborative clinical relationships with Yale in at least five areas: cancer, stroke, cardiac, neonatal and pediatric emergency care. Pursuing a full affiliation with Yale makes great sense, and I hope you will look favorably on it and approve it.

Very truly yours,

Naomi Rachleff

Naomi C. Rachleff, New London
Director Emeritus
Lawrence + Memorial Hospital

JAMES E. MITCHELL, PH.D.
47 Boulder Court
Mystic, Connecticut 06355
(860) 333-4666 (work/cell)
(860) 572-4159 (fax)
Jamesmitchell2242@sbcglobal.net

August 05, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As a member of the L+M Hospital Board, Chairman of the L+M Hospital Quality Council Committee, and President of the Dr. Martin Luther King Jr. Scholarship Trust Fund, a non-profit organization which provides scholarships to students of color in New London County, I am writing to express my enthusiastic support for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly changing healthcare environment, it has become increasingly difficult for not-for-profit, community hospitals to remain independent, as L+M has for more than a century and Westerly Hospital had for 88 years before its acquisition by L+M.

From my view, L+M's proposed affiliation with Yale makes great sense! Our New London-based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, tele stroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery. Personnel from both institutions know, respect, and have interacted very well with each other for several years. Now is the time! I believe that a full affiliation will improve both organizations by making it easier to recruit and retain medical personnel and substantially expand the accessibility of healthcare services especially to populations that are traditionally under-served. Both organizations will, also, be financially healthier from their affiliation.

Representatives from both organizations have completed extensive due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve.

I wholeheartedly support this affiliation, and strongly encourage you to approve this application.

Sincerely yours,

James E. Mitchell

LAWRENCE +MEMORIAL | L+M MEDICAL GROUP PATIENT CENTERED CARE

August 20, 2015

To whom it may concern,

Please accept this enthusiastic letter of support for the affiliation of the Yale/New Haven Health System with the L+M Healthcare organization. This potential relationship holds promise to better serve patients in Southeast CT and Southwest RI by enhancing the clinical offerings available, by improving the quality and consistency of that care, by improving the patients' experience and, not incidentally, by lowering the total cost of care.

Community hospitals have historically met the medical needs of their unique populations by paying close attention to the stated desires of their service areas tempered by what was financially feasible. This feasibility was often tied to the practicality of establishing standalone 24/7 clinical lines. Unfortunately, for many small and moderate sized community hospitals (like The Westerly Hospital in RI and the L+M Hospital in CT), the inability to support some full time service lines led to the unfortunate necessity for many patients of having to travel, often great distances, to larger medical centers. Almost without exception, these tertiary and quaternary medical facilities were also *very high cost centers* given their fixed costs of supporting academic programs, research and the burden of caring for the most medically complex patients in the region.

The result, high cost, inconvenient care with the potential for quality mishaps with regards to care coordination, care communication, redundant care or superfluous testing.

Enter into this environment the seismic shift in healthcare reimbursement that appropriately requires of providers an unrelenting focus on improving the value of care as opposed to simply extending more and more care. This new reality mandates that all healthcare organizations need to learn to treat patients in lower cost environments with similar or better quality than high cost settings. Moreover, they need to achieve proficiency in Population Health whereby the highest risk (and highest cost) patients are identified and preferentially offered more services and care to keep them, ideally, out of the high cost Emergency Department or inpatient care units.

Academic medical centers can't do this alone-they are too expensive. Community hospitals can't do it alone-they lack the organizational, analytical, clinical, human and capital resources to develop the Population Health infrastructure.

Only by locking arms (as opposed to locking horns) with each other can we meet the challenge of the IHI Triple Aim, and lower per capita cost while improving quality and the patients' experience. Combined with Yale, L+M is poised to do this successfully. As our mission is to "improve the health of this region," our patients will be the chief beneficiaries.

Many thanks for the consideration.

Christopher M. Lehrach, MD
President, L+M Medical Group/
Chief Transformation Officer

July 31, 2015

Kimberly R. Martone
Director of Operations; Office of Health care Access
410 Capital Avenue-MS#13HCA
PO BOX 340308
Hartford , Connecticut 06134-0308

Dear Ms. Martone,

As chair of the Lawrence and Memorial Medical Group Board of Directors and as a practicing physician in Southeastern Connecticut, I am writing to express my strong support for the proposed and critically necessary affiliation between Lawrence and Memorial Healthcare, Inc. and Yale New Haven Health system.

In this rapidly changing healthcare environment, it has become increasingly difficult for not-for- profit community hospitals to remain independent, as Lawrence and Memorial has been for more than a century and Westerly hospital had been for 88 years before it was acquired by Lawrence and Memorial. In addition relatively small medical groups such as the Lawrence and Memorial Medical Group will have considerable difficulty providing necessary care for patients in our community unless aligned with a large healthcare system. In the past Lawrence and Memorial Hospital has partnered with the Yale Medical Group and Yale New Haven Hospital in a number of important clinical areas including radiation oncology, invasive cardiology and vascular surgery, neonatology, telestroke, and more recently pediatric emergency medicine. Patients in our community in Southeastern Connecticut have greatly benefited from the expertise of the Yale physicians. As a physician who has frequently referred patients to endocrine surgeons in the Yale Medical Group I know firsthand how important and crucial to my patients this clinical partnership has been. Clinicians from both healthcare organizations know , respect, and interact well with each other. A full affiliation will greatly improve both healthcare systems and expand the already substantial accessibility for healthcare in the region-particularly to populations that are traditionally underserved. As a physician I am convinced that the affiliation of Lawrence and Memorial Healthcare with the Yale New Haven Healthcare system will facilitate the recruitment and retention of quality physicians in all areas of care. Clearly this is critically important for continuing to provide the healthcare necessary for our patients in Southeastern Connecticut. And very importantly both healthcare systems will be financially healthier from this affiliation.

Representatives from both healthcare organizations have completed an extensive due diligence and have concluded, along with community elected Board of Directors and the physicians on the Board of Directors for the Medical Group that the affiliation with Yale New Haven Healthcare would be the best outcome for both organizations and the communities they serve. I completely agree with this assessment.

Based on the above I strongly encourage you to approve this application,

Very truly yours,

Preston Lamberton, M.D.

Chair, Lawrence and Memorial Medical Group

LAWRENCE +MEMORIAL HOSPITAL

365 Montauk Avenue | New London, CT 06320
860.442.0711 | lmhospital.org

August 6, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford,Ct 06134-0308

Dear Ms. Martone:

As a physician and surgeon at L+M Hospital for the past 25 years and current President of its medical staff I am writing this letter in support of the proposed affiliation with the Yale New Haven Health System.

Months of hard work and due diligence by both institutions have led to a comprehensive affiliation agreement which contains the aspirational goals and rationales for the desired relationship and which I am sure you have as part of this filing. I won't repeat them here except to say that they are widely supported by the medical staff at L+M hospital.

The physicians and other clinical providers at our community hospital have seen many changes in the health care system in recent years and are quite knowledgable about those that are coming. We have been adept at negotiating these changes while still accomplishing the core mission of caring for the patients in our community. We also know that even more change is coming that will place even more demands on accomplishing the so called triple aim in medicine. This means improving patient experience, caring for populations of patients, and improving the value of care we provide. The collective wisdom of our physicians tells us that we will need to partner with a larger system to move into this future of health care and accomplish these aims which will allow not just the same care but vastly improved care.

The medical staff of L+M has considered the Yale system as its natural partner almost forever because of its deserved reputation as a worldwide leader in healthcare. We consider it a great fortune for us and our community to have them as our potential partner. Many L+M physicians historically came from the Yale system and we already have several stellar working clinical relationships.

Our medical staff is very diverse with physicians in many different configurations of practice. Employed and private practice. Hospital based and community based. Exclusive contract groups that provide our emergency room service, hospitalist care, pathology and anesthesia services. The proposed affiliation has the potential to affect all of us in as yet unknown ways. Despite this potential change to practitioners individually I can attest that the medical staff stands behind this initiative and I think this should speak volumes to the wisdom of the endeavor because it is the physicians and other clinical providers who have the expertise to understand that for L+M to continue to provide the best care to this community such an affiliation is necessary.

In addition to my confidence in the support of the medical staff for this initiative I have also been given the support of our Medical Executive Committee for the contents of this letter. If I can in any way provide you with more information regarding the physician perspective on the proposed affiliation please let me know.

Very truly yours,

David F. Reisfeld M.D., FACS
Medical Staff President and
the Medical Executive Committee of L+M Hospital

Adrian Hamburger, M.D.
Interventional Pain Specialist

45 Wells Street, Suite 201
Westerly, RI 02891
Phone (401) 348-3865
Fax (401) 596-6368

LETTER OF SUPPORT

To Whom It May Concern:

In my role as President of the Westerly Hospital Medical Staff, I have seen firsthand the difficulties that local community hospitals deal with on a day-to-day basis. As you know, our hospital went through receivership a few years ago, and was acquired by Lawrence & Memorial Hospital in June of 2013 after a lengthy regulatory process. L&M Hospital has made significant improvements - and even though the Westerly Hospital is finally making a slight profit the last few years – there is still a significant capital deficit to maintain the physical structure, and improve our current clinical offerings.

With further convulsions in the Healthcare industry, with unclear ACA mandates, nebulous insurance changes from year to year – and the growing focus on population health to better manage costs and care – it has become evident that as a health care system we need to be affiliated with a larger entity with further capital resources.

I support the planned merger of the L&M Healthcare system with the Yale New Haven Health system, because I believe it will improve the stability of our health industry in this region, it will allow for increased capital to improve our physical structures and increase our clinical reach, and it will bring tertiary/quarternary care to our region that is so desperately needed.

L&M Hospital already has a history of successful affiliation with the Yale New Haven Health system on several clinical endeavors, and I believe that this sets the tone for further collaborative efforts.

Thank you

Adrian Hamburger, M.D.
President of the Westerly Hospital Medical Staff

LAWRENCE +MEMORIAL | LM MEDICAL GROUP PATIENT CENTERED CARE

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

September 1, 2015

Dear Ms. Martone:

I am writing to send my unqualified endorsement of the proposed transition of the Lawrence and Memorial Medical Group to the Yale-affiliated New England Medical Group (NEMG)

I am a Cardiologist in a community hospital with professional aspirations first and foremost to provide for the health of this wonderful, diverse community of New London. I view the potential merger as a major step toward bringing needed healthcare resources into our county. By formalizing a relationship with NEMG, we are building upon and, indeed, formalizing an already existing strong bond. We already send the lion's share of our complex cardiac cases, for example, to our colleagues at Yale and its NEMG affiliate. Specifically, we rely heavily on the ability of NEMG for cardiac surgery, interventional cardiology, electrophysiology, and heart failure--areas in which we, a smaller hospital, could never realistically have the volume to support a competent cadre of physicians and staff.

By formalizing such an arrangement, it would facilitate a more rapid spread of information , a vital key- and the one most often overlooked- aspect in the provision of care to our complex and varied patients.

Of course there are political considerations, and seemingly bigger administrative questions about which I frankly don't much bother because I know, in my heart of hearts, that the single most important issue is to be able to sit with my patient, as I did yesterday with Gillian, a 53 year old woman recently diagnosed with advanced idiopathic cardiomyopathy, and tell her that I have a solid relationship with the heart failure team, the interventional team and the electrophysiology team at Yale and that together we will communicate together and with her so that I can hopefully help her navigate through some very dangerous waters and into a safe harbor of good health. It is quite clear to me that by merging into NEMG and by having instant access to their medical records and instant access to the leading specialists in each field, I will be more easily able to deliver safely Gillian (and every other patient I see) to that safe harbor.

Sincerely,

Jon C. Gaudio, MD

LAWRENCE+MEMORIAL Heart+Vascular Center

in affiliation with YALE-NEW HAVEN HOSPITAL Heart and Vascular Center

September 3, 2015

To Whom it May Concern:

As medical director of the Lawrence + Memorial Heart and Vascular Center in affiliation with Yale New Haven Hospital, I have been privileged to see enormous growth in the cardiovascular services made available locally to the patient's of the greater New London region. We have been able to develop an incredibly successful interventional cardiology program providing primary and elective percutaneous coronary interventions for both emergency heart attack victims and more stable patients with coronary artery disease. We have enhanced vascular services locally providing both surgical and percutaneous treatment options. We are slated to have advanced electrophysiologic and heart failure services beginning this year.

We have not accomplished this alone, but rather over the past 8 years we have worked side-by-side with the cardiologists of the Lawrence + Memorial Medical Group. Together we provide state of the art advanced heart care locally and have developed timely and efficient mechanisms to provide tertiary and quaternary services at Yale New Haven Hospital when necessary. This has gone a long way to help streamline patient care and provide for very effective means of communication among the members of the patient's care team.

We are now poised to take a broader position and align ourselves even closer with our colleagues from Yale New Haven as we hope to transition to the Northeast Medical Group. Such a merger would allow even closer collaboration and better communication among all services including primary care and a variety of subspecialties. Sharing common resources would go a long way to improve efficiency in the overall delivery of healthcare to our region. I am certain this would go a long way to help develop other healthcare service lines in much the same way we have done with cardiology.

Sincerely,

Brian Cambi MD

Brian Cambi, MD, FACC, FSCAI
Medical Director
L+M Heart and Vascular Center in affiliation with Yale New Haven

September 1, 2015

To Whom It May Concern:

I am writing this letter to support the affiliation of the Yale/New Haven Health System with the L+M Health care organization. My support is based upon the potential for improved coordination of care and outcomes for our shared patients, as well as improved cost effectiveness of this care, which will lead to reduced costs for our patients.

It goes without saying that viability of our smaller community hospitals are challenged given our current healthcare environment, and these hospital systems are increasingly aligning with larger healthcare organizations. While this practical goal would clearly be served by the above-mentioned affiliation, it is important to understand the potential benefits to our patients.

Accurate and thorough information of the patient's medical history is obviously important for providing optimal care. Unfortunately, achieving this has historically proven challenging, largely due our fragmented system of care. Alignment between these systems of care would facilitate seamless communication between care providers, and thereby improve transitions of care, which would allow for better care coordination for these patients in conjunction with their medical homes.

It is also important to acknowledge that this relationship would afford the opportunity to provide services to patients at a lower cost. Community hospitals are able to provide many of the same services as tertiary or quaternary medical facilities at significantly lower cost. Additionally, Improved care coordination allows us to identify, and therefore offer superior support, for our higher-risk patients. This brings the potential of reducing emergency department visits and hospital stays for these patients.

It is clear to me that alignment with the Yale/New Haven Health System will be of benefit to our patients. Given our model of patient-centric care at L+M Medical Group, I offer my unequivocal support for this relationship.

Sincerely,

Brian L. Williams MD
Medical Director of Informatics
L+M Medical Group

ATTACHMENT VIII

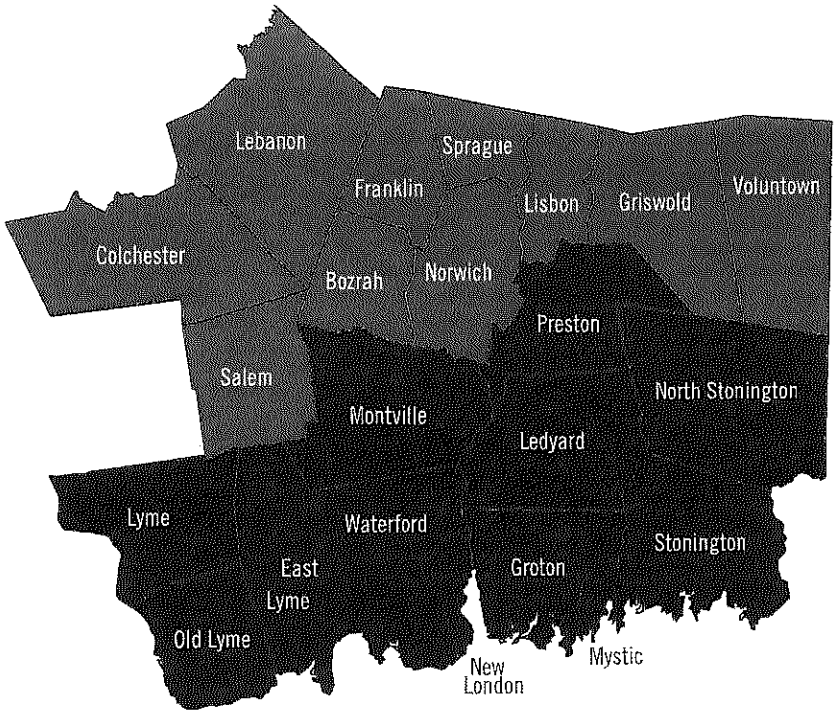
2012 REPORT:

COMMUNITY HEALTH NEEDS ASSESSMENT

LAWRENCE + MEMORIAL HOSPITAL

100 1912-2012

LMHOSPITAL.ORG



The Lawrence + Memorial Hospital primary service area includes the following Connecticut towns: New London, East Lyme, Lyme, Groton, Ledyard, Montville, North Stonington, Stonington, Old Lyme, and Waterford.

TABLE OF CONTENTS

COMMUNITY HEALTH NEEDS ASSESSMENT PLANNING COMMITTEE

Cindy Barry,
Senior Health Program Coordinator, Ledge Light Health District

Tim Bates,
Attorney, former L+M Chairman of the board

Stephanye Clarke,
Health Program Coordinator, Ledge Light Health District

Nancy Cowser,
VP of Planning, United Community & Family Services

Andrew Haffey,
Manager, L+M Waterfall Rehabilitation and Sports Medicine

Mary Lenzini,
President, Visiting Nurse Association of Southeastern CT

Alejandro Melendez-Cooper,
Site Director, Community Health Center of Groton and New London

Russell Melmed,
Epidemiologist, Ledge Light Health District

Jennifer Muggeo,
Supervisor, Health Education and Community Outreach, Ledge Light Health District

Mary Ann Nash,
Nutrition Program Coordinator, L+M Community Cancer Center

Jennifer O'Brien,
Program Officer, Community Foundation of Eastern Connecticut

Shraddha Patel,
Director of Planning, L+M

Tracee Reiser,
Associate Dean of Community Learning, Connecticut College

Dina Sears-Graves,
VP, Community Investment, United Way of Southeastern CT

Chris Soto,
Community Activist, Director, College Access Program

EXECUTIVE SUMMARY

Lawrence + Memorial Hospital (L+M) has been serving New London County, Connecticut for over 100 years and has been involved in ongoing community needs assessment and community health collaborations working to improve the health of area residents. In 2012, L+M contracted with Holleran Consulting, an independent research and consulting firm located in Lancaster, Pennsylvania, to execute a summary of trends and comparisons highlighted in their primary service area by the various regional and county assessments that have been conducted over the last five years. The following Connecticut towns are included in the primary service area: East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Stonington, and Waterford. (see map, page 2)

The assessment process included a review and analysis of data from four source types:

- Secondary Data (compiled from the Centers for Disease Control (CDC), Local and National health departments, the U.S. Census, and Healthy People 2020)
- Community Needs Assessments conducted by the United Way of Southeastern Connecticut (2010), and New London County Health Collaborative (2007)
- Hospital discharge data from 2008 through 2010
- Key informant interviews (Winter-Spring 2012)

This report is not necessarily a detailed representation of all the data that has been collected, but rather highlights the data and conclusions worth noting throughout the previous reports and research. Areas that have raised concern in the past and in which there are continued negative health outcomes reported include:

- **Cancer**
  Cancer incidences along with behavioral risk factors for cancer are higher in New London County than in Connecticut and in some instances the Nation.
- **Sexually transmitted diseases**
  Chlamydia rates were high in L+M's primary service area.
- **BMI and Obesity**
  The percentage of adults who reported a BMI indicating obesity in New London County was higher than that reported for the state.
- **Asthma**
  The incidence of Asthma within L+M's service area has remained constant over the previous three years and is much higher than the rates set forth by Healthy People 2020.
- **Diabetes**
  Diabetes incidence within the primary service area has steadily increased since 2008, and is much higher than the Healthy People 2020 goal.
- **Tobacco use**
  The percentage of adults currently smoking is higher in New London County than recommended by Healthy People 2020, a fact that raises concern due to its link to so many chronic diseases such as cancer.
- **Health status and access to care**
  Multiple sources report that residents of New London County face barriers to care such as delaying care due to cost and affordability of prescription medications.
- **Alcohol consumption**
  The percentage of adults who reported excessive drinking is high in both the state of Connecticut and New London County when making comparisons to the National Benchmark. As with tobacco use, higher than normal alcohol consumption is linked to many chronic conditions.

These areas of concern can have negative ramifications in many aspects of the community's health care and hospital systems. Many of these issues are behavioral risk factors for a variety of chronic health conditions, which place a heavy burden on local emergency departments, primary care centers, and disease management services.

It is also important to note that social determinants such as income and education can significantly impact health status, health behaviors, and health outcomes. Research has shown that lower educational attainment, poverty, and race/ethnicity are risk factors for certain health conditions. The demographic profile of the L+M service area correlates with the higher incidence of the negative health outcomes listed above.

Upon completion of data collection and analysis, in May 2012 L+M invited a team of hospital and community representatives to a community health strategic planning session. The purpose of the strategic planning session was to share the results of the community health needs assessment, to discuss and prioritize community health needs, and to develop community health goals and strategies to guide the L+M Community Health Implementation Plan. Holleran Consulting also facilitated this session. An asset mapping process was also undertaken in order to identify existing resources, services, and initiatives in the hospital service area.

Based on the quantitative results of the CHNA study, the qualitative feedback garnered from key informant interviews, and the expert knowledge of the group participants, a list of community health needs was refined and prioritized. The following list outlines the key health issues that were identified and prioritized.

PRIORITIZED COMMUNITY HEALTH NEEDS

RANK	ISSUE
1	Overweight & Obesity
2	Access to Care
3	Cancer
4	Sexual Health
5	Mental & Behavioral Health
6	Asthma

DEMOGRAPHICS

POPULATION

The **population** in the Lawrence and Memorial (L+M) primary service area is over 174,000, with a male to female ratio very close to the state and national ratios as seen in Figure A1. Actual numbers are displayed in Table 1.

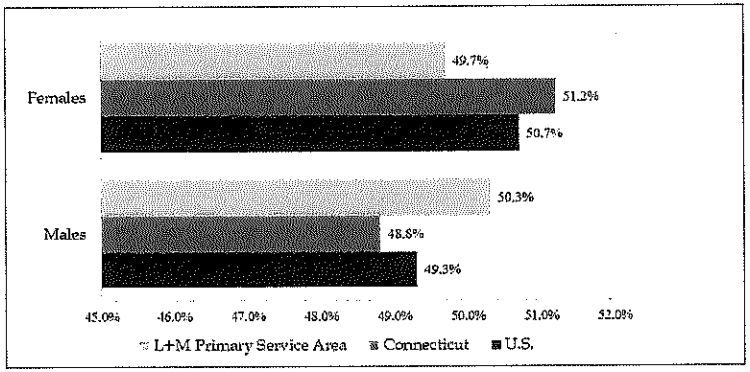


Figure A1: Gender breakdown for the United States, Connecticut, and the L+M primary service area, 2009

Table 1: Overall Population and Gender Breakdown (2009)

	U.S.*		Connecticut		L+M Service Area	
Population	307,006,550		3,518,288		174,884	
Gender	n	%	N	%	n	%
Male	151,449,490	49.3	1,717,636	48.8	87,915	50.3
Female	155,557,060	50.7	1,800,652	51.2	86,969	49.7

Source: Connecticut Department of Health, U.S. Census

*National data obtained from 2010 U.S. Census

The **age breakdown** in L+M's primary service area is similar to the associated breakdowns in Connecticut and the United States. There does seem to be a proportionally higher population of 45-64 year olds within the County.

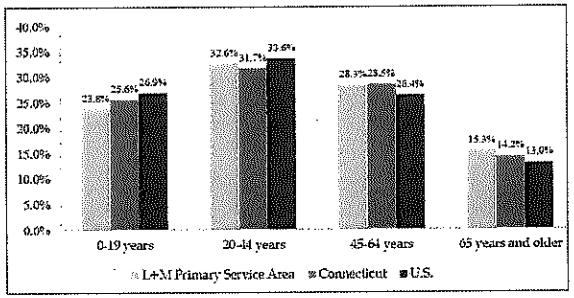


Figure A2: Age breakdown for the United States, Connecticut and L+M's primary service area, 2010 (U.S. Census)

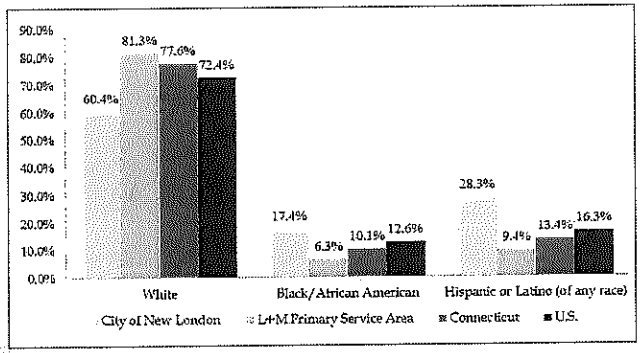
The **population change** of all races in New London County from 2000 to 2010 is shown below in Table 2. The total population increased by 5.8 percent during that time. This growth was primarily due to increases in minority populations.

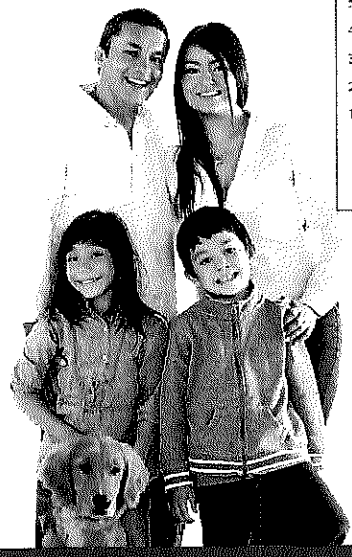
Table 2: Population change of all races in New London County (2000-2010)

	2000	2010	Change
Total Population	259,088	274,055	5.8
Race	n	n	%
White	225,406	225,213	-0.1
Black/African American	13,703	16,025	17.0
American Indian/Alaskan Native	2,487	2,505	0.7
Asian	5,075	11,383	124.3
Native Hawaiian/Pacific Islander	151	180	19.2
Other	5,319	8,722	64.0
Two or more races	6,947	10,027	44.3
Hispanic/Latino of any race	13,236	23,214	75.4

The **racial breakdown** of the primary service area is a mix between Hispanic/Latino, Black, and White. According to Figure A3, the service area's White population is much higher than National and State comparisons, while the proportion of Black and Hispanic/Latino residents is much lower. However, the City of New London has a much higher proportion of Hispanic/Latino and Black residents than the State and Nation.

Figure A3: Race breakdown for the United States, Connecticut, the City of New London, and L+M's primary service area, 2010 (U.S. Census)





According to the CDC Office of Minority Health & Health Equity (2012), race and ethnicity correlate with significant health disparities. Specifically, Hispanic/Latinos are at higher risk for asthma, diabetes, HIV/AIDS, cervical cancer, lack of prenatal care, and infant mortality. Blacks/African Americans are at higher risk for heart disease, hypertension, diabetes, and infant mortality. Both populations are also at higher risk for overweight/obesity issues.

DEMOGRAPHICS

HOUSEHOLD

Household statistics for the primary service area, including the number of families, married couple families, families with children under age 18 and households with only a female guardian, while similar are all slightly below the State and National numbers. These figures are displayed in Figure B1.

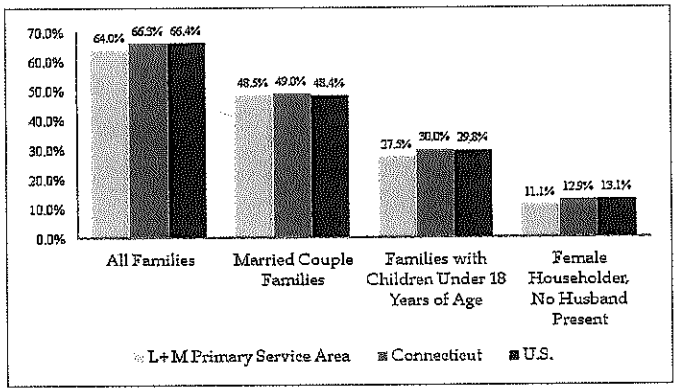


Figure B1: Household Type breakouts for the United States, Connecticut, and L+M's primary service area, 2010 (U.S. Census)

Regarding **marital status**, the primary service area has a smaller percentage of people who have never been married compared to the State and the Nation. The percent of the population that is divorced is also slightly higher in the service area than compared to the State and Nation. These marital status statistical comparisons are displayed in Figure B4.

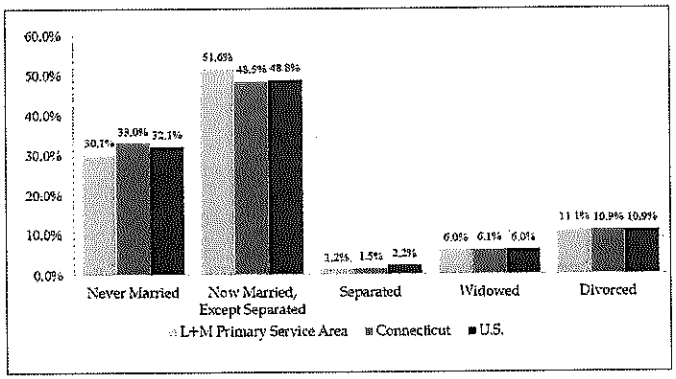


Figure B4: Marital Status statistics for the United States, Connecticut, and L+M's primary service area, 2010 (U.S. Census)

DEMOGRAPHICS

INCOME

The **poverty statistics** for New London County are lower than Connecticut and the United States in terms of percentages across the board. These statistics are displayed in Figure C3. However, poverty among all families and families with children are higher in the City of New London than compared to the State and the Nation.

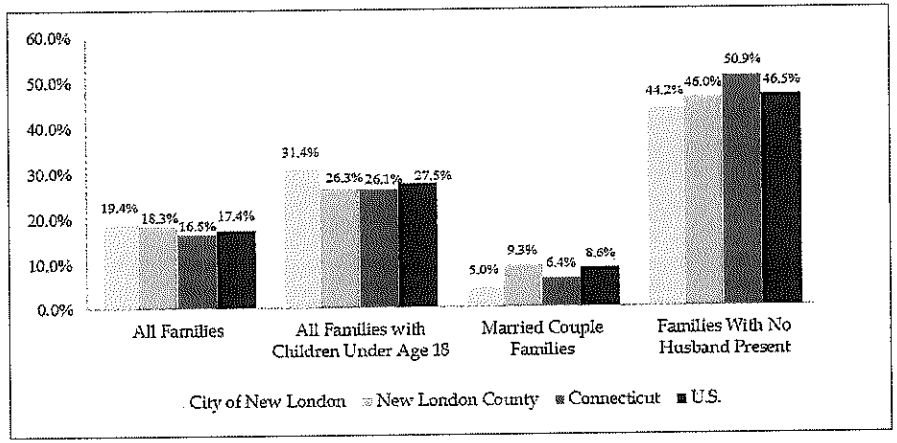


Figure C3: Poverty Statistics for the United States, Connecticut, the City of New London, and New London County, 2010 (U.S. Census)

*Data not available for primary service area

According to the CDC Office of Minority Health & Health Equity (2012), socioeconomic status is also a major factor leading to health disparities. Individuals living in poverty have higher rates of morbidity and mortality for a number of health issues including chronic diseases like diabetes, cancer, and heart disease.

DEMOGRAPHICS

HEALTH INSURANCE COVERAGE

The percent of those with **health insurance coverage** overall and those with private insurance is higher in New London County compared to both the State and National percentages. The proportion of those who reported having no health insurance was lower than the State and much lower than the Nation. These statistics are shown in Figure D1.

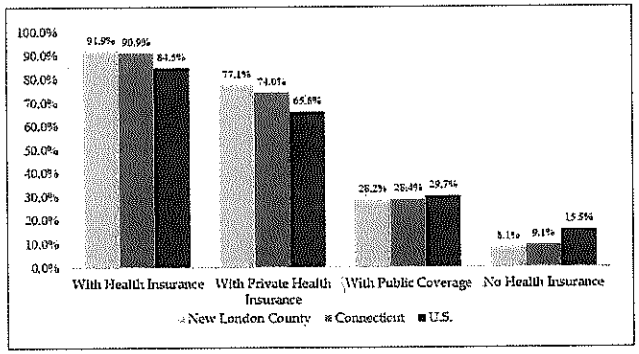


Figure D1: Employment Statistics for the United States, Connecticut, and New London County, 2010 (U.S. Census)

*Data not available for primary service area

DEMOGRAPHICS

EDUCATION

Regarding **educational attainment**, the percentage of New London County's population with a bachelor's degree or higher is lower than the State, but still remains above the National figure (Figure E1). New London County has a slightly higher percentage of high school graduates than the State and Nation. Educational attainment for the City of New London is lower than the County, State and Nation.

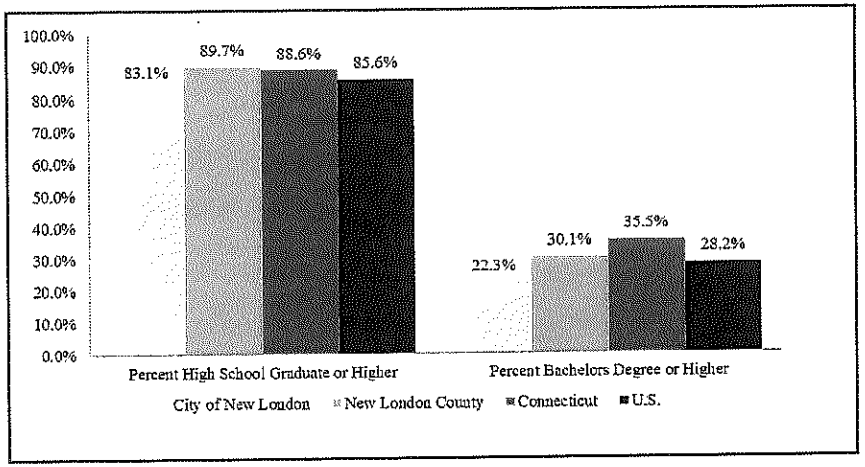


Figure E1: Educational Attainment for 25 years and older population in the United States, Connecticut, and New London County, 2010 (U.S. Census)* *Data not available for primary service area

Figure E2 further highlights educational status regarding only L+M's primary service area.

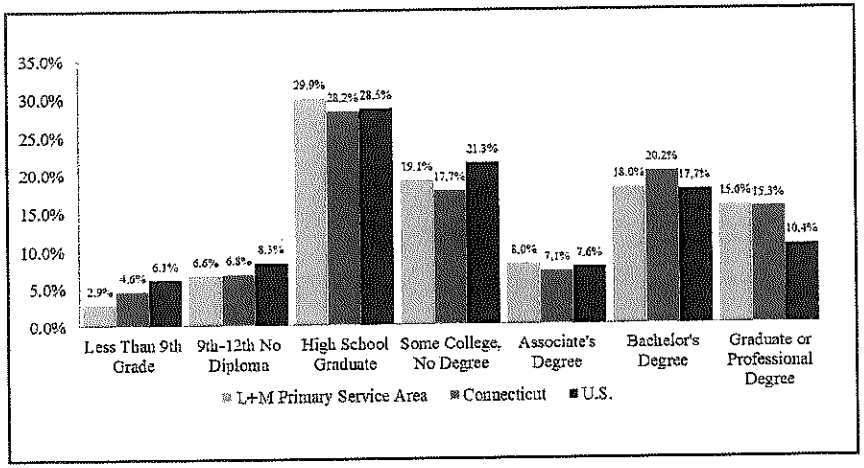


Figure E2: Educational Attainment for 25 years and older population in the United States, Connecticut, and L+M's primary service area, 2010 (U.S. Census)

HEALTH INDICATORS

CANCER STATISTICS

The incidence rates for selected leading cancers at the National, State, and Local level are displayed in Table 3. Additionally, incidence for childhood cancers is shown in Table 4 in the same fashion.

Table 3: Selected Cancer Incidence by Site and Gender (2004-2008)[a]

	U. S.[b]	Connecticut	New London County
Breast (female only)	121.0	136.2	137.8
Colorectal	47.6	49.2	49.3
Male	55.6	57.4	56.7
Female	41.4	42.9	43.7
Lung and Bronchus	67.9	68.1	74.1
Male	84.3	80.2	90.3
Female	55.8	60.0	63.0
Prostate (male only)	152.7	162.1	139.5
All Sites	465.0	504.7	520.4
Male	543.4	582.0	588.6
Female	410.4	453.8	477.0

Source: SEER National Cancer Registry, National Cancer Institute

[a] Age-Adjusted rates per 100,000

[b] Rates based on 2008 data

Table 4: Childhood (Ages 0-19 years) Cancer Incidence[a]

	U.S.		Connecticut		New London County	
	Number	Rate	Number	Rate	Number	Rate
2004 - 2008	N/A	16.9	166	17.8	14	20.9

Source: SEER National Cancer Registry, National Cancer Institute

[a] Rates per 100,000 population

Table 5: Selected Cancer Mortality by Site and Gender (2004-2008)[a]

	U.S.[b]	Connecticut	New London County	Healthy People 2020
Breast (Female only)	22.5	23.2	24.0	20.6
Colorectal	16.4	15.6	14.5	14.5
Male	19.7	18.1	18.3	14.5
Female	13.8	13.8	11.5	14.5
Lung and Bronchus	49.6	46.9	53.4	45.5
Male	64.0	58.5	67.9	45.5
Female	39.0	39.1	43.4	45.5
Prostate	22.8	25.7	23.6	21.2
All Sites	175.8	176.9	185.8	160.6
Male	215.7	216.4	233.4	160.6
Female	148.4	152.5	155.0	160.6

Sources: SEER National Cancer Registry, National Cancer Institute, 2008, Healthy People 2020

[a] Age-adjusted rates per 100,000

[b] Rates based on 2008 data

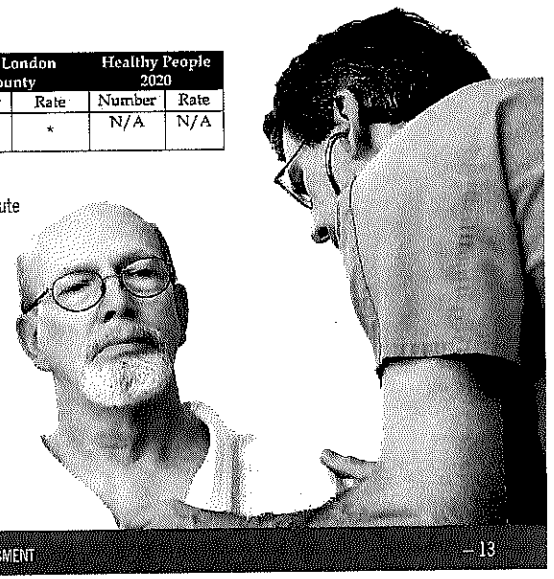
Table 6: Childhood (Ages 0-19 years) Cancer Mortality

	U.S.		Connecticut		New London County		Healthy People 2020	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
2004 - 2008	N/A	16.9	16	1.7	*	*	N/A	N/A

Source: SEER National Cancer Registry, National Cancer Institute

[a] Rates per 100,000 population

*3 or fewer cases reported



HEALTH INDICATORS

SEXUALLY TRANSMITTED DISEASES

Displayed below in Table 7 is the reported number of cases of Chlamydia at the National, State, and Local level. Also included in the table, is data pertaining only to the Lawrence + Memorial primary service area and for comparison purposes, the 2011 National Benchmark for reported cases of Chlamydia. Figure G1 further illustrates the differences between these regions and the Benchmark. Displayed in Tables 8 and 9 are the rates of chlamydia by age and race/ethnicity among females for the City of New London and Groton in 2007. Females have much higher rates of Chlamydia. Age and Race/Ethnicity are also risk factors for Chlamydia.

Table 7: Number of Chlamydia Infections per 100,000 (2008)

U.S.	Connecticut	New London County	L+M Primary Service Area	2011 National Benchmark
Number	Number	Number	Number	Number
398.1	357.0	236.0	245.4	83.0

Source: CDC STD Surveillance Report, 2010
Connecticut Department of Health, STD Statistics, 2009
County Health Rankings, 2011

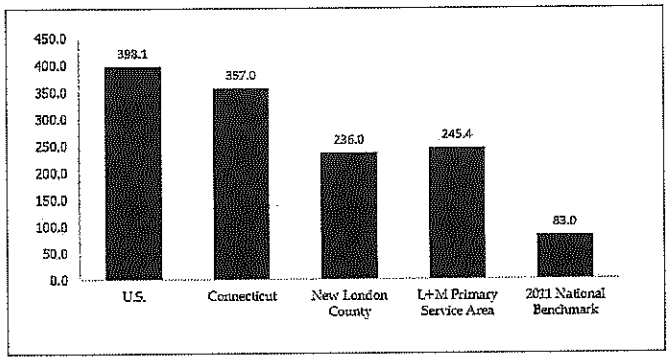


Figure G1: Number of Reported Chlamydia Cases per 100,000

Table 8: Chlamydia Infections per 100,000 in Groton by Race/Ethnicity and Age group: 15-29 Year Old Females (2007)

Race	15-19	20-24	25-29
White, Non-Hispanic	1504.8	1030.0	396.0
Hispanic	1033.6	3816.8	678.0
Black, Non-Hispanic	8000.0	4621.8	613.5

Source: Ledge Light Health District Epidemiology Program, 2010

Table 9: Chlamydia Infections per 100,000 in City of New London by Race/Ethnicity and Age group: 15-29 Year Old Females (2007)

Race	15-19	20-24	25-29
White, Non-Hispanic	1060.6	1097.8	623.3
Hispanic	0.0	1212.1	1036.3
Black, Non-Hispanic	3960.4	5494.5	0.0

Source: Ledge Light Health District Epidemiology Program, 2010

HEALTH INDICATORS

BMI AND OBESITY

The data regarding Obesity collected in 2007 pointed to childhood obesity as a major issue. These data are shown here in Table 10 along with the Healthy People 2020 objective for the percentage of the population that is obese. More recent data collected on the percentage of adults who reported BMI's above 30, indicating they were obese, are displayed in Table 11 along with the Healthy People 2020 target for that age group.

Table 10: Percent of Children in New London Public Schools who are Overweight or Obese

Grade/Gender	Percent Overweight or Obese	Healthy People 2020
Pre-K Girls	36.4	9.6
Pre-K Boys	41.0	9.6
Grade 4 Girls	58.6	15.7
Grade 4 Boys	44.9	15.7

Source: 2007 CHPPR NLC Community Health Assessment, Healthy People 2020

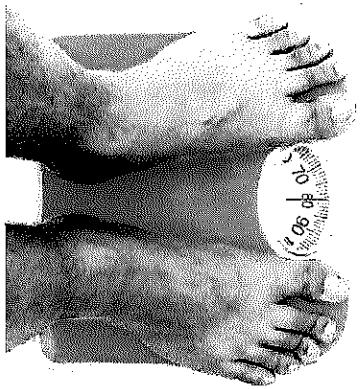


Table 11: Percent of Adults in New London County who Reported a BMI of 30 or Greater (2010)

Connecticut	New London County	Healthy People 2020
23.1	26.0	30.6

Source: Health Indicators Warehouse, Healthy People 2020

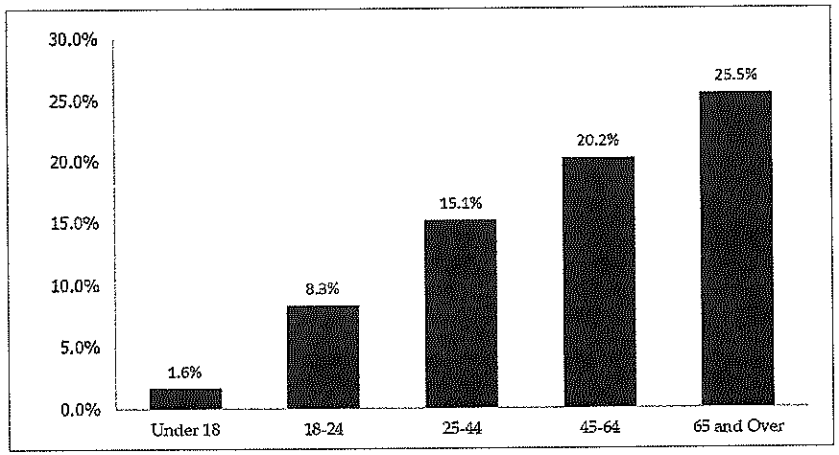


Figure H1: Percent Obese by age group in New London County, 2010 (Achieve New London)

HEALTH INDICATORS

ASTHMA

The following data regarding the crude incidence of Asthma within the primary service area is based upon hospital discharge data supplied by Lawrence +Memorial Hospital. Looking at Table 12, the crude incidence of Asthma within the primary service area far exceeds the goal set forth by Healthy People 2020. Additionally, data spanning three years, 2008 through 2010, is displayed in figure I1 below.

Table 12: Asthma Crude Incidence by Age Group for the L+M Primary Service Area (2010)

Age Group	L+M Service Area	Healthy People 2020
0-4 Years	234.4	18.1
5-64 Years	188.8	8.6
65 and Over	84.5	20.3

Source: Healthy People 2020, U.S. Census, L+M hospital discharge data

*Rates per 10,000 population

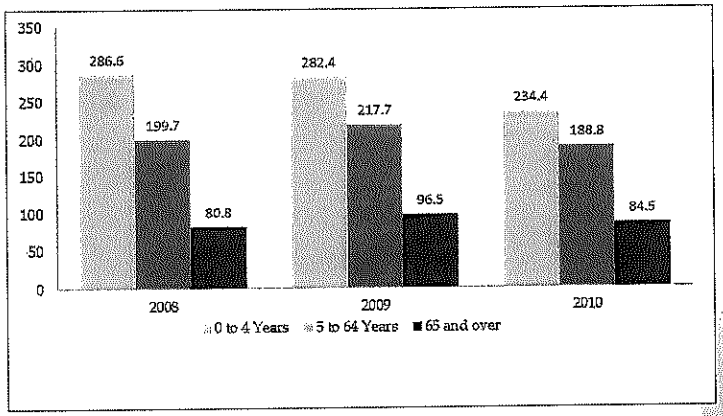


Figure I1: Crude Incidence of Asthma by Age Group from 2008 to 2010, L+M Primary Service Area (L+M hospital discharge data, U.S. Census)

*Rates per 10,000 population

HEALTH INDICATORS

DIABETES

The following data regarding the crude incidence of Diabetes in the primary service area was derived using hospital discharge data as was the case with Asthma (Table 13). The crude rate of Diabetes in L+M's primary service area is much higher than the goal determined by Healthy People 2020 for the 18 to 84 age group. Furthermore, looking at Figure J1, the rate of Diabetes within the 18 to 84 age group is increasing each year from 2008 through 2010.

Table 13: Crude Incidence of Diabetes in the L+M Primary Service Area for Ages 18-84

Year	L+ M Service Area	Healthy People 2020
2008	27.4	7.2
2009	31.3	
2010	33.7	

Source: Healthy People 2020, U.S. Census, L+M hospital discharge data

*Rates per 1,000 population

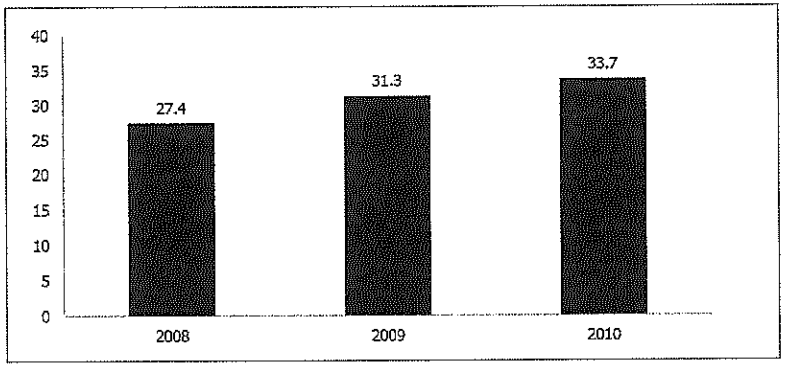


Figure J1: Crude Incidence of Diabetes for Ages 18 to 84 in L+M's Primary Service Area (L+M hospital discharge data, U.S. Census)

*Rates per 1,000 population

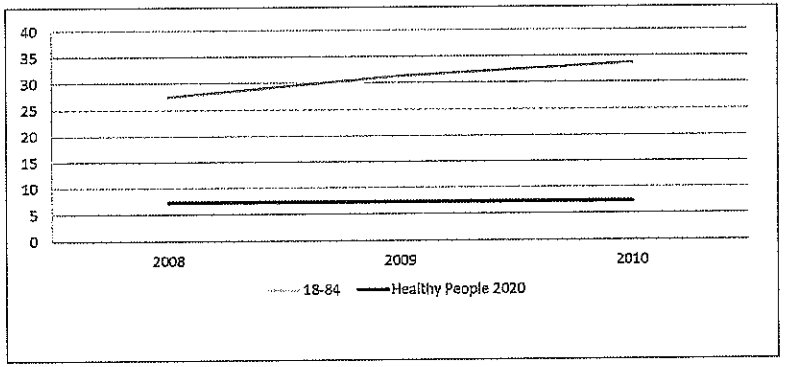


Figure J2: Crude Incidence of Diabetes in the L+M Primary Service Area Compared to HP2020 Goal Over Three Years (L+M hospital discharge data, U.S. Census)

*Rates per 1,000 population

HEALTH INDICATORS

TOBACCO USE/SMOKING

The following data represents survey results of those who smoke from the 2007 Connecticut SMART BRFSS for New London County, and the 2010 United Way of Southeastern Connecticut survey with comparisons to Healthy People 2020 (Table 14).

Table 14: Smoking Status of County and Regional Residents

Smoking Status	BRFSS 2007	UWSC 2010	Healthy People 2020
Every day	15.7	11.3	N/A
Some days	1.6	4.1	N/A
Currently smoking	17.3	15.4	12.0

Source: Connecticut SMART BRFSS of New London County, Healthy People 2020, United Way of Southeastern Connecticut 2010

HEALTH INDICATORS

HEALTH STATUS AND ACCESS

Table 15 presents data regarding respondent's health status or condition by race. A greater percentage of Hispanics reported asthma, high cholesterol, and diabetes as primary health conditions compared to both Blacks and Whites. The highest reported percentage of high blood pressure was recorded in the Black population.

Table 15: Percentage of Health Conditions Reported by Race/Ethnicity

Health Condition	Race/Ethnicity		
	White (%)	Black (%)	Hispanic (%)
Heart Disease	6.1	4.7	4.6
Asthma	9.9	14.1	17.9
High Blood Pressure	17.9	26.4	14.1
High Cholesterol	14.6	4.1	16.0
COPD	4.0	2.8	0.3
Diabetes	6.0	6.9	7.2
Overweight/Obesity	16.5	13.8	15.5

Source: 2010 ACHIEVE New London Healthy Resident Survey results

The remaining tables report access to services and prescription medicines. It is important to note that the ratio of primary care physicians to residents in New London County (1,098:1) is poor when compared to the National Benchmark (631:1) and Connecticut (729:1).

Table 16: Access to a Primary Source of Care within Southeastern Connecticut

Response	UWSC 2010	Healthy People 2020
Yes	95.5	95.0
No	4.2	N/A

Source: Healthy People 2020, United Way of Southeastern Connecticut 2010

Table 17: Percent of Population Who Delayed Medical Care Due to Cost in New London County and Southeastern Connecticut

HIW* 2008-2010	HIW* 2010	UWSC 2010	Healthy People 2020
7.4	5.9	14.2	4.2

Source: Healthy People 2020, Health Indicators Warehouse, United Way of Southeastern Connecticut 2010

Table 18: Percent of Those Who Could not Receive Prescription Medicines Due to Cost

UWSC 2010	Healthy People 2020
12.3	2.8

Source: Healthy People 2020, United Way of Southeastern Connecticut 2010

Data regarding the percent of those who had at least one drink within the past 30 days is displayed below in Table 19. The results come from the New London County SMART BRFSS questionnaire from 2007 and the United Way of Southeastern Connecticut 2010 Survey. The percent of those who reported excessive drinking is found in Table 20. This data is reported by the County Health Rankings website and is compiled from the annual BRFSS administered by the CDC.

Table 19: Percent of Those Who Had at Least One Drink Within the Past 30 Days

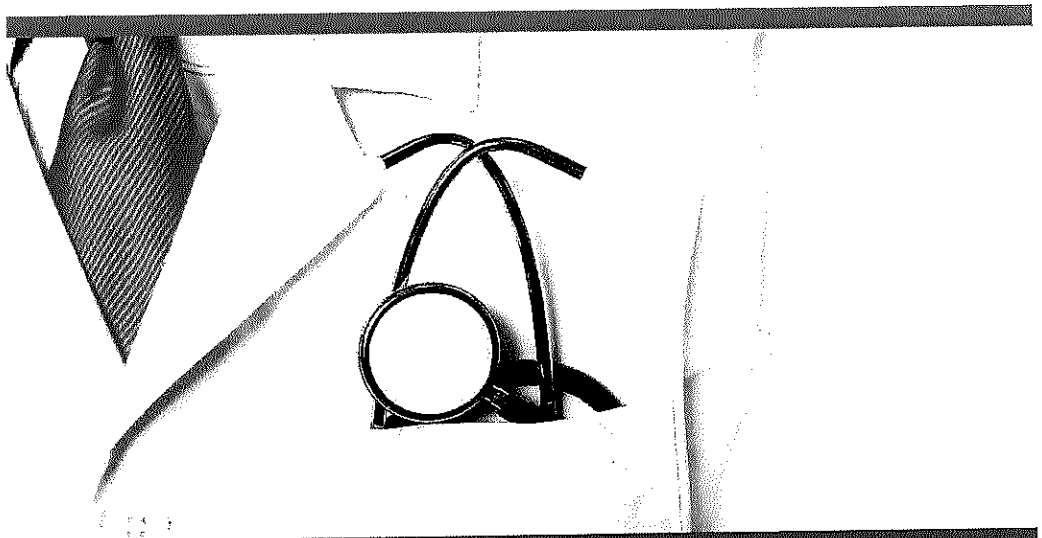
BRFSS 2007	UWSC 2010
62.5	43.1

Source: Connecticut SMART BRFSS for New London County, United Way of Southeastern Connecticut

Table 20: Excessive Drinking in Adults Age 18 and Over (2012)

National Benchmark	Connecticut	New London County
8.0%	18.0%	18.0%

Source: County Health Rankings 2012



CONCLUSIONS

STRENGTHS

Demographics

- The percent of families living in poverty with no husband present is much lower in New London County (13.3) than the U.S. (30.3) and Connecticut (22.2).
- The percent of individuals with health insurance is higher in New London County (91.9) than in the U.S. (84.5) and Connecticut (90.9).
- The percent of those that have graduated high school is highest in New London County (89.7) compared to National (85.6) and State (88.6) averages.
- When looking at the primary service area (15.6), the percent of individuals who have received a graduate or professional degree is higher than both the State (15.3) and Nation (10.4).

Cancer Statistics

- Prostate Cancer among males is lowest in New London County (139.5) compared to the State (162.1) and National statistics (152.7).
- Mortality due to Colorectal Cancer in both males and females is lowest in New London County (14.5) and has met the Healthy People 2020 goal of 14.5.
- Although higher than the State and Nation, mortality due to Lung and Bronchus Cancer in females (43.4) has reached and surpassed the Healthy People 2020 goal of 45.5. The same can be said for Cancer in females of all sites (155.0) which has reached and surpassed the Healthy People 2020 goal of 160.6.

BMI and Obesity

- The percent of adults who reported a BMI of 30 or greater in New London County (26.0) was lower than the Healthy People 2020 goal of 30.6. However, it was still higher than that reported for the State (23.1).

Asthma

- The crude incidence of Asthma in the 0 to 4 age group has seen a slight decline from 2008 through 2010.
- A decline in crude incidence was also seen from 2009 to 2010 in the 5 to 64 and 65 and over age groups.

Alcohol Consumption

- The number of those who reported at least one drink within the past 30 days has decreased from 2007 to 2010.

Tobacco Use

- The percent of those currently smoking has decreased from the 2007 survey (17.3) compared to both of the 2010 surveys (NLC 13.5, SE CT 15.4).

Health Status and Access

- According to the United Way survey of Southeastern Connecticut, 95.5% of residents surveyed have access to a primary source of care. This exceeds the Healthy People 2020 goal of 95.0%.

CONCLUSIONS

OPPORTUNITIES

Cancer Statistics

- Incidence of the following Cancers was higher in New London County than the State and Nation: Breast (female only), Colorectal in both males and females, Lung and Bronchus in both males and females, all sites in both males and females.
- The incidence of childhood Cancer was higher in New London County (20.9) than it was in the State (17.8) and Nation (16.9).
- Mortality for the following Cancers was higher in New London County compared to the State and Nation: Breast (female only), Lung and Bronchus in males, all sites in Males.

Sexually Transmitted Diseases

- The rate of Chlamydia infections per 100,000 people was higher in the L+M primary service area (245.5) compared to New London County (236) and the 2011 National Benchmark (83).
- In the city of New London and Groton, Chlamydia infections are highest among Blacks and Hispanics.

BMI and Obesity

- The percent of children in 2007 that were overweight or obese is much higher than recommended by Healthy People 2020. For example, the percent of Pre-K girls was 36.4, while the Healthy People 2020 goal is 9.6. The same was true for Pre-K boys, and both girls and boys in Grade 4.
- The 65 and over age group reported the highest percent (25.5) of obese individuals in 2010.

Asthma

- Crude incidence rates for Asthma in the primary service area were much higher than those recommended by Healthy People 2020. In the 0 to 4 age group, the rate is 234.4, while Healthy People 2020 sets the goal at 18.1.

Diabetes

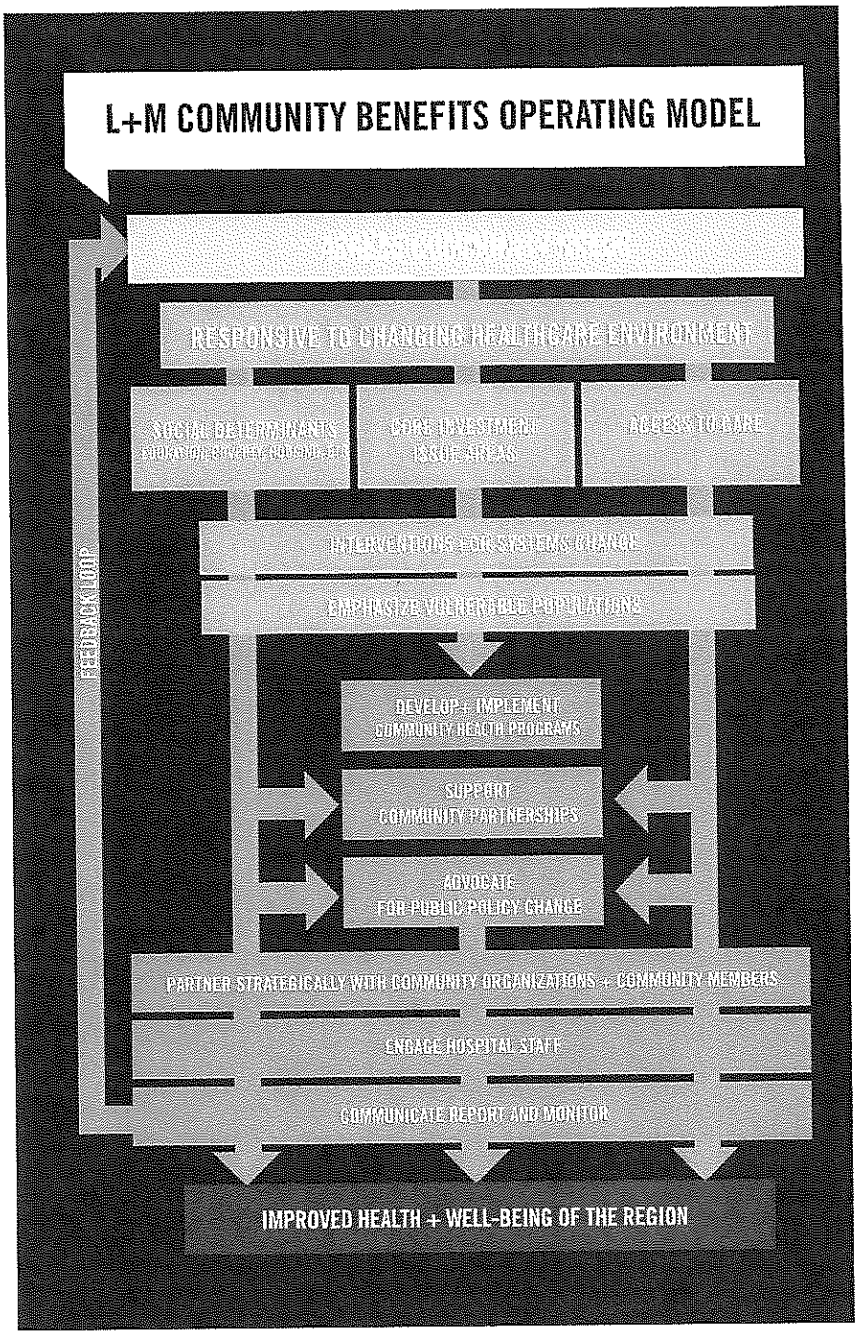
- The crude incidence of Diabetes in the L+M primary service area was much higher from 2008 through 2010 than recommended by Healthy People 2020. For example, in 2010, the rate for the service area was 33.7, while the Healthy People 2020 goal is 7.2.
- Another major concern in this area is the fact that hospitalizations, due to Diabetes, have been steadily increasing from 2008 through 2010 for the 18 to 84 age group.

Tobacco Use

- Looking at data from the 2007 survey compared to both of the 2010 surveys, the percent of those who are currently smoking in the county and region has decreased, but has still not reached the Healthy People 2020 goal.

Health Status and Access

- According to two sources, Health Indicators Warehouse and the United Way Survey, in 2010, the percent of the population who delayed medical care due to cost (5.9-14.2) was still higher than that recommended by the Healthy People 2020 goal of 4.2.
- According to the United Way Survey, 12.3 percent of those surveyed could not receive prescription medications due to cost. This is higher than the recommended 2.8 percent set by Healthy People 2020.



Facilitators provided a framework showing the relationship between assessing community needs and hospital community benefit planning to help guide the group discussion of health issues.

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LAWRENCE +MEMORIAL HOSPITAL

L+M in the Community

At L+M Hospital, doctors, nurses and staff are also your neighbors and friends, so it's no wonder we're deeply committed to the health of our region far beyond the doors of our buildings.

At L+M, we're determined to make southeastern Connecticut a better, healthier place to live, and that includes an array of outreach programs. In fact, L+M's "Community Benefits" totaled over $15 million last year, and our services are aimed at those who need it most, such as expectant mothers, infants, senior citizens, and those who are homeless.

There are many reasons for what we do, but the most obvious is quite simple: we believe in giving each other a hand up. Because we live here, too. And, like you, we care.

The broad range of L+M Hospital's **community benefit activity** includes educational programs, community disaster preparedness, health promotion, faith community outreach, and collaborative school programs. Furthermore, there are services for the homeless, injury prevention programs, student internships, and many other programs that simply wouldn't exist if not for the staff and resources provided by Lawrence + Memorial.

When it comes to community benefits, it's often the little things that make the biggest differences. Consider what happens each day at the Homeless Hospitality Center in New London: an employee from the shelter drops off dirty sheets at L+M Hospital; they return to the shelter with clean ones. It happens every day, all year, free of charge, thanks to L+M. The service saves the shelter time, boosts the moral of the guests who always sleep on clean linens, and, most importantly of all, the service saves the shelter many thousands of dollars.

Another such program is a collaboration between L+M and the Gemma E. Moran United Way Labor Food Center, to collect and distribute disposable diapers and baby wipes to families in need. When the program first kicked off in 2009, more than 7,000 diapers were delivered in the first two months.

Organizers found that in some cases, children were being left in dirty diapers all day until needy families could afford to buy more. For many families, the program helped bridge that gap until the next paycheck, improving the health and quality of life for both the child and family. Said one organizer: "The diaper bank program is a much-needed addition to the region's safety net and has made a tremendous impact."

But L+M's community commitment doesn't stop with infants. Outreach programs in schools also include such things as pediatric weight management to help children fight obesity, and health and exercise programs to encourage physical fitness.

Another major aspect of L+M's community involvement is subsidized healthcare services for those in need, ranging from emergency and trauma visits to neonatal intensive care. The OB Clinic at the hospital provides education and testing for expectant mothers, and women who qualify can also receive free exams for breast and cervical cancer as part of a community benefit.

ATTACHMENT IX

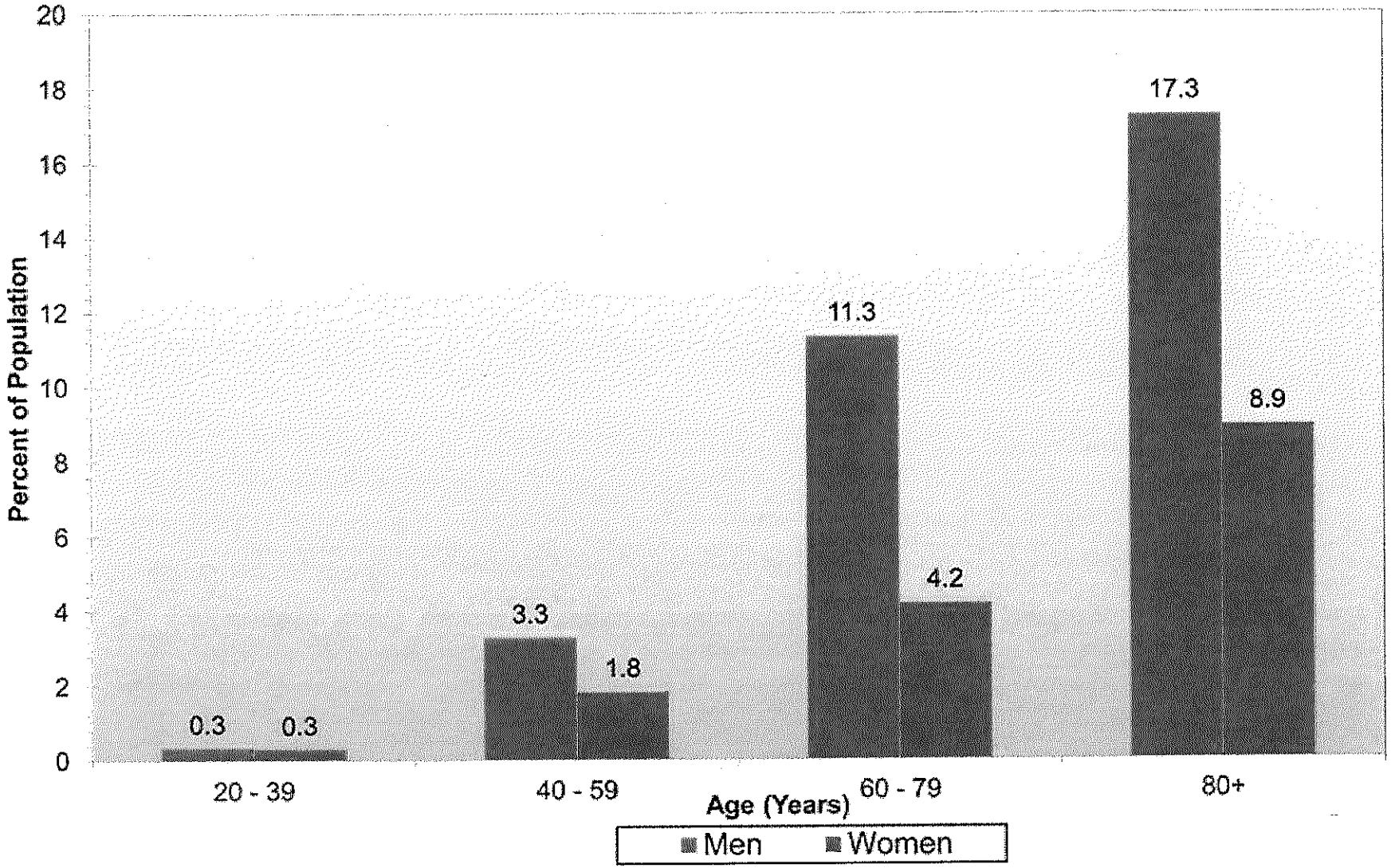
Heart Disease and Stroke Statistics—2015 Update

by Dariush Mozaffarian, Emelia J. Benjamin, Alan S. Go, Donna K. Arnett, Michael J. Blaha, Mary Cushman, Sarah de Ferranti, Jean-Pierre Després, Heather J. Fullerton, Virginia J. Howard, Mark D. Huffman, Suzanne E. Judd, Brett M. Kissela, Daniel T. Lackland, Judith H. Lichtman, Lynda D. Lisabeth, Simin Liu, Rachel H. Mackey, David B. Matchar, Darren K. McGuire, Emile R. Mohler, Claudia S. Moy, Paul Muntner, Michael E. Mussolino, Khurram Nasir, Robert W. Neumar, Graham Nichol, Latha Palaniappan, Dilip K. Pandey, Mathew J. Reeves, Carlos J. Rodriguez, Paul D. Sorlie, Joel Stein, Amytis Towfighi, Tanya N. Turan, Salim S. Virani, Joshua Z. Willey, Daniel Woo, Robert W. Yeh, and Melanie B. Turner

Circulation
Volume 131(4):e29-e322
January 27, 2015

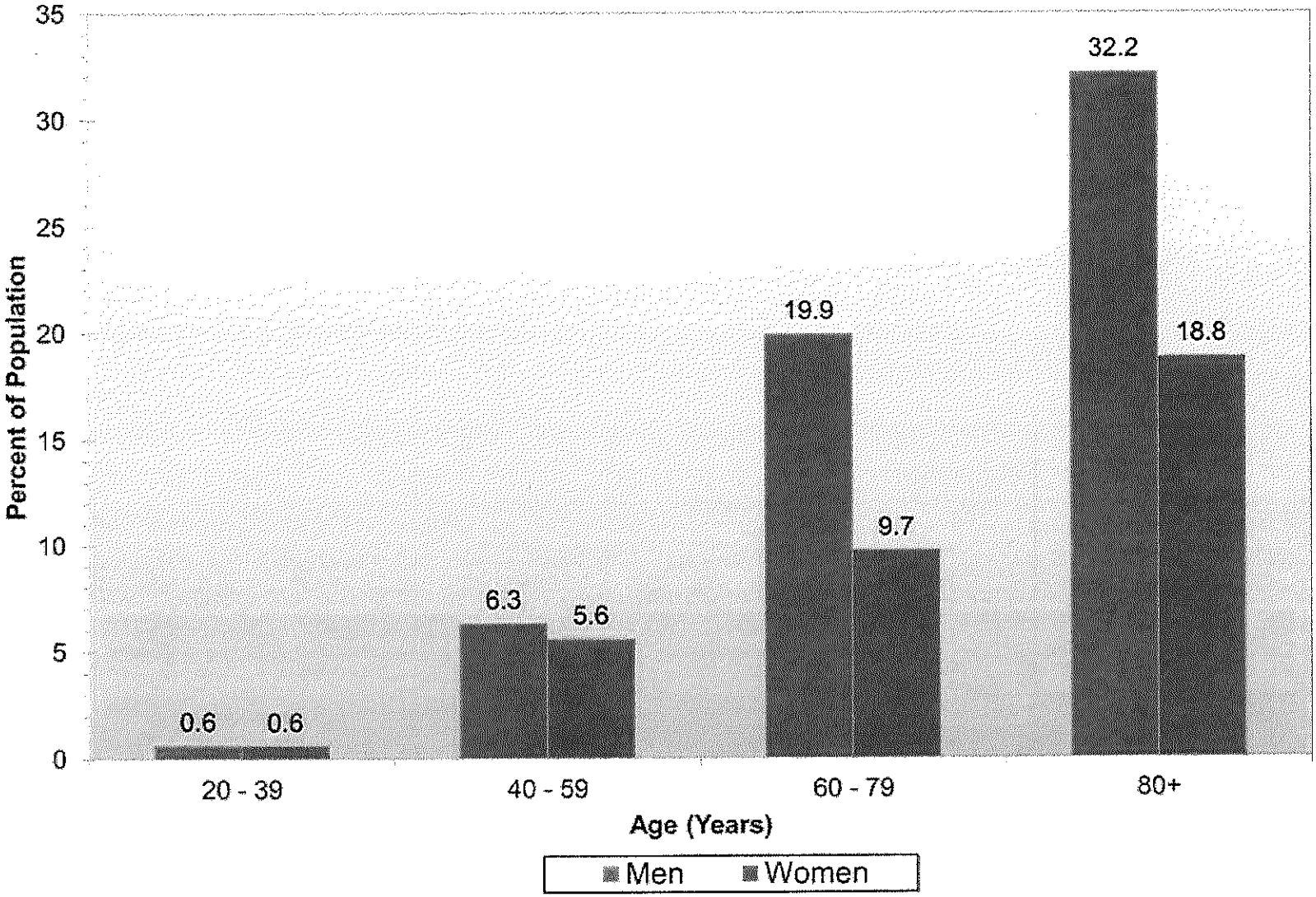
American Heart Association®

Prevalence of myocardial infarction by age and sex



National Health and Nutrition Examination Survey: 2009–2012.

Prevalence of coronary heart disease by age and sex

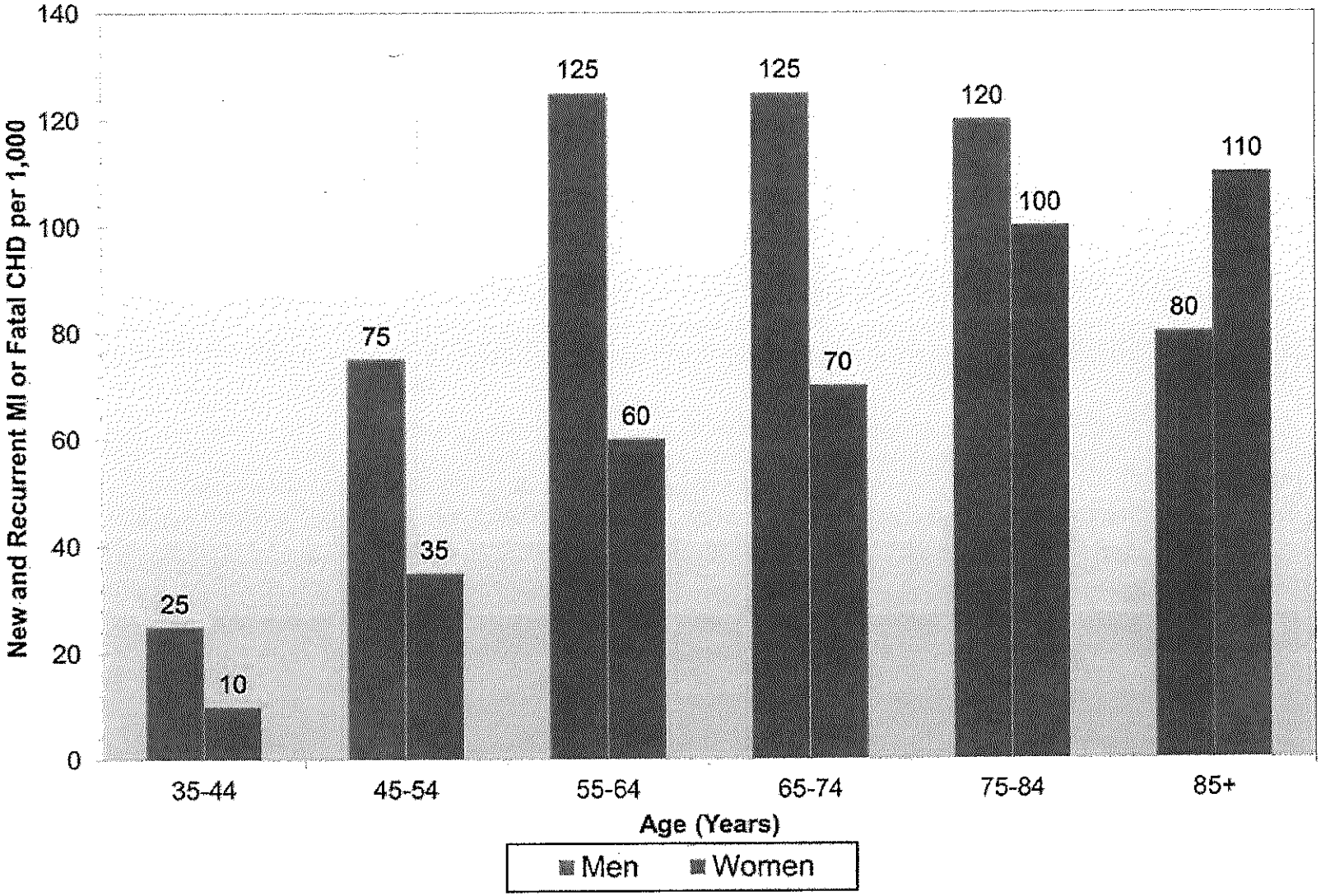


National Health and Nutrition Examination Survey: 2009–2012.

American Heart Association.

Mozaffarian D et al. Circulation. 2015;131:e29-e322

Annual number of adults per 1000 having diagnosed heart attack or fatal coronary heart disease (CHD) by age and sex

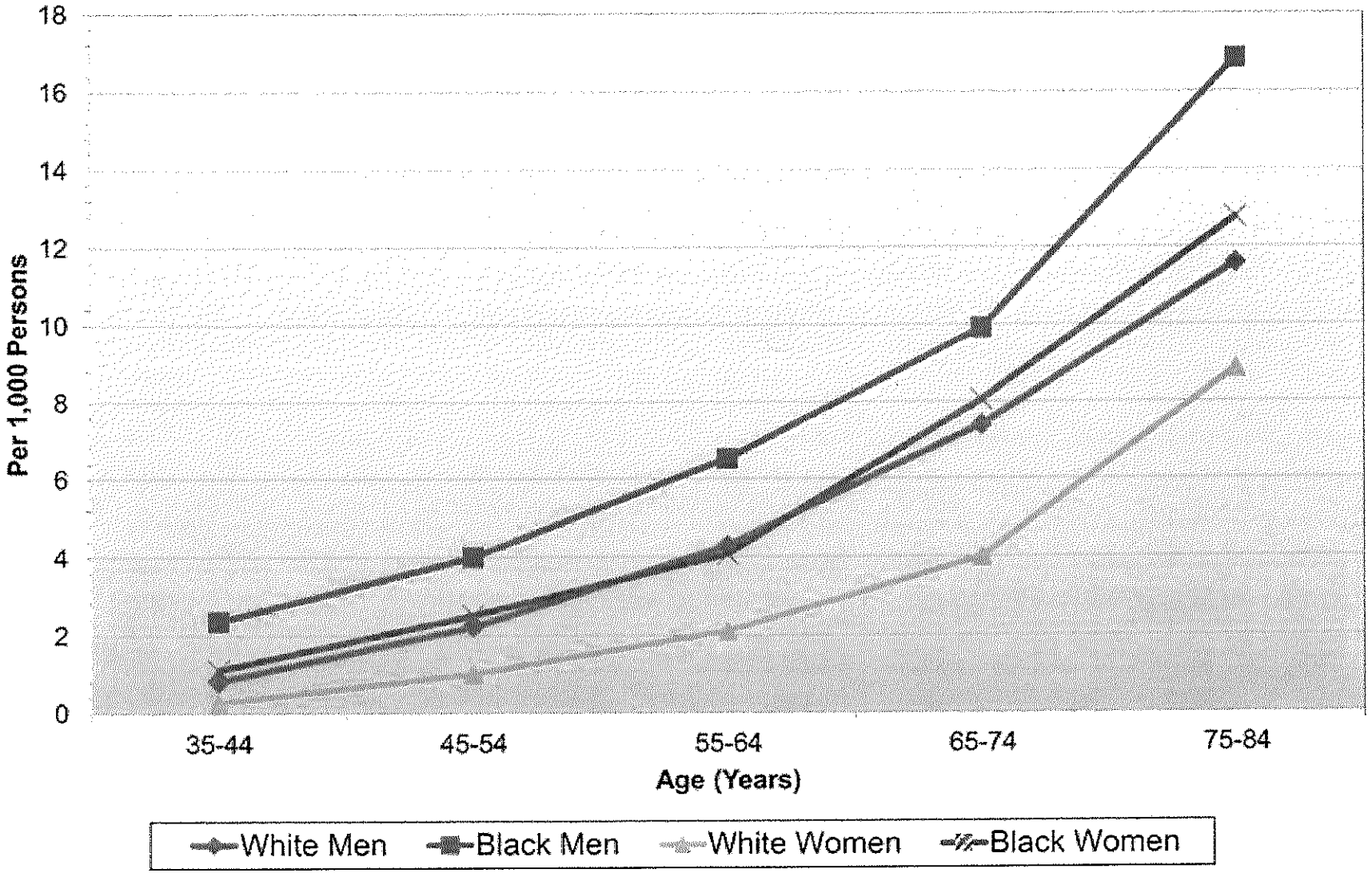


Atherosclerosis Risk in Communities Surveillance: 2005–2011 and Cardiovascular Health Study.

American Heart Association.

Mozaffarian D et al. Circulation. 2015;131:e29-e322

Incidence of heart attack or fatal coronary heart disease by age, sex, and race



Atherosclerosis Risk in Communities Surveillance: 2005–2011.

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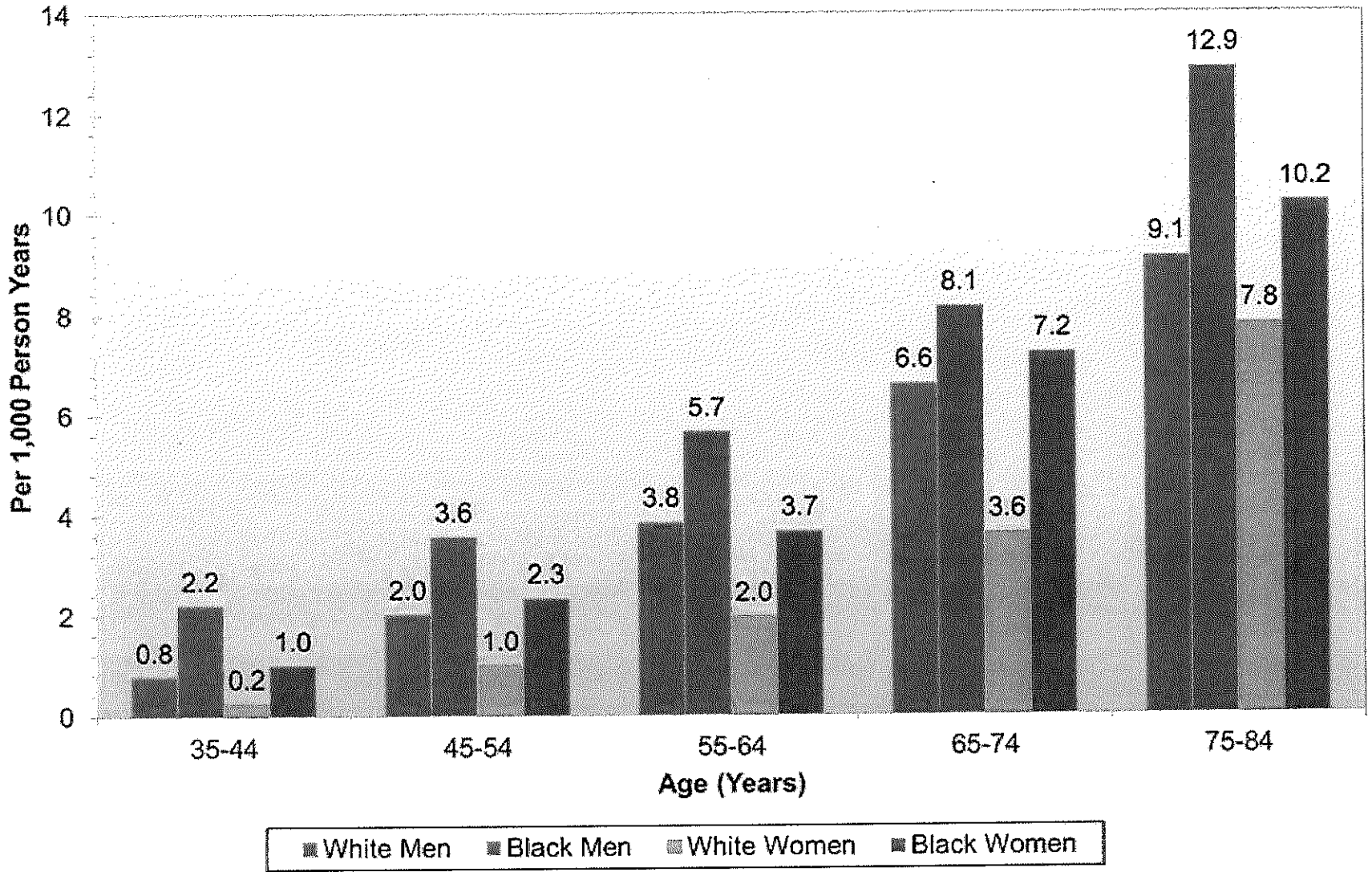
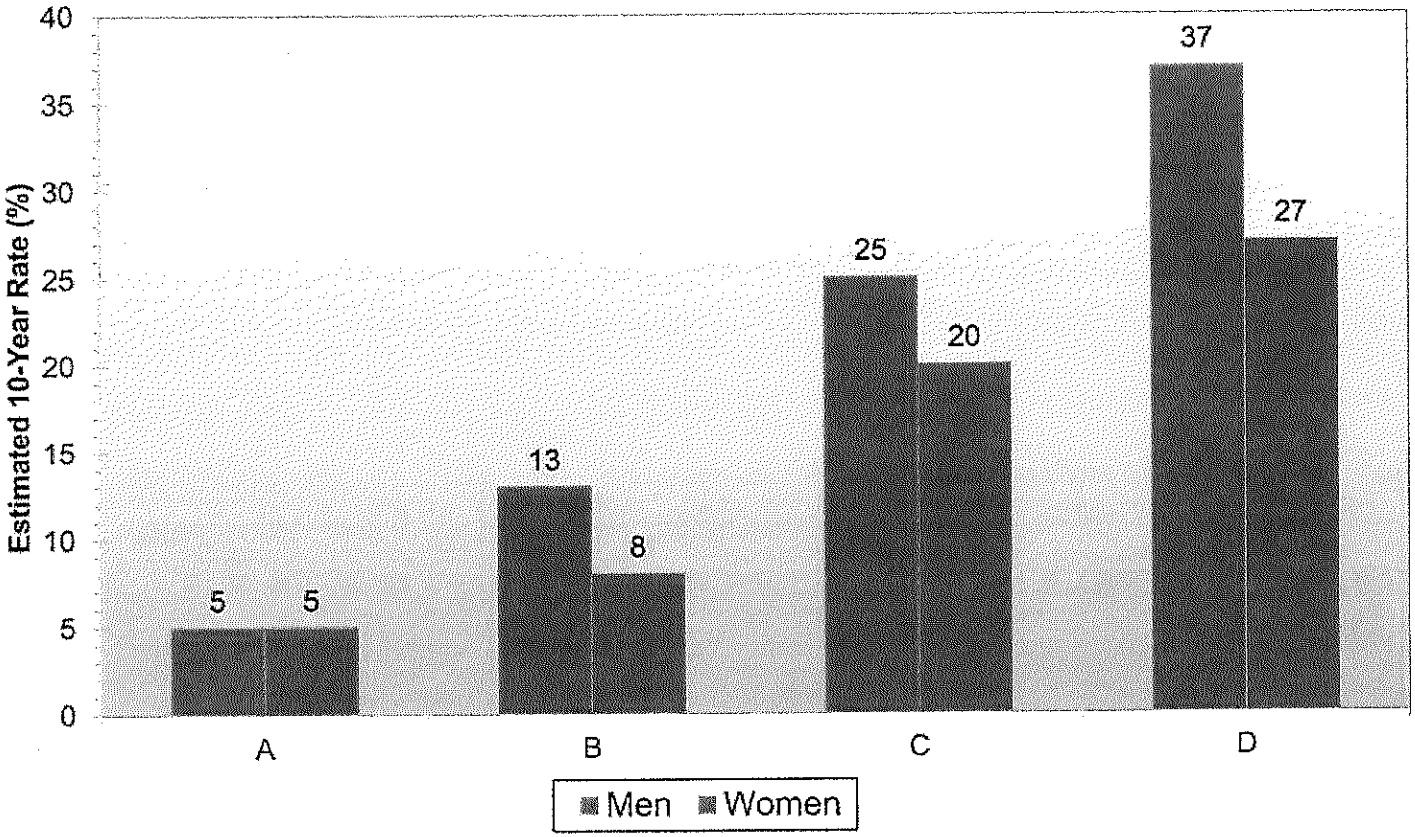
Incidence of myocardial infarction by age, sex, and race



Atherosclerosis Risk in Communities Surveillance: 2005-2011.

Estimated 10-year coronary heart disease risk in adults 55 years of age according to levels of various risk factors (Framingham Heart Study).

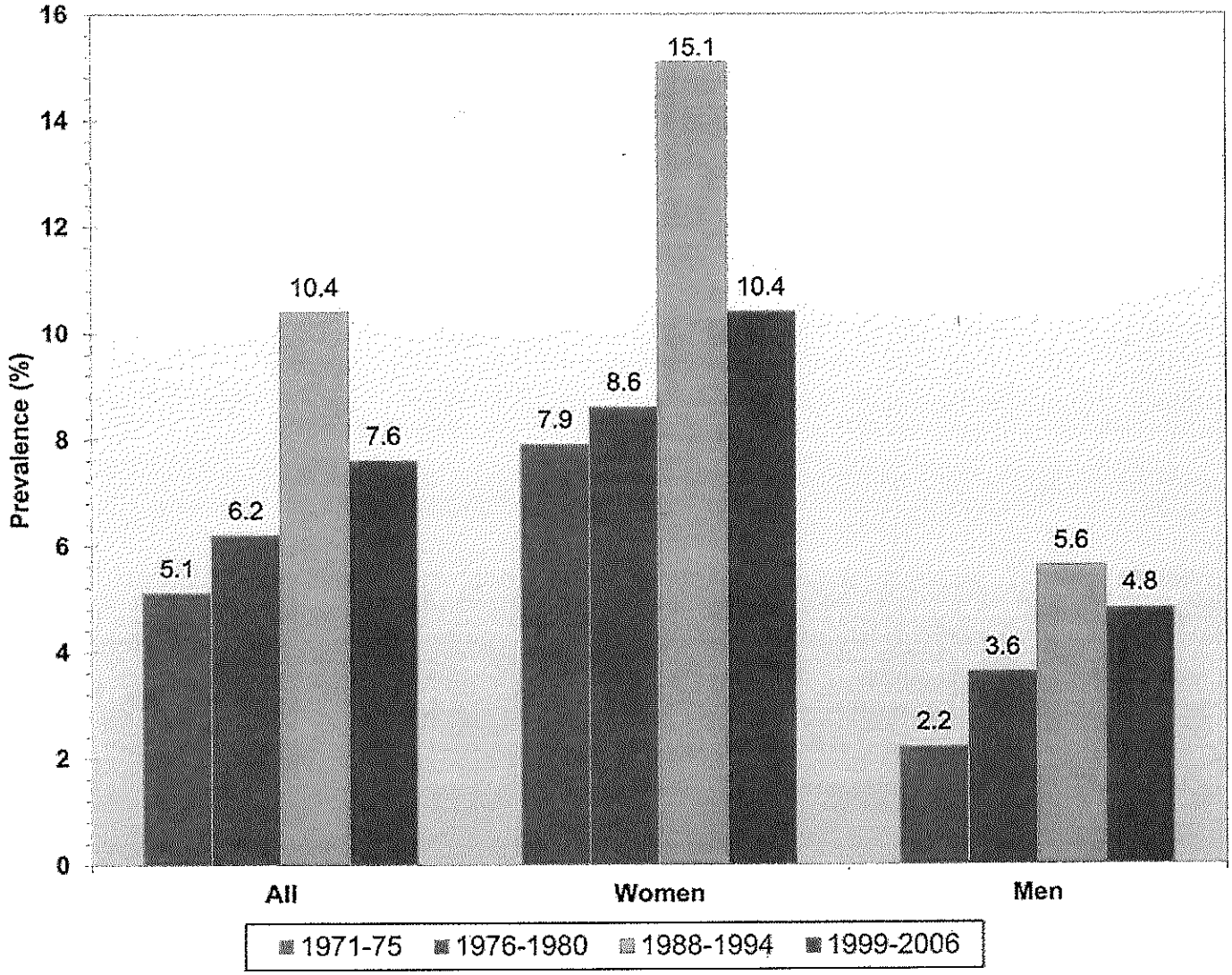


	A	B	C	D
Blood Pressure	120/80	140/90	140/90	140/90
Cholesterol	200	240	240	240
HDL-C	50	50	40	40
Diabetes	No	No	Yes	Yes
Cigarettes	No	No	No	Yes

American Heart Association.

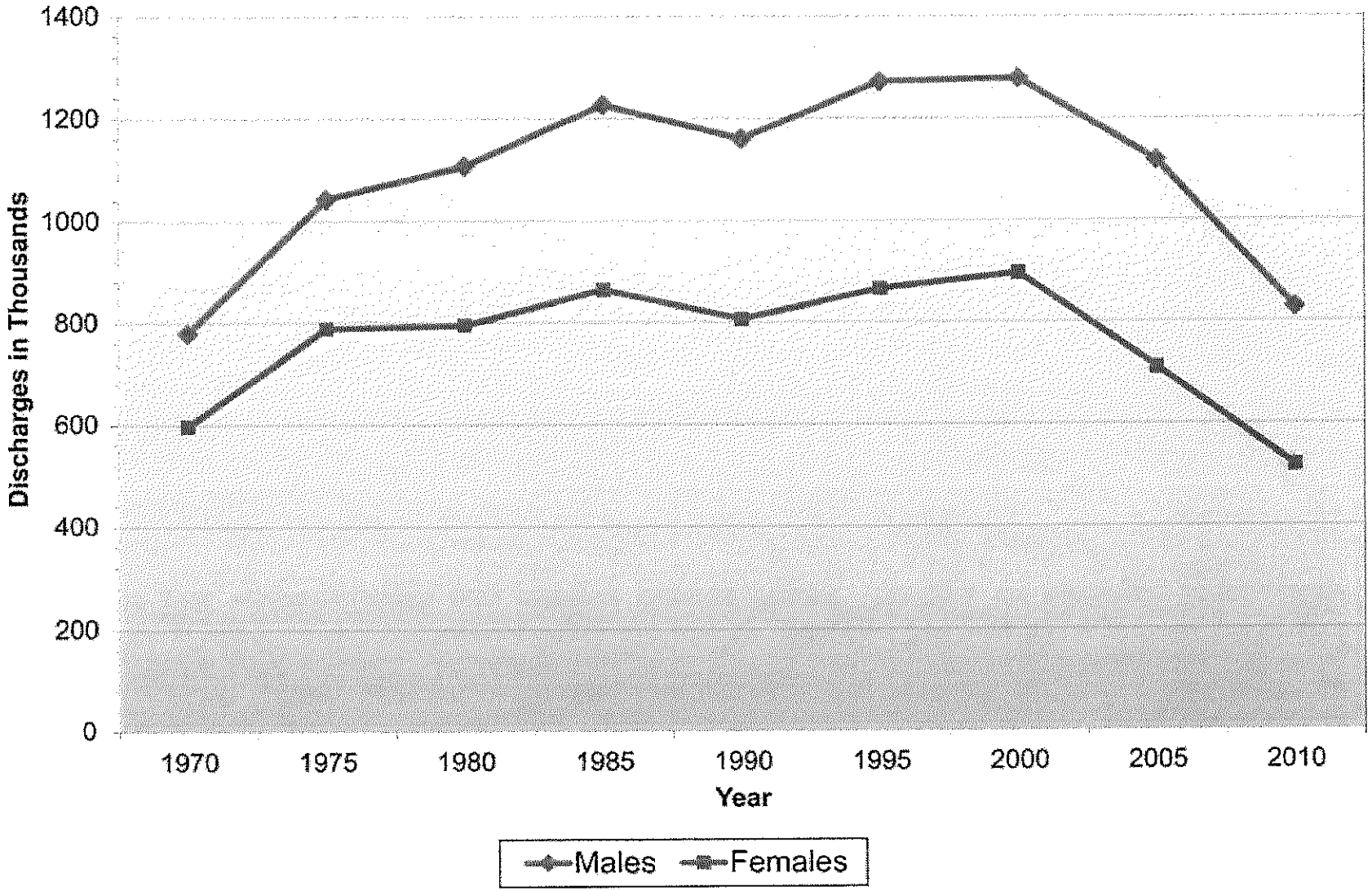
Mozaffarian D et al. Circulation. 2015;131:e29-e322

Prevalence of low coronary heart disease risk, overall and by sex



National Health and Nutrition Examination Survey: 1971–2006.

Hospital discharges for coronary heart disease by sex (United States: 1970–2010).



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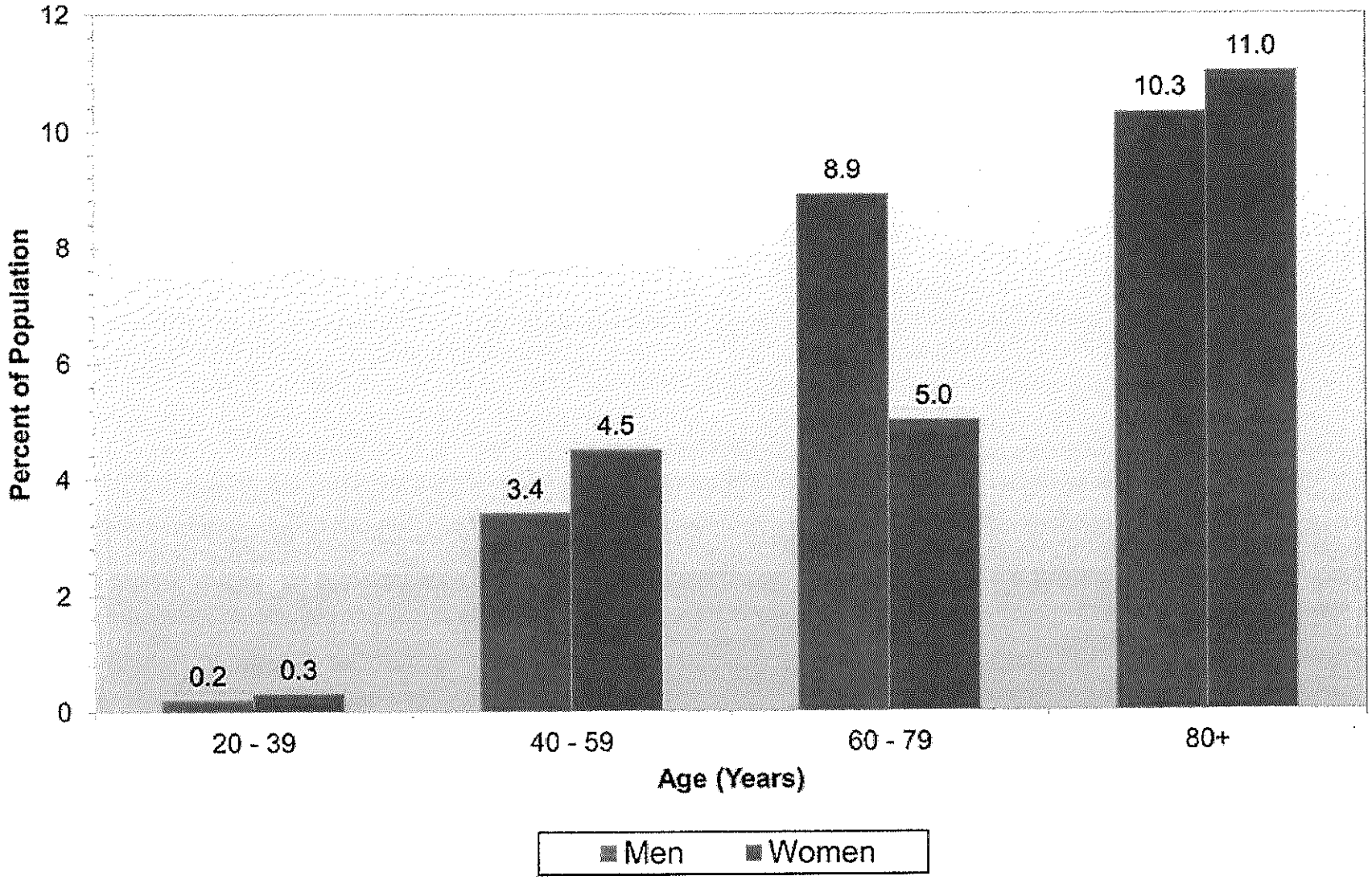
Prevalence of angina pectoris by age and sex

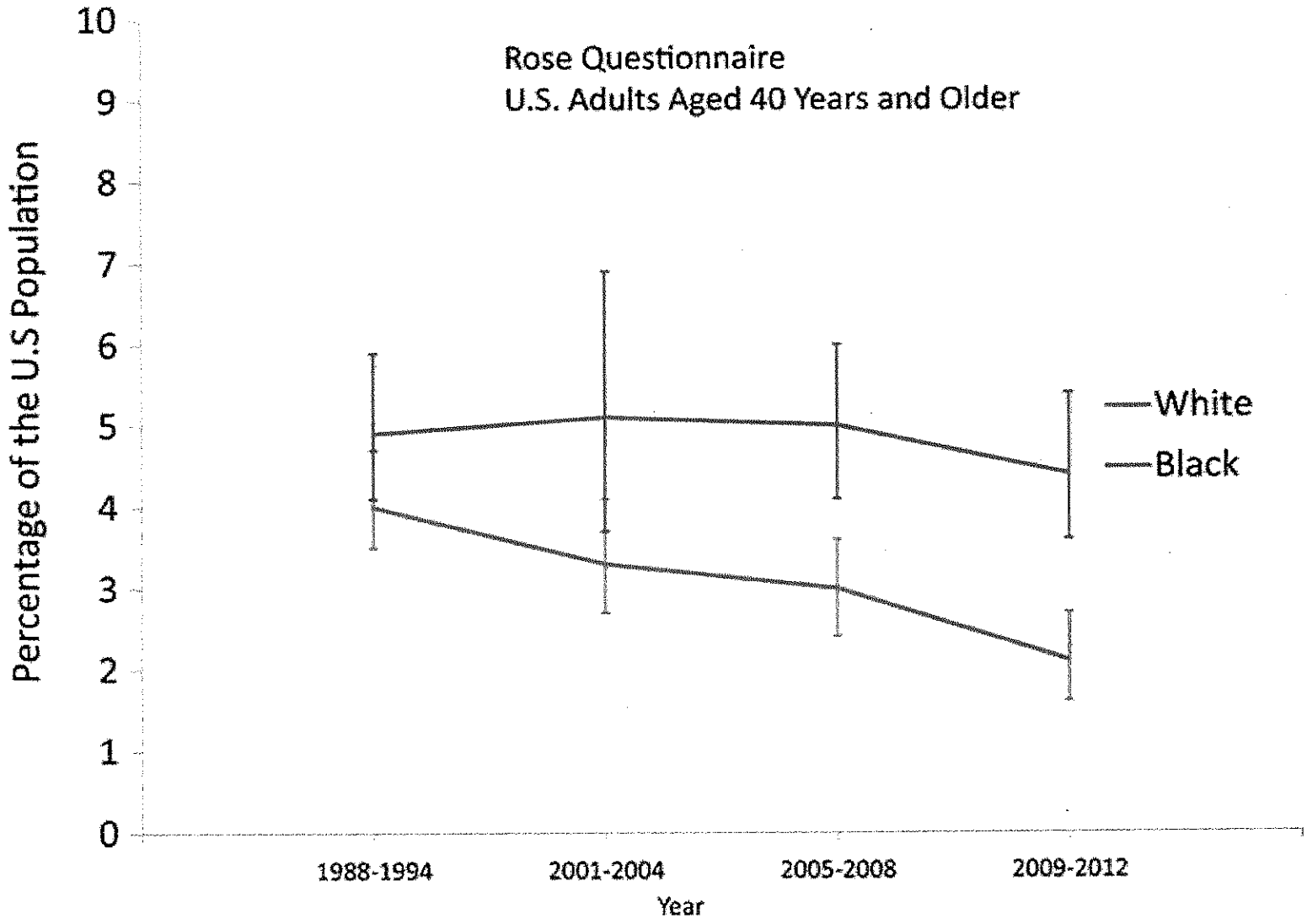


National Health and Nutrition Examination Survey: 2009–2012.

American Heart Association.

Mozaffarian D et al. Circulation. 2015;131:e29-e322

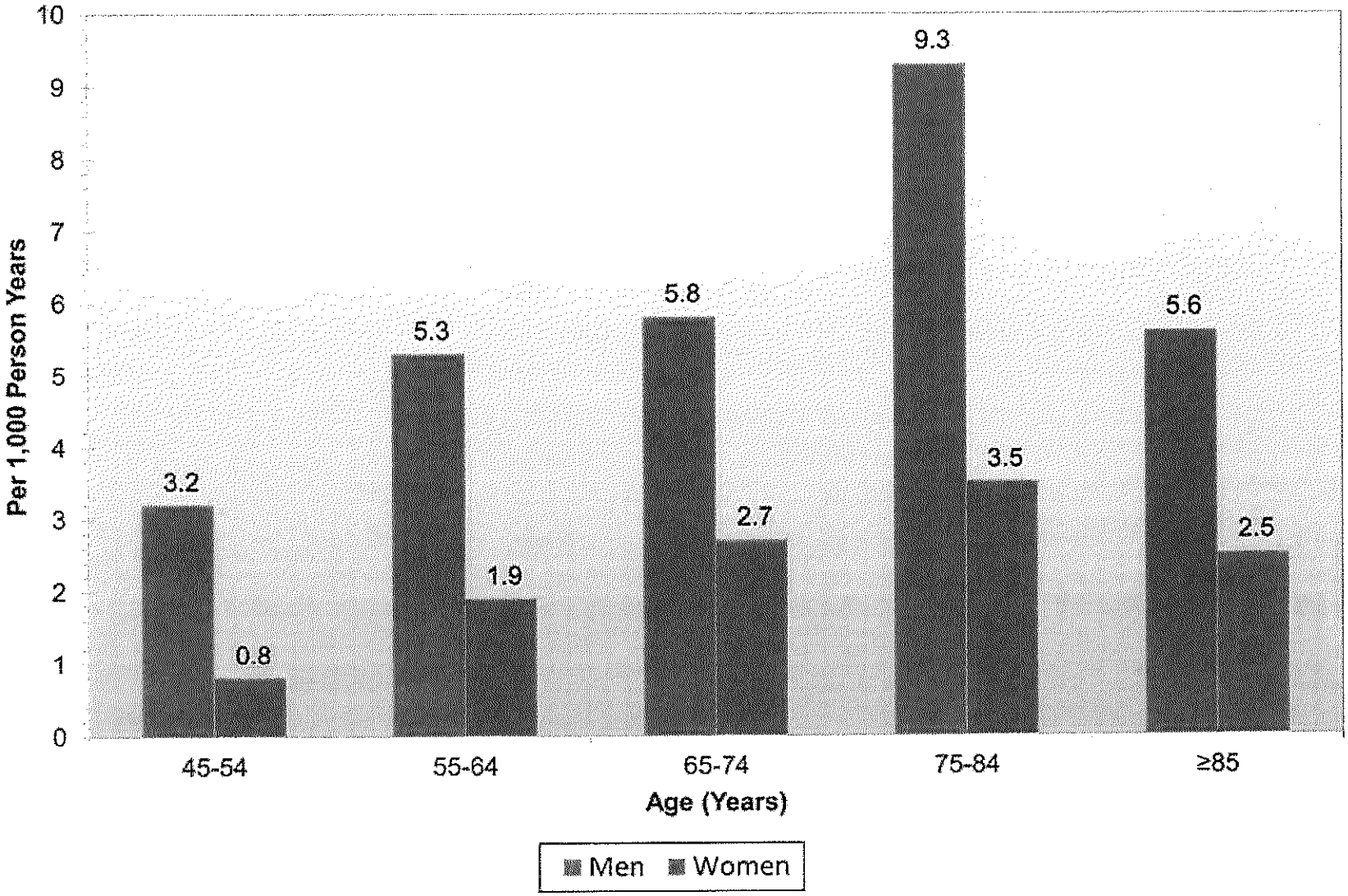
Secular trends in age-and sex-standardized prevalence rates of angina for adults aged ≥40 years in the United States, by race, for angina symptoms defined using the Rose questionnaire.



American Heart Association

Mozaffarian D et al. Circulation. 2015;131:e29-e322

Incidence of angina pectoris* by age and sex (Framingham Heart Study 1986–2009).



*Angina pectoris deemed uncomplicated on the basis of physician interview of patient.

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Lung Disease Data: 2008

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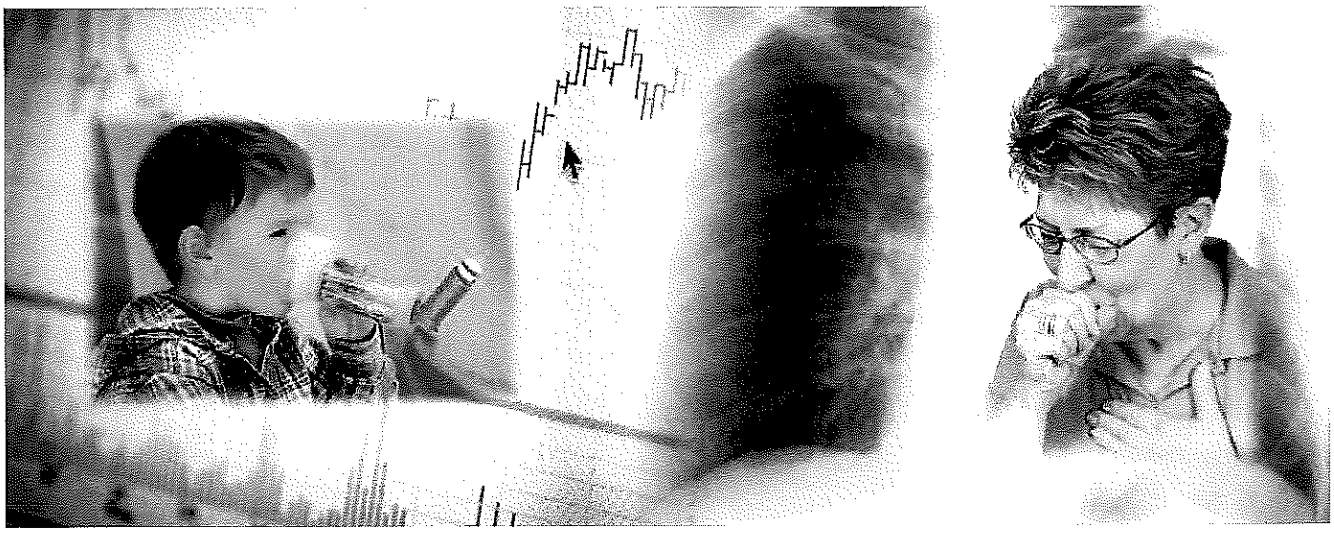

Acute Respiratory Distress Syndrome (ARDS)

Air Quality

Asthma

Chronic Obstructive Pulmonary Disease (COPD)

Cystic Fibrosis

HIV/AIDS Related Lung Disease

Influenza and Pneumonia

Lesser-Known Lung Diseases

Lung Cancer

Obstructive Sleep Apnea (Sleep-Disordered Breathing)

Occupational Lung Diseases

Pulmonary Arterial Hypertension (PAH)

Respiratory Distress Syndrome and Bronchopulmonary Dysplasia (RDS & BPD)

Respiratory Syncytial Virus (RSV)

Sarcoidosis

Sudden Infant Death Syndrome (SIDS)

Tobacco Use

Tuberculosis (TB)

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Other contributors and reviewers:

Paul G. Billings
William Blatt
Thomas Carr
Janine Chambers
Barbara Kaplan
Elizabeth Lancet
Jessica Lazar
Lynne Manley
Janice E. Nolen
Katherine Pruitt
Erika Sward
Terri Weaver

Copy editor:

Diane Maple

Online services:

Omar Cruz

Design:

Our Designs, Inc., Nashville, TN

American Lung Association
National Headquarters
61 Broadway, 6th Floor
New York, NY 10006-2701
Phone: (212) 315-8700
Fax: (212) 315-8800

Washington Office
1301 Pennsylvania Avenue, NW, Suite 800
Washington, DC 20004-1725
Phone: (202) 785-3355
Fax: (202) 452-1805

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Improving Life, One Breath at a Time

Table of Contents

Helpful Definitions

Prevalence: The number of existing cases of a particular condition, disease, or other occurrence (e.g., persons smoking) at a given time.

Incidence: The number of new cases (as, of a disease) occurring during a particular period of time (e.g., 100 cases of TB from 1998 to 2002).

Prevalence or incidence rate: Cases in a particular population quantity—e.g., per hundred or per thousand.

Age-adjusted figure: A figure that is statistically corrected to remove the distorting effect of age when comparing populations of different age structures.

Note: All statistics in this document apply specifically to the United States and are for the most recent available year. Factors used in expressing these data, as determined by the collecting agencies:

- Mortality (death) rates are per 100,000 population.
- Chronic disease prevalence is per 1,000 population.
- Hospital discharge rates are per 10,000 population.
- Incidence rates are per 100 or per 100,000 population.
- Morbidity is defined as illness.

Introduction

What do the lungs do?

The lungs, with their tiny air sacs called alveoli (pronounced al-vee-oh-lie), have sometimes been compared to sponges. They are actually far more complex than many other organs. The heart, for example, is a relatively basic muscular pump with one-way mechanical valves designed for the purpose of keeping the bloodstream flowing in one direction. The lungs must play multiple roles—supplier of oxygen, remover of wastes and toxins, and defender against hostile intruders, among others.

They contain at least three dozen distinct types of cells, each with its own special tasks and abilities. Some scavenge foreign matter. Others, equipped with delicate, hair-like cilia, sweep the mucous membranes lining the smallest air passages. Still others act on substances crucial to blood-pressure control, or serve as sentries to spot invading agents of infection. The roles of many others remain mysteries, posing challenges to researchers.

In mechanical terms, our lungs can be described as the site of gas exchange. Oxygen—the fuel all the cells and organs of our body need to function—is extracted from the air we inhale, carried within the bloodstream and distributed to other organs and tissues. With each exhalation, we dispose of the carbon dioxide that is the by-product of our bodily functions. In our lungs, in the course of a single day, an astonishing 8,000 to 9,000 liters of breathed-in air meet 8,000 to 10,000 liters of blood pumped in by the heart through the pulmonary artery. The lungs relieve the blood of its burden of waste and return a refreshed, oxygen-rich stream of blood to the heart through the pulmonary vein.

What are lung diseases?

The lungs are internal organs; yet they are uniquely and constantly exposed to our external environment, a direct interface with the world outside. With each breath, a host of alien substances enters our bodies, leaving the lungs a ravaged battlefield. Lung disease is any disease or disorder where lung function is impaired. Lung diseases can be caused by long-term and immediate exposure to smoking (active and passive), air pollution (indoor and outdoor), occupation-

al exposures such as asbestos and silica dust, carcinogens that trigger tumor growth, infectious agents, and overreactive immune system defenses.

There are many types of lung diseases including:

- *Obstructive lung diseases such as asthma, chronic bronchitis and emphysema.* These all affect a person's airways and limit or block the flow of air in or out of the lungs.
- *Infectious illnesses such as pneumonia, influenza, respiratory syncytial virus (RSV)* and *tuberculosis (TB).* Bacteria or viruses cause these diseases that can also affect the membrane (or *pleura*) that surrounds the lungs.
- *Lung cancer.* A disease characterized by uncontrolled growth and spread of abnormal cells.
- *Respiratory failure, pulmonary edema, pulmonary embolism* and *pulmonary hypertension.* These conditions are caused by problems with the normal gas exchange and blood flow in the lungs.
- *Pulmonary fibrosis and sarcoidosis.* These are diseases characterized by stiffening and scarring of the lungs.
- Occupational diseases, such as *mesothelioma* and *asbestosis*, caused by exposure to hazardous substances.

Just as there is no single cause for lung disease, there is no single symptom of lung disease. Some conditions may send disease-specific signals, such as the characteristic wheezing sound made as the asthma sufferer attempts to exhale.

Some lung disorders, such as emphysema, may be evidenced mainly by increasing shortness of breath, eventually upon the slightest physical effort, as tired muscles fail to receive sufficient oxygen.

Other forms of lung disease may be signaled by persistent cough, chest pain, shortness of breath, abnormal sputum production, bloody sputum or a combination of these symptoms.

When an infectious agent causes a lung disease, there may also be fever and/or chills. Any suspicion that the lungs might not be functioning properly means that a person should seek medical attention.

What is *Lung Disease Data: 2008*?

In the pages that follow, we have presented important facts and figures about some of the most common lung diseases in the United States today.

The American Lung Association strongly believes that if cigarette smoking, preventable premature childbirth, disregard for workers' safety and violation of clean-air laws were to end today, we could expect a future largely free of the most lethal forms of lung disease.

Below are a few important facts on lung diseases overall:

- Every year almost 400,000 Americans die from lung disease—an age-adjusted death rate of 135.5 per 100,000.[1]

- Lung disease is the number three killer (behind heart disease and cancer) in the United States, responsible for one in six deaths.[2]
- Lung disease death rates are currently increasing, while death rates due to other major causes of death, such as heart disease, cancer and stroke, are declining.[3]
- Overall, various forms of lung disease and breathing problems constitute one of the leading causes of death in babies under the age of one year, accounting for 20.2 percent of infant deaths in 2004.[4]
- More than 35 million Americans have chronic lung diseases.[5]
- An estimated 438,000 Americans die each year from diseases directly related to cigarette smoking, including heart and lung diseases.[6]
- Millions of children and adults with lung disease in this country are exposed to levels of ozone and particle air pollution that could potentially make them sick.
- Asthma and chronic obstructive pulmonary disease (emphysema and chronic bronchitis), the most common obstructive lung diseases, are associated with substantial health impairment and work disability.
- Lung disease costs the U.S. economy $95 billion in direct health-care expenditures every year, plus indirect costs of $59 billion—a total of $154 billion.[7]

Chronic Obstructive Pulmonary Disease (COPD)

What is chronic obstructive pulmonary disease?

Chronic obstructive pulmonary disease (COPD) is a term referring to two lung diseases, chronic bronchitis and emphysema. Both conditions cause obstruction of airflow that interferes with normal breathing. Both frequently exist together, so physicians prefer the term COPD. COPD is preventable and treatable. This definition of COPD does not include other obstructive diseases such as asthma, although uncontrolled asthma over a lifetime can result in damage and COPD.

Chronic bronchitis is the inflammation and eventual scarring of the lining of the bronchial tubes. When the bronchi are inflamed or infected, less air is able to flow to and from the lungs and a heavy mucus or phlegm is coughed up. Once the bronchial tubes have been irritated over a long period of time, excessive mucus is produced constantly, the lining of the bronchial tubes thickens, an irritating cough develops, air flow may be hampered and the lungs become scarred, eventually obstructing airflow.[1] The bronchial tubes then make an ideal breeding place for bacterial and viral infections.

Symptoms of chronic bronchitis include chronic cough, increased mucus, frequent clearing of the throat and shortness of breath.[2] The condition has been defined by the presence of a mucus-producing cough most days of the month, three months of a year for two years in a row without other underlying disease to explain the cough. More recent definitions include reduced lung function.

Emphysema begins with the destruction of air sacs (alveoli) in the lungs where oxygen from the air is exchanged for carbon dioxide in the blood. Damage to the air sacs is irreversible and results in permanent "holes" in the tissues of the lower lungs. As air sacs are destroyed, the lungs can transfer less and less oxygen to the bloodstream, causing shortness of breath. The lungs also lose their elasticity, which is important for keeping airways open. In advanced emphysema cases, patients are extremely short of breath.[3]

Symptoms of emphysema include cough, shortness of breath and a limited tolerance for exercise. As the disease advances, the work of breathing is so great that major weight loss occurs.

Smoking is the leading risk factor for COPD. Other risk factors include exposure to air pollution and second-hand smoke, a history of childhood respiratory infections and heredity. Particulate matter (PM) from cigarette smoke and air pollution, including smoke from poorly ventilated wood stoves and the burning of biomass[1,4], are related to lung damage. Particles that have a diameter of 2.5 to 10 microns, or less than 1/7 the diameter of a human hair, are called coarse particles and are of special concern. Larger particles are more easily trapped in the nose or throat, while smaller particles can be drawn into the small air passages.[5]

Fine particles, with a diameter of 2.5 microns or less ($PM_{2.5}$) represent the most serious threat. Particles this small easily reach deep into the lung and may even pass into the bloodstream.[6] Once they have penetrated the lungs, fine particles can cause inflammation and impair immune responses.[7]

Alpha-1 antitrypsin deficiency-related (Alpha-1) emphysema is caused by an inherited deficiency of a protein called alpha -1 antitrypsin (AAT) or alpha-1 protease inhibitor. Alpha-1 emphysema is responsible for five percent or less of the emphysema in the United States.[8] AAT, produced by the liver, is a "lung protector." In the absence of AAT, the risk of developing emphysema is far greater than normal. Symptoms almost never appear before 25 years of age and sometimes never develop, especially in nonsmokers. In those who smoke, symptoms occur between 32 and 41 years of age, on average.[9]

Want to learn more about chronic bronchitis? Please view the disease listing at **http://www.lungusa.org/chronicbronchitis**

One study found that certain genes in mice appear to influence the risk of developing emphysema. The researchers said this may explain why some smokers remain disease-free. If similar genes are found in humans, these findings may one day help identify people who are at risk of emphysema well in advance of symptoms.[10]

Occupational exposure to certain industrial pollutants also increases the risk for COPD and contributes to its burden. One study found that an estimated 19.2 percent[11] of COPD cases among workers aged 30 to 75 years was due to occupational exposures. A combination of tobacco use and occupational exposure greatly increases the risk of developing COPD.

Who gets COPD?

Over 12.1 million U.S. adults (aged 18 and over) were estimated to have COPD in 2006.[12] However, close to 24 million U.S. adults have evidence of impaired lung function, indicating an under-diagnosis of COPD.[13] This is a serious issue because damage to the lungs is not noticed until the disease is well-advanced, thus limiting effective treatment options.

Previously, COPD was more of a concern for men than women as women had lower prevalence rates of the disease. This was due to the far higher rate of

[1] Any organic material made from plants or animals.

smoking among men compared to women during much of the past century. As the smoking rate among women increased after World War II, so did their risk of developing COPD. Since there is a long lag period between smoking initiation and COPD diagnosis, the increased COPD prevalence rate in women has only been noticed recently. Women are twice as likely as men to be diagnosed with chronic bronchitis. In 2006, 2.9 million men were diagnosed compared to 6.6 million women.[14]

Want to learn more about COPD trends and data? Please view the *COPD Trend Report,* which delineates information available from national surveys on the mortality, prevalence, hospitalizations and economic costs due to COPD, at **http://www.lungusa.org/copdtrends**

The reasons behind this change and difference by gender have been understudied and are not well understood.[15] A recent study found that the variation between genders in COPD rates could be due primarily to differences in smoking behavior and exposure to other environmental risk factors, such as occupations where there is a lot of dust present.[16] However, women appear to have a greater vulnerability to cigarette smoking, the leading risk factor for COPD and lung cancer. This may be due to differences in how cigarette smoke is metabolized by women. Additional research suggests that women are at higher risk for DNA damage and are less able to repair DNA. While neither process is fully understood, it is likely that both contribute to the higher COPD and lung cancer rates seen in women along with other pathways that have yet to be discovered.[17] For more information on gender differences in smoking-related diseases, please see the tobacco and lung cancer chapters of this report.

Research suggests that one or more inherited risk factors interact with smoking to increase COPD risk. It is not known if such inherited risk factors differ among races.[18]

Want to learn more about COPD? Please view the fact sheet at **http://www.lungusa.org/copdfactsheet**

COPD prevalence is estimated by results of the National Health Interview Survey (NHIS), which asks respondents if they have been diagnosed with chronic bronchitis in the last year (current prevalence), and if they have ever been diagnosed with emphysema (lifetime prevalence). COPD prevalence takes into account the overlap of persons with both diseases (approximately 10%). The total estimated COPD prevalence is then slightly less than simply adding together prevalence estimates for chronic bronchitis and emphysema. Data on numbers of deaths represent counts obtained from death certificates. COPD deaths include those from any chronic lower respiratory disease, including chronic bronchitis, emphysema and bronchiectasis, but do not include asthma.

In 2006, an estimated 9.5 million Americans were diagnosed with chronic bronchitis by a health care professional: 3.2 million 18 to 44 year olds, 4.1 million 45 to 64 year olds and 2.2 million people over 65 years of age. Chronic

bronchitis affects people of all ages, but the highest prevalence rate was seen among those 65 years of age and older at 60.9 per 1,000 persons while those ages 18 to 44 had the lowest rate estimated at 28.8 per 1,000 persons. Persons aged 45 to 64 years had a prevalence rate of 55.4 per 1,000 persons.[19]

White Americans appear to be more likely to have COPD than other racial or ethnic groups.[20] Not only are they more likely to have the disease, but they are also more likely to die from it.[21]

Chronic bronchitis prevalence had decreased in recent years but increased slightly in 2006 for both Whites and Blacks. The highest prevalence rate among Whites was in the 65 years of age and older population (63.1 per 1,000) and in the 45 to 64 years of age population for Blacks (61.7 per 1,000).[22]

The emphysema prevalence rate is very low in those under age 45. Of the estimated 4.1 million Americans ever diagnosed with emphysema in their lifetime, 93 percent were 45 or older.[23] The risk of being diagnosed with COPD doubles every 10 years after the age of 40.[24] In 2006, the reported emphysema lifetime prevalence rate was 18.5 per 1,000 population.[25] Men tend to have higher emphysema prevalence rates than females. In 2006, almost 2.5 million males (23.4 per 1,000 population) had emphysema compared to 1.6 million females (13.9 per 1,000). From 1997 to 2006, the prevalence rate increased by 6 percent in women and 16 percent in men.[26]

Emphysema rates are highest in non-Hispanic Whites (23.5 per 1,000) and lowest in Hispanics (3.9 per 1,000). Non-Hispanic Blacks have an emphysema rate of 7.4 per 1,000.[27]

Want to learn more about COPD and diverse communities? Please view the *State of Lung Disease in Diverse Communities 2007* report at **http://www.lungusa.org/solddc-copd**

An estimated 100,000 Americans, primarily of northern European descent, have Alpha-1 deficiency emphysema. Another 20 million Americans carry a single deficient gene that causes Alpha-1 and may pass the gene on to their children.[28] A recent study suggested that there are at least 116 million Alpha-1 carriers among all racial groups, worldwide.[29]

What is the health impact of COPD?

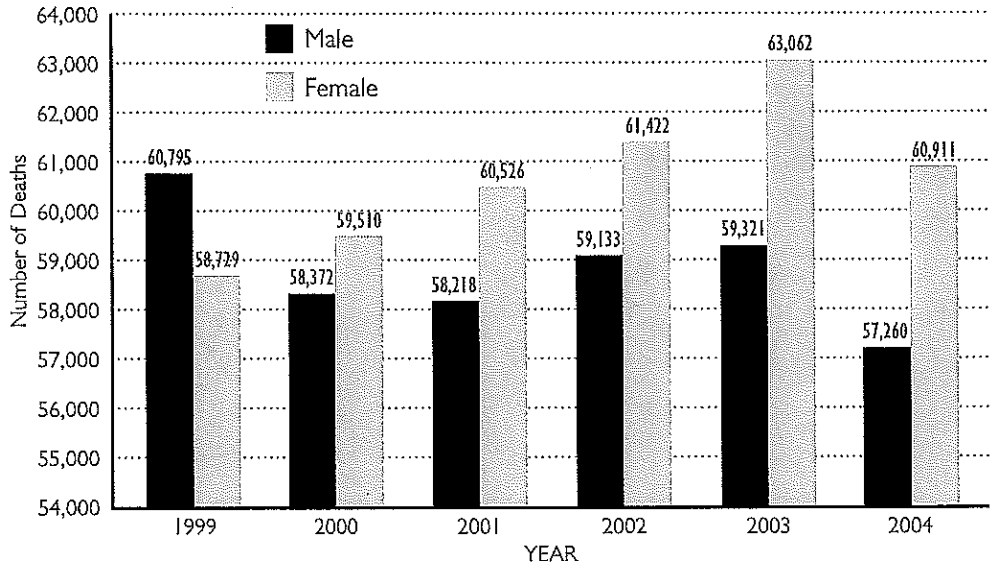
COPD is the fourth leading cause of death, claiming the lives of 118,171 Americans in 2004.[30] Preliminary data show this number increased to 127,000 in 2005.[31] That is one death every four to five minutes. COPD is expected to become the third leading cause of death by the year 2020.[32]

Approximately 80 to 90 percent of COPD deaths are caused by smoking. Men and women smokers are nearly 12 and 13 times as likely to die from COPD, respectively, compared to those who have never smoked.[33]

Although, historically, men have been more likely than women to die of COPD, women have exceeded men in the number of deaths since 2000. In 2004,

almost 61,000 females died of COPD compared with 57,000 males.[34] Figure 1 displays the number of deaths due to COPD by sex from 1999 to 2004.

Figure 1: Number of COPD Deaths by Year and Sex, U.S., 1999–2004*



Source: Centers for Disease Control and Prevention. National Center for Health Statistics, Monthly Vital Statistics Report, 1999–2004.

Note:

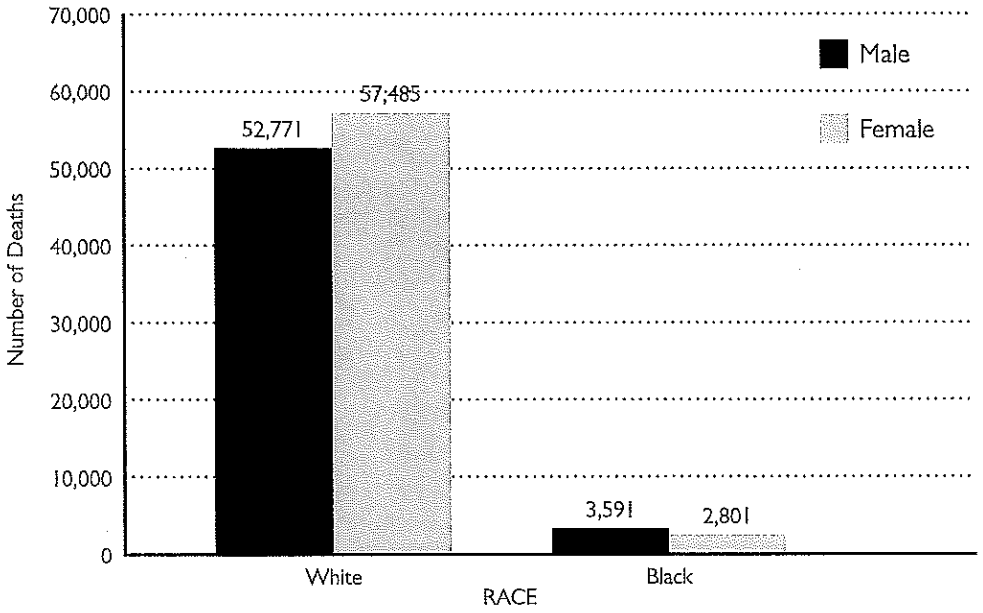
* **Comparisons should only be made between groups and diseases using rates, not number of deaths, as these do not take into account differences which may exist in population size or demographics.**

Racial and ethnic groups differ in smoking rates and patterns. Native Americans have the highest percentage of current smokers (26.9%) while Asians have the lowest (11.2%). Current smoking prevalence in Hispanics is relatively low (15.1%). Non-Hispanic Whites (21.8%) and non-Hispanic Blacks (22.6%) have similar current smoking prevalence percentages. Due to the long lag period between smoking onset and COPD presentation, future COPD prevalence rates among these groups are predicted to reflect these differences with more Native Americans and non-Hispanic Blacks presenting with the disease.[35]

In 2004, there were 6,330 deaths due to COPD in non-Hispanic Blacks and 2,826 in Hispanics. The age-adjusted death rate for chronic bronchitis was 0.2 per 100,000 persons for both non-Hispanic Blacks and Hispanics. This rate is 50 percent lower than that for non-Hispanic Whites, 0.3 per 100,000 persons. However, emphysema leads to far more deaths than chronic bronchitis. The age-adjusted death rate for emphysema in 2004 was 2.8 among non-Hispanic Blacks and 1.6 per 100,000 persons among Hispanics. The age-adjusted death rate for emphysema in non-Hispanic Whites was 5.1 per 100,000 persons, almost two times greater than that of non-Hispanic Blacks and over three times greater than Hispanics.[36]

Figure 2 shows the number of deaths by race and sex in 2004. White women suffered the most deaths due to COPD with almost 58,000 dying in 2004 alone.

Figure 2: Number of COPD Deaths by Race and Sex, U.S., 2004*

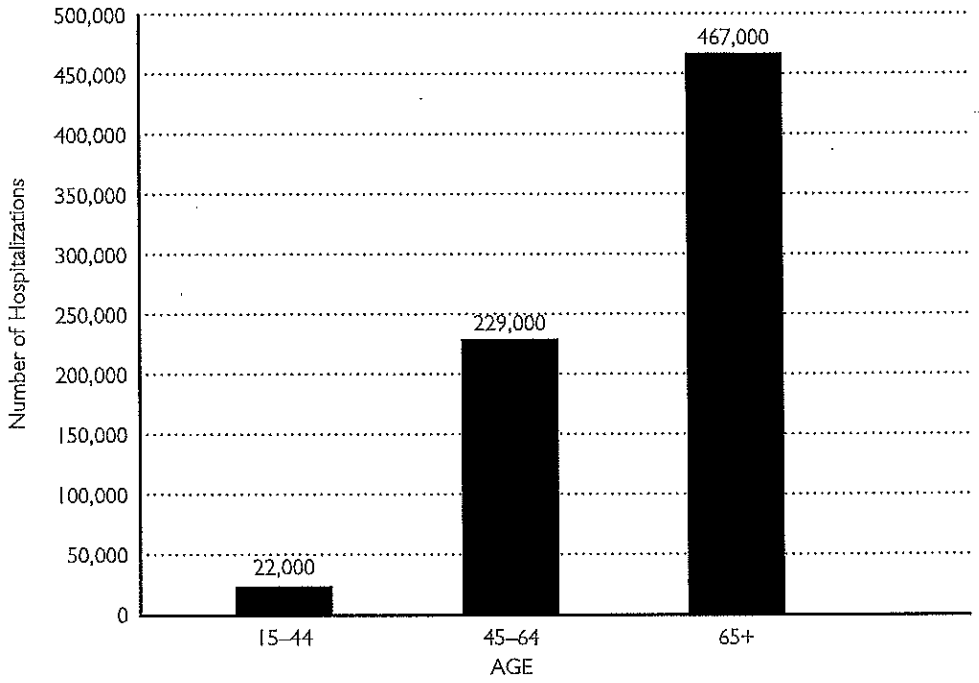


Source: Centers for Disease Control and Prevention. National Center for Health Statistics: National Vital Statistics Report. Deaths: Final Data for 2004.
Note:
* **Comparisons should only be made between groups and diseases using rates, not number of deaths, as these do not take into account differences which may exist in population size or demographics.**

An estimated 721,000 hospitalizations due to COPD were reported in 2005, a rate of 24.4 per 10,000 population.[37] Between 1988 and 1992, men had slightly higher rates of COPD hospitalization than women. However, since 1993, the rate in women has surpassed that for men. In 2005, the rates among men and women were 22.6 and 26.1 per 10,000, respectively. [38]

COPD is an important cause of hospitalization in the aged population. Approximately 65 percent of all COPD hospitalizations were in people 65 years of age and older in 2005. The rate for the population 65 years of age and older (126.9 per 10,000) was significantly higher than the rate for any other age group. For instance, the hospitalization rate in the 65 years of age and older group was over four times higher than that in the 45 to 64 years of age group (31.4 per 10,000).[39] The number of hospitalizations by age in 2005 are displayed in Figure 3.

Figure 3: Number of COPD Hospitalizations by Age, U.S., 2005[1,2,*]



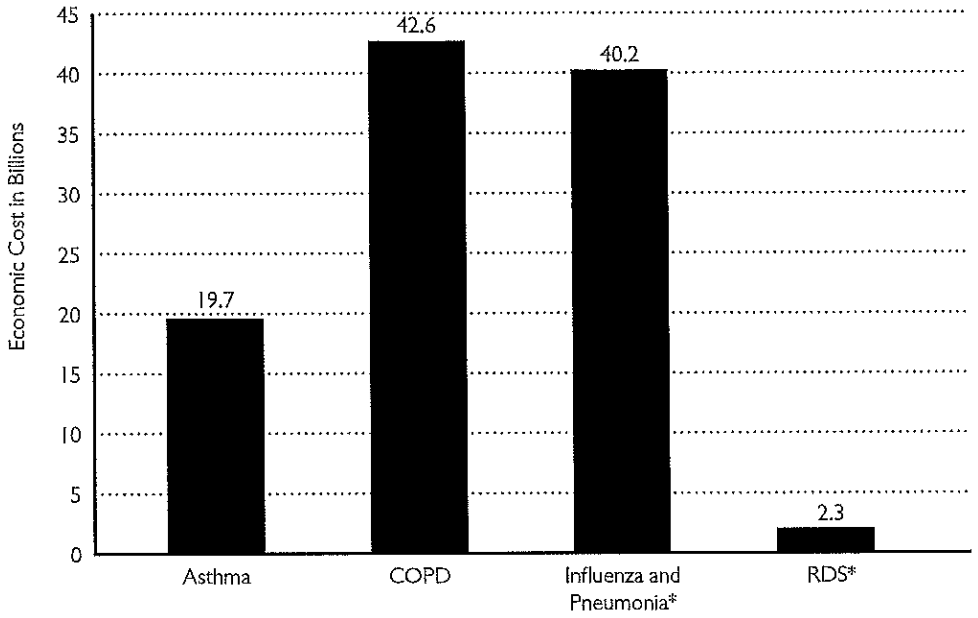
Source: National Center for Health Statistics. National Hospital Discharge Survey, 2005.
Notes:
1. ICD-9 codes 490-492, 494-496
2. Hospitalizations are estimated based on the recorded primary discharge diagnosis
*** Comparisons should only be made between groups and diseases using rates, not number of hospitalizations, as these do not take into account differences which may exist in population size or demographics.**

The impact of COPD on quality of life is profound. A survey by the American Lung Association revealed that half of all COPD patients (51%) say their condition limits their ability to work. It also limits them in normal physical exertion (70%), household chores (56%), social activities (53%), sleeping (50%) and family activities (46%).[40]

Patients with COPD also need psychological or other emotional support. COPD patients' inability to be as active as they once were, and their increasing dependency on others and even on machines, also can lead to profound depression and dependency, often further complicating their physical illness. One study of people with chronic breathing disorders found that 80 percent of the 1,334 people studied suffered from depression, anxiety or both. Although depression and anxiety are very treatable for people with COPD, only 31 percent of COPD patients are being treated for these conditions.[41]

Chronic bronchitis and emphysema take a heavy toll on the economy. According to estimates by the National Heart, Lung, and Blood Institute, in 2007 the annual cost to the nation for COPD was $42.6 billion. This included $26.7 billion in direct health care expenditures, $8 billion in indirect morbidity (illness-related) costs and $7.9 billion in indirect mortality (death-related) costs.[42] Figure 4 displays the economic cost of COPD compared to other select lung diseases.

Figure 4: Economic Cost of Selected Lung Diseases, U.S., 2007



Source: U.S. Department of Health and Human Services. National Institutes of Health. National Heart, Lung, and Blood Institute. Morbidity and Mortality: 2007 Chartbook on Cardiovascular, Lung, and Blood Diseases. Unpublished data provided upon special request to NHLBI.
Note:
* Unpublished data, 2005.

How is COPD diagnosed and managed?

COPD does not strike suddenly and is often neglected by individuals until it has reached an advanced state, because people mistakenly believe that the disease is not life-threatening. By the time a patient sees a health care provider, the lungs frequently have been critically injured and the patient may be in danger of developing serious respiratory problems or heart failure. For this reason, COPD is called the "silent killer."

COPD can be easily diagnosed with a pulmonary function test known as spirometry. Spirometry measures how well the lungs exhale. In the test, a person breathes into a mouthpiece connected to an instrument called a spirometer. The spirometer records the amount and rate of air that is breathed in and out over a specified time.

Other tests that may be used to assess a patient with COPD include bronchodilator reversibility testing, chest x-ray (to exclude other diagnoses), arterial blood gas measurement (amount of oxygen and carbon dioxide in the blood) and alpha-1 antitrypsin deficiency screening. Alpha-1 screening should be performed when COPD develops in patients under 45 years of age, in patients with a strong family history of COPD, people with COPD who have never smoked, smokers with a family history of COPD and people with a family history of alpha-1 emphysema.

If AAT deficiency is discovered in a child or young person in whom emphysema has not yet developed (in children, liver disease may also occur, and the defect

can be detected by a blood test), a remedy may be liver transplantation, effectively preventing emphysema. If lung disease is already evident, lung transplantation is sometimes considered.

A second treatment alternative for alpha-1 emphysema is administration of the missing AAT protein. However, AAT replacement therapy is costly and it must be given intravenously, on a weekly basis, for life. Its long-term effects are still being studied.

While COPD lung damage is irreversible, there are treatments that can improve a patient's quality of life. Stopping smoking is the single most effective—and cost-effective—way to reduce the risk of developing COPD and slow its progression. Any current or former smoker over age 40 or never-smoker with a family history of COPD, emphysema or chronic bronchitis, those with exposure to occupational or environmental pollutants and those with a chronic cough, sputum (matter discharged from air passages) production or breathlessness, should seek testing for COPD with spirometry.[43] For more information about the health benefits of quitting smoking, please see the tobacco chapter of this report.

Treatment with medication can improve and prevent COPD symptoms, reduce the frequency and severity of exacerbations, improve health status and improve the ability to exercise.

Bronchodilators are used to help open the airways in the lungs and decrease shortness of breath. Inhaled or oral steroids can help decrease inflammation in the airways in some people. Antibiotics are often used to treat infections.

A study was conducted among 6,112 patients between the ages of 40 to 80 who had been diagnosed with COPD and were current or former smokers. The study was conducted to determine the effect of inhaled corticosteroids and a long-acting bronchodilator on the treatment of COPD. The study supports the use of the drugs salmeterol plus fluticasone propionate in the management of COPD. This combination treatment resulted in less worsening of symptoms and improved health status and lung function.[44]

Non-drug treatment such as pulmonary rehabilitation, oxygen therapy and surgery can improve a COPD patient's quality of life. One factor that can help protect against COPD development or slow its progression is physical activity, which keeps muscles working effectively and may help slow the decline in lung function.[45]

Want to learn where pulmonary rehabilitation is available near you? Please visit **http://www.lungusa.org** or call the Lung HelpLine at 1-800-LUNGUSA (586-4872).

COPD patients of all ages benefit from pulmonary rehabilitation programs that focus on supervised exercise training and education to help the patients manage their disease. These activities play an important part in helping a patient maximize their ability to perform daily activities. The minimum length of an effective rehabilitation program varies with insurance coverage but is usually two months; the longer the program continues, the more effective the results.

The long-term administration of oxygen (>15 hours per day) to patients with chronic respiratory failure increases survival and exercise capacity and improves mental state. Close to one million persons living in the United States are on long-term oxygen therapy.[46] The introduction of portable oxygen concentrators has allowed thousands of patients with chronic lung disease to travel and maintain active lifestyles.

Lung transplantation is now being done and may be a more readily available option in the future. Techniques have been improving, many more such operations are being performed each year and pulmonary specialists are optimistic about the procedure's lifesaving potential. Racial disparities in who gets transplantations are due, in part, to social determinants of health such as poverty and unequal access to health care.[47] These factors need to be addressed in order to eliminate this disparity.

There has been much interest in a procedure called lung volume reduction surgery (LVRS), in which some of the most severely damaged lung tissue is removed to ease the burden on the remaining tissue and chest muscles. Recently, a study was conducted to determine the effects of LVRS. It was found that LVRS for pulmonary emphysema improved weight (body mass index), airflow obstruction, breathing difficulties (dyspnea) and exercise capacity (BODE) index. The BODE index is a predictor of survival in COPD.[48] Another study, conducted by the National Emphysema Treatment Trial Research Group, concluded that LVRS can be recommended for patients whose emphysema is concentrated in the upper-lobe of a lung and who suffer from low-exercise capacity, and may be considered for other patients.[49]

What is new in COPD research?

Scientists have identified a single gene, the SERPINA1 gene, located on human chromosome number 14, that bears the code that triggers AAT production in the liver.[50] Future therapy may correct this inherited defect by delivering DNA carrying the missing genetic coded "message" to the liver or other organs.

Recently, a study was conducted to determine the association between the use of corticosteroids in the treatment of COPD and the risk of pneumonia among the elderly. Almost 176,000 patients with COPD were followed for 15 years (1988-2003), with their use of inhaled corticosteroids and any hospitalizations due to pneumonia being tracked over this time. Use of inhaled corticosteroids was associated with a 70 percent increase in risk of hospitalization for pneumonia; those taking the largest dose (equivalent to fluticasone 1,000 micrograms per day or more) were at 2.3 times greater risk. The authors concluded that there is an excess risk of pneumonia hospitalization and an excess risk of hospitalization followed by death within 30 days for elderly COPD patients using inhaled corticosteroids. The death rate due to all causes was not different among pneumonia patients who had or had not inhaled corticosteroids in the recent past.[51]

As lung cancer risk may increase among patients with COPD, a study was conducted in 2006 to evaluate whether the use of inhaled corticosteroids by

COPD patients would decrease their risk of lung cancer. The study focused on patients who took their medication for COPD regularly (80% of the time) and found that corticosteroid medications show promise as a COPD medication and that these patients had a decreased risk of developing lung cancer.[52] Other studies also support the use of corticosteroids in the treatment of COPD to reduce the risk of death and lung cancer.[53,54]

What is the American Lung Association doing about COPD?

The American Lung Association funds researchers working in the laboratory and with patients who are looking for answers to fundamental questions about how the lungs are damaged in COPD and what can be done to treat and prevent this destruction. Several examples of the many COPD studies being funded by the American Lung Association include:

Determining the risk of COPD in HIV-positive versus HIV-negative smokers.

Examining two types of molecules involved in inflammation, interleukin-13 (IL-13) and leukotrienes, to see whether they play a role in determining who develops COPD from cigarette smoke exposure.

Investigating whether excess air trapped in the lungs may be one of the reasons why some patients with COPD remain dependent on a mechanical ventilator.

Studying a protein, elastin, responsible for the elasticity of the lungs. When elastin in the lungs is broken down, lung elasticity is lost, a hallmark of COPD. Building a comprehensive understanding of the role of elastin in COPD eventually will allow for positive identification of patients at increased risk for premature and severe forms of COPD.

The American Lung Association is currently working on a nationwide initiative to create state-of-the-art programs and services as well as to facilitate collaborative partnerships with key organizations who share the Lung Association's commitment to improve the quality of life for people living with COPD.

In advocacy, the American Lung Association is a leader in COPD-related policy change in Congress. The Lung Association advocates for increasing funding for COPD research at the National Institutes of Health, Department of Veterans Affairs and other federal programs. The Lung Association also is working to raise the profile of COPD at the Centers for Disease Control and Prevention. As a longtime leader on tobacco control, Lung Association volunteers and staff advocate for policies at the federal, state and local level that will increase access to smoking cessation programs, protect the public from secondhand smoke, and prevent children from starting to smoke. Such policies include comprehensive state and local smokefree laws, granting the U.S. Food and Drug Administration (FDA) regulatory control over the manufacturing, distribution and advertising of tobacco products, increasing funding for comprehensive tobacco control and cessation programs at the state level, and increasing cigarette excise taxes. The Lung Association actively supports legislation to provide

Medicare coverage for pulmonary rehabilitation services for COPD patients. Further, the Lung Association continues to work for regulatory changes to facilitate air travel for patients on oxygen therapy. As a member of the U.S. COPD Coalition's policy workgroup, the American Lung Association works closely with key members of the Congressional COPD Caucus, which promotes public awareness, prevention and early detection of COPD.

The Lung Association also has worked to increase state and national surveillance and collection of data on COPD. For example, due to several proposals by the Lung Association, the state of Hawaii will include a question in its 2008 Behavioral Risk Factor Surveillance Survey (BRFSS) on COPD in order to collect state-level prevalence data. The Lung Association is optimistic that other states will follow Hawaii's lead in the future so that state-level COPD surveillance can be attained nationwide. In turn, effective programs can be developed targeting states with high prevalence of COPD in order to reduce its burden.

People with COPD often say that one of the worst aspects of their illness is the feeling that they have lost control over their health. For over 40 years, the American Lung Association has helped millions of patients through its Better Breathers Clubs. These support groups are located throughout the United States and meet regularly to provide peer support and education needed to understand and better manage the disease. These clubs are for adults with all chronic lung diseases, their families and their caregivers.

By joining a support group, participants gain a sense of control over their disease and enter a positive cycle: They get out of the house, meet other people and become motivated to take action. Then they start to feel better—psychologically and physically.

Want to learn more about Better Breathers Club and find one in your area? Please view the club listings at **http://www.lungusa.org/bbc**

Often these groups are led by a respiratory therapist who can educate group members and their families about ways to live well with COPD. Groups may invite medical professionals to share their expertise on topics including nutrition, exercise, breathing techniques, new treatments, stress and depression, and medical equipment. The education patients receive in these groups may help them to avoid preventable hospitalizations and emergency room visits.

The COPD NexProfiler is an interactive decision support tool provided under the auspices of the American Lung Association and NexCura, Inc. The COPD NexProfiler helps COPD patients and their physicians make better-informed treatment decisions using information from evidence-based, peer-reviewed medical literature.

Need help with treatment decisions for COPD? Please view the COPD NexProfiler at **http://www.lungusa.org/copdtreatment**

Thousands of patients with COPD have joined with the Lung Association to

tell Congress to make life easier for people with this disease by broadening the use of portable oxygen concentrators and other approved devices on airplanes, by cleaning up outdoor pollution and by covering pulmonary rehabilitation under Medicare. Join the American Lung Association in its advocacy work by visiting http://lungaction.org.

In addition to its advocacy efforts, the Lung Association offers smoking cessation programs such as Freedom From Smoking® and Not On Tobacco, as well as self-help programs to assist smokers who want to quit. The American Lung Association Lung Help Line (1-800-LUNG-USA; 586-4872), staffed by registered nurses, respiratory therapists and quit-smoking specialists offers free counseling and support to callers, including those seeking information about COPD.

Influenza and Pneumonia

What are influenza and pneumonia?

Influenza (flu) is a highly contagious viral infection that is one of the most severe illnesses of the winter season. The reason influenza is more prevalent in the winter is not known; however, data suggest the virus survives and is transmitted better in cold temperatures. Influenza is spread easily from person to person, usually when an infected person coughs or sneezes.

A person can have flu more than once because the virus that causes the disease may belong to different strains of one of three different influenza virus families, A, B or C. Type A viruses tend to have a greater effect on adults, while Type B viruses are a greater problem in children.[1]

Symptoms of influenza include fever, headache, cough, chills, sore throat, nasal congestion, muscle aches, loss of appetite and a general achy and lousy feeling.

Want to learn more about the symptoms of influenza? Please view the disease listing at **http://www.lungusa.org/flu**

Influenza can be complicated by pneumonia, which is a serious infection or inflammation of the lungs. The air sacs fill with pus and other liquid, blocking oxygen from reaching the bloodstream. If there is too little oxygen in the blood, the body's cells cannot work properly, which can lead to death.

Pneumonia can have over 30 different causes which include various chemicals, bacteria, viruses, mycoplasmas[1] and other infectious agents such as pneumocystis (fungi). Certain diseases, such as tuberculosis, also can cause pneumonia. Pneumonia also can be caused by the inhalation of food, liquid, gases or dust. The most common cause of community-acquired (compared to hospital-acquired) pneumonia is the pneumococcus bacterium; infection by this bacterium is known as pneumococcal disease.[2] The pneumococcal bacterium also causes meningitis, bacteremia, otitis media and sinusitis.[3]

Symptoms of pneumonia include fever, wheezing, cough, chills, rapid breathing, chest pains, loss of appetite and malaise, or a general feeling of weakness or ill health.

[1] Mycoplasma is an infectious organism which has characteristics of both bacteria and viruses.

Want to learn more about the symptoms of pneumonia? Please view the disease listing at **http://www.lungusa.org/pneumonia**

Who gets influenza and pneumonia?

People most at risk from these infections and their complications are those whose defenses against disease are not operating well. They include the very young, the very old, those with chronic disease and those whose immune systems have been affected by birth defects, medications (including some drugs used to treat cancer) or AIDS.

About 5 percent to 20 percent of the population gets the flu each year.[4] In the United States, influenza generally strikes between December and March, although it may appear a little earlier.

Along with other respiratory conditions, such as the common cold and acute bronchitis, these disorders are major causes of days lost from work and school.

What are the health impacts of influenza and pneumonia?

Influenza and pneumonia are major causes of illness and death. In 2005, these conditions ranked as the eighth leading cause of death in the United States and the sixth leading cause in people over 65 years of age.[5]

In 2004, 59,664 deaths from these diseases were recorded, for a combined death rate of 19.8 per 100,000. Of these, pneumonia caused the majority of deaths (58,564). Close to 90 percent of influenza and pneumonia deaths occurred in persons aged 65 and over.[6] According to preliminary data, there were 62,804 deaths due to influenza and pneumonia in 2005, an age-adjusted rate of 20.3 per 100,000.[7]

Influenza deaths have increased substantially in the last two decades, in part because of the aging population.[8] Influenza and its complications are responsible for an average of 226,000 hospitalizations and 36,000 deaths in the United States each year.[9] The number of influenza deaths includes associated underlying respiratory and circulatory deaths in order to provide a more specific estimate of the total burden of influenza.[10]

Want to learn more about influenza? Please view the fact sheet at **http://www.lungusa.org/influenzafactsheet**

Influenza and pneumonia are most likely to require hospitalization in those over 65 years of age. Data from 2005 show that persons aged 65 and older accounted for 60 percent of the total number of pneumonia hospital discharges (the diagnosis made upon leaving a hospital stay).[11] The number (36,000) and rate (9.8 per 10,000 persons) of influenza discharges were both highest in those 65 years and older.[12]

Pneumonia can strike anyone at any time of the year. All-cause pneumonia hospital admission rates for children under two years in age in 2004 were 39

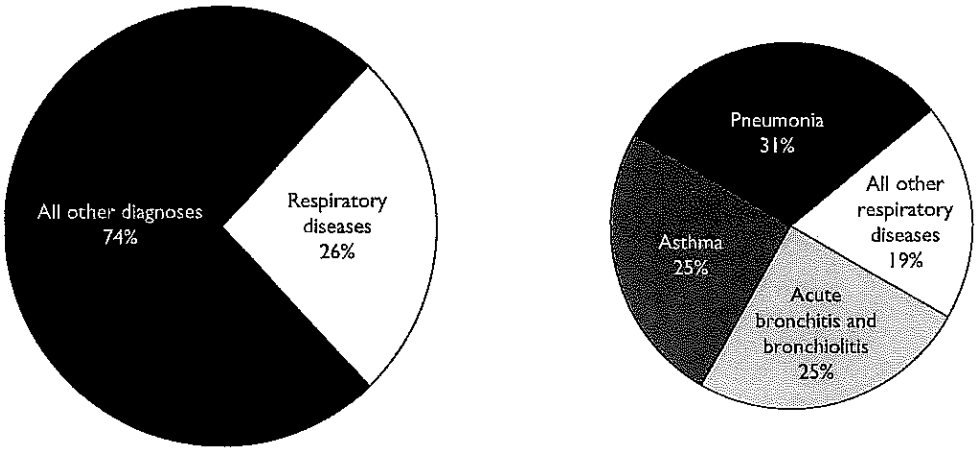
percent lower than during 1997 to 1999, a decrease in approximately 41,000 pneumonia admissions for that year. This decrease was due to the release and broad administration of a new pneumonia vaccine in 2000.[13]

Want to learn more about pneumonia? Please view the fact sheet at **http://www.lungusa.org/pneumoniafactsheet**

From 2000 to 2004, the average annual influenza hospitalization rate was 0.9 per 1,000 children under five years of age. This age group also was responsible for 95 clinic and 27 emergency department visits per 1,000 children during the 2003-2004 flu season. Despite the usefulness of rapid influenza tests, only 28 percent of hospitalizations and 17 percent of outpatient visits had a discharge diagnosis of influenza among children with laboratory-confirmed influenza. Improving these rates will offer the opportunity for improved infection control, increased use of antiviral therapy, and education about vaccination.[14]

Figure 1 shows the percent of all hospitalizations due to respiratory diseases and the type of respiratory disease for children under 15 years of age. Over a quarter (26%) of all hospitalizations in 2005 for this age group was due to respiratory diseases; almost a third (31%) of those were due to pneumonia.[15]

Figure 1: Hospitalizations for Types of Respiratory Diseases, Children Under 15 Years, 2005

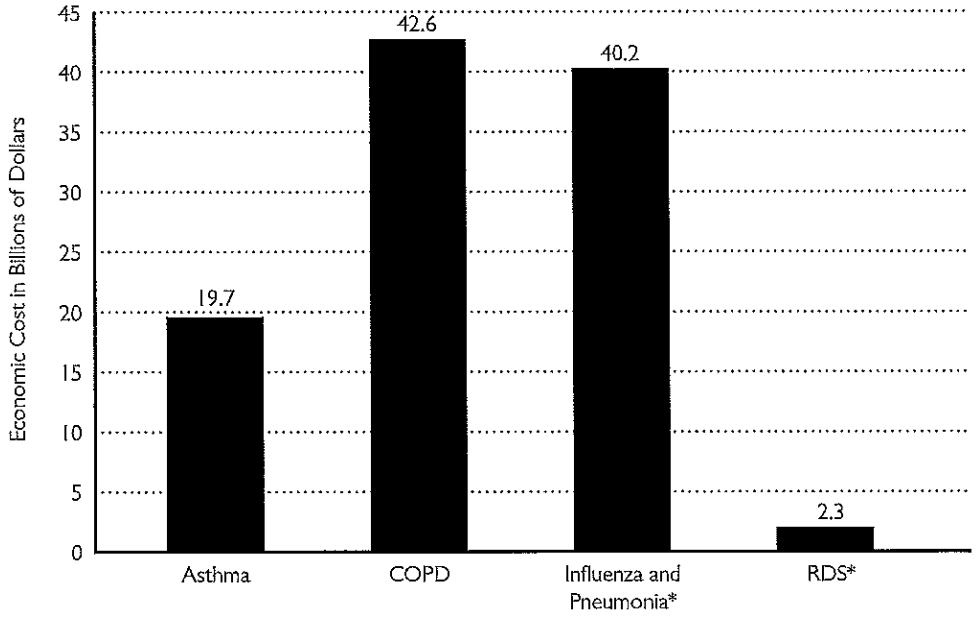


Source: Centers for Disease Control and Prevention. Quickstats: Percentage Distribution of Hospitalizations for Types of Respiratory Diseases Among Children Aged <15 Years—National Hospital Discharge Survey, United States, 2005. *Morbidity and Mortality Weekly Report.* July 20, 2007; 56(28):713.

Want to learn more about pneumonia and influenza trends and data? Please view the Trend Report on Pneumonia and Influenza, which includes information and statistics on morbidity and mortality attributed to pneumonia and influenza available from national surveys and vaccine recommendations to prevent pneumonia and influenza, at **http://www.lungusa.org/pitrends**

Together, pneumonia and influenza cost the U.S. economy more than $40.2 billion in 2005. This figure includes more than $6 billion due to indirect costs (such as time lost from work) and $34.2 billion due to direct costs (such as medical expenses).[16] Figure 2 shows the total economic cost of influenza and pneumonia in the United States compared to other lung diseases.

Figure 2: Economic Cost of Select Lung Diseases, U.S., 2007



Source: U.S. Department of Health and Human Services. National Institutes of Health. National Heart, Lung, and Blood Institute. Morbidity and Mortality: 2007 Chartbook on Cardiovascular, Lung, and Blood Diseases and unpublished data provided upon special request to NHLBI.
Note:
* Unpublished data, 2005.

Can influenza and pneumonia be prevented?

Influenza

Influenza viruses change constantly and different strains circulate around the world every year. The body's natural defenses cannot keep up with these changes. Therefore, a person should get a flu vaccine each year. The flu vaccine is modified on the assumption of which strain will most likely be dominant throughout the season. However, this prediction may not be 100 percent accurate, as has been the case with the 2007-2008 flu season. Therefore the effectiveness of the flu vaccine will vary with each new season.

The Advisory Committee on Immunization Practices (ACIP) recommends influenza vaccination for all persons, including school-age children, who want to reduce the risk of becoming ill with influenza or giving it to others. For anyone at high risk, influenza can be a very serious illness and the ACIP strongly recommends vaccination. Annual immunization is the best way to protect against influenza.[17] The American Lung Association urges anyone at high risk to get vaccinated as early as possible during the influenza season. Vaccination typically begins in October and can continue through March.

In most seasons, influenza virus activity does not peak until February or March.[18]

The flu shot may be given at the same time as other routine immunizations, such as pertussis, and is recommended for children at risk for influenza-related complications, such as those who have asthma. Protection lasts approximately six months. The influenza vaccine is safe for use in pregnancy.[19]

Want to learn more about preventing cold and flu? Please view the guidelines at **http://www.lungusa.org/coldandfluguidelines**

All health care providers including home care providers, household contacts and out-of-home caregivers to high-risk persons should also be immunized against both influenza and pneumonia to prevent transmission to these susceptible groups.

In addition, the ACIP has voted to expand the current flu vaccination recommendation to include all children from 5 to 18 years of age, which increases the number of children by 30 million and brings the total to approximately 250 million people. This change will take effect as soon as feasible, but no later than the 2009-2010 influenza season.[20]

Want to learn more about those at risk and the ACIP recommendations? Please visit **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm?s_cid=rr5606a1_e**

There are two vaccine options available in the United States for influenza[II]: the flu shot (trivalent inactivated vaccine or TIV) and the flu nasal spray (activated, live attenuated influenza vaccine or LAIV) called FluMist®.

FluMist is approved to prevent influenza illness due to influenza A and B viruses in healthy people aged 2 to 49 years only.[21] In clinical trials, the effectiveness of the FluMist vaccine in preventing influenza was approximately 87 percent among children. In healthy adults aged 18 to 49 years, FluMist was effective in reducing severe illnesses with fever, and upper respiratory problems which may be caused by influenza infection.[22]

Certain people should not receive FluMist as the safety of FluMist in the following groups has not been established. FluMist should not be given to people with a history of asthma. FluMist is not recommended for children under two years of age, children under five with recurrent wheezing or adults over 49 years of age.[23,24] FluMist should not be given to women who are pregnant or people who have weakened immune systems (such as those with HIV) or chronic underlying medical conditions that may make them vulnerable to severe flu infections. High-risk individuals should receive the trivalent inactivated vaccine (TIV).[25, 26]

[II] The 2007-2008 TIV and LAIV strains are A/Solomon Islands/3/2006 (H1N1)-like, A/Wisconsin/67/2005 (H3N2)-like and B/Malaysia/2506/2004-like antigens.

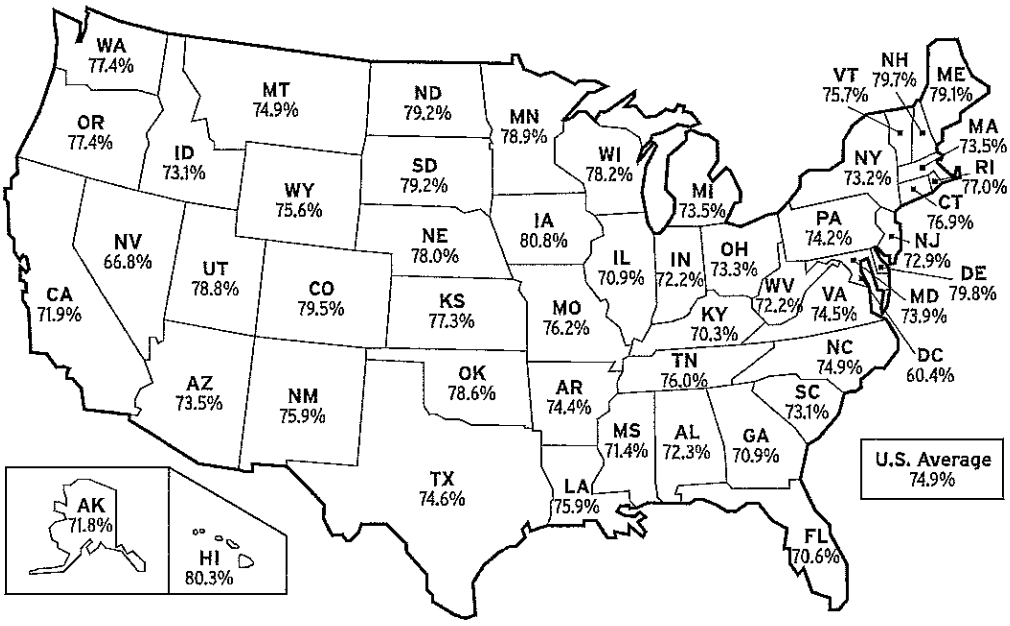
A national health objective for 2010 is to increase influenza and pneumococcal vaccination levels to greater than 90 percent among persons ages 65 and older. That goal, however, is far from being realized. In 2006, 69.6 percent of people aged 65 and older received a flu shot.[27] Medicare covers both flu shots and pneumococcal vaccines for people over 65 years of age.

Initial results from the 2006-2007 influenza season indicate that children 6 to 59 months of age are under-vaccinated. Less than 30 percent of children 6 to 23 months of age were fully vaccinated during that past flu season, while less than 20 percent of children 24 to 59 months old were fully vaccinated. The ACIP also recommends that previously unvaccinated children under the age of nine receive two doses of influenza vaccine at least one month apart to be fully vaccinated.[28]

Diverse communities are less likely to receive these vaccines. In 2006, among people ages 65 and older, non-Hispanic Whites were more likely to report receiving a flu shot (66.2%) than Hispanics (43.1%) and non-Hispanic Blacks (45.3%).[29]

There is great variation across the country in vaccination rates in those over 65. Figure 3 shows the percentage of fee-for-service Medicare beneficiaries aged 65 and older that received flu shots, by state, in 2004. Percentages ranged from a low of 60.4 percent in the District of Columbia to a high of 80.8 percent in Iowa. The United States average was 74.9 percent.[30]

Figure 3: 2004 Fee-for-Service Medicare Beneficiaries, Age 65 or Older Receiving a Flu Shot



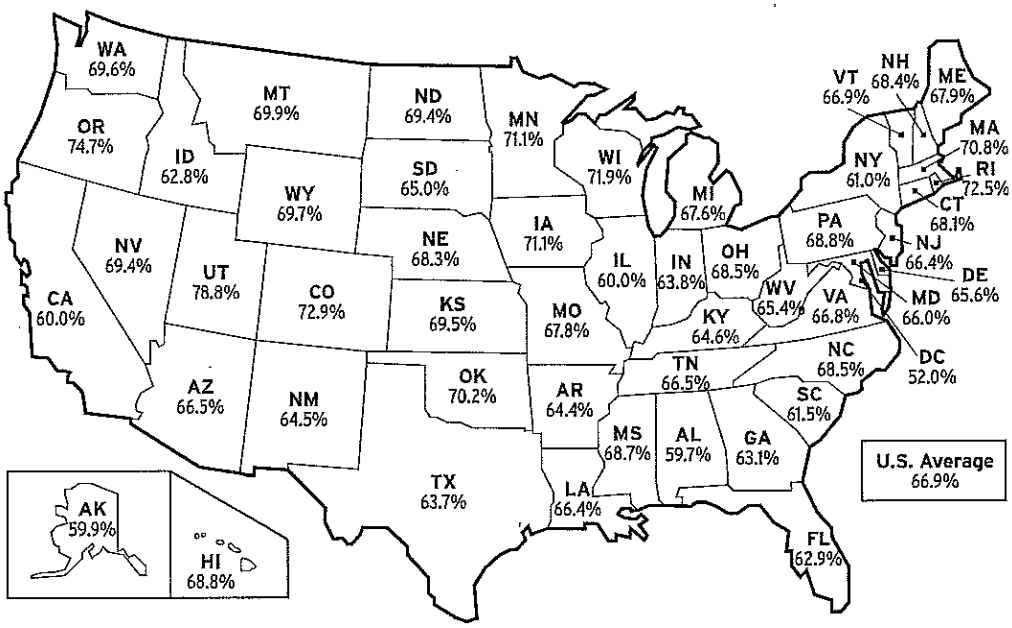
Source: Centers for Medicare and Medicaid Services. Consumer Assessment of Health Providers and Systems (CAHPS), 2004.

Pneumonia

The pneumococcal vaccine protects against 23 types of pneumococcal bacteria populations and is effective in approximately 80 percent of healthy adults. Unfortunately, the vaccine may be less effective in people in high-risk groups. According to the Centers for Disease Control and Prevention (CDC), pneumococcal pneumonia accounts for 25 percent to 35 percent of all community-acquired pneumonia (mostly caused by *Streptococcus pneumoniae* bacterium) and an estimated 40,000 deaths yearly.[31,32]

Older persons are advised to receive the pneumococcal vaccine since pneumonia is a major complication of the flu. Figure 4 displays the percentage of Medicare beneficiaries aged 65 and older that had ever received a pneumococcal vaccination as of 2006, by state. Percentages ranged from a low of 52.0 percent in the District of Columbia to a high of 74.7 percent in Oregon. The U.S. average for that year was 66.9 percent.[33, 34]

Figure 4: 2006 Medicare Beneficiaries, Age 65 or Older Ever Receiving Pneumococcal Vaccination



Source: Centers for Disease Control and Prevention. 2006 Behavioral Risk Factor Surveillance System.
Note:
Data reflects claims paid for by Medicare for non-HMO beneficiaries only. Total immunization rates may be higher in those areas with free or publicly-supported programs.

There is a racial disparity among people ages 65 and older receiving the pneumonia shot which needs to be addressed. In 2006, 59.9 percent of non-Hispanic Whites, 33.5 percent of non-Hispanic Blacks and 31.2 percent of Hispanics reported ever having received a pneumonia vaccine.[35]

How are influenza and pneumonia diagnosed and managed?

A number of laboratory tests are available to confirm the diagnosis of influenza or pneumonia, including sputum and blood cultures, chest x-rays and blood tests.

Influenza

Health care providers usually will make the diagnosis of influenza based on symptoms and findings of a physical examination. Currently, a new office-based rapid test is available.

Drugs that fight viruses (antivirals) are sometimes used in the management of flu. These drugs either shorten the duration of the flu, if taken early at the onset of the flu, or prevent the flu. There are currently four influenza antiviral drugs available in the United States: amantadine, rimantadine, zanamivir and oseltamivir.

According to the ACIP guidelines for the 2007-2008 influenza season, neither amantadine nor rimantadine should be used for treatment or prevention of influenza A infections. Oseltamivir or zanamivir should be prescribed if an antiviral drug is indicated for the treatment of influenza.[36] This recommendation is based on increasing resistance to the older drugs, amantadine and rimantadine. A recent study found that worldwide resistance to amantadine and rimantadine has increased 12 percent since the mid-1990s.[37] Analysis of influenza viruses found globally in 2005 and 2006 indicates that 96.4 percent of A(H3N2) and 15.5 percent of A(H1N1) viruses circulating in the United States were resistant to amantadine and rimantadine.[38]

Zanamivir (called Relenza, an inhalant) and oseltamivir (called Tamiflu, a pill) reduce flu symptoms if taken at the onset of the illness. The Food and Drug Administration (FDA) does not recommend Relenza for patients with underlying respiratory disease, including asthma and chronic obstructive pulmonary disease (emphysema and chronic bronchitis). Relenza has not been shown to shorten the length of influenza for this population and increases their risk of bronchospasm (wheezing) or serious breathing problems.[39] Studies also have shown that oseltamivir might be effective in reducing secondary complications due to the flu such as pneumonia in adults and ear infections in children. These newer drugs can be used to treat strains from both the Type A and B influenza viruses. Oseltamivir also can be used to prevent influenza. The CDC has stressed that these drugs are not substitutes for vaccination.

Over-the-counter medications can minimize discomfort associated with flu symptoms, but these medications do not treat the virus infection. Aspirin should not be used to treat flu symptoms in children under 18 years old because it may play a role in causing Reye Syndrome, a rare but severe liver and central nervous system condition.

Congestion, cough and nasal discharge are best treated with a decongestant, an antihistamine or a combination of these two types of medication. Many over-the-counter flu remedies contain both. However, pediatric specialists do

not recommend their use in children. Also, patients who have chronic medical conditions such as thyroid disease or high blood pressure should check with a health care provider before taking over-the-counter drugs for flu symptoms.

Adequate liquids and nutrition are necessary for rapid recovery from the flu and to prevent dehydration. Bed rest is also a good idea. Until symptoms are gone, it is not advisable to go back to full activity.

Prevention of flu is key to reduce the burden of influenza. Frequent hand washing and mouth covering during coughing and sneezing helps to prevent transmission of the influenza virus.

Want to learn more about good flu health habits? Please view the recommendations at **http://www.lungusa.org/goodfluhealthhabits**

Pneumonia

In August 1999, the FDA cleared for marketing a simple, quick test for a certain form of pneumonia. A swab is dipped into a urine sample and then inserted into a test device, which detects *Streptococcus pneumoniae* antigen.[III] The laboratory test provides results in 15 minutes. The test is intended for use in conjunction with review of a patient's symptoms to rule out other potential causes of pneumonia. Test results can enable health care providers to make a probable diagnosis more quickly and start treatment with the appropriate antibiotics sooner. Conventional methods for diagnosing pneumonia, primarily testing sputum or blood, require two days to several weeks for results, are often complex and are not always reliable.

There are no generally effective treatments for most types of viral pneumonia, which usually heal on their own. Early treatment with antibiotics can cure bacterial pneumonia and speed recovery from mycoplasma pneumonia. However, the disease has become more resistant to these drugs, making treatment of pneumococcal infections more difficult. New guidelines for community-acquired pneumonia (CAP), issued by the Infectious Disease Society of America and the American Thoracic Society, recommend that patients admitted to the hospital from the emergency department with a diagnosis of CAP should receive their first dose of antibiotics while still in the emergency department.[40]

What is bird flu?

An emerging Type A strain is the avian influenza virus or bird flu. Bird flu viruses do not usually infect humans, but several cases of human infection with bird flu viruses have occurred since 1997, especially in Asia. The virus is mainly transmitted to humans by direct contact with live, sick or dead poultry; however, it is thought that a few cases of human-to-human spread have occurred.[41] Due to limited person-to-person transmission, there has not been a widespread epidemic of the bird flu.

[III] A foreign substance that triggers the formation of antibodies that react to make the substance harmless.

Want to learn more about bird flu? Please view the fact sheet at
http://www.lungusa.org/avianinfluenza

The highest number of bird flu cases have been reported in Vietnam and Indonesia. The majority of cases have been reported in children and adults under 40 years of age. Overall mortality is approximately 60 percent and is highest in those 10 to 19 years old.[42]

The bird flu and the risk for human infection is currently an area of research focus. Human infection with bird flu is expected to continue on a sporadic basis due to contact with birds carrying the disease.[43] The virus could cause an influenza pandemic[IV] if it changes into a form easily spread by human-to-human contact. High rates of illness and death could occur worldwide due to the lack of any pre-existing natural immunity in humans or the availability of an effective vaccine. Fortunately, there has been no indication of such a change in the existing strains of the virus.[44] While avian flu has shown resistance to the antiviral medications amantadine and rimantadine, the other two drugs in this category (oseltamivir and zanamivir) should still be effective against the current strains of the virus.[45]

Want to learn more about flu pandemics? Please view the fact sheet at
http://www.lungusa.org/pandemicinfluenza

In April 2007, the FDA approved a vaccine for humans against the H5N1 influenza virus,[46] one type of bird flu that has caused infections in birds and humans.[47] This vaccine could provide limited protection from an H5N1 pandemic while a more specific vaccine is created. However, the H5N1 vaccine will not be available for commercial use because all amounts are going to the National Stockpile to ensure adequate supplies in the event of an outbreak.[48]

What is new in influenza and pneumonia research?

A recent study found that persons 65 years of age and older who received the flu shot had a 27 percent reduction in the risk of hospitalization for pneumonia or influenza and a 48 percent reduction in the risk of death. This was despite the fact that those receiving flu shots also tended to have more serious medical conditions that should increase their risk of hospitalization or death.

Based on other studies that show fewer influenza outbreaks and deaths in the United States and Japan due to immunization programs, researchers recommend focusing on developing new and more effective vaccines for elderly populations and children as well as increasing the percentage of those receiving flu shots.

Another key but disturbing finding is the low rate of vaccination of health care providers. If the elderly were not exposed through direct contacts, fewer cases

[IV] A pandemic occurs when a novel strain of influenza virus emerges and has the ability to infect and easily pass between humans. Because humans have little immunity to the new virus, a worldwide epidemic, or pandemic, can ensue.

of influenza would occur in this susceptible group. The best way to protect the elderly is to reduce influenza in groups of people they have contact with, such as children and health care providers. While this strategy requires more research to validate its effectiveness, increasing flu vaccination of all groups will prevent unnecessary hospitalizations and deaths.[49,50]

What is the American Lung Association doing about influenza and pneumonia?

American Lung Association volunteers and staff work with different public health organizations, Congress, and other policymakers to improve funding for research, surveillance, vaccine supply and public health response to influenza. The Lung Association also works in coalition to educate the public and policymakers to provide funding, develop resources and plan for a future influenza pandemic.

A study conducted by the American Lung Association Asthma Clinical Research Centers Network recently found that flu shots are safe for children and adults with asthma. Influenza causes substantial illness in both children and adults with asthma. The study puts to rest previous concerns about possible side effects of the flu shot in people with asthma. The study found that people with asthma did not have any higher rates of side effects within 14 days after receiving the flu shot compared with those who received a placebo, or inactivated flu shot.[51]

Want to learn more about flu in people with asthma? Please view the fact sheet at **http://www.lungusa.org/influenza-asthma**

To ensure that people understand the seriousness of influenza, the American Lung Association will continue its Faces of Influenza educational initiative to show why protecting families against this serious illness is so important. Actress Jennifer Garner recently partnered with the American Lung Association as another "face" in the initiative, which is made possible through collaboration with sanofi pasteur, the nation's largest manufacturer of influenza vaccines. The site, available at www.facesofinfluenza.org, provides additional resources such as a flu clinic locator and information for both the general public and specific groups, such as health care providers and high-risk individuals.

Thousands of advocates have joined with the ALA to tell Congress that more needs to be done to fight influenza and pneumonia. To join the American Lung Association in the battle against influenza, pneumonia and other lung diseases, visit http://lungaction.org.

Lung Cancer

What is lung cancer?

Lung cancer is the uncontrolled growth of abnormal cells in one or both of the lungs. While normal lung tissue cells reproduce and develop into healthy lung tissue, these abnormal cells reproduce faster and never grow into normal lung tissue. Lumps of cancer cells (tumors) then form and disturb the lung, making it difficult for it to work properly.

There are two major types of lung cancer: small cell lung cancer (SCLC) and non-small cell lung cancer (NSCLC). Sometimes a lung cancer may have characteristics of both types, which is known as mixed small cell/large cell carcinoma.

Non-small cell lung cancer is much more common and accounts for 87 percent of all lung cancer cases.[1] It usually spreads to different parts of the body more slowly than small cell lung cancer. There are three main types of non-small cell lung cancer. They are named for the type of cells in which the cancer develops: squamous cell carcinoma, adenocarcinoma and large cell carcinoma.

Small cell lung cancer, also called "oat cell cancer," accounts for the remaining 13 percent of all lung cancers.[2] This type of lung cancer grows more quickly and is more likely to spread to other organs in the body.

Lung cancer symptoms may include a persistent cough, sputum streaked with blood, chest pain, and recurring pneumonia or bronchitis.[3] Unfortunately, symptoms often do not appear and diagnosis is not made until the disease is in an advanced stage.

Want to learn more about lung cancer? Please view the disease listing at **http://www.lungusa.org/lungcancer**

Smoking, a main cause of small cell and non-small cell lung cancer, contributes to 80 percent and 90 percent of lung cancer deaths in women and men, respectively. Men who smoke are 23 times more likely to develop lung cancer. Women are 13 times more likely, compared to never-smokers.[4] Fortunately, lung cancer is preventable. To learn more about the impact of tobacco on the lungs and the development of lung cancer, please refer to the Tobacco Control

section of this report.

Nonsmokers who breathe in smoke from others' cigarettes also are at increased risk of lung cancer. Nonsmokers have a 20 to 30 percent greater chance of developing lung cancer if they are exposed to secondhand smoke at home or at work.[5]

Exposure to radon is estimated to be the second leading cause of lung cancer, accounting for an estimated 15,000 to 22,000 lung cancer deaths each year (9% to 14% of the total). Radon is a tasteless, colorless and odorless gas that is produced by decaying uranium and occurs naturally in soil and rock. The majority of these deaths occur among smokers since there is a greater risk for lung cancer when smokers also are exposed to radon.[6]

The main source of high-level radon pollution is uranium-containing soil such as granite, shale, phosphate and pitchblende that surrounds buildings. Radon enters a home through cracks in walls, basement floors, foundations and other openings. It also may contaminate the water supply, especially in private wells.[7]

A study was carried out over a five-year period to determine the risk posed by residential radon exposure. The participants included over 1,000 women throughout Iowa, the state with the highest average radon concentrations, who lived in their current home for at least 20 years. Of the participants, 413 had developed lung cancer, while the remaining 614 were controls who did not have lung cancer. The outcomes suggested that cumulative radon exposure in the residential environment is a significant risk factor for lung cancer in women.[8]

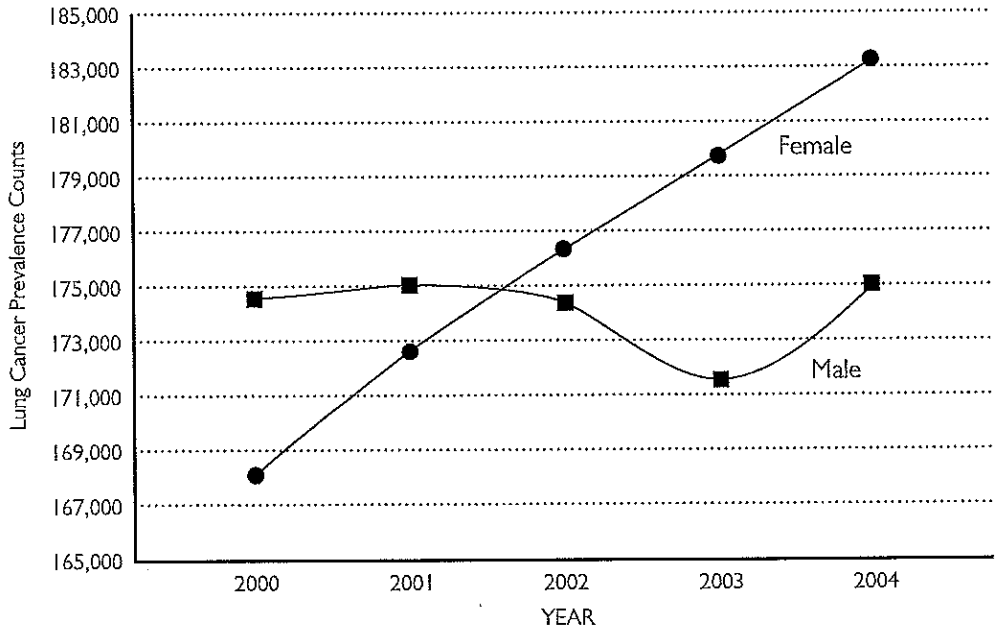
Want to learn more about radon and lung cancer? Please view the fact sheet at **http://www.lungusa.org/radonfactsheet**

Lung cancer also can be caused by occupational exposures, including asbestos, uranium, and coke (an important fuel in the manufacture of iron in smelters, blast furnaces, and foundries). The combination of asbestos exposure and smoking greatly increases the risk of developing lung cancer.[9] Nonsmoking asbestos workers are five times more likely to develop lung cancer than nonsmokers not exposed to asbestos; if they also smoke, the risk factor jumps to 50 or higher.[10] Environmental exposures also can increase the risk of lung cancer death.[11]

Who has lung cancer?

In 2004, 358,128 Americans were living with lung cancer. Figure 1 displays the prevalence of lung cancer for men and women since 2000, and shows that women surpassed men in lung cancer prevalence in 2002. In 2004, women accounted for 183,248 lung cancer cases in the United States while men accounted for 174,880 cases.[12]

Figure I: Lung Cancer Prevalence Counts, U.S., 2000–2004*



Source: National Cancer Institute: SEER Cancer Statistics Review, 2000–2004
Note:
* **Comparisons should only be made between groups and diseases using rates, not number of cases, as these do not take into account differences which may exist in population size or demographics.**

The majority of living lung cancer patients have been diagnosed within the last five years. Lung cancer is mostly a disease of the elderly. From 2000 to 2004, the median age at diagnosis was 70 years.[13]

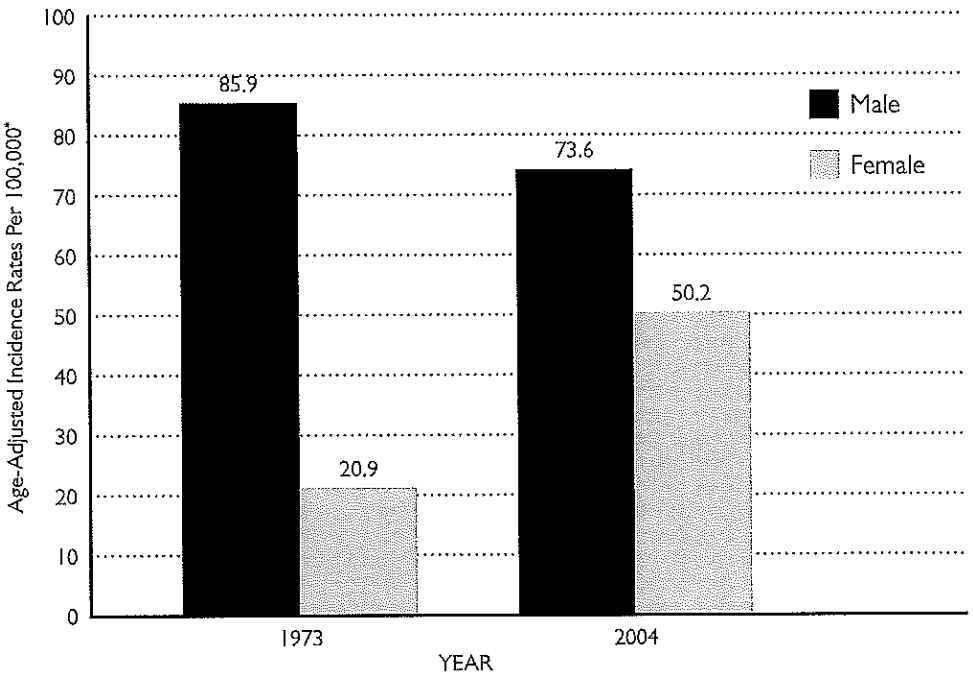
During 2007, an estimated 213,380 new cases of lung cancer were diagnosed, representing about 15 percent of all cancer diagnoses.[14]

In 2004, Kentucky had the highest age-adjusted lung cancer incidence rates (rates of new cases) in both men (133.2 per 100,000) and women (75.5 per 100,000). Utah had the lowest age-adjusted cancer incidence rates in both men and women (37.5 per 100,000 and 20.6 per 100,000, respectively). These state-specific rates were parallel to smoking prevalence rates.[15]

Want to learn more about lung cancer? Please view the fact sheet at **http://www.lungusa.org/lcfactsheet**

Each year more men are diagnosed with lung cancer, but more women are living with the disease. The rate of new cases in 2004 showed that men develop lung cancer more often than women (73.6 and 50.2 per 100,000 respectively). However, as Figure 2 shows, the rate of new lung cancer cases (incidence) over the past 31 years has dropped for men (14% decrease), while it has risen for women (140% increase). In 1973 rates were low for women, but began to rise for both men and women. In 1984, the rate of new cases for men peaked (102.1 per 100,000) and then began declining. The rate of new cases for women increased further and did not peak until 1998 (52.8 per 100,000) but has remained stable since then.[16]

Figure 2: Rate of New Lung Cancer Cases by Gender, U.S., 1973 & 2004



Source: National Cancer Institute: SEER Cancer Statistics Review, 1973–2004
Note:
*Rates are per 100,000 persons and are age-adjsuted to the 2000 U.S. standard population.

Lung cancer in people who have never smoked is a major public health problem and continued research is needed. Women, compared to men, appear to have higher prevalence rates of lung cancer that is not associated with smoking; 25 percent of lung cancer occurs in women who are nonsmokers.[17] One study reported that the age-adjusted rates of new nonsmoking-associated lung cancer cases in women ages 40 to 79 years range from 14.4 to 20.8 per 100,000 person-years[1,18,19], compared with 4.8 to 13.7 per 100,000 person-years in men. Differences in genetics, biology and hormones could explain this finding.[20] However, another study showed that the death rate from lung cancer among lifelong nonsmokers aged 35 to 84 years was 14.7 per 100,000 person-years among women and 17.1 per 100,000 person-years among men. The study also found little evidence that the lung cancer death rate among people who have never smoked is increasing over time.[21] More research is necessary to explain these conflicting results.

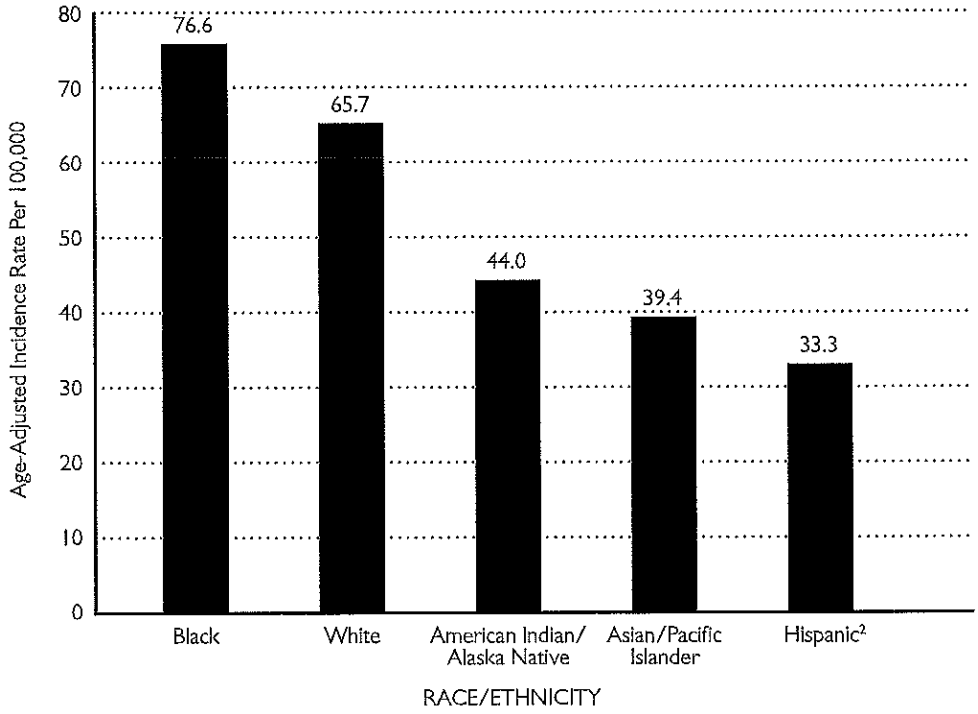
Want to learn more about lung cancer trends and data? Please view the Lung Cancer Trend Report, which delineates data on lung cancer mortality, prevalence, incidence, hospitalizations, and survival, at **http://www.lungusa.org/lctrends**

[1] Average number of events per cumulative amount of time observed. Person-years is used for counting time when individuals are observed over different periods of time. For example, the number of person years for two people being observed for five years each is the same as that of ten people observed for one year or ten person-years.

Blacks are more likely to develop and die from lung cancer than persons of any other racial or ethnic group. The age-adjusted lung cancer incidence rate among Black men is approximately 38 percent higher than for White men, even though their overall exposure to cigarette smoke, the primary risk factor for lung cancer, is lower. Equally disturbing is the fact that the lung cancer incidence rate for Black women is roughly equal to that of White women, despite the fact that they smoke fewer cigarettes.[22,23]

Figure 3 displays lung cancer age-adjusted incidence rates by race/ethnicity between 2000 and 2004. Over this five-year period, Hispanics, Asians/ Pacific Islanders and Native Americans were less likely to develop lung cancer than Blacks or Whites.[24]

Figure 3: Lung Cancer Age-Adjusted Incidence Rates by Race/Ethnicity, 2000–2004[1]



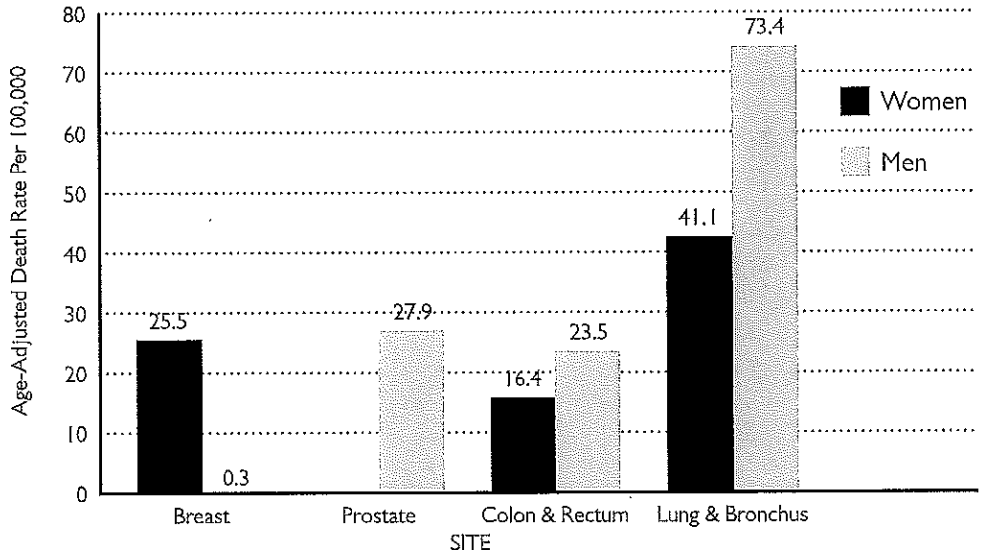
Source: National Cancer Institute, SEER Cancer Statistics Review, 2000–2004.
Notes:
1. Rates are per 100,000 age-adjusted to the 2000 U.S. Standard Population. Incidence rates obtained from 17 SEER areas.
2. Hispanics are not mutually exclusive from Whites, Blacks, Asian/Pacific Islanders and American Indians/ Alaska Natives.

Want to learn more about lung cancer in diverse communities?
Please view the *State of Lung Disease in Diverse Communities 2007* report at
http://www.lungusa.org/solddc-lc

What is the health impact of lung cancer?

Lung cancer is the leading cause of cancer deaths among both men and women in the United States. In 2007, about 160,390 Americans were expected to die of lung cancer, accounting for approximately 29 percent of all cancer deaths.[25] Figure 4 displays cancer death rates by gender and type of cancer from 2000 to 2004. Lung cancer death rates were higher than death rates due to cancer of other common cancer sites among both men and women. In 2004, there were 89,630 deaths due to lung cancer in men and 68,461 in women.[26]

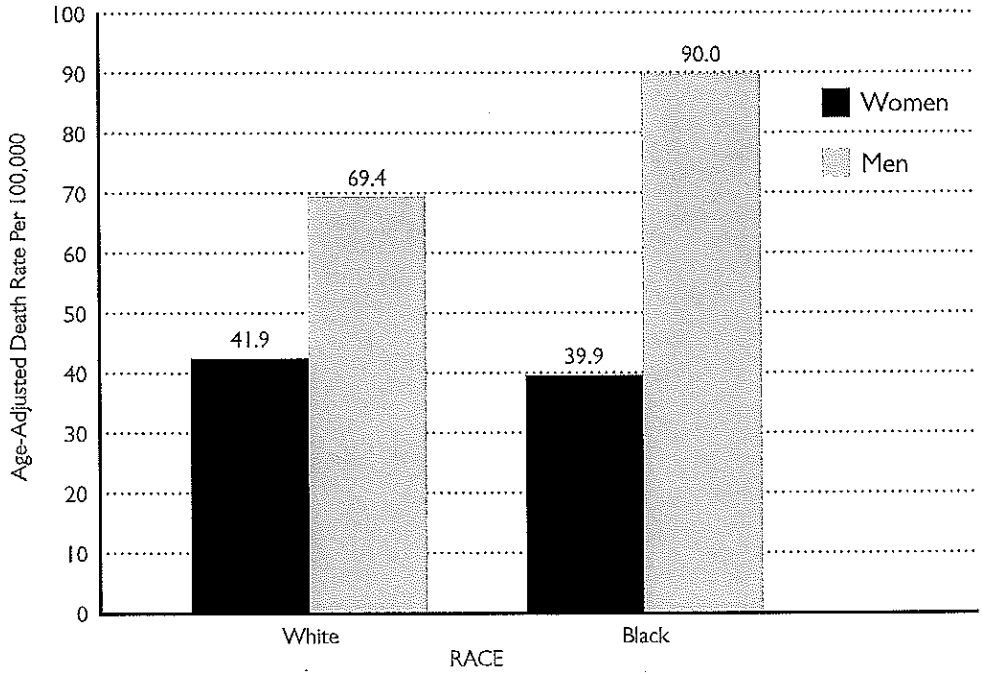
Figure 4: Cancer Death Rates by Gender and Site, U.S., 2000–2004*



Source: National Cancer Institute, SEER Cancer Statistics Review, 2000–2004.
Note:
* Rates are per 100,000 persons, age adjusted to the 2000 U.S. population and coded by ICD-10 Revision (C33-C34).

The age-adjusted death rate for lung cancer is higher for men (73.4 per 100,000 persons) than for women (41.1 per 100,000 persons).[27] It also is higher for Blacks (59.8 per 100,000 persons) compared to Whites (53.6 per 100,000 persons). Black men have a far higher age-adjusted lung cancer death rate than White men, while Black and White women have similar rates.[28] Figure 5 shows this disparity.

Figure 5: Lung Cancer Death Rates by Gender and Race, U.S., 2004*



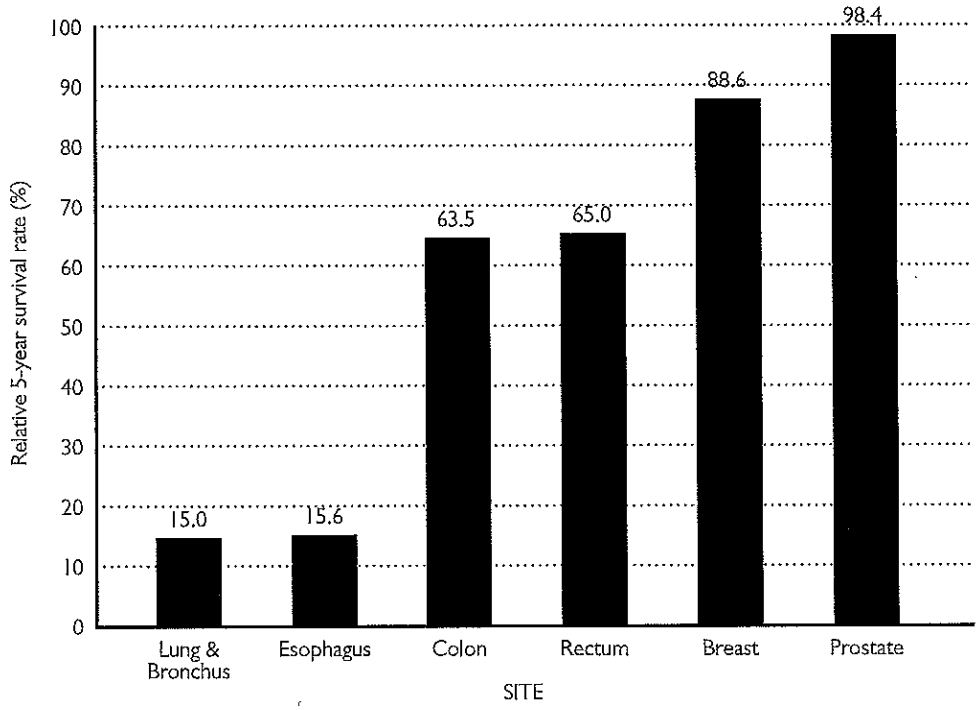
Source: Centers for Disease Control and Prevention. National Vital Statistics Report. Deaths: Final Data for 2004. Volume 55 No 19, August 21, 2007.
Note:
* Rates are per 100,000 persons, age-adjusted to the 2000 U.S. population and coded by ICD-10 Revision (C33-C34).

Before the 1940s, smokers were overwhelmingly male. That has changed—and so have the lung cancer statistics. Currently, approximately 45 percent of adult smokers are female. In 2004, 43.3 percent of lung cancer deaths occurred in women compared to 26 percent of deaths in 1979.[29] Lung cancer surpassed breast cancer as the leading cause of cancer death in women in 1987.[30]

Between 1997 and 2001, an average of 123,836 Americans (79,026 men and 44,810 women) died of smoking-attributable lung cancer each year.[31] Exposure to secondhand smoke causes approximately 3,400 lung cancer deaths among nonsmokers every year.[32]

Figure 6 displays five-year survival rates for selected cancer sites. The lung cancer five-year survival rate (15%) is lower than many other leading cancer sites, such as the colon (63.5%), breast (88.6%) and prostate (98.4%).[33]

Figure 6: 5-Year Survival Rates by Selected Cancer Sites, U.S., Cases Diagnosed 1996–2003*



Source: National Cancer Institute, SEER Cancer Statistics Review, 1996–2004.
Note:
* Rates are from the 17 SEER areas (California excluding SF/SJM/LA, Kentucky, Louisana and New Jersey contribute cases for diagnosis years 2000–2003. The remaining 13 SEER areas contribute cases for the entire period.)

The prognosis for a patient with lung cancer depends, to a large extent, on the stage of the cancer. Staging is used to determine whether the cancer has spread and, if so, to what other parts of the body. Stages include localized (within lungs), regional (spread to lymph nodes) and distant (spread to other organs). The five-year survival rate is 49 percent for cases detected when the disease is still localized. Unfortunately, only 16 percent of lung cancer cases are diagnosed at an early stage. For distant tumors, the five-year survival rate is only 3 percent. About 6 out of 10 people with lung cancer die within one year of being diagnosed.[34]

The financial costs of cancer are staggering. According to the National Institutes of Health, cancers cost the United States an overall $206 billion in 2006.[35] It is estimated that approximately $9.6 billion per year is spent in the United States on lung cancer treatment alone.[36]

How is lung cancer diagnosed and managed?

All cancer patients benefit from early intervention when the growth is localized and has not spread to distant parts of the body. Since most symptoms do not appear until advanced stages, lung cancer is difficult to diagnose in early stages.

When a person undergoes a medical exam, the health care provider asks about the person's medical history, including exposure to hazardous substances. The

provider also will give the patient a physical exam. If the patient has a cough that produces sputum (mucus), it may be examined for cancerous cells. Other diagnostic tests include chest x-ray and fiberoptic examination of the airways. Newer tests such as low dose spiral computed tomography (CAT or CT) scans and molecular markers in sputum have produced promising results in detecting lung cancers at earlier, more treatable stages.[37]

If lung cancer is found relatively early, treatment—surgery, radiation, drug therapy or a combination of these approaches—is often effective. Choice of treatment and prognosis also may depend on the specific type of tumor. Many clinical trials are underway to study new lung cancer treatments.[38]

In 2002, the National Cancer Institute launched a study to determine if screening high-risk people with spiral CT scans before they have symptoms can reduce death from lung cancer. The National Lung Screening Trial has enrolled around 50,000 current or former smokers and monitored them at more than 30 sites throughout the United States.[39] Results from the trial will not be available until after it concludes in 2009.[40]

Spiral CT scan screening for lung cancer has some limitations. The technique requires specialized knowledge. Research has indicated that 25 to 60 percent of scans may show abnormalities in both smokers and former smokers. While most of the abnormalities are not lung cancer, they can mimic lung cancer on the CT scans. As a result, additional testing is required. That can cause the patient added anxiety and unnecessary biopsies or surgery and their related risks. While complications from biopsies and surgery rarely occur, they can include partial collapse of the lung, bleeding, infection, pain and discomfort. Furthermore, patients and control groups have not yet been followed to determine whether, in fact, the spiral CT scan technique will lead to fewer lung cancer deaths. It is hoped that the trial will determine whether the benefits of potential, earlier lung cancer detection outweigh these limitations and if widespread use is cost-effective.[41]

What is new in lung cancer research?

Scientists currently are exploring the link between lung disease and lung cancer in nonsmokers.

A significant risk factor for life-long nonsmokers is a history of physician-diagnosed emphysema or chronic bronchitis and emphysema, the base elements of chronic obstructive pulmonary disease (COPD). In a 10-year study, nonsmokers were 1.7 times more likely to have lung cancer listed as the cause of death if they had ever been diagnosed with emphysema, and 2.4 times more likely if ever diagnosed with both chronic bronchitis and emphysema. A diagnosis of chronic bronchitis alone did not increase this risk.[42]

Another study was conducted among 10,474 U.S. veterans enrolled in primary care clinics to determine whether the use of inhaled corticosteroids among patients with COPD decreased the risk of lung cancer. Although the findings may need additional support, it was suggested that inhaled corticosteroids may play a role in decreasing the risk of lung cancer in patients with COPD.[43]

Tobacco use is the main cause of lung cancer and tends to mask other risk factors that are not as widespread or do not contribute as significantly to lung cancer development. A study was conducted between 1998 and 2002 to determine the association between lung cancer and occupation, independent of smoking. The study consisted of 1,039 control cases and 223 people that had never smoked. The findings suggest that women in suspected high-risk occupations[ll] have an increased risk of lung cancer. Both men and women employed in occupations with exposure to nonferrous metal dust and fumes, silica and organic solvents also had an increased risk of lung cancer.[44]

Observational data in the 1980s led to the belief that beta-carotene (an A vitamin) could protect against lung cancer, even in smokers. Research on this topic has been extensive since that time, along with work on other nutritional factors. However, a review of the best studies from the field found that no protective effect was offered by beta-carotene, vitamin E, retinol or any combination of the three. Some trials even reported increased rates of lung cancer, total deaths and cardiovascular deaths due to the use of beta-carotene, alone or with vitamin E or retinol.[45]

A study in the *New England Journal of Medicine* showed that erlotinib, a medication prescribed to treat patients with advanced non-small cell lung cancer, extended survival by an average of two months in tests on about 700 patients. Patients were more likely to respond to erlotinib if their tumors contained a certain protein or had many copies of a particular gene. The study also confirmed that patients most likely to benefit from the drug included women, nonsmokers, Asians and those with an adenocarcinoma (cancer associated with glands).[46]

Another study found that phytoestrogens (compounds from plants) found in soy products, grains, carrots, spinach, broccoli, and other fruits and vegetables may protect against certain solid lung tumors.[47]

What is the American Lung Association doing about lung cancer?

While most of its education and advocacy efforts focus on prevention, there are several ways the American Lung Association addresses the needs of those living with lung cancer. The American Lung Association Lung HelpLine, staffed by registered nurses, respiratory therapists and quit-smoking specialists offers free counseling and support to callers, including those seeking information about lung cancer. In addition, the American Lung Association has helped millions through its Better Breathers Clubs. These support groups are located throughout the United States and meet regularly to provide peer support and education needed to understand and better manage their disease. These clubs are for adults with all chronic lung diseases, their families and their caregivers.

[ll] Agriculture- insecticide application, mining and quarrying- zinc-lead and metal, food industry- butchers and meat workers, leather industry- tanners and processors, wood and wood products- carpenters and joiners, printing- rotogravure workers, printing pressmen, machine room workers, binders and other, chemical production, rubber industry, ceramic- ceramic, pottery and glass workers, metals, motor vehicle manufacture and repair- mechanics, welders, etc, transport- railroad workers, bus and truck drivers, operators of excavator machines or heavy equipment and filling station attendants and other- laundry and dry cleaners.

Often these groups are run by a respiratory therapist who can educate group members and their families about ways to live well with lung cancer and find additional resources. Groups may invite medical professionals to share their expertise on topics including nutrition, exercise, breathing techniques, new treatments, stress and depression, and medical equipment. The education patients receive in these groups may help them to avoid preventable hospitalizations and emergency room visits. Many hospitals may offer similar support groups for people with chronic lung disease.

The American Lung Association also provides information on treatment options through the NexCura profiler on lung cancer. The lung cancer NexProfiler helps asthma patients and their physicians make better-informed treatment decisions using information from evidence-based, peer-reviewd medical literature.

Need help with treatment decisions for lung cancer? Please view the lung cancer NexProfiler at **http://www.lungusa.org/lctreatment**

The American Lung Association is partnering with The Wellness Community (TWC) to help people living with lung cancer and their loved ones manage treatment options and side-effects through education and support. TWC is an international non-profit organization dedicated to providing emotional support, education and hope for people affected by cancer. TWC programs include weekly cancer support groups, diagnosis-specific support groups, family/caregiver support groups, bereavement groups, online support groups, nutritional/exercise programs, physician lectures, mind/body programs and stress reduction workshops. The American Lung Association is distributing TWC Frankly Speaking About Lung Cancer materials to callers via its Lung HelpLine and several Lung Associations are expanding the availability of the TWC education workshop, Frankly Speaking About Lung Cancer. Through this partnership, the Lung Association and TWC hope to reach and better serve diverse communities of lung cancer survivors nationwide. For more information about The Wellness Community, visit http://www.thewellnesscommunity.org. For questions about lung cancer, please contact the American Lung Association at 1-800-586-4872 (1-800-LUNG-USA).

The American Lung Association and the LUNGevity Foundation have joined to provide resources to researchers seeking new treatments and a cure for lung cancer. As part of this partnership, the Lung Cancer Discovery Award was created in 2004 to provide funding for investigators and to support clinical, laboratory, epidemiological and other lung cancer research.

Want to learn more about the Lung Cancer Discovery Award? Please view the 2008 award announcement at **http://www.lungusa.org/lcdiscoveryaward**

The American Lung Association also works to increase federal funding for a broad range of lung disease-related biomedical research, treatment and prevention programs conducted by the National Institutes of Health, Centers for

Disease Control and Prevention, Department of Veterans Affairs and other federal agencies.

American Lung Association volunteers and staff also advocate for policies at the federal, state and local levels that can reduce lung cancer by decreasing the number of Americans who smoke and protecting everyone from exposure to secondhand smoke. Such policies include comprehensive state and local smokefree laws; granting the U.S. Food and Drug Administration regulatory control over the manufacturing, distribution and advertising of tobacco products; increasing funding for comprehensive tobacco control and cessation programs at the state level; and increasing cigarette excise taxes. To join the American Lung Association in the battle to reduce the number of lung cancer deaths, please go to http://www.lungaction.org.

The American Lung Association also advocates for clean air through enforcement of the Clean Air Act, tighter air pollution standards and reduced radon exposure, a leading cause of lung cancer.

In addition to its advocacy efforts, the American Lung Association offers programs to help smokers who want to quit, including Freedom From Smoking® and Not On Tobacco (N-O-T), a program to help teenagers quit smoking.

Want to learn more about smoking cessation through the American Lung Association's Freedom from Smoking® or Not On Tobacco programs? Please view the online programs at **http://www.ffsonline.org/** or **http://www.lungusa.org/not**

ATTACHMENT X

NON-PROFIT

Applicant: Yale New Haven Health Services Corp.
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$11,992,047,000	$13,374,327,000	$599,124,000	$13,973,451,000	$13,298,161,000	$1,254,311,000	$14,552,472,000	$13,330,316,000	$1,319,830,000	$14,650,146,000	$13,379,236,000	$1,386,537,000	$14,765,773,000
2	Less: Allowances	$8,473,961,000	$9,395,854,000	$346,059,000	$9,741,913,000	$9,333,090,000	$741,688,000	$10,074,778,000	$9,331,729,000	$797,652,000	$10,129,381,000	$9,346,867,000	$858,637,000	$10,205,504,000
3	Less: Charity Care	$51,134,000	$147,836,000	$3,766,000	$151,604,000	$146,923,000	$7,888,000	$155,811,000	$149,896,000	$8,300,000	$158,196,000	$150,878,000	$8,719,000	$159,597,000
4	Less: Other Deductions	$55,517,000	$182,106,000	$9,101,000	$191,207,000	$182,106,000	$18,202,000	$200,308,000	$182,106,000	$18,202,000	$200,308,000	$182,106,000	$18,202,000	$200,308,000
	Net Patient Service Revenue	**$3,411,435,000**	**$3,648,531,000**	**$240,196,000**	**$3,888,727,000**	**$3,634,042,000**	**$486,533,000**	**$4,120,575,000**	**$3,666,585,000**	**$495,676,000**	**$4,162,261,000**	**$3,699,385,000**	**$500,979,000**	**$4,200,364,000**
5	Medicare	$1,102,618,000	$1,198,850,000	$86,990,000	$1,285,840,000	$1,183,306,000	$175,699,000	$1,359,005,000	$1,189,982,000	$178,902,000	$1,368,884,000	$1,195,809,000	$180,751,000	$1,376,560,000
6	Medicaid	$391,367,000	$425,524,000	$25,955,000	$451,479,000	$420,005,000	$52,423,000	$472,429,000	$422,376,000	$53,378,000	$475,754,000	$424,444,000	$53,930,000	$478,374,000
7	CHAMPUS & TriCare	$10,732,000	$11,669,000	$5,715,000	$18,384,000	$11,515,000	$13,563,000	$25,081,000	$11,583,000	$13,810,000	$25,393,000	$11,639,000	$13,953,000	$25,592,000
8	Other	($55,517,000)	($182,106,000)	($9,101,000)	($191,207,000)	($182,106,000)	($18,202,000)	($200,308,000)	($182,106,000)	($18,202,000)	($200,308,000)	($182,106,000)	($18,202,000)	($200,308,000)
	Total Government	**$1,449,200,000**	**$1,453,937,000**	**$110,559,000**	**$1,564,496,000**	**$1,432,724,000**	**$223,483,000**	**$1,656,207,000**	**$1,441,835,000**	**$227,888,000**	**$1,669,723,000**	**$1,449,786,000**	**$230,432,000**	**$1,680,218,000**
9	Commercial Insurers	$1,840,390,000	$2,062,116,000	$116,568,000	$2,178,684,000	$2,070,557,000	$235,268,000	$2,305,825,000	$2,093,250,000	$239,550,000	$2,332,800,000	$2,117,455,000	$242,023,000	$2,359,478,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$97,042,000	$105,512,000	$5,371,000	$110,883,000	$104,144,000	$10,848,000	$114,992,000	$104,731,000	$11,046,000	$115,777,000	$105,244,000	$11,160,000	$116,404,000
12	Workers Compensation	$24,803,000	$26,968,000	$4,635,000	$31,603,000	$26,618,000	$9,362,000	$35,980,000	$26,768,000	$9,533,000	$36,301,000	$26,899,000	$9,631,000	$36,530,000
13	Other	$0	$0	$3,064,000	$3,064,000	$0	$7,573,000	$7,573,000	$0	$7,659,000	$7,659,000	$0	$7,733,667	$7,733,667
	Total Non-Government	**$1,962,235,000**	**$2,194,596,000**	**$129,638,000**	**$2,324,234,000**	**$2,201,319,000**	**$263,051,000**	**$2,464,370,000**	**$2,224,749,000**	**$267,788,000**	**$2,492,537,000**	**$2,249,598,000**	**$270,547,667**	**$2,520,145,667**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$3,411,435,000**	**$3,648,533,000**	**$240,197,000**	**$3,888,730,000**	**$3,634,043,000**	**$486,534,000**	**$4,120,577,000**	**$3,666,584,000**	**$3,666,584,000**	**$7,333,168,000**	**$3,699,384,000**	**$500,979,667**	**$4,200,363,667**
14	Less: Provision for Bad Debts	$123,743,000	$105,127,000	$8,820,000	$113,947,000	$105,887,000	$17,537,000	$123,424,000	$106,583,000	$17,654,000	$124,237,000	$107,286,000	$17,664,000	$124,950,000
	Net Patient Service Revenue less provision for bad debts	**$3,287,692,000**	**$3,543,404,000**	**$231,376,000**	**$3,774,780,000**	**$3,528,155,000**	**$468,996,000**	**$3,997,151,000**	**$3,560,002,000**	**$478,022,000**	**$4,038,024,000**	**$3,592,099,000**	**$483,315,000**	**$4,075,414,000**
15	Other Operating Revenue	$87,934,000	$112,600,000	$9,313,000	$121,913,000	$115,976,000	$18,625,000	$134,603,000	$119,457,000	$18,625,000	$138,082,000	$123,040,000	$18,625,000	$141,665,000
17	Net Assets Released from Restrictions	$19,060,000	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	$3,394,686,000	$3,656,004,000	$240,689,000	$3,896,693,000	$3,644,133,000	$487,621,000	$4,131,754,000	$3,679,459,000	$496,647,000	$4,176,106,000	$3,715,139,000	$501,940,000	$4,217,079,000
B.	OPERATING EXPENSES													
1	Salaries and Wages	$1,366,361,000	$1,471,076,000	$111,777,000	$1,582,853,000	$1,464,693,000	$220,020,000	$1,684,713,000	$1,494,063,000	$222,920,000	$1,716,983,000	$1,525,348,000	$225,493,000	$1,750,841,000
2	Fringe Benefits	$377,757,000	$434,848,000	$31,756,000	$466,604,000	$429,113,000	$61,230,000	$490,343,000	$436,279,000	$61,774,000	$498,053,000	$445,533,000	$62,181,000	$507,714,000
3	Physicians Fees	$548,304,000	$589,037,000	$22,261,000	$611,298,000	$597,313,000	$33,966,000	$631,279,000	$618,512,000	$34,176,000	$652,688,000	$640,614,000	$34,535,000	$675,149,000
4	Supplies and Drugs	$474,136,000	$493,629,000	$38,648,000	$532,277,000	$496,851,000	$78,195,000	$575,046,000	$510,533,000	$80,226,000	$590,759,000	$525,236,000	$81,646,000	$606,882,000
5	Depreciation and Amortization	$192,072,000	$197,286,000	$14,369,000	$211,655,000	$199,607,000	$30,394,000	$230,001,000	$193,522,000	$30,785,000	$224,307,000	$193,657,000	$31,804,000	$225,461,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$26,917,000	$44,341,000	$1,684,000	$46,025,000	$45,505,000	$3,168,000	$48,673,000	$49,426,000	$3,001,000	$52,427,000	$48,812,000	$2,755,000	$51,567,000
8	Malpractice Insurance Cost	$9,731,000	$38,435,000	$8,417,000	$46,852,000	$39,449,000	$16,833,000	$56,281,000	$41,316,000	$16,863,000	$58,179,000	$43,232,000	$16,840,000	$60,072,000
9	Lease Expense	$30,893,000	$33,079,000	$3,982,000	$37,061,000	$32,940,000	$7,964,000	$40,904,000	$33,531,000	$7,985,000	$41,516,000	$34,163,000	$7,969,000	$42,132,000
10	Other Operating Expenses	$198,384,000	$285,171,000	$8,494,000	$293,665,000	$230,956,000	$21,282,000	$252,238,000	$195,238,000	$21,858,000	$217,096,000	$150,242,000	$22,319,000	$172,561,000
	TOTAL OPERATING EXPENSES	$3,224,575,000	$3,586,902,000	$241,388,000	$3,828,290,000	$3,536,426,000	$473,052,000	$4,009,478,000	$3,572,420,000	$479,588,000	$4,052,008,000	$3,606,837,000	$485,542,000	$4,092,379,000
	INCOME/(LOSS) FROM OPERATIONS	$170,111,000	$69,102,000	($699,000)	$68,403,000	$107,707,000	$14,569,000	$122,276,000	$107,039,000	$17,059,000	$124,098,000	$108,302,000	$16,398,000	$124,700,000
	NON-OPERATING REVENUE	$34,189,000	$34,997,000	$4,429,000	$39,426,000	$49,298,000	$8,859,000	$58,157,000	$49,420,000	$8,859,000	$58,279,000	$49,533,000	$8,859,000	$58,392,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$204,300,000	$104,099,000	$3,730,000	$107,829,000	$157,005,000	$23,428,000	$180,433,000	$156,459,000	$25,918,000	$182,377,000	$157,835,000	$25,257,000	$183,092,000
	Principal Payments	$8,008,000	$19,196,000	$2,755,000	$21,951,000	$20,027,000	$5,726,000	$25,753,000	$19,942,000	$5,911,000	$25,853,000	$21,957,000	$6,137,000	$28,094,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	5.0%	1.9%	-0.3%	1.8%	3.0%	3.0%	3.0%	3.0%	3.4%	3.0%	3.0%	3.3%	3.0%
2	Hospital Non Operating Margin	1.0%	1.0%	1.8%	1.0%	1.4%	1.8%	1.4%	1.3%	1.8%	1.4%	1.3%	1.8%	1.4%
3	Hospital Total Margin	6.0%	2.8%	1.5%	2.8%	4.3%	4.8%	4.4%	4.3%	5.2%	4.4%	4.2%	5.0%	4.3%
D.	FTEs	16,037	16,322	1,411	17,733	16,382	2,712	19,094	16,418	2,704	19,122	16,454	2,704	19,158
E.	VOLUME STATISTICS[c]													
1	Inpatient Discharges	109,275	115,101	8,833	123,934	116,139	17,474	133,613	116,960	17,474	134,434	117,790	17,508	135,298
2	Outpatient Visits	1,754,308	1,828,007	313,826	2,141,833	1,843,660	632,244	2,475,904	1,859,472	637,543	2,497,015	1,875,446	640,471	2,515,917
	TOTAL VOLUME	1,863,583	1,943,108	322,658	2,265,766	1,959,799	649,718	2,609,517	1,976,432	655,017	2,631,449	1,993,236	657,979	2,651,215

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Applicant: L+M Health System
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$1,078,627,000	$1,166,643,000	($15,527,000)	$1,151,116,000	$1,213,309,000	($24,164,000)	$1,189,145,000	$1,251,841,000	($9,784,000)	$1,252,057,000	$1,312,315,000	$3,739,000	$1,316,054,000
2	Less: Allowances	$615,857,000	$673,832,000	($6,486,000)	$667,346,000	$717,136,000	($8,305,000)	$708,831,000	$762,089,000	$105,000	$762,194,000	$811,978,000	$8,494,000	$820,472,000
3	Less: Charity Care	$6,783,000	$7,336,000	$38,000	$7,374,000	$7,630,000	$130,000	$7,760,000	$7,935,000	$232,000	$8,167,000	$8,252,000	$328,000	$8,580,000
4	Less: Other Deductions	$2,458,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000
	Net Patient Service Revenue	**$453,529,000**	**$467,273,000**	**($9,079,000)**	**$458,194,000**	**$470,341,000**	**($15,989,000)**	**$454,352,000**	**$473,615,000**	**($10,121,000)**	**$463,494,000**	**$473,883,000**	**($5,083,000)**	**$468,800,000**
5	Medicare	$161,244,000	$169,559,000	($2,854,000)	$166,705,000	$170,162,000	($4,894,000)	$165,268,000	$171,320,000	($2,848,000)	$168,472,000	$171,415,000	($1,094,000)	$170,321,000
6	Medicaid	$48,110,000	$50,591,000	($1,355,000)	$49,236,000	$50,771,000	($2,496,000)	$48,275,000	$51,116,000	($1,886,000)	$49,230,000	$51,144,000	($1,363,000)	$49,781,000
7	CHAMPUS & TriCare	$12,447,000	$13,089,000	($276,000)	$12,813,000	$13,136,000	($493,000)	$12,643,000	$13,225,000	($336,000)	$12,889,000	$13,232,000	($200,000)	$13,032,000
8	Other	($2,458,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)
	Total Government	**$219,343,000**	**$215,037,000**	**($4,485,000)**	**$210,552,000**	**$215,867,000**	**($7,883,000)**	**$207,984,000**	**$217,459,000**	**($5,070,000)**	**$212,389,000**	**$217,589,000**	**($2,657,000)**	**$214,932,000**
9	Commercial Insurers	$215,639,000	$226,760,000	($4,072,000)	$222,688,000	$227,567,000	($7,250,000)	$220,317,000	$229,115,000	($4,517,000)	$224,598,000	$229,242,000	($2,170,000)	$227,072,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$9,955,000	$10,469,000	$24,000	$10,493,000	$10,506,000	$109,000	$10,615,000	$10,577,000	$236,000	$10,813,000	$10,583,000	$344,000	$10,927,000
12	Workers Compensation	$8,592,000	$9,035,000	($124,000)	$8,911,000	$9,067,000	($203,000)	$8,864,000	$9,129,000	($94,000)	$9,035,000	$9,134,000	($1,000)	$9,133,000
13	Other	$0	$5,972,000	($422,000)	$5,550,000	$7,334,000	($761,000)	$6,573,000	$7,334,000	($675,000)	$6,659,000	$7,334,000	$1,232,000	$8,566,000
	Total Non-Government	**$234,186,000**	**$252,236,000**	**($4,594,000)**	**$247,642,000**	**$254,474,000**	**($8,105,000)**	**$246,369,000**	**$256,155,000**	**($5,050,000)**	**$251,105,000**	**$256,293,000**	**($595,000)**	**$255,698,000**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$453,529,000**	**$467,273,000**	**($9,079,000)**	**$458,194,000**	**$470,341,000**	**($15,988,000)**	**$454,353,000**	**$473,614,000**	**($10,120,000)**	**$463,494,000**	**$473,882,000**	**($3,252,000)**	**$470,630,000**
14	Less: Provision for Bad Debts	$20,298,000	$17,177,000	($54,000)	**$17,123,000**	$17,240,000	($289,000)	**$16,951,000**	$17,359,000	($291,000)	**$17,068,000**	$17,369,000	($291,000)	**$17,078,000**
	Net Patient Service Revenue less provision for bad debts	**$433,231,000**	**$450,096,000**	**($9,025,000)**	**$441,071,000**	**$453,101,000**	**($15,700,000)**	**$437,401,000**	**$456,256,000**	**($9,830,000)**	**$446,426,000**	**$456,514,000**	**($4,792,000)**	**$451,722,000**
15	Other Operating Revenue	$20,795,000	$18,625,000	($4,622,000)	**$14,003,000**	$18,625,000	($9,243,000)	**$9,382,000**	$18,625,000	($9,243,000)	**$9,382,000**	$18,625,000	($9,243,000)	**$9,382,000**
17	Net Assets Released from Restrictions	$876,000	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	TOTAL OPERATING REVENUE	**$454,902,000**	**$468,721,000**	**($13,647,000)**	**$455,074,000**	**$471,726,000**	**($24,943,000)**	**$446,783,000**	**$474,881,000**	**($19,073,000)**	**$455,808,000**	**$475,139,000**	**($14,035,000)**	**$461,104,000**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$213,468,000	$221,743,000	($16,504,000)	$205,239,000	$218,732,000	($32,626,000)	$186,106,000	$220,764,000	($33,139,000)	$187,625,000	$223,224,000	($32,879,000)	$190,345,000
2	Fringe Benefits	$59,186,000	$61,336,000	($2,486,000)	$58,850,000	$59,362,000	($4,868,000)	$54,494,000	$59,611,000	($4,866,000)	$54,745,000	$59,980,000	($4,677,000)	$55,303,000
3	Physicians Fees	$54,475,000	$36,263,000	$11,193,000	$47,456,000	$29,552,000	$16,363,000	$45,915,000	$29,231,000	$17,197,000	$46,428,000	$29,615,000	$18,070,000	$47,685,000
4	Supplies and Drugs	$71,996,000	$77,728,000	($1,408,000)	$76,320,000	$78,133,000	($2,333,000)	$75,800,000	$79,258,000	($1,760,000)	$77,498,000	$80,383,000	($1,273,000)	$79,110,000
5	Depreciation and Amortization	$27,479,000	$28,415,000	$41,000	$28,456,000	$30,071,000	$67,000	$30,138,000	$30,348,000	$65,000	$30,413,000	$31,453,000	$55,000	$31,508,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,555,000	$3,368,000	$0	$3,368,000	$3,168,000	$0	$3,168,000	$2,974,000	$0	$2,974,000	$2,749,000	$0	$2,749,000
8	Malpractice Insurance Cost	$14,513,000	$16,833,000	($1,286,000)	$15,547,000	$16,833,000	($2,571,000)	$14,262,000	$16,833,000	($2,571,000)	$14,262,000	$16,833,000	($2,571,000)	$14,262,000
9	Lease Expense	$6,970,000	$7,964,000	($1,068,000)	$6,896,000	$7,964,000	($2,136,000)	$5,828,000	$7,964,000	($2,136,000)	$5,828,000	$7,964,000	($2,136,000)	$5,828,000
10	Other Operating Expenses	$21,944,000	$23,767,000	($2,057,000)	$21,710,000	$20,618,000	($4,115,000)	$16,503,000	$21,103,000	($4,128,000)	$16,975,000	$21,576,000	($4,137,000)	$17,439,000
	TOTAL OPERATING EXPENSES	**$473,588,000**	**$477,417,000**	**($13,575,000)**	**$463,842,000**	**$464,433,000**	**($32,219,000)**	**$432,214,000**	**$468,086,000**	**($31,338,000)**	**$436,748,000**	**$473,777,000**	**($29,548,000)**	**$444,229,000**
	INCOME/(LOSS) FROM OPERATIONS	**($18,686,000)**	**($8,696,000)**	**($72,000)**	**($8,768,000)**	**$7,293,000**	**$7,276,000**	**$14,569,000**	**$6,795,000**	**$12,265,000**	**$19,060,000**	**$1,362,000**	**$15,513,000**	**$16,875,000**
	NON-OPERATING REVENUE	$15,297,000	$8,859,000	$0	**$8,859,000**	$8,859,000	$0	**$8,859,000**	$8,859,000	$0	**$8,859,000**	$8,859,000	$0	**$8,859,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**($3,389,000)**	**$163,000**	**($72,000)**	**$91,000**	**$16,152,000**	**$7,276,000**	**$23,428,000**	**$15,654,000**	**$12,265,000**	**$27,919,000**	**$10,221,000**	**$15,513,000**	**$25,734,000**
	Principal Payments	$5,153,000	$5,511,000	$0	**$5,511,000**	$5,726,000	$0	**$5,726,000**	$5,911,000	$0	**$5,911,000**	$6,137,000	$0	**$6,137,000**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	-4.1%	-1.9%	0.5%	-1.9%	1.5%	-29.2%	3.3%	1.4%	-64.3%	4.2%	0.3%	-110.5%	3.7%
2	Hospital Non Operating Margin	3.4%	1.9%	0.0%	1.9%	1.9%	0.0%	2.0%	1.9%	0.0%	1.9%	1.9%	0.0%	1.9%
3	Hospital Total Margin	-0.7%	0.0%	0.5%	0.0%	3.4%	-29.2%	5.2%	3.3%	-64.3%	6.1%	2.2%	-110.5%	5.6%
D.	**FTEs**	2,849	2,821	(181)	2,641	2,711	(325)	2,386	2,701	(323)	2,378	2,691	(313)	2,378
FTEs associated with the integration of NEMG and LMPA are excluded in the incremental column. Please refer to the Medical Group CON to reference the corresponding additional FTEs														
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	17,288	17,243	211	17,454	17,081	393	17,474	16,900	574	17,474	16,753	755	17,508
2	Outpatient Visits	585,965	618,543	4,554	623,097	620,364	11,880	632,244	621,913	15,630	637,543	621,913	18,558	640,471
	TOTAL VOLUME	603,253	635,786	4,765	640,551	637,445	12,273	649,718	638,813	16,204	655,017	638,666	19,313	657,979

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Applicant: L+M Hospital
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	**OPERATING REVENUE**													
1	Total Gross Patient Revenue	$795,287,000	$860,183,000	$14,094,000	$874,277,000	$894,590,000	$37,460,000	$932,050,000	$930,374,000	$53,320,000	$983,694,000	$967,589,000	$68,908,000	$1,036,497,000
2	Less: Allowances	$450,251,000	$487,244,000	$8,282,000	$495,526,000	$521,292,000	$22,590,000	$543,882,000	$553,773,000	$32,780,000	$586,553,000	$590,539,000	$43,352,000	$633,891,000
3	Less: Charity Care	$5,449,000	$5,894,000	$97,000	$5,991,000	$6,375,000	$267,000	$6,642,000	$6,895,000	$395,000	$7,290,000	$7,457,000	$531,000	$7,988,000
4	Less: Other Deductions	$2,458,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000
	Net Patient Service Revenue	**$337,129,000**	**$348,843,000**	**$5,715,000**	**$354,558,000**	**$348,721,000**	**$14,603,000**	**$363,324,000**	**$351,504,000**	**$20,145,000**	**$371,649,000**	**$351,391,000**	**$25,025,000**	**$376,416,000**
5	Medicare	$116,154,000	$123,581,000	$1,924,000	$125,505,000	$123,539,000	$4,916,000	$128,455,000	$124,491,000	$6,783,000	$131,274,000	$124,452,000	$8,426,000	$132,878,000
6	Medicaid	$36,748,000	$39,097,000	$609,000	$39,706,000	$39,084,000	$1,555,000	$40,639,000	$39,385,000	$2,146,000	$41,531,000	$39,373,000	$2,666,000	$42,039,000
7	CHAMPUS & TriCare	$10,981,000	$11,683,000	$182,000	$11,865,000	$11,679,000	$465,000	$12,144,000	$11,769,000	$641,000	$12,410,000	$11,766,000	$797,000	$12,563,000
8	Other	($2,458,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)
	Total Government	**$161,425,000**	**$156,159,000**	**$2,715,000**	**$158,874,000**	**$156,100,000**	**$6,936,000**	**$163,036,000**	**$157,443,000**	**$9,570,000**	**$167,013,000**	**$157,389,000**	**$11,889,000**	**$169,278,000**
9	Commercial Insurers	$163,214,000	$173,649,000	$2,704,000	$176,353,000	$173,591,000	$6,908,000	$180,499,000	$174,928,000	$9,531,000	$184,459,000	$174,873,000	$11,839,000	$186,712,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,132,000	$5,460,000	$85,000	$5,545,000	$5,458,000	$217,000	$5,675,000	$5,500,000	$300,000	$5,800,000	$5,498,000	$372,000	$5,870,000
12	Workers Compensation	$7,358,000	$7,829,000	$122,000	$7,951,000	$7,826,000	$311,000	$8,137,000	$7,886,000	$430,000	$8,316,000	$7,884,000	$534,000	$8,418,000
13	Other	$0	$5,746,000	$89,000	$5,835,000	$5,746,000	$229,000	$5,975,000	$5,746,000	$315,000	$6,061,000	$5,746,000	$392,000	$6,138,000
	Total Non-Government	**$175,704,000**	**$192,684,000**	**$3,000,000**	**$195,684,000**	**$192,621,000**	**$7,665,000**	**$200,286,000**	**$194,060,000**	**$10,576,000**	**$204,636,000**	**$194,001,000**	**$13,137,000**	**$207,138,000**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$337,129,000**	**$348,843,000**	**$5,715,000**	**$354,558,000**	**$348,721,000**	**$14,601,000**	**$363,322,000**	**$351,503,000**	**$20,146,000**	**$371,649,000**	**$351,390,000**	**$25,026,000**	**$376,416,000**
14	Less: Provision for Bad Debts	$14,930,000	$13,803,000	$210,000	**$14,013,000**	$13,798,000	$537,000	**$14,335,000**	$13,909,000	$741,000	**$14,650,000**	$13,904,000	$921,000	**$14,825,000**
	Net Patient Service Revenue less provision for bad debts	**$322,199,000**	**$335,040,000**	**$5,505,000**	**$340,545,000**	**$334,923,000**	**$14,066,000**	**$348,989,000**	**$337,595,000**	**$19,404,000**	**$356,999,000**	**$337,487,000**	**$24,104,000**	**$361,591,000**
15	Other Operating Revenue	$28,151,000	$31,186,000	$0	**$31,186,000**	$31,186,000	$0	**$31,186,000**	$31,186,000	$0	**$31,186,000**	$31,186,000	$0	**$31,186,000**
17	Net Assets Released from Restrictions	$672,000	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	TOTAL OPERATING REVENUE	**$351,022,000**	**$366,226,000**	**$5,505,000**	**$371,731,000**	**$366,109,000**	**$14,066,000**	**$380,175,000**	**$368,781,000**	**$19,404,000**	**$388,185,000**	**$368,673,000**	**$24,104,000**	**$392,777,000**
B.	**OPERATING EXPENSES**													
1	Salaries and Wages	$143,839,000	$143,577,000	$604,000	$144,181,000	$140,019,000	$761,000	$140,780,000	$141,973,000	$755,000	$142,728,000	$143,983,000	$1,270,000	$145,253,000
2	Fringe Benefits	$51,045,000	$54,026,000	$848,000	$54,874,000	$52,457,000	$1,229,000	$53,686,000	$52,771,000	$1,255,000	$54,026,000	$53,086,000	$1,408,000	$54,498,000
3	Physicians Fees	$38,648,000	$30,254,000	$2,845,000	$33,099,000	$22,993,000	$4,678,000	$27,671,000	$22,533,000	$4,789,000	$27,322,000	$22,849,000	$4,922,000	$27,771,000
4	Supplies and Drugs	$59,538,000	$64,289,000	$55,000	$64,344,000	$64,610,000	$346,000	$64,956,000	$65,541,000	$652,000	$66,193,000	$66,471,000	$918,000	$67,389,000
5	Depreciation and Amortization	$22,728,000	$26,054,000	$77,000	$26,131,000	$27,572,000	$154,000	$27,726,000	$27,826,000	$154,000	$27,980,000	$28,840,000	$154,000	$28,994,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,543,000	$3,368,000	$0	$3,368,000	$3,168,000	$0	$3,168,000	$2,974,000	$0	$2,974,000	$2,749,000	$0	$2,749,000
8	Malpractice Insurance Cost	$4,539,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000
9	Lease Expense	$4,619,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000
10	Other Operating Expenses	$25,333,000	$30,491,000	$0	$30,491,000	$30,491,000	$0	$30,491,000	$30,795,000	$0	$30,795,000	$29,256,000	$0	$29,256,000
	TOTAL OPERATING EXPENSES	**$353,832,000**	**$361,724,000**	**$4,429,000**	**$366,153,000**	**$350,975,000**	**$7,168,000**	**$358,143,000**	**$354,078,000**	**$7,605,000**	**$361,683,000**	**$356,901,000**	**$8,672,000**	**$365,573,000**
	INCOME/(LOSS) FROM OPERATIONS	**($2,810,000)**	**$4,502,000**	**$1,076,000**	**$5,578,000**	**$15,134,000**	**$6,898,000**	**$22,032,000**	**$14,703,000**	**$11,799,000**	**$26,502,000**	**$11,772,000**	**$15,432,000**	**$27,204,000**
	NON-OPERATING REVENUE	$8,789,000	$8,263,000	$0	**$8,263,000**	$8,263,000	$0	**$8,263,000**	$8,263,000	$0	**$8,263,000**	$8,263,000	$0	**$8,263,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$5,979,000**	**$12,765,000**	**$1,076,000**	**$13,841,000**	**$23,397,000**	**$6,898,000**	**$30,295,000**	**$22,966,000**	**$11,799,000**	**$34,765,000**	**$20,035,000**	**$15,432,000**	**$35,467,000**
	Principal Payments	$5,153,000	$5,511,000	$0	**$5,511,000**	$5,726,000	$0	**$5,726,000**	$5,911,000	$0	**$5,911,000**	$6,137,000	$0	**$6,137,000**
C.	**PROFITABILITY SUMMARY**													
1	Hospital Operating Margin	-0.8%	1.2%	19.5%	1.5%	4.1%	49.0%	5.8%	4.0%	60.8%	6.8%	3.2%	64.0%	6.9%
2	Hospital Non Operating Margin	2.5%	2.3%	0.0%	2.2%	2.3%	0.0%	2.2%	2.2%	0.0%	2.1%	2.2%	0.0%	2.1%
3	Hospital Total Margin	1.7%	3.5%	19.5%	3.7%	6.4%	49.0%	8.0%	6.2%	60.8%	9.0%	5.4%	64.0%	9.0%
D.	**FTEs**	1,849	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	**VOLUME STATISTICS[c]**													
1	Inpatient Discharges	14,151	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	TOTAL VOLUME	472,261	469,289	3,641	472,930	469,160	11,259	480,419	469,017	14,967	483,984	468,900	18,035	486,935

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

ATTACHMENT XI

Lawrence + Memorial Health System Affliation with Yale New Haven Health System Assumptions

Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2) Non-Government	0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3) Inpatient Volume	1.1%	0.1%	0.0%	0.2%
4) Outpatient Volume	1.0%	1.5%	0.8%	0.5%

	FY 2016	FY 2017	FY 2018	FY 2019
EXPENSES				
A. Salaries and Fringe Benefits	1.5%	1.5%	1.5%	1.5%
B. Non-Salary				
1) Supplies and Drugs	2.0%	1.5%	1.5%	1.5%
2) Professional and Contracted Services	2.0%	1.5%	1.5%	1.5%
3) Malpractice Insurance and Lease Expense	0.0%	0.0%	0.0%	0.0%
4) All Other Expenses	1.0%	1.0%	1.0%	1.0%
5) All Other Expenses				

	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	2,641	2,386	2,378	2,378

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

YALE-NEW HAVEN System
Lawrence + Memorial Affiliation
Assumptions

Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	1.0%	1.0%	1.0%	1.0%
2) Non-Government	1.0%	1.0%	1.0%	1.0%
3) Inpatient Volume	1.0%	1.0%	1.0%	1.0%
4) Outpatient Volume	1.0%	1.0%	1.0%	1.0%

	FY 2016	FY 2017	FY 2018	FY 2019
EXPENSES				
A. Salaries and Fringe Benefits	3.0%	3.0%	3.0%	3.0%
B. Non-Salary				
1) Supplies and Drugs	3.0%	3.0%	3.0%	3.0%
2) Professional and Contracted Services	3.0%	3.0%	3.0%	3.0%
3) Malpractice Insurance and Lease Expense	3.0%	3.0%	3.0%	3.0%
4) All Other Expenses	3.0%	3.0%	3.0%	3.0%

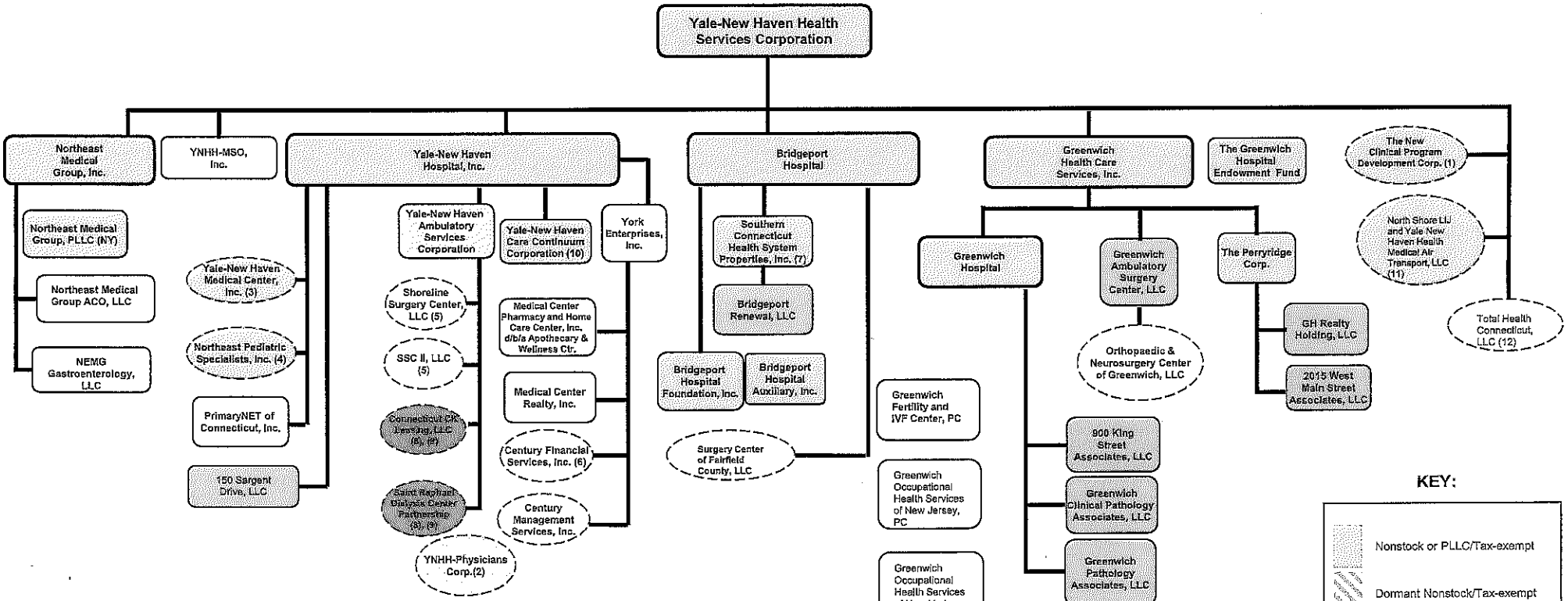
	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	14,391	14,412	14,418	14,450

ATTACHMENT A

CURRENT

Yale New Haven Health System

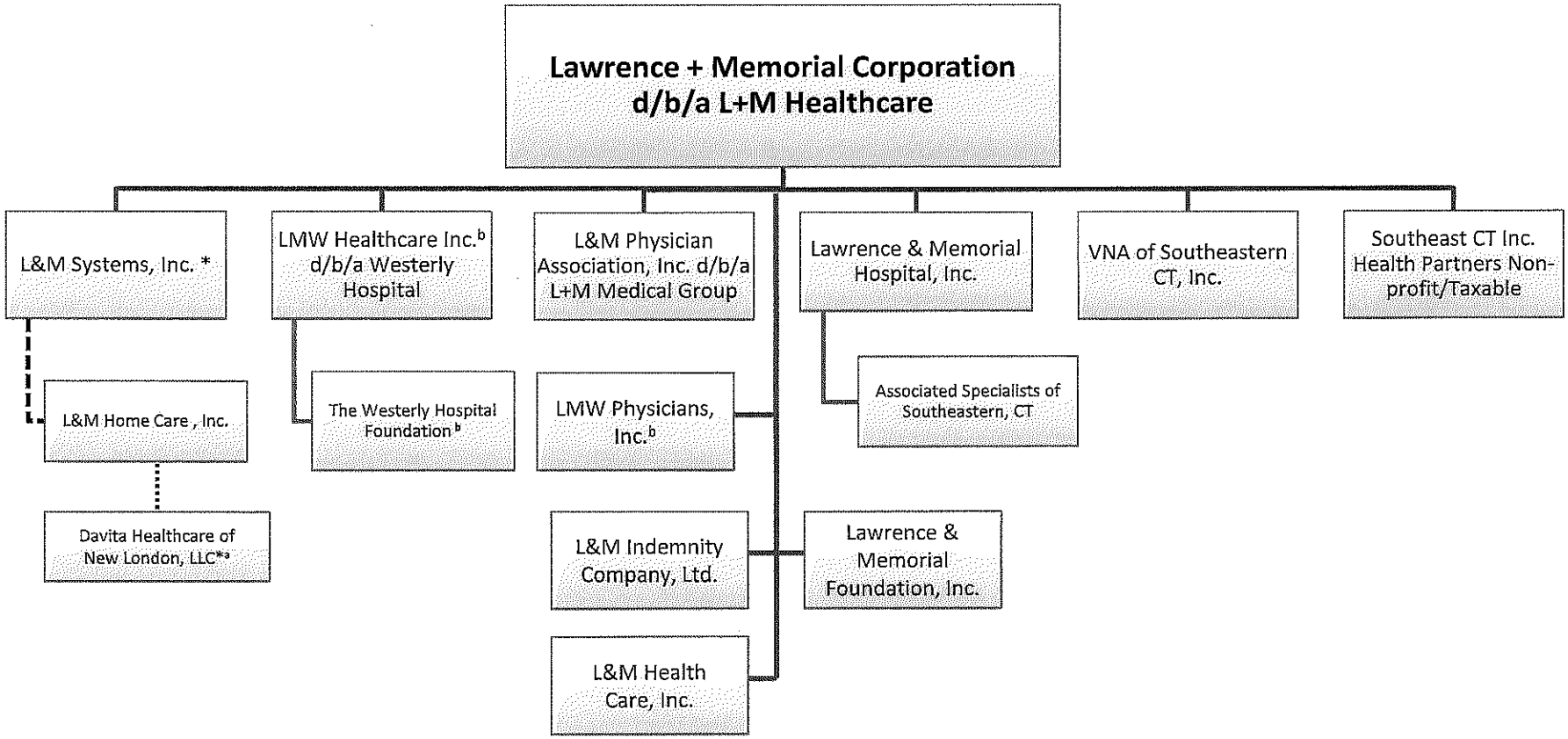
Last updated 07/09/2015



NOTES:

1. Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
2. Yale-New Haven Community Medical Group, Inc. is also a member of YNHH-Physicians Corp.
3. Yale University is an equal member (with Yale-New Haven Hospital) of Yale-New Haven Medical Center, Inc.
4. Connecticut Children's Medical Center is an equal member (with Yale-New Haven Hospital) in Northeast Pediatric Specialists, Inc.
5. Physician joint venture.
6. 47.6 % of the stock of Century Financial Services, Inc. is owned by York Enterprises, Inc. Another 47.6% is owned by Bridgeport Hospital. The remaining stock is held by other hospitals or affiliates thereof.
7. This organization is exempt from Federal Income Tax under IRC Section 501(c)(2).
8. Acquired as an asset of the Hospital of Saint Raphael's affiliated entities.
9. Joint ventures with physicians or physician groups held by affiliates of Hospital of Saint Raphael.
10. Formed to acquire the assets of and to manage The Grimes Center.
11. Joint Venture between NorthShore - LIJ (90%) and Yale-New Haven Health Services Corporation (10%).
12. Joint Venture between St. Francis Healthcare Partners, Inc. (SFHP) and Yale-New Haven Health Services Corporation (YNHHS) – 80% YNHHS and 20% SFHP

L+M Healthcare

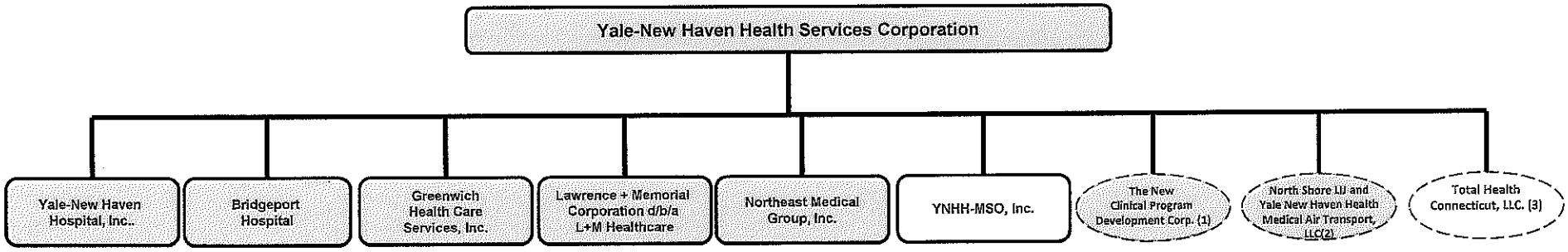


Note:
** - for profit*
a – Joint Venture with Backus Dialysis Corporation and Davita
b – Rhode Island non-profit companies
[v: 20July2015 Karen Santacroce]

PROPOSED

Draft: 9/21/2015
To be Effective as of Closing
Of YNHHS – L+M Transaction

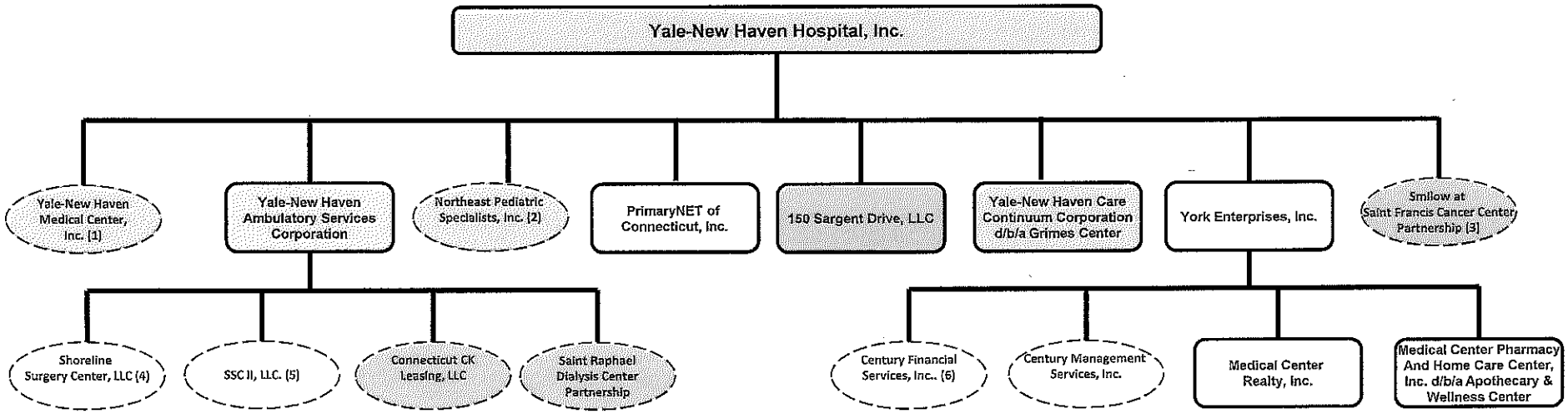
YALE NEW HAVEN HEALTH SYSTEM



Notes:

1. Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
2. Joint Venture between NorthShore - LIJ (90%) and Yale-New Haven Health Services Corporation (10%).
3. Joint Venture between St. Francis Healthcare Partners, Inc. (SFHP) and Yale-New Haven Health Services Corporation (YNHHS) – 60% YNHHS and 40% SFHP.

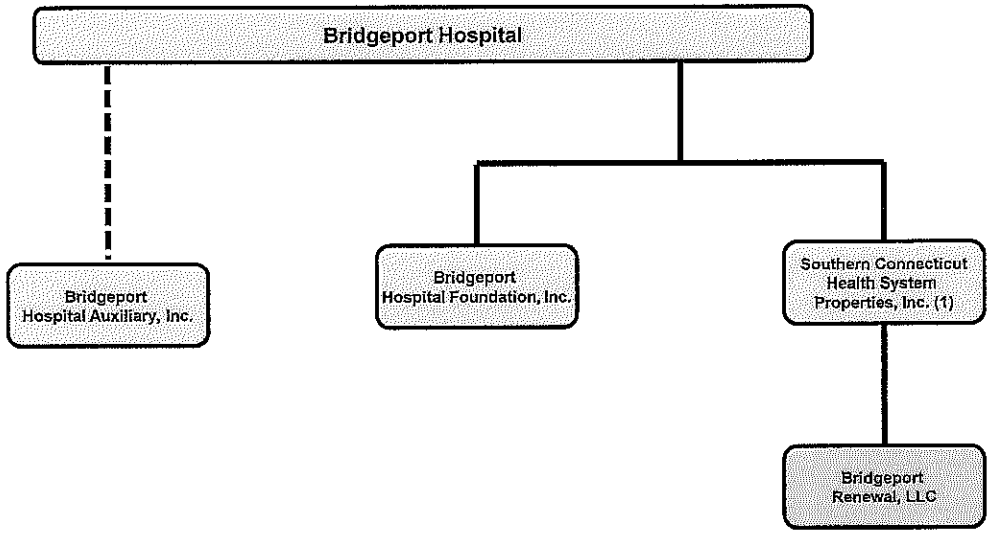
YNHH Delivery Network



Notes:

1. Yale University is an equal member (with Yale-New Haven Hospital) of Yale-New Haven Medical Center, Inc.
2. Connecticut Children's Medical Center is an equal member (with Yale-New Haven Hospital) in Northeast Pediatric Specialists, Inc.
3. Partnership between YNHH (50%) and Saint Francis Hospital and Medical Center (SFHMC(50%)) related to the joint operation of SFHMC's outpatient medical oncology and hematology program located at SFHMC's main campus)
4. Joint Venture between Yale-New Haven Ambulatory Services Corporation (51%) and CGC Endoscopy, LLC. (49%) (Shoreline Surgery Center).
5. Joint Venture between Yale-New Haven Ambulatory Services Corporation (51%) and Constitution Surgery Centers, LLC (15%) and Shoreline Physician Holding Company, LLC (34%) (SSC II, LLC).
6. Century Financial Services, Inc. is owned by York Enterprises, Inc. (47.6%), Bridgeport Hospital (47.6%) with the remaining stock (4.8%) is held by other hospitals or affiliates thereof.

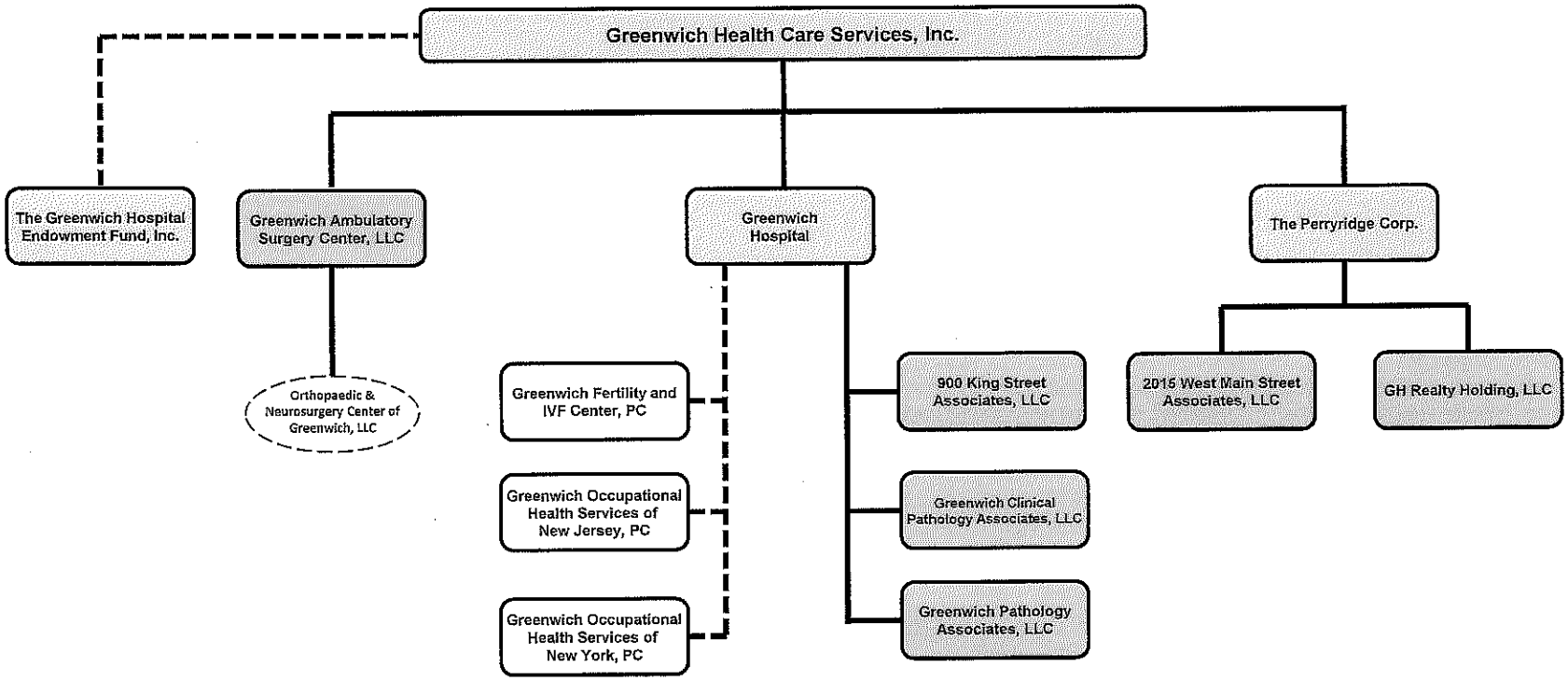
BH Delivery Network



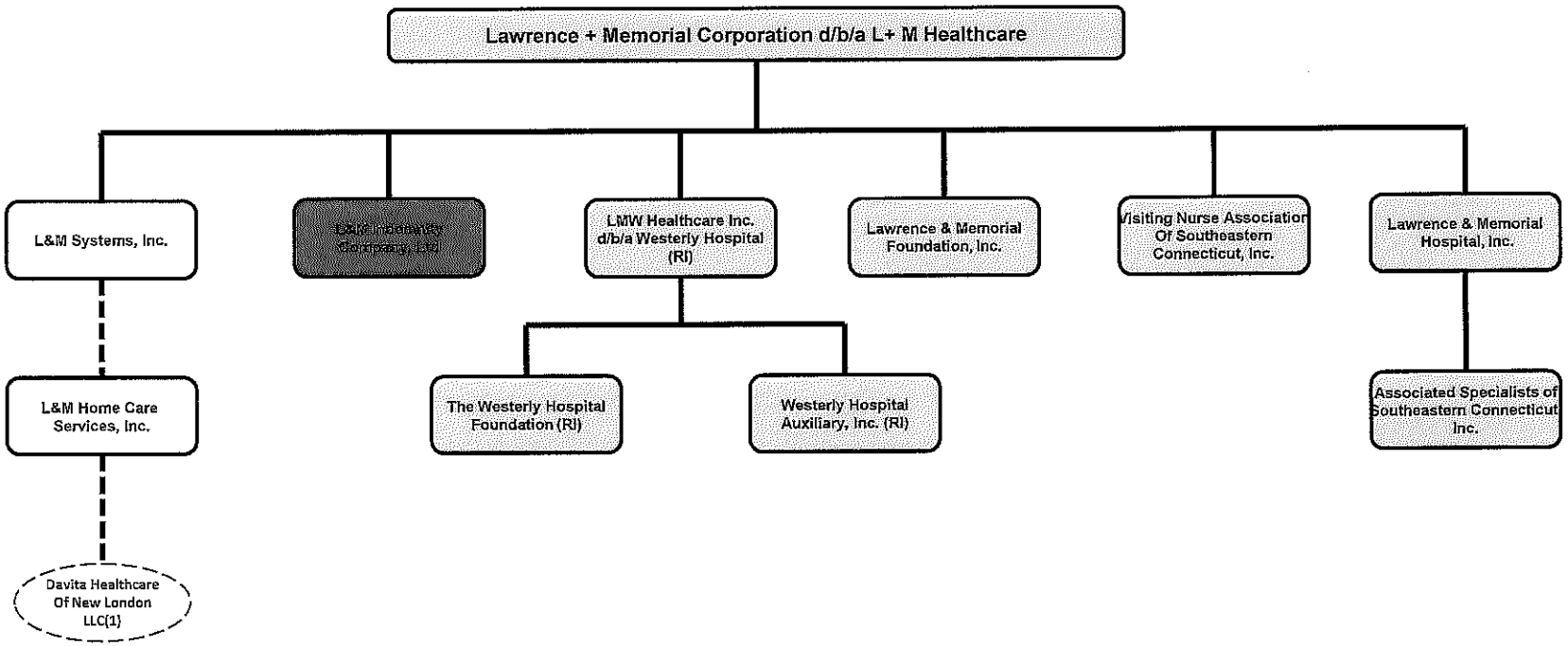
Notes:

1. This organization is exempt from Federal Income Tax under IRC Section 501(c)(2).

Greenwich Delivery Network



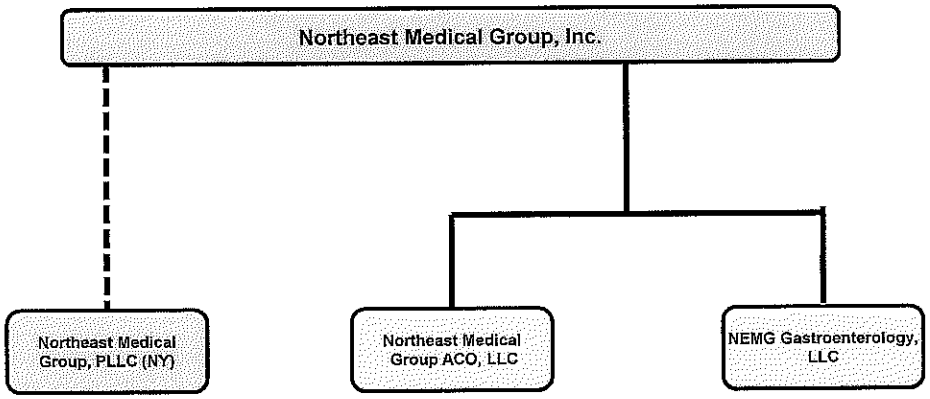
L + M Delivery Network



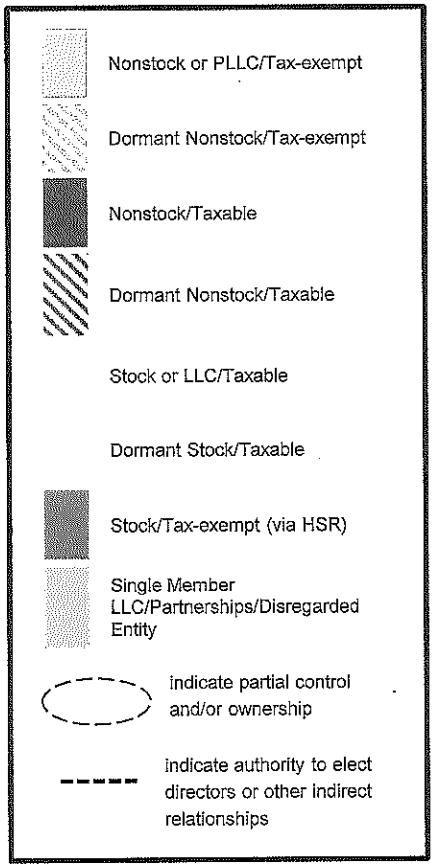
Notes:

1. Joint Venture between Backus Dialysis Corporation, DaVita and Lawrence + Memorial Corporation.

NEMG Delivery Network



Color/Outline Key



ATTACHMENT B

4k. Provide monthly financial reports that include statistics for the current month, and year to date and comparable month from the previous year for the following:

	L&M Hospital				L+M Corporation (Consolidated)			
	Jun-15 YTD	Jun-14 YTD	Jun-15 MTD	Jun-14 MTD	Jun-15 YTD	Jun-14 YTD	Jun-15 MTD	Jun-14 MTD
Monthly Financial Measurement/Indicators								
A. Operating Performance:								
Operating Margin	1.63%	-2.10%	3.92%	6.34%	-1.46%	-4.65%	-0.08%	-5.26%
Non operating Margin	NA	NA	NA	NA	NA	NA	NA	NA
Total Margin	4.82%	0.55%	4.78%	29.62%	1.81%	-2.24%	0.78%	12.84%
Bad Debt as % of Net Revenue	6.46%	8.33%	4.00%	4.13%	5.89%	7.28%	3.97%	4.08%
B. Liquidity:								
Current Ratio	3.5	3.8	3.5	3.8	4.0	3.7	4.0	3.7
Days Cash on Hand	140.2	143.7	140.2	143.7	152.5	157.1	152.5	157.1
Days in Net Accounts Receivable	39.1	40.8	39.1	40.8	37.6	39.2	37.6	39.2
Average Payment Period	52.2	51.8	52.2	51.8	56.1	61.9	56.1	61.9
C. Leverage and Capital Structure:								
Long-term Debt to Equity	71.2%	65.7%	71.2%	65.7%	37.0%	37.7%	37.0%	37.7%
Long-term Debt to Capitalization	40.4%	38.6%	40.4%	38.6%	26.1%	29.3%	26.1%	29.3%
Unrestricted Cash to Debt	118.7%	119.2%	118.7%	119.2%	167.8%	164.9%	167.8%	164.9%
Times Interest Earned Ratio	5.9	1.5	6.1	29.9	3.4	-1.5	2.0	16.5
Debt Service Coverage Ratio	5.3	3.2	5.3	3.2	3.5	1.8	3.5	1.8
Equity Financing Ratio	0.44	0.46	0.44	0.46	0.55	0.55	0.55	0.55
D. Additional Statistics:								
Income from Operation	4,383,117	(5,459,380)	1,182,419	1,879,595	(5,069,835)	(15,657,118)	(34,108)	(2,047,222)
Revenue Over/(Under) Expense	12,925,878	1,435,693	1,438,775	8,774,668	6,277,126	(7,548,235)	331,768	5,000,976
EBITA	24,317,418	13,675,745	3,380,998	4,093,432	18,734,359	7,860,281	2,633,787	628,268
Patient Cash Collected	NA	NA	NA	NA	NA	NA	NA	NA
Cash and Cash Equivalents	5,989,197	7,871,852	5,989,197	7,871,852	16,566,226	21,984,755	16,566,226	21,984,755
Net Working Cash	129,563,076	138,690,089	129,563,076	138,690,089	201,559,544	200,870,144	201,559,544	200,870,144
Unrestricted Assets	127,734,763	145,546,948	127,734,763	145,546,948	259,079,232	266,824,194	259,079,232	266,824,194
Credit Ratings (S&P, Fitch, Moody's)								

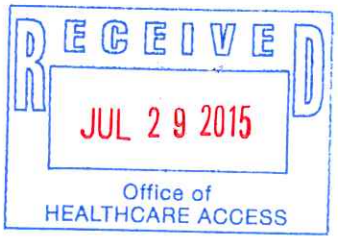
Fitch A with Stable
S&P A- with Negative

GREATER MYSTIC CHAMBER OF COMMERCE

Bridging Business and Community

July 28th, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308



Dear Ms. Martone,

As President of the Greater Mystic Chamber of Commerce and on behalf of our Board of Directors I am writing to express our enthusiastic endorsement for the proposed affiliation between L+M Healthcare, Inc. and Yale New Haven Health System.

In the rapidly and ever-changing health care environment, it has become increasingly difficult for not-for-profit community hospitals to remain independent. L+M has sustained their independence for over a century and Westerly Hospital had remained independent as well for over 88 years prior to their acquisition by L+M.

L+M's proposed affiliation with Yale would be very compatible. The New London based hospital already partners with Yale in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/ angioplasty and vascular surgery. These and other personnel from both institutions know, respect and interact well with each other. A full affiliation will only improve both organizations and expand their already substantial accessibility- particularly to populations that are traditionally under-served. The joining of forces will also make it easier to recruit and retain physicians in all areas of care. Both organizations will be financially healthier from their affiliation.

Representatives from both organizations have completed due diligence and concluded, along with community-elected boards of directors, that this would be the best outcome for both institutions and the communities they serve and the Greater Mystic Chamber of Commerce is in complete agreement.

I strongly encourage you to approve this application.

Sincerely,

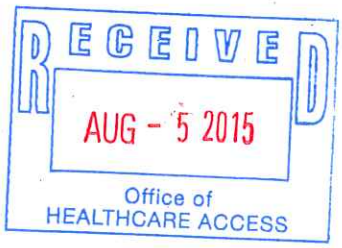
Tricia Walsh

Greater Mystic Chamber of Commerce
12 Roosevelt Avenue
P.O. Box 143
Mystic, CT 06355-0143

Phone: 860.572.9578
Fax: 860.572.9273
info@mysticchamber.org
www.MysticChamber.org

ANTONINO AUTO GROUP

543 Colman Street • New London, Connecticut 06320 • Phone (203) 447-3141
Route 184 • Groton, Connecticut 06340 • Phone (203) 448-0050



August 4, 2015

Kimberly R.Martone
Director of Operation
410 Capital Ave
MS#13HCA
PO Box 340308
Hartford CT 06134-0308

Dear Kimberly,

I am writing this letter to express my support of the Lawrence and Memorial Hospital and Yale New Haven Hospital's affiliations.

My name is John Antonino, I am the principle of the Antonino Auto Group of Southern Connecticut. I have been in business in Connecticut for 50 years and have had many pleasurable experiences with health needs at Lawrence and Memorial Hospital. My four children and twelve grandchildren were all born at Lawrence and Memorial Hospital. I also have had four occasions with health issues that doctors and staff have helped me though, all with success. Both of my parents were also treated there in the last days of their lives, and always with respectful care.

My business employs 650 people at all skill levels, their extended family member's total over 2000 individuals. Most of our employees have health insurance coverage through us, and all enjoy the benefits of Lawrence and Memorial Hospital.

It is apparent to me that Lawrence and Memorial Hospital has always endeavored, though the years, to provide the people of Southeastern Connecticut with the most modern and up to date medical and facilities possible. An affiliation with Yale New Haven Hospital can only improve the reputable status of Lawrence and Memorial Hospital has earned, particularly the Cancer Center which is also state of the art.

It would be an injustice if affiliation of these two fine establishments were not possible. If allowed, the union would quite possibly make them the best in New England.

Thank you for your consideration.

Sincerely,

John Antonino

Leeway
Leaders in AIDS Care

Support Letter for Yale-New Haven Hospital & Yale New Haven Health System
Re: Lawrence & Memorial Hospital Affiliation

August 13th, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As a community partner I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Leeway, with support from Yale New Haven Health, has had a significant impact on the lives of underserved families in our region. Under the proposed affiliation agreement that is before you, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for the communities they serve.

As you know, healthcare is undergoing significant change across our country and across our state. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and result in significant investments in clinical programs in southeastern Connecticut and western Rhode Island.

I encourage you to approve the affiliation. Thank you for the opportunity to offer my support.

Sincerely,

Heather Aaron
Executive Director

Connecticut General Assembly
SENATE DEMOCRATS

Legislative Office Building, Room 3300
Hartford, Connecticut 06106-1591

August 18, 2015

Ms. Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

We are writing to share with you the conditions that would allow us to support the proposed affiliation between L & M Healthcare, Inc. and Yale New Haven Health System.

Our rapidly changing healthcare environment requires significant oversight to protect both patients and workers as well as to ensure that the health care market does not become increasingly distorted. It has become difficult for small not-for-profit, community hospitals to remain independent in this era of hospital consolidation. Often when a larger health system moves to acquire a community hospital, the health system promises better care and lower costs. However, the subsequent reality does not always reflect either of these goals. We write to encourage the Office of Health Care Access (OHCA) to require conditions for this acquisition that would protect patients both in terms of quality of care and cost of care. We would also encourage OHCA to protect patient quality of care by requiring the maintenance of appropriate staffing levels at these hospitals. In addition, we believe that any entity created by this affiliation must respect all existing collective bargaining agreements.

We realize that there is logic to this acquisition in that Yale already assists L & M in at least five clinical areas: radiation oncology, neonatology, telestroke, pediatric emergency medicine, invasive cardiology/angioplasty and vascular surgery; therefore, personnel from both institutions already interact and cooperate regularly. A full affiliation has the potential to improve both organizations and expand accessibility. The joining of forces may have the potential to allow L & M to recruit and retain physicians in all areas of care. However, the state must be an active partner to ensure that the main beneficiaries of this acquisition will be the patients and not the financial bottom line of the institutions involved.

We look forward to working with you on this transaction.

Sincerely,

Martin M. Looney
Senate President Pro Tem

Andy Maynard
State Senator

Cathy Osten
State Senator

Gary Winfield
State Senator

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE CHRISTOPHER ROSARIO
128TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 5006
CAPITOL: (860) 240-8585
E-MAIL: Christopher.Rosario@cga.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
ENERGY COMMITTEE
TRANSPORTATION COMMITTEE

August 20, 2015

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to express my support for the proposed affiliation of Lawrence + Memorial Health with the Yale New Haven Health System which includes Bridgeport Hospital that is located within our community.

I recognize that healthcare is evolving rapidly and that an affiliation between L+M and YNHHS will drive access to high quality healthcare in the most efficient manner possible. As your agency reviews the proposed affiliation, we encourage you to consider the interests of patients in our region who will directly benefit from this partnership. I view the affiliation of L+M with Yale New Haven Health System as a critically important way to preserve access to services for patients throughout the State. Building upon a long and significant history of collaboration and alignment, we see exceptional value and unique synergies in this partnership.

This affiliation will allow L+M and YNHHS and its affiliated hospitals to continue to manage an extraordinarily complex environment and allow these organizations to deliver exceptional care to the patients in our region. We are confident that a thorough review of this affiliation will reveal the strong benefits of this affiliation and we urge its approval.

Sincerely,

Christopher Rosario
State Representative

Kimberly R. Martone

Director of Operations

Office of Health Care Access

410 Capitol Avenue

MS#13HCA

P.O. Box 340308

Hartford, CT 06134-0308

Dear Ms. Martone:

I am writing to support the proposed affiliation of Lawrence + Memorial Healthcare with the Yale New Haven Health System. I firmly believe that this affiliation will allow both organizations to continue to provide access to high quality care in the most efficient and effective manner possible.

Under the affiliation agreement, YNHHS has committed to invest in the southeastern Connecticut and western Rhode Island region. This investment is built upon the enormous efficiencies that can be generated through this partnership. That is good for L+M. It is good for YNHHS. Most importantly, it is good for patients.

I understand that healthcare is undergoing significant change. I believe these types of innovative solutions to the challenges facing hospitals and healthcare systems are the right course of action. The partnership will provide L+M with enhanced capabilities to manage population health, provide the IT infrastructure to offer seamless care, and feature significant investments in clinical programs in both states.

Thank you for the opportunity to offer my support. I believe this affiliation should be approved.

Sincerely,

Jeffrey A. Klaus

127 Everit Street

New Haven, CT 06511

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, October 16, 2015 9:20 AM
To: Greer, Leslie
Cc: Riggott, Kaila; Ciesones, Ron; Hansted, Kevin
Subject: FW: YNHHSC and L+M Corporation - Support Letter
Attachments: Letter of support For Ms. Blake.pdf; ATT00001.htm

Leslie,

Please add to the original file.

Thank you,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Friday, October 16, 2015 8:54 AM
To: Lazarus, Steven
Cc: Martone, Kim
Subject: YNHHSC and L+M Corporation - Support Letter

Good morning Steve-
Can the attached letter of support be added to the recently submitted CON for YNHHSC and L+M Corporation's affiliation? Do you need me to send via US mail or is an email copy sufficient? Thanks for letting me know.

Karen

Karen M. Banoff, DNP, RN
Principal
203- 459-1601 (office)
203-209-0681 (mobile)

SENATOR GARY WINFIELD
Tenth District

Tel. 860-240-0393
Toll-free 1-800-842-1420
Legislative Office Building
Room 2400
Hartford, Connecticut 06106-1591
www.SenatorWinfield.cga.ct.gov

State of Connecticut
SENATE

Chair
Banking Committee
Housing Committee
Vice Chair
Education Committee
Member
Appropriations Committee
Finance, Revenue & Bonding Committee
Judiciary Committee

Kimberly R. Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Martone:

As an elected official representing New Haven, I am writing to express my strong support for the proposed affiliation of Lawrence + Memorial Health with the Yale New Haven Health System (YNHHS).

I recognize that healthcare is evolving rapidly and that an affiliation between L+M and YNHHS will drive access to high quality healthcare in the most efficient manner possible. As your agency reviews the proposed affiliation, I encourage you to consider the interests of patients in my region who will directly benefit from this partnership.

I view the affiliation of L+M with Yale New Haven Health System as a critically important way to preserve access to services for patients throughout the State. Building upon a long and significant history of collaboration and alignment, I see exceptional value and unique synergies in this partnership.

This affiliation will allow both L+M and YNHHS and its affiliated hospitals to continue to manage an extraordinarily complex environment and allow these organizations to deliver exceptional care to the patients in the our region.

I am confident that a thorough review of this affiliation will reveal the strong benefits of this affiliation and I urge its approval.

Sincerely,

Senator Gary Winfield

THE MOHEGAN TRIBE
MUNDU WIGO

August 7, 2015

Ms. Kimberly R. Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06134

Dear Ms. Martone:

I am writing as Chairman of the Mohegan Tribe of Indians, which owns – among other entities – the Mohegan Sun Casino in Uncasville, and employs more than 6,000 thousand people there. This letter is in strong support of the proposed L+M Healthcare, Inc./Yale New Haven Health System affiliation that will be considered by the Connecticut Office of Health Care Access in the coming months.

Many of our employees receive their healthcare from L+M affiliates – whether it is New London-based Lawrence + Memorial Hospital, Westerly Hospital in Rhode Island, the Visiting Nurse Association of Southeastern Connecticut and/or a physician from Lawrence + Memorial Medical Group. The quality of care our employees and Tribal members receive is unfailingly compassionate and of high quality.

This affiliation would strengthen both organizations clinically, competitively and financially. This – along with Yale's committed capital investment of $300 million over five years - would help strengthen our economy here in eastern Connecticut.

L+M does business with Mohegan Sun, having held two of its annual Spring Galas here – including the hospital's 100th anniversary celebration, which drew a record sit-down crowd of 2,000 people for the event. We proudly hosted L+M's Well Healed Woman in our same Uncas Ballroom in 2014, when more than 1,200 women heard financial advisor Suze Orman speak to eastern Connecticut's largest and longest running women's health conference. We are excited about the 2015 Well Healed Woman conference, which we expect will draw another large crowd to hear this year's keynote speaker, Rebecca Lobo. Additionally, the Mohegan Tribe actively supports L+M philanthropically in a variety of ways, including, but not limited to the use of our arena's Tribal skybox for popular fundraising events.

For these and so many other reasons, I hope you will look favorably on this application. It will benefit both of these quality healthcare providers and – more important – the hundreds of thousands of patients for whom they provide care each year.

Sincerely,

Kevin P. Brown, "Red Eagle"
Chairman

THE MOHEGAN TRIBE
13 Crow Hill Road • Uncasville, CT 06382 • Telephone (860) 862-6100

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, November 06, 2015 3:07 PM
To: nancy.rosenthal@ynnh.org
Cc: Greer, Leslie; Riggott, Kaila; Ciesones, Ron
Subject: Completeness Letter Re: Docket Number 15-32033-CON
Attachments: 15_32033_Compleness Letter One_11_6_15.docx

Good Afternoon Nancy,

Please see the attached Completeness Letter document in the matter of Yale-New Haven Health Services Corporation's acquisition of Lawrence + Memorial Hospital. In responding to the Completeness Letter questions, follow the instructions included in the letter and provide the response document as an attachment to an email only and emailed to OHCA@ct.gov and copied to Ronald.Ciesones@ct.gov and Steven.lazarus@ct.gov. No hard copies are required. If you have any questions regarding the Completeness Letter, please feel free to contact Ronald Ciesones at 860-418-7030 or at Ronald.Ciesones@ct.gov or myself.

Sincerely,

Steven

Ps. Please respond to this email, confirming that you have received this email including the Completeness Letter. Thank you.

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

Ms. Rosenthal:

On October 7, 2015, OHCA received the Certificate of Need application of Lawrence + Memorial Corporation ("L+M") and Yale New Haven Health Services Corporation ("YNHHSC") for the YNHHSC to acquire L+M and its assets. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format at the earliest convenience as an attachment to a responding email.

Repeat each question before providing your response and paginate and date your response, i.e., each page, in its entirety. Information filed after the initial CON application submission (e.g., completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document preceding it. Please begin your submission using **Page 603** and reference "**Docket Number: 15-32033-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date that this request was transmitted. Therefore, please provide your written responses to OHCA no later than **January 5, 2016**, otherwise your application will be automatically considered withdrawn.

1. Is this proposal being submitted due to the provision of the Federal Sherman Antitrust Act and/or Conn. Gen. Stat. §35-24 seq. statutes? Explain in detail.

2. Page 25 states some (but not all) of the benefits related to the proposed affiliation include enhanced access to clinical services, strengthened ability to retain and recruit talent, and access to population health expertise and infrastructure.
    a) Explain what is meant by each of the items listed above.
    b) Provide specific examples.
    c) What is the current status for each of the items discussed?
    d) How will the proposed affiliation be a benefit to each of the items listed above? Please be specific.

3. How does this proposal benefit Lawrence + Memorial Hospital ("L+MH") service area residents? Provide specific examples that would be a direct result of becoming a member of the YNHHSC.

4. Provide a list prioritizing the health issues identified in L+MH's Community Needs Health Assessment ("CHNA") (referenced on pages 32-33 & Exhibit VIII).

5. How will this proposal specifically address the identified health issues identified in the response to question 4 above? Provide specific examples before and after the proposal.

6. Is there or will there be a committee or board that will oversee the CHNA implementation plan to address the priorities? Provide a detailed explanation.

7. How has L+M involved other community providers as partners in the CHNA or in the CHNA implementation plan? Please explain.

8. Detail how this proposal will impact L+MH's negotiating position with vendors and/or payers. If an improved negotiating position is anticipated, quantify the tangible savings for the health of the consumer.

9. Please reconcile the primary service area ("PSA") provided on page 27, with the following table.

L+M Hospital Primary Service Area*: FY 2014

Patient Town	L+M Discharges	Total Discharges	%Share of Town Discharges	%Share of Hospital Discharges	Cumulative % Share of Hospital Discharges
Groton	3,733	4,747	79%	26%	26%
New London	3,019	3,766	80%	21%	48%
Waterford	1,797	2,421	74%	13%	60%
East Lyme	1,291	1,875	69%	9%	70%
Ledyard	911	1,530	60%	6%	76%
Other**	3,404	386,066	1%	24%	100%
Total	**14,155**	**400,405**	4%	100%	

Source: *CT DPH Office of Health Care Access Acute Care Hospital Inpatient Discharge Database*
*Based on top 75% of discharges.
**Includes 90 in and out of state towns that individually account for less than 5% of the hospital's discharges.

10. Describe how this proposal will impact quality of care at L+MH.

11. Provide comment on both YNHHSC and L+MH's performance under the following CMS quality improvement programs. Compare to national, state and local performance standards as well as YNHHSC's current affiliated hospitals (Bridgeport and Greenwich Hospitals) and L+MH's current performance statistics:

    a.) Hospital Inpatient Quality Reporting Program;
    b.) Hospital Outpatient Quality Reporting Program;
    b) Hospital Value-Based Purchasing Program; and
    c) Hospital Readmissions Reduction Program.

12. Describe how this proposal will lower the cost of delivering the health care services at L+MH.

13. How will this proposal impact the diversity of health care providers and patient choice in the geographic region?

14. Regarding the "formation of new models such as accountable care organizations," has either YNHHSC or L+M already established an ACO(s)? If so, provide information on such operational ACOs.

15. What is L+M's current access to and capabilities for "population health expertise and infrastructure?"

16. Identify any significant differences between the L+MH's and the YNHHSC's existing charity care policies. What specific benefits will be realized for L+MH's patient population under the YNHHSC policy vs. the existing L+MH policy?

17. Identify the source of the assumption that some patients "are traveling to more expensive, distant and out-of-state medical centers for their care" as indicated on page 34.

18. Explain how this proposal will specifically allow for the "avoidance of duplication of services between the applicants" as noted on page 36. In addition, explain how this proposal will specifically allow for the "coordination and implementation of clinical programs."

19. What 2015 program initiatives took place in the cardiac, oncology and surgical programs as indicated on page 54 of the application?

20. Please provide additional detail and explain further how the proposal relates to (or is submitted due to the provisions of) the Patient Protection and Affordable Care Act (PPACA).

21. The Applicants state there are no changes planned for L+MH's chargemaster. Will the savings realized from improved position in group purchasing, etc. translate directly to savings for the patients/payers? Please explain.

22. Explain why the net community benefit expense for research is not estimated to increase (p. 60) if Educational and Research Opportunities will improve as a result of the proposal (p. 94).

23. Explain why the Other Community Benefits, such as Community Health Improvement and Subsidized Health Services are not projected to increase if L+M "may dedicate and commit at least $11,000,000 to support community benefit programs and reinvestments (p 95)."

Provide a table with expected expenditures for this money and explain what will happen with this commitment after the 5 year period is over.

24. Will this affiliation end the L+M relationship with Dana-Farber Cancer Institute?

25. Exhibit B to the revised Bylaws for L+M and L+MH, outlines "Direct Authority Retained by YNHHSC, separate from the Actions Requiring Approval of the Member and YNHHSC."

    a) Is this exact same YNHHSC authority set forth in Bridgeport and Greenwich Hospitals' Bylaws?
    b) This exhibit provides control over "major activities." Provide examples of what this would include.

26. Respond to the following questions related to the L+M chart of organization from page 592 of the application:

    a) What do the dotted lines represent between L&M Systems/L&M Home Care and between L&M Home Care and Davita Healthcare of New London?
    b) Why are certain entities, indicated on page 322 as being subsidiaries of either L+M, LMH or one of their immediate subsidiaries, excluded from the organization chart on page 592?
    c) The chart indicates that L&M Systems and Davita Healthcare of New London are the only two for-profit entities affiliated with L+M, while page 322 indicates an additional 4 for-profit entities (L&M Healthcare, L&M Indemnity, LMW Physicians and Southeast CT Health Partners). Please update the chart on page 592 or explain the discrepancies between the chart and page 322 of the application.

27. With respect to YNHHSC's commitment of $300 million, respond to or provide the following:

    a) Is the $300 million amount an all cash commitment or is part of the commitment in some other form?
    b) Will a set portion of the $300 million amount be spent in each of the five years?
    c) What is YNHHSC's expected source of funding for the $300 million?
    d) If Yale-New Haven Hospital experiences an operating loss, will YNHHSC or any affiliated entity need to borrow a portion of the $300 million?
    e) A preliminary capital and operating plan and timeline for the $300 million commitment by YNHHSC.

28. Regarding the $41 million in resources that will be available for updating IT platforms, branding and access to the YNHHSC population health infrastructure, provide the following:

    a) A table that breaks down how the $41 million will be spent with a description of each amount.
    b) A cost comparison of the implementation of Epic by L+M as a stand-alone entity and as a YNHHSC affiliate.
    c) An explanation of the $10 million amount for "value represented by participation in and access to YNHHSC population health infrastructure."

29. Regarding the $215 million in new services to be located at L+M, provide the following information in a table:

    a) Which projects will be given the highest priority over the first three years; and
    b) What are the expected costs of those projects?

30. Regarding the $44 million in resources that will be available to support the new clinical programs and services indicated above, provide a detailed breakdown to show how the $44 million may be spent, using tables if necessary to explain this statement further.

31. Provide a table with estimated cost savings amounts for each of the categories (IT, finance, insurance, equipment and supplies, and other administrative services) expected to realize savings as a result of economies of scale as noted on page 37 for the first three years of the affiliation. Be sure that the amounts agree with the incremental column of Financial Worksheet and if the amounts are not in agreement, explain the differences.

32. Provide the FY 2015 Balance Sheet, Statement of Operations and Statement of Cash Flows for L+MH (which excludes Associated Specialists of Connecticut), L+M and YNHHSC. The internal financials may be provided if audited financials aren't completed at the time responses are submitted.

33. Respond to the following questions regarding the Financial Worksheets on pages 583-585 for L+MH, L+M and YNHHSC:

    a) Update the spreadsheets to include actual results for FY 2015 even if the amounts are internal and unaudited.
    b) Provide a detailed breakdown thoroughly explaining how all of the financial amounts, volume statistics and FTEs were derived, expanding on the assumptions provided on pages 587 and 588. In the response, be specific and also include a narrative to explain the figures provided in the incremental columns, indicating months included for FY 2016 data provided.

c) Explain why Other Deductions remain the same in FY's 2016 – 2019 for all three financial worksheets. Explain why Other Operating Revenue doesn't change in these same years for both L+M and L+MH.
d) How have the volumes, revenues and expenses related to the expected programmatic growth in musculoskeletal, neurosurgery/spine, cardiovascular, general surgery, maternity and children's services noted on page 41 been reflected in the financial projections?
e) How are the "assessed fees" to YNHHSC from L+M Affiliates reflected in the incremental projected expenses?

34. In reference to the Financial Worksheet submitted for L+MH, address the following:

a) Provide a new Financial Worksheet A with amounts for LMH which exclude the activity of Associated Specialists of Connecticut, the medical group consolidated with the Hospital.
b) Explain why there are no incremental amounts provided for Uninsured Net Patient Revenue, Other Operating Revenue, Net Assets Released from Restrictions, Bad Debts-Other, Interest expense, Malpractice, Lease expense and Other Operating Expense.
c) Detail why the amounts for Malpractice Insurance and Lease expense remain the same in FY's 2016 – 2019 without the project.
d) The FTE amounts provided on Financial Worksheet A don't agree with the FTE amounts given on page 588, which provides assumptions. Revise as appropriate and explain why additional FTEs are needed in each of the first 3 years of the proposal and the types of positions they represent.

35. With respect to the Financial Worksheet for L+M, address the following:

a) Provide details of the $72,000 incremental loss in FY 2016.
b) Explain why there are no amounts provided for Uninsured Net Patient Revenue projections, Net Assets Released from Restrictions, Bad Debts-Other and Interest expense.
c) Detail why the amounts for Malpractice Insurance and Lease expense remain the same in FY's 2016 – 2019 without the project.
d) Explain why physician fees decreased from $55 million in FY 2014 to $36 million in FY 2016 and just over $29 million in FY's 2017-2019 without the project.
e) Verify that the amounts in the incremental column exclude any activity related to the integration of NEMG and LMPA or revise the amounts as applicable.

36. In reference to the Financial Worksheet for YNHHSC, address the following:

a) Provide details of the $699,000 incremental loss in FY 2016.
b) Explain why there are no amounts provided for Uninsured Net Patient Revenue projections, Net Assets Released from Restrictions and Bad Debts-Other.
c) Explain why the revenue, expense and FTE amounts in the "Projected Incremental" column do not agree with the amounts shown in the "Projected with CON" column of the L+M Financial Worksheet.
d) Detail why Other Operating Expense decreases from over $285 million in FY 2016 to slightly above $150 million in FY 2019 without the project.
e) Related to the statement on page 45 that "Incremental revenue and expenses are negative values due to the removal of L&MPA which will be merged into NEMG," explain if the incremental column for YNHHSC includes the additional revenue, expenses and FTEs of L&MPA. If the medical group amounts are not part of the YNHHSC amounts, the Financial Worksheet A should be revised.

37. After the affiliation, it is expected that L+M will become part of the YNHHSC Obligated Group. Regarding the obligated group respond to the following:

a) Which YNHHSC entities are currently part of the obligated group?
b) Do the YNHHSC Obligated Group members ever change?
c) Provide further details why YNHHSC would include L+M as part of the System's obligated group considering the increasing operating losses over the last several years for both L+M and the Hospital.
d) Will the Obligated Group attempt to refinance any of L+M's existing long term debt commitments or pension deficiencies? Explain in detail.
e) In FY 2014, YNHHSC changed its corporate structure so that Yale-New Haven Hospital and Bridgeport Hospital are now wholly owned directly by YNHHSC "in connection with the formation of an Obligated Group" (per the system's audited financial statements). Is it intended for this to also occur for L+M in the short term?

38. Regarding the monthly financial reports submitted on page 602, respond to the following:

a) Update the report with data through the year ending September 30, 2015.
b) Provide the Moody's credit rating for L+M and the L+MH.
c) Submit the same document for YNHHSC which also includes all three major credit ratings.

39. What is the basis or the source for the Key Financial Metrics on page 316? Provide the calculation for the Operating Margin and the Days Cash on Hand.

40. Explain what is meant by “L+M is considering adopting retention bonuses for certain select individuals” as noted on page 344, what the expected costs of these bonuses will be and who is expected to receive the bonuses.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

TO: Kevin Hansted, Hearing Officer

FROM: Jewel Mullen, M.D., M.P.H., M.P.A., Commissioner

DATE: December 16, 2015

RE: Certificate of Need Application; Docket Number: 15-32033-CON
Yale New Haven Health Services Corporation and Lawrence + Memorial Corp.
Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation.

I hereby designate you to sit as a hearing officer in the above-captioned matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, January 05, 2016 9:05 AM
To: Greer, Leslie
Cc: Riggott, Kaila; Ciesones, Ron; Roberts, Karen; Greci, Laurie
Subject: FW: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA
Attachments: NEMG - LMPA Completeness Questions_01 05 16_FINAL w attachments.pdf; NEMG - LMPA Completeness Questions_01 05 16_FINAL.doc; NEMG- L&MPA completeness signed cover letter.pdf; YNHHSC - L+M Completeness Questions_01 05 16 FINAL w attachments.pdf; YNHHSC - L+M Completeness Questions_01 05 16 FINAL.docx; YNHHSC and L+MCompleteness Signed cover letter.pdf

Leslie,

Please add to the original files.

Thank you,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Tuesday, January 05, 2016 7:41 AM
To: Martone, Kim
Cc: Lazarus, Steven; Greci, Laurie
Subject: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Good morning and Happy New Year Kim-

As per OHCA's completeness letter, I am sending responses to the completeness questions for the above referenced dockets via email. As requested, an Adobe Acrobat and MS Word File is included for each. A cover letter pertaining to each application is also included.

I would appreciate receiving an email confirmation that the documents have been received.

Thank you for your time and attention to this matter.

Sincerely, Karen

Karen M. Banoff, DNP, RN
Principal
203- 459-1601 (office)
203-209-0681 (mobile)

YALE NEW HAVEN HEALTH

January 5, 2016

Ms. Kimberly Martone
Director of Operations
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation (DN: 15-32033-CON)

Dear Ms. Martone:

Please find attached to this email communication, an MS Word and Adobe Acrobat file containing the responses to the completeness questions posed by the Office of Healthcare Access on November 9, 2015.

We appreciate OHCA's time and effort related to this critically important proposal. Please feel free to contact me at (203) 688-5721 with any questions.

Sincerely,

Nancy Rosenthal

Nancy Rosenthal
Vice President, Strategy and Regulatory Planning

Copy to Steven Lazarus

Enclosures

789 Howard Avenue
New Haven, CT 06519

Yale-New Haven Health Services Corporation
Lawrence + Memorial Corporation

Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation
Docket Number: 15-32033-CON

Responses to Completeness Questions

January 5, 2016

Please note that the applicant, Yale-New Haven Health Services Corporation, is the parent entity of a network of integrated health care providers and related service providers, known collectively as Yale New Haven Health System (YNHHS). Responses to completeness questions will reference YNHHS when referring to entities and providers.

1. Is this proposal being submitted due to the provision of the Federal Sherman Antitrust Act and/or Conn. Gen. Stat. §35-24 seq. statutes? Explain in detail.

   Response
   This proposal is not being submitted due to the provision of the Federal Sherman Antitrust Act and/or Conn. Gen. Stat §35-24 seq. statutes. As explained in the response to question 3a of the initial Supplemental Certificate of Need (CON) Application, the proposed affiliation CON is being submitted in accordance with OHCA's CON requirements; however, the parties also intend to comply with all applicable federal and state antitrust laws and regulations. The transaction did require a Hart-Scott-Rodino filing with the Federal Trade Commission under 18 USC S. 18a, however, and that filing was made on August 7, 2015. The Connecticut Attorney General also received a courtesy copy of that filing on August 10, 2015. On September 8, 2015, the FTC informed Yale-New Haven Health Services Corporation (YNHHSC) and Lawrence + Memorial Corporation (L+M) that it would allow the waiting period outlined by the Hart-Scott-Rodino Antitrust Improvements Act to expire without further investigating the transaction.

2. Page 25 states some (but not all) of the benefits related to the proposed affiliation include enhanced access to clinical services, strengthened ability to retain and recruit talent, and access to population health expertise and infrastructure.

   a) Explain what is meant by each of the items listed above.

      Response
      Enhanced access to clinical services
      YNHHS is able to provide affiliated organizations with access to highly sophisticated clinical services and physicians through Yale New Haven Hospital (YNHH), the Yale Medical Group (YMG) and Northeast Medical Group (NEMG). As an affiliate of YNHHS, L+M will join a Health System with a reputation for clinical advances and cutting edge medicine. If approved, YNHHS will make investments in bolstering services in the areas of primary care; orthopedics; oncology; obstetrics; maternal-fetal medicine; vascular; neurology/stroke; bariatrics; and physiatry. The specific investments will be determined on further assessment of need and strategic planning processes to follow. Notwithstanding, and by way of example, it is expected that YNHHS will bring new therapeutic services to L+M's service area such as infusions for neurology, electrophysiology services along with enhanced women's health services.

Strengthened ability to retain and recruit talent

YNHHS brings the depth and breadth of clinical and administrative support that is unrivaled in the region. To address clinical recruitment and retention needs at L+M, YNHHS will work directly through NEMG and YMG to fill existing gaps or vacancies on a part-time or full-time basis. Although a majority of these gaps relate to clinicians, it has been YNHHS's experience that many executives, managers and staff are attracted to working for large academic health systems. Accordingly, the Applicants believe that the proposed affiliation will enhance recruitment of executives, managers and staff.

Unmet physician specialty service demand, in some instances, can be met with providers affiliated with NEMG or YMG who will practice in the L+M service area on a part-time (1-2x per week) basis. Other times a more permanent solution is required through recruitment into the area. Regardless of the need, YNHHS has made a significant investment in the infrastructure of NEMG, including persons dedicated to physician recruitment. The largest growth area for the YNHHS physician network has been primary care and that will continue to play a major role in the future. Additionally, providers from the L+M service area will be able to participate in YNHHS initiatives and develop experience in areas such as population health management, as a broad network of clinically integrated programs and services is developed.

YMG is focused on providing specialists to expand access to acute care and ambulatory services. Working in collaboration with NEMG and YMG, L+M can identify any additional clinical needs, and develop a recruitment plan specifically targeted to meet those needs.

Population health expertise and infrastructure

YNHHS has access to population health management expertise and infrastructure to proactively manage the care of defined populations of patients to improve health outcomes, to improve the experience of care, and to reduce health care costs. These processes include coordination of care across a continuum of settings, and clinical care transformation through the adoption of shared evidence-based best practices across providers to reduce unnecessary variation and waste. To be effective, these processes require the technology and infrastructure to support sharing patient information, analytics capabilities to identify patients and populations with the greatest need for care coordination, and multiple points of entry for patients to access the care and services they need.

YNHHS has been and continues to develop these resources over the past several years. This affiliation will provide greater access to the population health expertise and infrastructure noted above, which will expand the ability of YNHHS and L+M to proactively manage the care of a larger population, to improve outcomes and patient experience, while reducing the cost of care by providing access to the right type of care, in the most appropriate setting.

b) Provide specific examples.

Response

Enhanced access to clinical services

Please refer to the response to question 2(a). Patients who require subspecialty services (currently not available at L+M) will be better served after the affiliation with YNHHS because these services will be offered in a more coordinated, seamless and timely manner, within one coordinated and connected health system. Examples of subspecialty services not currently available at L+M that will be brought to the service area by YNHHS include: minimally invasive gastrointestinal surgery, bariatric surgery, thoracic surgery, surgical oncology, medical oncology, endocrinology/bone specialist, and neurosurgery. Please refer to the response to question 29(a) for additional clinical services that may be added to the L+M service area after being evaluated through a strategic planning process.

As an example of the ability to expand access to clinical services in the L+M service area, in January 2015, YMG and YNHH executed an agreement to introduce a new pediatric hospitalist program at L+MH. This resulted in a reduction of 11 patient transports from the L+MH's Emergency Department to Yale New Haven Children's Hospital in the first month of operation.

Strengthened ability to retain and recruit talent

Please refer to the response to question 2(a). YNHHS brings financial stability, potential career paths, and recruiting resources to attract physicians to the area. With this affiliation, there are also opportunities to share subspecialist physicians between New Haven and New London if there is insufficient patient demand in the L+M service area.

If the proposed affiliation is approved, L+M believes that it will be more successful in attracting physicians who want to practice as part of a nationally recognized academic medical center and innovative healthcare system.

Population health expertise and infrastructure

YNHHS currently has the care management and technology infrastructure that allows its affiliated providers to connect on a shared platform to; (i) advance consistent clinical practice processes (e.g., currently focused on diabetes, cardiovascular disease, asthma, COPD, advanced and education care planning, transitions of care and geriatric care); (ii) promote patient management through medical homes and patient outreach/education; (iii) assist patients in navigating their healthcare needs to prevent avoidable hospitalizations and achieve improved outcomes; (iv) provide specialty telehealth services to L+M patients regardless of their location, and (v) provide data analytics for risk stratification, and quality metric reporting. All of these capabilities are currently in place, and will be available to L+M within the year should the proposed affiliation be approved. As

evidence of the effectiveness of these capabilities, YNHHS has reduced emergency room visits of its employees by 13% in one year and has experienced $8.7 million in savings in healthcare costs using these tools.

c) What is the current status for each of the items discussed?

Response
All items discussed currently exist within YNHHS. Please refer to the response to question 2(a) and 2(b).

d) How will the proposed affiliation be a benefit to each of the items listed above? Please be specific.

Response
See above 2(a) and (b). The capital required to accomplish all of the above objectives is significant and difficult for community hospitals to afford on their own. However, if the capital costs are spread across a system, the capital expense associated with the establishment of the necessary infrastructure is more manageable. Patients within L+M's service area deserve access to the same world class clinicians as patients who utilize YNHHS's facilities.

3. How does this proposal benefit Lawrence + Memorial Hospital ("L+MH") service area residents? Provide specific examples that would be a direct result of becoming a member of the YNHHSC.

Response
Residents of the L+M service area will benefit in the following ways:

- The enhanced financial stability of L+M will preserve health care access for L+M service area residents.
- Access to valuable administrative and clinical expertise will further enhance L+M operations and potentially preserve existing clinical programs that might otherwise need to be reduced or terminated.
- Access to more primary care physicians and specialists (e.g., invasive gastrointestinal surgery, bariatric surgery, neurology, thoracic surgery, surgical oncology, and medical oncology). NEMG and YMG are both very effective in attracting the best and brightest physicians.
- Improved care coordination, reducing unnecessary overutilization and hospitalizations through the YNHHS's population health infrastructure.
- Standardized protocols have been developed based on evidence-based best practices and data sharing occurs with all YNHHS hospitals to help achieve excellent patient outcomes.

4. Provide a list prioritizing the health issues identified in L+MH's Community Needs Health Assessment ("CHNA") (referenced on pages 32-33 and Exhibit VIII).

Response

In 2013[1], L+M's CHNA identified the following issues that were prioritized:

- Prevalent chronic conditions including heart disease, diabetes, and obesity
- Access to Care
- Cancer
- Sexual Health
- Mental and Behavioral Health
- Asthma

5. How will this proposal specifically address the identified health issues identified in the response to question 4 above? Provide specific examples before and after the proposal.

Response

Specific examples as to how L+M has (before the proposal) addressed the identified health issues as listed in response to question 4 are summarized below.

Prevalent chronic conditions including heart disease, diabetes, and obesity

Pediatric Weight Management Program (Kidz Fit Club)

The program employs an integrated and multi-disciplinary approach to engaging children in positive, entertaining ways by addressing the complex components of obesity, including poor nutrition, lack of exercise, and psychological factors such as low self-esteem. The program underscores the necessity of educating family members and enlisting their support and participation. Children are encouraged to bring relatives and peers to the sessions that provide coordinated instruction on diet, nutrition, and exercise. Program staff offer personalized individual and group support for the entire family as well as extended follow-up support upon request.

Walk with a Doc

In collaboration with area Parks and Recreation Departments, this program provides an opportunity for area residents to hear a short talk by a physician, to have their blood pressure checked, and then walk a short course. "Walk with a Doc" creates another physical activity and community partnership option while incorporating an educational component.

Access to Care

Dispensary of Hope Project

The Dispensary of Hope works with healthcare providers, clinics, and pharmaceutical companies nationwide to provide low-income and at-risk patients with needed medications at no cost to the patient. This is accomplished largely by distributing unused sample medications or medications which are nearing their expiration date to qualifying individuals without prescription coverage.

[1] The next CHNA is currently underway.

Cancer

CT Early Detection and Prevention Program

This program delivers integrated early detection and health screening services including breast and cervical cancer for women ages 21-64, with a focus on women rarely or never screened. Services are targeted to persons who are at or below 250% of the Federal Poverty Level, are uninsured or underinsured. The program, funded by the State of Connecticut Department of Public Health, was established to support greater community involvement and efficiency in cancer screenings and diagnostics and cardiovascular risk reduction.

Head and Neck Cancer Community Screenings

Free cancer screenings to promote education and awareness are organized through the Head and Neck Cancer Alliance. Participants receive a screening and education on risk factors.

Lung Cancer Screening

Based on smoking history, eligible patients may be screened for lung cancer using low-dose CT scan technology. This method has proven highly effective in detecting cancers in asymptomatic individuals.

Colorectal Cancer Screening Outreach

The L+M Cancer Center is engaged in a partnership with the Visiting Nurse Association of SE CT to distribute home testing kits through senior housing, health centers and other community locations.

Sexual Health

Community Partnerships

Due to significant efforts to address sexual health issues by other community providers and agencies, particularly sexually transmitted diseases and reducing teen births, L+MH's involvement is one of support through the provision of in-kind advisory staff.

Mental and Behavioral Health

Reconnecting the Homeless Program

L+MH's Reconnecting the Homeless Program (RHP) has reduced the utilization of emergency department services and dramatically improved the health status of some of the community's most vulnerable individuals by enrolling them in entitlement programs, connecting them to housing, health care, and social services and ultimately bringing greater stability to their lives. In partnership with many community agencies including, the Homeless Hospitality Center in New London, RHP provides a coordinated system of care for homeless individuals in the area. The RHP is managed by a full-time social worker, who is bi-lingual in Spanish and works primarily in the emergency department where she connects exclusively with homeless individuals or those at-risk for homelessness. The program also brings employment opportunities to clients as appropriate.

Asthma

100 Day Rapid Results Intervention on Asthma

Following a Rapid Results methodology, a collaborative team at L+M addressed gaps in optimal asthma control among a subset of students at an urban elementary school. Impetus for the program was the persistent health concern in southeastern Connecticut of asthma and

its impact on quality of life and use of healthcare services. Too many children and adults have poorly managed asthma resulting in missed days of school and work, high use of acute health care services, and a degraded quality of life. Children and adults with asthma, and their caregivers, possess gaps in knowledge around environmental triggers, asthma symptoms, and medication/inhaler/spacer use. The team takes a population-centered approach, including education and intensive case management to improve asthma control, and reduce school absences.

After the proposal, YNHHS agrees to sustain L+M's current commitment to community benefit programs (see Section 2.3 of the Affiliation Agreement at page 95 of the CON Application). Noted below are examples of YNHHS's efforts in similar areas. Following completion of L+M's next CHNA in 2016, programs and initiatives will be developed to address the priority health needs. As part of YNHHS, L+M will benefit from learning about other best practices which may help address and improve the health of L+M's community.

Listed below are examples of YNHHS's work in similar areas and possible future strategies after the close of the affiliation.

- Prevalent chronic conditions including heart disease, diabetes, and obesity
    - *Get Healthy CT:* YNHHSC and its partners have created a community coalition to reduce obesity and chronic disease by enhancing access to healthy affordable foods and easy ways to be physically active called Get Healthy CT.
    - *Employee Wellness:* Employee wellness programs play an important role in the YNHHS health improvement plans. "Know Your Numbers" is an annual YNHHS system-wide employee wellness program to help employees heighten their health awareness. This includes a health screening that provides key health measurements – blood pressure, cholesterol, triglycerides and blood glucose; height, weight, and body mass index (BMI); and waist hip circumference (a pre-Diabetes indicator).
- Access
    - *Project Access:* YNHH provides ongoing financial and in-kind support for Project Access-New Haven (PA-NH), which provides timely high quality specialty care for uninsured individuals who reside in the Greater New Haven area with the use of an intensive patient navigation model.
- Cancer
    - *Cancer Screening, Detection & Prevention Programs*: Smilow Cancer Center offers many screening, education, cancer detection and prevention programs to the community.
    - *Smilow Cancer Center- Closer to Free:* Local residents are encouraged to participate in the hugely successful "Closer to Free" cancer awareness bike ride that takes place every year.
- Mental Health
    - *Community Care Teams:* YNHHS's hospitals and their community partners have created Community Care Teams to perform community-wide case management for patients with mental health issues who are high emergency department utilizers.

- Asthma
    - *Clinical Integration Program*: YNHHS's Population Health Department has developed a Clinical Integration Program, which includes a pulmonary workgroup dedicated to COPD and Asthma (as well as workgroups dedicated to Diabetes and Heart Disease). This multidisciplinary workgroup is working collaboratively to develop a disease registry, clinical practice guidelines, and a core panel of quality metrics.

6. Is there or will there be a committee or board that will oversee the CHNA implementation plan to address the priorities? Provide a detailed explanation.

Response

The Board of Directors for L+MH oversees L+MH's role in the CHNA implementation plan. This will remain unchanged after the proposed affiliation and YNHHS is available to offer assistance with planning, sharing best practices and data analysis.

The L+MH's community health improvement partnership (CHIP) was developed by teams specific to each of the prioritized community health needs. Teams included subject matter experts, both internal and external to L+MH, and represented diverse perspectives and areas of intervention. Following completion of the 2016 CHNA, the development of the CHIP will follow a similar process but will be overseen and coordinated by the Southeastern CT Health Improvement Collaborative (the Collaborative) and chaired by L+MH and Ledge Light Health District, the local public health agency. The Collaborative has been convened to engage in the planning and implementation of the current CHNA process. A listing of participating individuals and their organizations is included in Attachment I.

The Collaborative has actively participated in outreach efforts for the WellBeing Survey as led by DataHaven, with whom L+M has partnered for collection of primary data in its service area. The Collaborative has also created supplemental primary data gathering strategies in order to reach constituencies that may be under-represented in the DataHaven Survey. Once all data are collected and analyzed, the Collaborative will engage in a prioritization process and will lead the planning toward development of the CHIP. Issue-specific sub-committees will develop strategies to address identified priorities ultimately contributing to the CHIP, the product being a community plan, not simply a plan for a single organization in isolation. Strategies will align with the State of CT Health Improvement Plan with a focus on the social determinants of health and health equity. All of these initiatives will continue should the proposed affiliation be approved by OHCA.

7. How has L+M involved other community providers as partners in the CHNA or in the CHNA implementation plan? Please explain.

Response

Please refer to the response to question #6.

8. Detail how this proposal will impact L+MH's negotiating position with vendors and/or payers. If an improved negotiating position is anticipated, quantify the tangible savings for the health of the consumer.

Response

With regard to payers, and as stated in response to question 4(f) of the Supplemental CON Application Form, there are no anticipated changes to existing payer contracts as a result of this proposal. YNHHS negotiates separate hospital payer agreements for each of its hospitals.

As stated in the response to question 4(m) in the Supplement of the original CON submission, it is expected that YNHHS's supply chain management department will be able to obtain volume discounts and reduce supply and other costs for L+M overall.

Any savings associated with supply chain savings will improve the health of the consumer via continuation of health care services in the L+M service area, and investment in developing clinical programs in the region. YNHHSC and L+M believe that the affiliation, which will achieve a variety of benefits for L+M, will permit its continued operation and the continued provision of necessary health care services to residents of the L+M service area. Moreover, to the extent specialty services are more accessible on a local level; patients from L+M's service area will not have to incur the cost of traveling to distant locations for specialty care. In addition to the challenges associated with health care reform, reimbursement reductions, particularly those from the State of Connecticut, have led hospitals such as L+MH to look to larger health systems for cost efficiencies and service enhancements in order to remain viable. L+MH is facing a projected FY 2016 operating budget loss of $9 million due to the state hospital tax and rescinded supplemental Medicaid payments. The proposed affiliation will help L+M address this loss through growth and cost savings initiatives associated with the affiliation.

9. Please reconcile the primary service area ("PSA") provided on page 27, with the following table.

L+M Hospital Primary Service Area*: FY 2014

Patient Town	L+M Discharges	Total Discharges	%Share of Town Discharges	%Share of Hospital Discharges	Cumulative % Share of Hospital Discharges
Groton	3,733	4,747	79%	26%	26%
New London	3,019	3,766	80%	21%	48%
Waterford	1,797	2,421	74%	13%	60%
East Lyme	1,291	1,875	69%	9%	70%
Ledyard	911	1,530	60%	6%	76%
Other**	3,404	386,066	1%	24%	100%
Total	**14,155**	**400,405**	4%	100%	

Source: *CT DPH Office of Health Care Access Acute Care Hospital Inpatient Discharge Database*
*Based on top 75% of discharges.
**Includes 90 in and out of state towns that individually account for less than 5% of the hospital's discharges.

Response

Page 27 of the original CON submission contains the service area for L+M, including Westerly Hospital. The table noted above by OHCA pertains to L+MH only and therefore will not be consistent with Page 27. It should be noted, however, that L+MH defines its PSA service area using two methodologies. For physician recruitment and other requirements, L+MH defines its PSA as the lowest number of continuous zip codes or towns from which the hospital draws 75% of its inpatients (reflected above in the table provided by OHCA). However, for service line marketing and planning purposes, L+MH takes a more regional approach to its PSA service area definition. This regional strategy is best reflected in L+MH's community health needs assessments, which considers the broader market outlined on page 28 of the original CON application. As one of only two acute care providers in New London County, L+MH believes that a more expansive service area definition enables the organization to better identify community needs, strategize site of service placements, and plan for programmatic initiatives that meet the health care requirements of all residents of southeastern Connecticut.

An error was noted in Table 2 in the original CON submission and has been revised as noted below.

TABLE 2 (Revised)
SERVICE AREA TOWNS

List the official name of town* and provide the reason for inclusion.

Town*	Reason for Inclusion
Primary Service Area includes: East Lyme, CT Groton, CT Ledyard, CT Lyme, CT Montville, CT New London, CT North Stonington, CT Old Lyme, CT Stonington, CT Waterford, CT Secondary Service Area includes: Bozrah, CT Colchester, CT Franklin, CT Griswold+Lisbon, CT Norwich, CT Old Saybrook, CT Preston, CT Salem, CT Voluntown, CT Westerly, RI	For towns of East Lyme, Groton, Ledyard, New London, and Waterford, the basis for inclusion of these towns is that L+M currently services this town to fulfill its mission in serving the community's healthcare needs, these towns are part of the service area that L+M has represented to OHCA for years during the CON process, and these towns collectively fit the definition of "Primary Service Area" as set forth in the Statewide Facilities and Services Report published in 2012 ("that geographic area (by town), for the service location in the application, consisting of the lowest number of contiguous zip codes from which the applicant draws at least 75% of its patients for this service at such location"). For remaining towns, the basis for inclusion is that L+M currently services these towns to fulfill its mission in serving the community's healthcare needs and these towns are part of the service area that L+M has represented to OHCA for years during the CON process.

* Village or place names are not acceptable.

10. Describe how this proposal will impact quality of care at L+MH.

Response

Please see the responses to Questions 2 and 3. The Applicants strongly believe that the proposed affiliation will positively impact the quality of care delivered to residents of L+M's service area long into the future. Although L+MH has a long history of providing high quality care to its patients, the proposed affiliation is expected to offer additional resources, and clinical expertise to ensure high quality services are available in these financially challenging times. More specifically, the proposed affiliation will also ensure that certain infrastructure investments are implemented to maintain and improve the facilities. With greater access to locally available specialists and cutting-edge clinical developments such as an electronically monitored intensive care units, and evidence-based best practices, L+M will be able to offer the patients in its service area more sophisticated care due to its association with YNHHS and its physicians.

11. Provide comment on both YNHHSC and L+MH's performance under the following CMS quality improvement programs. Compare to national, state and local performance standards as well as YNHHSC's current affiliated hospitals (Bridgeport and Greenwich Hospitals) and L+MH's current performance statistics:

    a.) Hospital Inpatient Quality Reporting Program;
    b.) Hospital Outpatient Quality Reporting Program;
    c.) Hospital Value-Based Purchasing Program; and
    d.) Hospital Readmissions Reduction Program.

Response

Performance in CMS quality improvement programs is measured at the individual hospital level. Bridgeport Hospital (BH), Greenwich Hospital (GH) and L+MH generally have performed well in comparison to national and state averages. CMS does not provide local data, only state and national averages. Recent results for each of the programs above have been reviewed and a summary of GH, BH and L+MH's performance is provided in Attachment II.

Copies of the most recent reports from CMS for the first three programs listed above are also included in Attachment III.

12. Describe how this proposal will lower the cost of delivering the health care services at L+MH.

Response

It is important to acknowledge that health care costs are likely to continue to increase statewide with the aging population, more people with chronic health conditions, and new technology and medications. However, the Applicants believe that the proposed affiliation will contribute to slowing the trend of increasing health care costs. Slowing this trend is

essential to the future survival of health care organizations. Medicaid reimbursement covers only a portion of every dollar of cost and along with the state hospital tax, L+M will not be able to sustain its services without reductions in costs wherever possible.

The proposed affiliation will allow L+M and its physicians to participate in more shared savings arrangements. For example, NEMG physicians have been successful in meeting shared savings targets in risk contracts with several payors. These savings were generated as a result of NEMG's population health management infrastructure. Systems are in place to provide physicians with critical data on health care utilization, patients at risk for hospitalization or readmission, and best practices to manage chronic health conditions. All of these efforts help to avoid unnecessary health care services or interventions which increase costs.

With this affiliation, L+M will be positioned to access the necessary performance tools needed to perform in an environment that requires access to data, seamless care coordination and volume based discounts for supply chain management.

13. How will this proposal impact the diversity of health care providers and patient choice in the geographic region?

Response

The proposal will not hinder diversity or patient choice, but may in fact enhance the diversity of providers and patient choice by introducing more specialists in areas of need into the L+M service area. Currently, the geographic region is and will continue to be served by two acute care hospitals (L+MH and Backus Hospital, an affiliate of Hartford HealthCare), various outpatient satellite locations, and by a multitude of physicians employed by L&MPA, NEMG, or in private practice as part of a physician group unaffiliated with L&MPA or YNHHS (please refer to Attachment IV for a listing of physicians currently practicing in the community).

14. Regarding the "formation of new models such as accountable care organizations," has either YNHHSC or L+M already established an ACO(s)? If so, provide information on such operational ACOs.

Response

L+M has not established an ACO because it lacks the scale, experience, and resources needed to invest in developing sophisticated clinical integration expertise and patient management tools. YNHHSC, through its physician foundation, NEMG, has a Medicare Shared Savings Program ACO. This program has been in place since January 2015 and includes approximately 23,600 covered lives. NEMG also has a number of shared savings agreements in place with commercial payers for commercially insured and Medicare Advantage plans. These are not formally labeled "ACOs" but the principles are basically the same. Some of these plans have been in place since 2013 with more added in 2014 and 2015 and include approximately 69,000 covered lives.

Success achieved to date by NEMG through its participation in shared savings contracts is summarized in the table below.

Metric	% Improvement	Measurement Period
All Cause Readmission Rate	2.4% Decrease in Readmissions Rate	CYTD through June 30, 2015 vs. CY2014
ED Utilization	3.6% Decrease in ED Utilization	CYTD through June 30, 2015 vs. CY2014
Acute ALOS	25% Decrease in Acute ALOS	CYTD through June 30, 2015 vs. CY2014
Breast Cancer Screening	2% Increase	CYTD through June 30, 2015 vs. CY2014

In addition, NEMG has demonstrated over $4 million in savings in one of the commercial shared savings contracts.

Further, YNHHS is a founding member of Total Health. Total Health is a Connecticut-based network of physicians, hospitals and other providers working together to improve value in healthcare. Total Health seeks to recognize high-value care, efficiency, effective coordination of care with other providers and improved patient outcomes. Total Health is a voluntary and non-exclusive provider network with physician-driven governance. Total Health members benefit from a state-wide provider network for coverage and access, availability of all levels of care, including tertiary and quaternary, extensive primary care representation, adoption of clinical standards to enhance patient care and outcomes while reducing costs, and access to a state-of-the-art data repository, data analytics and a care management platform with a successful track record for population health management (Conifer Value-Based Care Suite).

15. What is L+M's current access to and capabilities for "population health expertise and infrastructure?"

Response

Currently, L+M has extremely limited access to and capabilities for "population health expertise and infrastructure." There are a few care coordinator/navigators positions in place. L&MPA's primary care offices have obtained recognition by NCQA as Patient Centered Medical Homes. However, none of the extensive infrastructure that is required to be successful in population health is in place, nor could L+M afford to purchase what is required.

16. Identify any significant differences between the L+MH's and the YNHHSC's existing charity care policies. What specific benefits will be realized for L+MH's patient population under the YNHHSC policy vs. the existing L+MH policy?

Response
A review of L+MH's and YNHHS existing charity care policies was undertaken. Both policies provide a significant amount of financial assistance.

Differences between the policies are noted below:

	YNHHS Policy	L+MH's Policy
Sliding scale cap	None	400% federal poverty guidelines
Requests for Assistance – time limit	None	2 years after date of service
Payroll stub requirement	2; also allow patients and/or employer to provide written verification of income	3; only employer can provide written verification of income
Period of free care eligibility	6 months plus discounted care eligibility for 1 year	6 months
Monthly payment plan – # months and minimum payment amount	48 months; $50 minimum payment	18 months; $25 minimum payment
Asset test requirement	No	Yes

If the affiliation is approved, L+MH would adopt the YNHHS financial assistance policy (over time). L+MH's patient population also will have, by way of example, access to the additional benefits listed below:

- Patients who qualify for a partial charity care adjustment who may have been required to leave a deposit equivalent to 20% of charges will no longer have to do so; and
- Self pay patients who previously received a 25% discount if payment was made within 30 days will now receive a 55% discount at the time of the first bill; regardless of when/if payment is made.

17. Identify the source of the assumption that some patients "are traveling to more expensive, distant and out-of-state medical centers for their care" as indicated on page 34.

Response
A review of inpatient market data from the Connecticut Hospital Association (CHA), State of Massachusetts, Rhode Island Department of Health (RI DOH), and the New York's Statewide Planning and Research Cooperative System (SPARCS) revealed that there were 1,931 discharges from L+MH's Connecticut service area towns that were attributed to hospitals in Rhode Island, Massachusetts and New York (see the table below).

Outmigration from L&M Hospital CT PSA/SSA Towns to Hospitals in RI, MA, & NY	NY FY14, RI FY14, MA FY13
Massachusetts Hospitals	349
New York Hospitals	153
Rhode Island Hospitals	1429
TOTAL	**1931**

Approximately 50% of these discharges were from Westerly Hospital, which is part of L+M. However, there were still more than 350 discharges from hospitals in Massachusetts and New York Hospitals, the majority of which are large academic hospitals (shaded pink), as shown in the table below.

Outmigration from L&M Hospital CT PSA/SSA Towns to Hospitals in MA, & NY	NY FY14, MA FY13
Brigham and Women's (Boston, MA)	88
Massachusetts General Hospital (Boston, MA)	72
Boston Children's Hospital (Boston, MA)	44
Beth Israel Deaconess Medical Center (Boston, MA)	29
Hospital for Special Surgery (New York City, NY)	24
Memorial Sloan-Kettering (New York City, NY)	23
UMass Memorial Medical Center (Worcester, MA)	21
NYP-Columbia (New York City, NY)	15
Lahey Clinic-Burlington (Burlington, MA)	14
NYP-Cornell (New York City, NY)	12
Tufts Medical Center (Boston, MA)	8
Mount Sinai Medical Center (New York City, NY)	8
Subtotal	**358**

The Applicants believe that with YNHHS's clinical and programmatic support, a significant portion of this outmigration can be reversed. As an efficient, low-cost provider, patients stand to benefit from receiving their care locally whenever possible. As outlined in the original CON application, and other sections of this response, a key intent of the L+M affiliation with YNHHSC is to bolster health care resources to allow residents to stay local to their community hospital, thus reducing the need for patients to seek care at higher cost institutions both in- and out-of-state.

18. Explain how this proposal will specifically allow for the "avoidance of duplication of services between the applicants" as noted on page 36. In addition, explain how this proposal will specifically allow for the "coordination and implementation of clinical programs."

Response

As has been described throughout the CON application and responses to several completeness questions, obtaining the majority of routine health care locally is the most convenient, preferred, and cost-effective option for residents of L+M's service area.

YNHHS will provide specialty providers in the local L+M service area to improve access to these services for L+M patients. Tertiary and quaternary procedures and treatments that may be required will likely not be offered locally and in these cases patients will have to travel. But, for more routine care and access to specialty physician consultations and follow-up care, the affiliation will facilitate the local establishment of specialty providers.

This proposal will allow for the coordination and implementation of clinical programs via a strategic planning process that will be the responsibility of both local (L+M) and YNHHS system-wide leadership to ensure that community needs are being met in the most cost effective way. This process will begin following the close of the affiliation where specific programs and services will be identified for implementation. Most importantly, through enhanced care coordination, patients within the YNHHS will not undergo duplicate diagnostic testing and have medically unnecessary procedures because of lack of care coordination and access to real time patient information. This proposal will allow leadership from both organizations to coordinate and implement clinical programs by fully understanding the strengths and needs of both organizations and the community to improve healthcare in the region.

19. What 2015 program initiatives took place in the cardiac, oncology and surgical programs as indicated on page 54 of the application?

Response

With respect to cardiac services, L&MPA had an unanticipated loss of a key cardiologist who performed electrophysiology (EP) procedures at L+MH. In order to maintain local access and continuity of care for service area residents, L+MH and L&MPA contracted with YMG to provide local, part-time coverage of EP services with fellowship-trained YMG EP physicians. L+MH and YNHHS share a long history of collaboration in the heart and vascular arena, dating back to the approval of L+MH's emergent angioplasty program in 2005. This new initiative builds upon an already collaborative partnership and utilizes YNHHS's strong physician base to meet the needs of the local community.

Supplemental to cardiac services, but within the surgical service line has been an investment in the expansion and enhancement of peripheral vascular procedures (open and endovascular) locally through a clinical partnership with YNHHS and YMG to retain patients locally. Market demand in the L+MH service area for these vascular services is not high enough to justify a full-time physician. Therefore, in this partnership, YMG physicians provide services to the L+M service area on a part-time basis so residents can stay local and not have to travel to New Haven or other locations for procedural and follow-up care.

Lastly, L+MH's most recent Community Health Needs Assessment (CNHA), which can be found in Attachment VIII of the original CON submission, highlights oncology and breast cancer specifically as significant health issues due to higher incidence and mortality rates compared to statewide and national statistics. To address this area, L+MH and its key clinical stakeholders have worked to improve assessment, coordination and preventative care for breast cancer and high-risk patients. These efforts culminated in the accreditation of

L+MH's breast health program by the National Accreditation Program for Breast Centers (NAPBC) in December 2014. Through this programmatic investment, L+MH patients can choose to stay in the local community for their oncologic and surgical care.

20. Please provide additional detail and explain further how the proposal relates to (or is submitted due to the provisions of) the Patient Protection and Affordable Care Act (PPACA).

Response

The United States' health care industry has been transforming at an accelerated pace, especially since the enactment of the PPACA. With greater emphasis and demand for improved outcomes along with lower levels of reimbursement, community hospitals typically do not have access to the necessary resources and capital to meet the challenges of health care reform. More specifically, with an increased emphasis on payment being linked to performance, providers must have the infrastructure (i.e., information systems, data analytics, care management tools, and disease management expertise) to achieve improved outcomes with less reimbursement. In addition, providers are being asked to assume some or all of the financial risk for the health care needs of their patients. To successfully manage such risk, providers must invest in comprehensive integrated provider networks, sophisticated technology and patient care protocols to manage patient populations. L+MH will benefit by being part of YNHHS's larger system so that, in association with pay for performance, the cost and risk can be spread across the system.

The proposed affiliation with YNHHS will provide L+MH with this necessary infrastructure and support, in terms of technology, human resource expertise and clinical care processes, to succeed in the new health care payment models of today and those expected in the near future. In this way, the proposal relates to PPACA.

21. The Applicants state there are no changes planned for L+MH's chargemaster. Will the savings realized from improved position in group purchasing, etc. translate directly to savings for the patients/payers? Please explain.

Response

Please refer to the response to question #8. In addition, it should be noted that a significant percentage of L+MH's revenue is dictated by state and federal reimbursement (49%) rates and negotiated commercial payer contracts (38%) and has little to no relationship to the chargemaster. Please refer to the response to question #31. Savings will be achieved from volume discounts associated with group purchasing and these savings will offset the reductions in state and federal payer reimbursement that L+M is currently experiencing.

22. Explain why the net community benefit expense for research is not estimated to increase (p. 60) if Educational and Research Opportunities will improve as a result of the proposal (p. 94).

Response
The Affiliation Agreement (page 94) indicates that after the closing L+M and YNHHS will "jointly explore education and research opportunities at the L+M Affiliates in light of their respective academic strengths and mission commitments." Until this review occurs, it is not known what impact the affiliation will have on educational and research opportunities. Until the affiliation closes, there are legal restrictions on the amount of information that can be shared and the degree of planning that can be done between YNHHS and L+M. Therefore, the projected amount on page 60 was assumed to remain the same. Notwithstanding, by being affiliated with an academic medical center and having access to clinicians who are regularly involved in research, it is expected that L+M clinicians and patients will have greater access to clinical research opportunities.

23. Explain why the Other Community Benefits, such as Community Health Improvement and Subsidized Health Services are not projected to increase if L+M "may dedicate and commit at least $11,000,000 to support community benefit programs and reinvestments (p 95)." Provide a table with expected expenditures for this money and explain what will happen with this commitment after the 5 year period is over.

Response
It should be emphasized that YNHHSC has been and will continue to be fully committed to providing significant support for community benefit and community building activities. In FY 2014, YNHHS's hospitals provided over $569.2 million (at cost) in community benefit and community-building activities. Community benefits also include costs associated with health professions-related education, uncompensated and under-compensated care. YNHHSC will continue to support L+M making community investments at the same level it is currently making (see Section 2.3 of the Affiliation Agreement on page 95 of the CON application).

The $11 million figure represents an approximate 5-year total of the non-insurance shortfall related community benefit typically provided by L+M (approximately $2.2 million annually) at the time the Affiliation Agreement was executed. The statement in the Affiliation Agreement was never intended to reflect "new" community investment but rather to reflect YNHHSC's support of at least L+M's current level of investment. The reference to the $11 million figure does not set any specifics around future community benefit expenses other than to acknowledge that each party affirmed its commitment to providing community benefit. The expected expenditures after the 5-year period is over are not known at this time.

24. Will this affiliation end the L+M relationship with Dana-Farber Cancer Institute?

Response
Dana-Farber Cancer Center and L+M Hospital have mutually agreed to terminate their existing clinical relationship as of December 31, 2015. To avoid any interruption in services, L+M Hospital is planning on entering into an agreement with Yale School of Medicine (YSM) for the provision of professional medical oncology services and YNHH for some

administrative support on or around January 1, 2016. This agreement will expand on the current radiation oncology relationship between Smilow Cancer Center and L+MH.

25. Exhibit B to the revised Bylaws for L+M and L+MH, outlines "Direct Authority Retained by YNHHSC, separate from the Actions Requiring Approval of the Member and YNHHSC."

    a) Is this exact same YNHHSC authority set forth in Bridgeport and Greenwich Hospitals' Bylaws?

    Response
    Exhibit B to the proposed revised bylaws for L+M is identical to Exhibit B to the Bridgeport Hospital bylaws, and sets forth the exact same authority that YNHHSC retains and may assert on behalf of Bridgeport Hospital. Greenwich Hospital has not yet adopted the common revised bylaws, and so the reserve powers held by YNHHSC over Greenwich Hospital currently are marginally different. It is anticipated that within the next few years, Greenwich Hospital will adopt revised bylaws that grant YNHHSC the same direct authority as are currently set forth in the Bridgeport and proposed L+M revised bylaws.

    b) This exhibit provides control over "major activities." Provide examples of what this would include.

    Response
    The YNHHSC Board of Trustees has not yet voted to declare any particular activities to be "major activities" as set forth in Exhibit B to the Bridgeport Hospital and L+M bylaws, therefore examples cannot be provided at this time.

26. Respond to the following questions related to the L+M chart of organization from page 592 of the application:

    a) What do the dotted lines represent between L&M Systems/L&M Home Care and between L&M Home Care and Davita Healthcare of New London?

    Response
    The dotted line between L&M Systems and L&M Home Care on the organizational chart is an error as L&M Systems is the sole shareholder of L&M Home Care. The line shown should be solid as it would reflect a controlling interest in L&M Home Care, and has been corrected on the updated organizational chart included in Attachment V. The dotted line between L&M Home Care and Davita Healthcare of New London indicates that L&M Home Care does not hold a controlling interest in Davita Healthcare.

b) Why are certain entities, indicated on page 322 as being subsidiaries of either L+M, LMH or one of their immediate subsidiaries, excluded from the organization chart on page 592?

Response

The L+M organizational chart on page 592 of the application has been updated to include Westerly Hospital Auxiliary and Westerly Hospital Energy as subsidiaries of Westerly Hospital (see previously referenced Attachment V). The chart does not include Southeastern Connecticut Imaging Center, LLC which is a non-operating LLC whose sole member is Lawrence + Memorial Hospital as it is anticipated that such entity will be dissolved by the end of 2015. It also does not include L+M Home Medical Equipment, LLC which is a non-operating joint venture entity domiciled in Delaware which is also in the process of being dissolved in the near future. The information provided on Page 322 of the Application is a schedule to the Affiliation Agreement and the level of detail provided was required to be in compliance with the terms of the Affiliation Agreement to which it refers, but is more detailed than L+M would typically maintain for its operating entity organizational charts.

c) The chart indicates that L&M Systems and Davita Healthcare of New London are the only two for-profit entities affiliated with L+M, while page 322 indicates an additional 4 for-profit entities (L&M Healthcare, L&M Indemnity, LMW Physicians and Southeast CT Health Partners). Please update the chart on page 592 or explain the discrepancies between the chart and page 322 of the application.

Response

L&M Health Care, Inc., LMW Physicians, Inc. and Southeastern Connecticut Health Partners, Inc. are all organized as non-stock corporations, and are not for-profit entities. The list shown on Page 322 of the Application reflects a schedule to the Affiliation Agreement between the parties that specifically identified those entities that are *tax-exempt*, so did not include other non-stock corporations if they had not also received tax-exempt status from the IRS. Please note that L&M Health Care, Inc. should have been identified on that schedule as a tax-exempt entity, which was inadvertently omitted in the final draft of the Affiliation Agreement.

LMW Physicians, Inc. and Southeastern Connecticut Health Partners, Inc. have never commenced any operations. SCHP was dissolved on December 21, 2015, and LMW Physicians is also slated to be dissolved in the near future. L&M Indemnity Company, Ltd. is organized as a stock corporation and the L+M organizational chart on page 592 of the Application has been updated to reflect this change.

27. With respect to YNHHSC's commitment of $300 million, respond to or provide the following:
    a) Is the $300 million amount an all cash commitment or is part of the commitment in some other form?

       Response
       The $300 million is not an all cash commitment. The commitment is dependent on the performance of YNHHS and L+M, as well as community need, YNHHS's strategic plan and mutually agreed upon business plans that achieve a positive return on investment. Sources for the $300 million will include L+M base operating cash flows (e.g., $163 million), incremental cash flows from L+M as a result of synergies and efficiencies (e.g., $68 million) and an additional $85 million from YNHHS.

    b) Will a set portion of the $300 million amount be spent in each of the five years?

       Response
       Forty-one million of the $85 million will be made available by YNHHS to L+M based upon the strategic plan (please see breakdown identified in response to question #28 below). An additional $44 million from YNHHS will be made available for specific clinical and operational initiatives that will occur in years 2 through 5 post-closing. This amount is dependent on mutually agreed upon business plans that show a positive return on investment and performance of YNHHS and L+M. These expenditures will be the result of an ongoing, deliberate and collaborative strategic planning process to enhance the quality and breadth of YNHHS's clinical services, and to be responsive to the identified needs of the L+M community in eastern Connecticut.

    c) What is YNHHSC's expected source of funding for the $300 million?

       Response
       The anticipated funding source for the investments to be made to L+M is anticipated to come from two primary areas: operating cash flows and cash reserves at YNHHS and L+M. There is no current plan for a debt offering at this time relating to these commitments.

    d) If Yale-New Haven Hospital experiences an operating loss, will YNHHSC or any affiliated entity need to borrow a portion of the $300 million?

       Response
       In the event that any market forces result in an operating loss at YNHHSC, multiple options will be assessed in order to continue to advance investments for L+M. These options could include an L+M debt offering or funding from existing YNHHSC cash. Any of these decisions depend entirely on the nature of the operating loss at YNHHSC and the revised multiyear financial forecast that incorporates that loss. Given that there are several other options available in the event of an operating loss, YNHHSC is not likely to need to borrow in order to meet the $300 million

commitment. Please see 2.11 (d) of the Affiliation Agreement on page 99 of the CON application.

e) A preliminary capital and operating plan and timeline for the $300 million commitment by YNHHSC.

Response

Given the competitive nature of the affiliation, YNHHSC and L+M have only been able to have preliminary discussions regarding the investment of the $300 million, but post affiliation it is anticipated that the Applicants will work together to develop a more detailed strategic plan. The timelines and dollar amounts shown below represent anticipated spending based upon preliminary discussions.

Capital Investments (Equipment and Facilities)

Over the course of the next 5 years significant investments will be needed to maintain and improve the equipment and facilities at L+M. The table shown below outlines a preliminary estimate of the capital spending plan to be funded from the $300 million.

	Year 1	Year 2	Year 3	Year 4	Year 5
Capital Infrastructure	$46M	$27M	$28M	$30M	$32M

Upon the completion of a detailed assessment these amounts and allocations could change to meet the needs and performance of L+M and YNHHSC.

Epic Implementation

L+M will commit $20 million to implement Epic. An additional investment of $14M will be made post-closing for full clinical integration of Epic, upgrade and enhancement of other clinical systems in the operating rooms and other treatment areas and to bring L+M, in the first year, onto contemporary Financial and Enterprise Resource Planning (ERP) solutions that support a modern health care enterprise. These funding levels will ensure project completion and include needed investment in core information technology network and infrastructure, cybersecurity, and remaining software license costs.

Rebranding

The rebranding initiative at L+M is anticipated to cost $2 million of capital expenditures and is expected to be spent within the first year of the affiliation.

Development of clinical programs and services

Fifteen million dollars will be made available at the time of closing to be spent on clinical program development. Of this amount it is expected that approximately $2 million will be utilized for capital expenditures to support these programs. The rate of spending for this investment will be dependent on physician and staff recruitment and the strategic and business plans.

Population Health Infrastructure
Ten million dollars of the investment is associated with population health infrastructure. In the past several years, YNHHS has made significant strides in developing a clinically integrated network to support the population health payment environment. As part of the system, L+M will be able to utilize these resources, and will avoid an estimated $10M operating/capital cost.

Remaining Investment
The remainder of the $300 million will be allocated to specific areas following a more detailed assessment to be performed post-closing as described in the Affiliation Agreement on pages 99 and 100 of the CON application.

28. Regarding the $41 million in resources that will be available for updating IT platforms, branding and access to the YNHHS population health infrastructure, provide the following:

a) A table that breaks down how the $41 million will be made available with a description of each amount.

Response
The table below provides a break-down of how the $41 million will be made available with a brief description of each amount.

Break-down of $41 Million	Description
$14 million	Epic installation and other IT investments
$10 million	Population health infrastructure and related services
$15 million	Development of clinical programs and services for eastern CT and western Rhode Island
$2 million	Rebranding and communication initiatives

b) A cost comparison of the implementation of Epic by L+M as a stand-alone entity and as an YNHHSC affiliate.

Response
Epic is not available to L+M for purchase as a stand-alone entity. Epic only sells its EMR to large health systems, academic medical centers or children's hospitals. L+M can purchase Epic through YNHHSC via the Community Connect option which affords L+M cost savings as compared with stand-alone purchase and installation of an enterprise wide EMR. L+M is currently pursuing this option, however, L+M's costs for this option are higher than the costs they will incur as an affiliate of YNHHSC. The table below provides a comparison of the Community Connect costs and the costs as an YNHHSC affiliate. If the affiliation is approved, L+M will be able to reduce its costs to implement Epic by $13.8M as shown in the table below.

Description	Costs via Community Connect	Costs via YNHHSC Affiliate
Epic systems licenses	$8.9M	$6.5M
Epic system maintenance	$1.875M	$1.0M
Application support team	$467,000	$312,000
Integration to clinical and financial systems	$800,000	$395,000
Hardware & infrastructure	$17.5M	$7.5M
TOTAL	$29.5	$15.7
Difference		$13.8M

It should also be emphasized that if L+M had to pursue an EMR implementation completely on their own, the expense would likely be $40M.

c) An explanation of the $10 million amount for "value represented by participation in and access to YNHHSC population health infrastructure."

Response
As part of the system, L+M will be able to utilize the resources associated with YNHHS's population health infrastructure and avoid an estimated $10M operating/capital cost. This infrastructure will support high risk patient identification and management, payer program management, clinical integration among providers, case management and community based patient education programs.

29. Regarding the $215 million in new services to be located at L+M, provide the following information in a table:

a) Which projects will be given the highest priority over the first three years; and

Response
Projects that will be given the highest priority over the first three years will be determined through a comprehensive strategic planning process that L+M and YNHHSC will undertake. Areas to be considered include:

- Behavioral Health;
- Emergency/Urgent Care;
- Heart and Vascular Services;
- Medicine Services;
- Musculoskeletal Services;
- Oncology;
- Pediatrics;
- Primary Care;
- Surgery/Ambulatory Surgery; and
- Women's Health.

b) What are the expected costs of those projects?

Response
Detailed costs for these projects have not yet been developed and will be addressed during the strategic planning process following the closing. Strategic planning will allow the Applicants to determine the precise scope of the identified clinical needs and thus, determine more accurate capital costs associated with the programs.

30. Regarding the $44 million in resources that will be available to support the new clinical programs and services indicated above, provide a detailed breakdown to show how the $44 million may be spent, using tables if necessary to explain this statement further.

Response
As noted above, detailed breakdowns are not yet developed and will be pursued during the strategic planning process post-closing. At this time, the applicants expect that about half of the funds will be directed to funding new physician recruitment. As noted below, the remaining 50% will be targeted towards staff, office/faculty development and equipment.

- Launch funding for new physician recruits 50%
- Other, such as staff augmentation and clinical support 50%

31. Provide a table with estimated cost savings amounts for each of the categories (IT, finance, insurance, equipment and supplies, and other administrative services) expected to realize savings as a result of economies of scale as noted on page 37 for the first three years of the affiliation. Be sure that the amounts agree with the incremental column of Financial Worksheet and if the amounts are not in agreement, explain the differences.

Response
The table below depicts the anticipated savings for the proposed combined Health System in the above categories for the next three fiscal years:

Projected Savings: Categories ($ in millions)	FY 2016	FY 2017	FY 2018
IT	($0.42)	$1.38	$1.51
Finance & Corporate Services	0.50	2.16	2.97
Insurance	0.00	0.00	0.00
Equipment and Supplies	0.84	1.68	1.68
Other Administrative	0.25	1.08	1.48
Total	**$1.17**	**$6.29**	**$7.65**

When looking at the Financial Attachment A's incremental amounts for L+M or YNHHSC, these figures will not match for the associated years. These amounts will not be consistent with the incremental columns of the financial worksheets for L+M or YNHHSC for the reasons discussed below:

- The financial worksheet for L+M post affiliation does not include L&MPA because it will be merged into NEMG. Therefore, the salaries and benefits of those individuals are subtracted from the total incremental column in addition to the anticipated savings above;
- Cost savings were reduced due to additional fringe benefit rates associated with the merger of L&MPA into NEMG which offers a richer fringe benefit package; and
- Cost savings were reduced by the costs for incremental staff and supplies that are required to meet anticipated incremental volume due to the affiliation. The incremental staffing and supply expenses are incorporated into the incremental column in addition to the anticipated savings above.

32. Provide the FY 2015 Balance Sheet, Statement of Operations and Statement of Cash Flows for L+MH (which excludes Associated Specialists of Connecticut), L+M and YNHHSC. The internal financials may be provided if audited financials aren't completed at the time responses are submitted.

Response
FY 2015 audited financial statements for L+M, L+MH and YNHHSC are included in Attachment VI. Please note that audited financials for L+M and L+MH are marked "draft". Once received, a final version will be provided to OHCA if required. All figures are final.

33. Respond to the following questions regarding the Financial Worksheets on pages 583-585 for L+MH, L+M and YNHHSC:

a) Update the spreadsheets to include actual results for FY 2015 even if the amounts are internal and unaudited.

Response
Spreadsheets that include actual results for FY 2015 have been included in Attachment VII.

b) Provide a detailed breakdown thoroughly explaining how all of the financial amounts, volume statistics and FTEs were derived, expanding on the assumptions provided on pages 587 and 588. In the response, be specific and also include a narrative to explain the figures provided in the incremental columns, indicating months included for FY 2016 data provided.

Response
In order to develop Financial Worksheet A for the CON application, YNHHSC utilized several approaches to provide the most accurate and updated results.

These approaches are outlined below.

- **Multiyear Forecast Presented to the Board** – YNHHSC developed a multiyear financial forecast that was presented to the Board of Trustees in conjunction with obtaining approval of the Affiliation Agreement. This forecast provided a high level overview of revenues and expenses.
- **YNHHSC Updated Multiyear Forecast** – A more detailed multiyear projection was updated between the time of the Affiliation Agreement and the submission of the CON. This model included more detail for projected revenues and expenses for each delivery network in YNHHS. Based on additional reimbursement reductions from Medicaid, adjustments to revenue and expenses were necessary.
- **FY 2016 Board Approved Budget** – After the development of the updated Multiyear Forecast and prior to the submission of the CON, YNHHSC finalized the FY 2016 proposed budget for both revenue and expense which were subsequently approved.

These three approaches were the source for the four year plan submitted in the CON in Financial Attachment A.

Revenue and Expense Assumptions:
The table below summarizes the assumptions included in Financial Worksheet A in terms of revenues, expenses and FTEs based on the process described above.

Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
Revenues	Annual increase of 1% assumed from baseline. Revenues were adjusted down for the hospital tax paid by YNHHS and is shown in the revenue category labeled "Other" of the Governmental payer category. The state hospital tax was updated to the new $182M figure in the "Other Governmental Category" which encompassed both the previous tax and the addition that will be required. That amount was then allocated out to the various governmental and commercial payers based on the payor mix provided. An adjustment was made to FY 17 to account for an expected decrease in inpatient volume as	Revenues without the CON for YNHHSC were increased in accordance with L+M's projected revenues with the affiliation. Growth assumptions as outlined in Tables C and D in the original CON submission (see Applicant pages 53 and 54) are associated with the various clinical investments and were incorporated. (Please refer to discharge and outpatient visit increases included in L+M's Financial Attachment A).

Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
	the trend of short stay inpatient cases continue to move to outpatient or observation. Beyond FY 17 this is expected to stabilize.	
Expenses	Annual increase of 3% assumed for all expense categories. Adjustments were made to the multiyear forecast to account for anticipated savings activities that are aimed at decreasing operating expense. A small portion of these savings which have been identified are included within the various expense categories while the majority of the targeted savings are in other "operating expense" line as a credit.	Expenses without the CON for YNHHS were increased in accordance with L+M's projected expenses with the affiliation. (Please refer to projected expenses included in L+M's Financial Attachment A). Additions were made to the expenses to account for fringe benefit changes associated with the integration of LMPA with NEMG, and staff and supplies needed to support the incremental volume growth mentioned above. Expenses also include savings projected in the following areas: corporate services consolidation, IT systems integration, and supply chain savings.
FTEs	Small increases in FTEs without the CON correspond to minimal volume growth	Incremental FTEs represent the FTEs from L+M that will be incorporated into YNHHSC (Please refer to projected FTEs included in L+M's Financial Attachment A).

The table below outlines more details on the assumptions used to complete Financial Worksheet A for L+M and L+MH.

L+M: Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
Revenues	Annual increase of 1% assumed from baseline. Revenues were adjusted down for the hospital tax paid by	Revenues without the CON were increased in accordance with L+M's projected revenues with the affiliation. Growth assumptions as outlined in

L+M: Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
	L+M is shown in the revenue category labeled "Other" of the Governmental payer category. The state hospital tax was updated to the new $18M figure in the "Other Deductions" which encompassed both the previous tax and the addition that will be required. Adjustments were made to the out years for expected payer reimbursement.	Tables C and D in the original CON submission (see Applicant pages 53 and 54) are associated with the various clinical investments and were incorporated. (Please refer to discharge and outpatient visit increases included in L+M's Financial Attachment A). They were further decreased by the reclassification of LMPA to NEMG.
Expenses	Annual increase of 2% assumed for salaries, fringe benefits, outside services, supplies and 1% assumed for other operating expenses in addition to other initiatives expected for these categories. Adjustments were made to the multiyear forecast to account for anticipated savings activities that are aimed at decreasing operating expense. These changes are necessary to generate a positive margin to have a sustainable bottom line for the L+M.	Expenses without the CON were increased in accordance with L+M's projected expenses with the affiliation. (Please refer to projected expenses included in L+M's Financial Attachment A). Additions were made to the expenses to account for fringe benefit changes associated with the integration of LMPA with NEMG, and staff and supplies needed to support the incremental volume growth mentioned above. Expenses also include savings projected in the following areas: corporate services consolidation, IT systems integration, and supply chain savings. Expenses also include contracted service fee for YNHHS System support fee.

L+M: Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
		All expense categories were decreased by the reclassification of LMPA to NEMG.
FTEs	Decreases in FTEs without the CON correspond to adjustments to decrease operating expenses.	Incremental FTEs represent the FTEs from L+M that will be incorporated as well as reclassification of LMPA to NEMG. (Please refer to projected FTEs included in L+MC's Financial Attachment A).

L+MH: Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
Revenues	Annual increase of 1% assumed from baseline. Revenues were adjusted down for the hospital tax paid by L+M and is shown in the revenue category labeled "Other" of the Governmental payer category. The state hospital tax was updated to the new $18M figure in the "Other Deductions" which encompassed both the previous tax and the addition that will be required. Adjustments were made to the out years for expected payer reimbursement.	Revenues without the CON were increased in accordance with L+M's projected revenues with the affiliation. Growth assumptions as outlined in Tables C and D in the original CON submission (see Applicant pages 53 and 54) are associated with the various clinical investments and were incorporated. (Please refer to discharge and outpatient visit increases included in L+M's Financial Attachment A).
Expenses	Annual increase of 2% assumed for salaries, fringe benefits, outside services,	Expenses without the CON were increased in accordance with L+M's projected expenses with

L+MH: Financial Assumptions	Without the CON	With the CON- Assumed 4/1/16 start date
	supplies and 1% assumed for other operating expenses in addition to other initiatives expected for these categories. Adjustments were made to the multiyear forecast to account for anticipated savings activities that are aimed at decreasing operating expense. These changes are necessary to generate a positive margin to have a sustainable bottom line for the L+MH.	the affiliation. (Please refer to projected expenses included in L+M's Financial Attachment A). Additions were made to the expenses to account for fringe benefit changes associated with the integration of LMPA with NEMG, and staff and supplies needed to support the incremental volume growth mentioned above. Expenses also include savings projected in the following areas: corporate services consolidation, IT systems integration, and supply chain savings. Expenses also include contracted service fee for YNHHS System support fee.
FTEs	Decreases in FTEs without the CON correspond to adjustments to decrease operating expenses.	Incremental FTEs represent the FTEs from L+M that will be incorporated (Please refer to projected FTEs included in L+M's Financial Attachment A).

c) Explain why Other Deductions remain the same in FY's 2016-2019 for all three financial worksheets. Explain why Other Operating Revenue doesn't change in these same years for both L+M and L+MH.

Response

Other deductions refer to current tax amounts to the State of Connecticut. At this time these amounts have been kept constant based on current available information.

Other operating revenue includes cafeteria and grant funds. These revenues are not expected to materially change in the future and have therefore been held constant.

d) How have the volumes, revenues and expenses related to the expected programmatic growth in musculoskeletal, neurosurgery/spine, cardiovascular, general surgery, maternity and children's services noted on page 41 been reflected in the financial projections?

Response
As referenced in response to question #31, incremental salary and fringe benefit expenses, which are projected to be necessary to manage programmatic growth due to the affiliation, are incorporated into all the models. Additionally, there are revenue and non-salary expenses incorporated that are projected to match the anticipated volume increases. These amounts are incorporated into all components of the revenue, expense, and FTE assumptions on the multi-year plans.

e) How are the "assessed fees" to YNHHSC from L+M Affiliates reflected in the incremental projected expenses?

Response
The fee paid by L+M to YNHHSC is accounted for in the "Physician Fees" category on Financial Worksheet A given there is no other relevant category on the form. This category represents all third-party contractual related fees.

34. In reference to the Financial Worksheet submitted for L+MH, address the following:

a) Provide a new Financial Worksheet A with amounts for L+MH which exclude the activity of Associated Specialists of Connecticut, the medical group consolidated with the Hospital.

Response
As requested, Financial Worksheet A for L+MH without the activity of Associated Specialists of Connecticut has been included in Attachment VIII.

It should be noted that Associated Specialists of Connecticut includes physician revenues and expenses associated with L&MPA's cancer center and wound care services. Following the affiliation, the physician revenues associated with the wound center will become part of NEMG.

b) Explain why there are no incremental amounts provided for Uninsured Net Patient Revenue, Other Operating Revenue, Net Assets Released from Restrictions, Bad Debts-Other, Interest expense, Malpractice, Lease expense and Other Operating Expense.

Response
All incremental costs have been allocated to the appropriate cost category. Projections do not assume any incremental Uninsured Net Patient Revenue as any

additional volume in this category is offset by bad debt. In addition, no incremental amounts are projected for Other Operating Revenue (see #33c) or Net Assets Released from Restrictions as a result of the proposed affiliation.

The Bad Debts-Other category has not been identified in any base figures or projections in that no additional debt is expected by virtue of the proposed affiliation. Lease and Other Operating expenses are projected to remain flat with no change in the future. Please refer to 34c for reference to Malpractice costs.

c) Detail why the amounts for Malpractice Insurance and Lease expense remain the same in FY's 2016-2019 without the project.

Response
L+MH will obtain malpractice insurance through YNHHS's program. L+MH has had a very mature self-insured malpractice program and, more recently, an insurance captive (L+M Indemnity) which together have provided over twenty years of experience. The expense has remained fairly consistent from year to year. YNHHS's malpractice insurer will be conducting underwriting due diligence in the first quarter of CY 2016 and the premium for L+MH will be set after that point. Given L+M's stable experience over the last 20 years with its own malpractice insurance program, it has projected no change in the premium.

d) The FTE amounts provided on Financial Worksheet A don't agree with the FTE amounts given on page 588, which provides assumptions. Revise as appropriate and explain why additional FTEs are needed in each of the first 3 years of the proposal and the types of positions they represent.

Response
An assumption page for L+MH was inadvertently omitted from the original CON application. Please refer to Attachment IX for these assumptions. The FTE amounts provided on page 588 pertain to YNHHSC.

35. With respect to the Financial Worksheet for L+M, address the following:

a) Provide details of the $72,000 incremental loss in FY 2016.

Response
FY 2016 financials assume 6 months of the affiliation. Projected volume and revenue increases have minimal impact in the first year. There are some incremental expenses related to the proposed affiliation which are not yet offset by incremental revenue and therefore a small incremental loss is projected.

b) Explain why there are no amounts provided for Uninsured Net Patient Revenue projections, Net Assets Released from Restrictions, Bad Debts-Other and Interest expense.

Response
Projections do not assume any incremental Uninsured Net Patient Revenue as any additional volume in this category is offset by Bad Debt. In addition, no incremental amounts are projected for Net Assets Released from Restrictions, Bad Debts-Other and Interest expense as a result of the affiliation.

c) Detail why the amounts for Malpractice Insurance and Lease expense remain the same in FY's 2016-2019 without the project.

Response
Please refer to the response to question #34c. L+M and L+MH have a very mature self-insured malpractice program that has existed for over twenty years. This expense has remained fairly consistent from year to year and therefore was assumed to remain the same in the financial attachments.

d) Explain why physician fees decreased from $55 million in FY 2014 to $36 million in FY 2016 and just over $29 million in FY's 2017-2019 without the project.

Response
This expense line item as explained above is utilized for all purchased third-party services. In FY 2014, L+M experienced a strike which required a non-recurring expense in excess of $14 million for replacement workers and incurred $5 million in consulting fees. The "Physician Fee" category captures all contracted fees. These expenses are not applicable to future time frames and therefore explain the declining trend.

e) Verify that the amounts in the incremental column exclude any activity related to the integration of NEMG and L&MPA or revise the amounts as applicable.

Response
The amounts in the incremental column exclude any activity related to the integration of NEMG and L&MPA.

36. In reference to the Financial Worksheet for YNHHSC, address the following:

a) Provide details of the $699,000 incremental loss in FY 2016.

Response
There will be costs associated with implementation of the proposed affiliation and any of the benefits are not fully realized in the six months of the proposed affiliation in FY 2016. The incremental loss in the first year of the affiliation at YNHHSC takes into account a number of factors. L+M inclusive of L&MPA, projects an estimated $8.7 million loss in FY 2016 (see the CON application on page 584) which, without any realized benefits from the affiliation, would

translate to a loss of roughly $4.4 million on the YNHHSC's incremental forecast. The projected first year cost savings from the categories of Supply Chain, Finance & Corporate Services, information technology, etc. help to mitigate this loss. In addition to the cost savings, the initial incremental volume impact at L+M, due to the work done during the initial phase of the proposed affiliation, will help to further reduce the loss (please refer to the CON Application on page 47).

b) Explain why there are no amounts provided for Uninsured Net Patient Revenue projections, Net Assets Released from Restrictions and Bad Debts-Other.

Response

There are no amounts in these categories due to their inclusion in other line items or due to the fact that they are not forecasted. Specifically, Uninsured Net Patient Revenue is included in the "Self Pay" category. Net Assets Released from Restrictions is not a category that is forecasted and is only reported retrospectively. Bad Debts-Other are grouped in a single "Bad Debt" category.

c) Explain why the revenue, expense and FTE amounts in the "Projected Incremental" column do not agree with the amounts shown in the "Projected with CON" column of the L+M Financial Worksheet.

Response

There are a number of reasons for this discrepancy. The proposed affiliation of YNHHSC and L+M has significant financial benefits for L+M as the entity exists today, but there are also financial impacts to YNHHSC that are not accounted for in the L+M financial assumptions. An example of this is the assessed fees referenced in question 33(e). Within the L+M financial assumptions, the system support fee paid to YNHHSC is shown on the physician support fee expense line (which is inclusive of all third-party contractual expense). When comparing this to the YNHHSC five year plan, this fee is both paid and received by the YNHSSC because it now includes L+M.

Another primary reason for the discrepancy has to do with the L+M's exclusion of L&MPA in the financial forecasts in the column "with the CON." The proposed affiliation model includes the merger of L&MPA with and into NEMG. Therefore, when modeling projected financials with CON approval, revenue, expense, and FTEs associated with L+M do not include any amounts for L&MPA.

Additionally, the projected first year of YNHHSC's financial forecasts only includes 6 months of the affiliation whereas the L+M figures include a full year.

d) Detail why Other Operating Expense decreases from over $285 million in FY 2016 to slightly above $150 million in FY 2019 without the project.

Response
Included in the YNHHS multiyear plan is the projected results of a project called "Cost and Value." This project's primary goal is to improve care while at the same time reducing cost. The significant reduction in expense seen in the Other Expense category is a result of this project. Targets are developed and cost savings projected, however, it is currently not clear which line item expense will be impacted. Therefore the reduction is Other Operating Expense reflects projected savings from this initiative.

e) Related to the statement on page 45 that "Incremental revenue and expenses are negative values due to the removal of L&MPA which will be merged into NEMG," explain if the incremental column for YNHHSC includes the additional revenue, expenses and FTEs of L&MPA. If the medical group amounts are not part of the YNHHSC amounts, the Financial Worksheet A should be revised.

Response
The figures included in this model incorporate the projected financials associated with the proposed L&MPA/NEMG integration.

The incremental column for YNHHSC does include the additional revenue, expenses and FTEs of L&MPA.

37. After the affiliation, it is expected that L+M will become part of the YNHHSC Obligated Group. Regarding the obligated group respond to the following:

a) Which YNHHSC entities are currently part of the obligated group?

Response
Currently, the following entities are part of the obligated group:
(i) Yale-New Haven Health Services Corporation;
(ii) Yale-New Haven Hospital Inc.;
(iii) Bridgeport Hospital;
(iv) Bridgeport Hospital Foundation, Inc.;
(v) Northeast Medical Group, Inc.; and
(vi) Yale-New Haven Care Continuum Corporation.

b) Do the YNHHSC Obligated Group members ever change?

Response
Members of the Obligated Group do not leave the Obligated Group once they join. Since the implementation of the YNHHSC Obligated Group, the members have remained the same although the expectation has been that members would be added over time. The legal documents supporting the YNHHSC Obligated Group allow for both entrance to and withdrawal from provided certain tests are met.

c) Provide further details why YNHHSC would include L+M as part of the System's obligated group considering the increasing operating losses over the last several years for both L+M and the Hospital.

Response
As previously stated, there are no immediate plans to include L+M in the YNHHSC Obligated Group given L+M's current debt obligations. At the appropriate time, L+M will join the Obligated Group. Participation in the YNHHSC Obligated Group affords members with many benefits, not the least of which are a lower cost of capital and superior terms than non-obligated group members might be able to obtain when issuing indebtedness on their own credit ratings. L+M will be able to take advantage of these benefits when it can be incorporated into the Obligated Group.

d) Will the Obligated Group attempt to refinance any of L+M's existing long term debt commitments or pension deficiencies? Explain in detail.

Response
L+M is not expected to join the YNHHSC Obligated Group upon consummation of the transaction due to potential refinancing costs related to its outstanding indebtedness.

e) In FY 2014, YNHHSC changed its corporate structure so that Yale-New Haven Hospital and Bridgeport Hospital are now wholly owned directly by YNHHSC "in connection with the formation of an Obligated Group" (per the system's audited financial statements). Is it intended for this to also occur for L+M in the short term?

Response
As previously stated, in the short term, L+M will not join the Obligated Group and therefore the corporate changes made in connection with forming the Obligated Group are not relevant to the proposed corporate structure which will result from the proposed affiliation. In the event L+M changes its overall corporate structure after the affiliation for reasons other than joining the Obligated Group, it will notify OHCA to the extent required by applicable law.

38. Regarding the monthly financial reports submitted on page 602, respond to the following:

a) Update the report with data through the year ending September 30, 2015.

Response
The monthly financial report submitted on page 602 has been updated to include data through the year ending September 30, 2015. Please refer to Attachment X.

b) Provide the Moody's credit rating for L+M and the L+MH.

Response
L+M and L+MH are not rated by Moody's. Ratings are only provided by Fitch and S&P and are provided below.

Rating Agency	L+M Rating
S&P	A- with Negative
Fitch	A with Stable

c) Submit the same document for YNHHSC which also includes all three major credit ratings.

Response
The monthly financial report (as submitted on page 602 of the Application) has been provided for YNHHSC and is included in Attachment XI. Credit ratings for all three major rating agencies are provided below.

Rating Agency	YNHHSC Rating
Moody's	Aa3 with Stable
S&P	A+ with Positive
Fitch	AA- with Stable

39. What is the basis or the source for the Key Financial Metrics on page 316? Provide the calculation for the Operating Margin and the Days Cash on Hand.

Response
The basis for the Key Financial Metrics is the preliminary financial forecasts prepared in conjunction with the proposed affiliation.

The calculation for Operating Margin and the Days Cash on Hand is provided below:

- Cash plus Investments/(Total Operating Expenses minus Depreciation)/Days in Period

Note: This calculation is only L+MH and L+M Corporation as they are the only L+M Obligated Group members.

40. Explain what is meant by "L+M is considering adopting retention bonuses for certain select individuals" as noted on page 344, what the expected costs of these bonuses will be and who is expected to receive the bonuses.

Response
The statement referenced in the completeness question is taken from a schedule to the Affiliation Agreement between L+M and YNHHSC dated as of July 17, 2015 that relates to a set of representations and warranties otherwise made in Section 3.17 of the Affiliation

Agreement concerning L+M's benefit plans. The effect of placing that statement on the schedule at the time the Affiliation Agreement was executed to preserve L+M's right to adopt retention bonuses for certain employees if determined to be necessary or desirable for maintaining business operations during the course of the transaction and remain in compliance with the terms of the Affiliation Agreement. At this juncture, L+M anticipates that retention bonuses will be limited to certain personnel within the Information Services and Finance Departments in order to ensure continued business operations through the anticipated installation of a new EMR system and closing of the proposed affiliation transaction. However, decisions have not yet been finalized and expected costs cannot yet be determined.

ATTACHMENT I

LIST OF PARTICIPATING COMMUNITY PROVIDERS

SE CT Health Improvement Coalition Participants

First	Last	Affiliation
Lindsey	Addis	New London Housing Authority
Deb	Barrett	TVCCA
Rayallen	Bergman	SERAC
Mark	Berry	Town of Groton, Parks and Rec
Mary	Blankson	Community Health Center
Michael	Blefeld	Director of Health, Stonington
Maritza	Bond	Eastern Area Health Education Center
Yolanda	Bowes	UCFS
Carl	Brisson-Lopez	New London Police Department
Megan	Brown	TVCCA
Aundre	Bumgardener	State Rep, Groton
Stephanye	Clarke	African Amer. Health Council
Florence	Clarke	Ministerial Alliance of SECT
Nancy	Cowser	VP of Planning, UCFS
Tammy	Daugherty	City of New London
Michelle	Devine	ED, SE Regional Action Council
JoAnn	Eaccarino	Manager, SBHC
Frank	Greene	Director of Health, North Stonington
Stephenie	Guess	Southeastern Mental Health Authority
Jim	Haslam	CT Legal Services
Leah	Hendriks	School Nurse Supervisor, VNASC
Laurel	Holmes	Director, Community Partnerships + Population Health, L+M
Larry	Keating	lieutenant, NLPD
Jennifer	Keatley	United Cerebal Palsy
Pamela	Kinder	UCFS
Mary	Lenzini	President, Visiting Nurse Assoc.
Arthur	Lerner	FRESH NL
Jerry	Lokken	Groton Parks and Rec
Steve	Mansfield	LLHD
Jason	Martin	TVCCA
Syed Masood	Asghar	Southeastern Mental Health Authority
Cathy	McCarthy	Social Worker, L+M Cancer Center
Patrick	McCormack	Uncas HD, Director of Health
Rebecca	McCue	Holleran Center
Alejandro	Melendez-Cooper	Hispanic Alliance
Russell	Melmed	Ledge Light Health
Deb	Monahan	TVCCA
Jen	Muggeo	Ledge Light Health
Mary Ann	Nash	Admin Dir. L+M Cancer Ctr.
Jennifer	O'Brien	Cmty Foundation of SE CT
Michael	Passero	NL Mayor
Shraddha	Patel	Director of Planning, L+M
Abby	Piersall	Town of Waterford, Planning
Jonathan	Reiner	Town of Groton, Planning
Tracee	Reiser	Assoc Dean Cmty Learning Conn Coll
Dianna	Rodriguez	CHC
Ariella	Rotramel	Asst. Prof, Gender and Women's Studies, Conn College
Kim	Sanchez	Conn College
Michele	Scott	
Dina	Sears-Graves	VP Cmty Investment, United Way
Jessica	Seyfried	
Sue	Shontell	NL Housing Authority
Vijay	Sikand, MD	Director of Health, Lyme – OL
Kate	Sikorski	Town of Ledyard, Youth and Family Services
Doria	Sklar	EB Wellness Coordinator
Steve	Smith, MD	Physician, CHC
Chris	Soto	Higher Edge
Kathleen	Stauffer	The ARC
Miriam	Taylor	Asst. Superintendent, NLPS
Stephanie	Thayer	Navy
Victor	Villagra, MD	CT Health
Cathy	Wilson	East Lyme Senior Center

ATTACHMENT II

CMS QUALITY IMPROVEMENT PROGRAM – SUMMARY OF RESULTS

CMS Program	L+MH Executive Summary	GH Executive Summary	BH Executive Summary
Hospital IP Quality Reporting Program - 2Q14-15 This report outlines performance for the specified time period across all clinical process of care measures for Inpatient Quality Reporting, HCAHPS measures, Mortality, Readmissions, Risk Standardized Complication measures, 30 day condition-specific payment measures, select AHRQ PSIs, and Hospital Acquired Infection Measures.	Lawrence + Memorial Hospital performed as well or better than others on most of the measures. In comparison to the state and national performance data opportunities for improvement exist in: AMI, Heart Failure, Stroke 1,3,5; VTE 1,2,5; PN-6; SCIP Inf-1,2, SCIP Card-2; most HCAHPS and PAYM-30-PN.	Greenwich Hospital performed as well or better than others on most of the measures. In comparison to the state and national performance data opportunities for improvement exist in SCIP-Inf-9, SCIP-Card 2and IMM-2, AMI and COPD readmissions .	Bridgeport Hospital was no different than the national or state rate on many measures. There are several opportunities for improvement in comparison to the state and national performance. These include some in stroke care, VTE-1, VTE6, SCIP prophlyactic antibiotics, hospital cleanliness, ED arrival time to admission, IMM-2,PC-01 elective deliveries, hospital cleanliness, complications for Hip/Knee , PSI-12 DVD/PE and C.diff.
Hospital OP Quality Reporting Program - 2Q14-1Q 15 This report outlines performance for the specified time period across measures for Outpatient Quality Reporting including Healthcare Personnel Influenza Vaccination, AMI Cardiac Care Measures, Outpatient Imaging Efficiency measures, ED throughput, Pain Management, and Stroke Care.	Lawrence + Memorial Hospital performed better than the State and National Performance in: the ED measures; OP-21 Median time to pain management for long bone fracture; OP-27 Influenza Vaccination Coverage among Healthcare Personnel, most AMI Cardiac Care and most of the Outpatient Imaging Efficiency Measures. Opportunity areas, in comparison to state and national performance, include: OP-4 Aspirin on Arrival; OP-5 Median Time to ECG; OP-8 MRI Lumbar Spine for Low Back pain; OP-13 Cardiac Imaging for preoperative risk assessment for non-cardiac low-risk surgery and OP-23 Head CT Scan for Stroke patients who received head CT or MRI interpretation within 45 min of ED arrival.	Greenwich Hospital performed well in AMI Cardiac Care, most of the Outpatient Imaging Efficiency Measures and the ED measures. Opportunity areas, in comparison to state and national performance, include: OP-27 Influenza Vaccination Coverage among Healthcare Personnel, OP-10 - the use of contrast in Abdomen CTs and OP-13 - cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery and OP-21, median time to pain management for long bone fracture.	Bridgeport Hospital has room for improvement on OP-27, influenza vaccination among healthcare workers, had mixed results on the outpatient imaging efficiency measures and needs improvement on OP-20 median time from arrival to provider contact.
Hospital Value-Based Purchasing Program – Value-Based Percentage Payment Summary Report This report outlines the Hospital Value-Based Purchasing Program Payment Summary report for the FY 2016 Value-Based Purchasing Period.	Lawrence + Memorial Hospital received 1.37% (of the possible 1.75%) base operating DRG payment withheld, resulting in a final payment reduction of 0.38% The total score of 28.18 is lower (higher is better) than the state and national performance score of 35.19 and 40.47 respectively.	Greenwich Hospital received 1.63% (of the possible 1.75%) base operating DRG payment withheld, resulting in a final payment reduction of .12% The total score of 33.57 is lower (higher is better) than the state and national performance score of 35.19 and 40.47 respectively.	Bridgeport Hospital received 1.58% of the base operating DRG payment withheld, resulting in a reduction of .17%. The total score of 32.50 was lower than (higher is better) than the state and national performance score of 35.19 and 40.47 respectively.
Hospital Readmissions Reduction Program FY'16 This report outlines the Hospital Readmission Reduction Program Results for FY 2016, which summarizes the condition specific readmission ratios for AMI, HF, COPD, HIP/KNEE, and PN.	Target performance is a readmission ratio $\leq$ 1.0. Lawrence + Memorial achieved that ratio for Hip/knee, AMI and Heart failure, but has opportunities for improvement in pneumonia and COPD.	Target performance is a readmission ratio $\leq$ 1.0. Greenwich achieved that ratio for hip/knee and pneumonia, but has opportunities for improvement in AMI, HF and COPD.	Target performance is a readmission ratio $\leq$ 1.0. Opportunities for improvement exist for AMI, HF, COPD and PN. Hip/Knee is the only readmission area performing <1.

ATTACHMENT III

CMS QUALITY IMPROVEMENT PROGRAM – REPORTS

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Address: 365 MONTAUK AVE	Type of Facility: Short-term
City, State, ZIP: NEW LONDON, CT 06320	Type of Ownership: Voluntary non-profit - Private
Phone Number: (860) 442-0711	Emergency Service Provided: Yes
County Name: NEW LONDON	

Structural Measures (SM)		
SM-1	Participation in a Systematic Database for Cardiac Surgery	Does Not Have a Program
SM-3	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Yes
SM-4	Participation in a Systematic Clinical Database Registry for General Surgery	Yes
SM-5	Safe Surgery Checklist Use	Yes

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Acute Myocardial Infarction (AMI)					
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	N/A(7)	100%	100%	60%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	92% of 49 patients(3)	100%	97%	96%
Heart Failure (HF)					
HF-2	Evaluation of LVS Function	97% of 224 patients(2,3)	100%	100%	99%
Stroke (STK)					
STK-1	Venous Thromboembolism (VTE) Prophylaxis	95% of 256 patients	100%	97%	97%
STK-2	Discharged on Antithrombotic Therapy	99% of 216 patients	100%	100%	99%
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	96% of 26 patients	100%	98%	97%
STK-4	Thrombolytic Therapy	90% of 21 patients	100%	88%	81%
STK-5	Antithrombotic Therapy By End of Hospital Day 2	97% of 226 patients	100%	98%	98%
STK-6	Discharged on Statin Medication	98% of 177 patients	100%	97%	97%
STK-8	Stroke Education	94% of 109 patients	100%	93%	94%
STK-10	Assessed for Rehabilitation	100% of 233 patients	100%	99%	98%

Footnote Legend

1 . The number of cases/patients is too few to report.
2 . Data submitted were based on a sample of cases/patients.
3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Venous Thromboembolism (VTE)					
VTE-1	Venous Thromboembolism Prophylaxis	83% of 462 patients(2)	100%	94%	93%
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	88% of 121 patients(2)	100%	96%	96%
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	96% of 57 patients(2)	100%	96%	95%
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	100% of 58 patients(2,3)	100%	98%	99%
VTE-5	Venous Thromboembolism Warfarin Therapy Discharge Instructions	53% of 34 patients(2)	100%	89%	90%
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism	0% of 16 patients(2)	0%	3%	5%
Pneumonia (PN)					
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	95% of 61 patients(2,3)	100%	97%	96%
Surgical Care Improvement Project (SCIP)					
SCIP-Inf-1	Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	98% of 248 patients(2,3)	100%	99%	99%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	98% of 248 patients(2,3)	100%	99%	99%
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	99% of 248 patients(2,3)	100%	98%	98%
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	99% of 238 patients(2,3)	100%	99%	98%
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	92% of 87 patients(2,3)	100%	98%	98%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	100% of 283 patients(2,3)	100%	100%	100%

Footnote Legend

1 . The number of cases/patients is too few to report.
2 . Data submitted were based on a sample of cases/patients.
3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Emergency Department (ED)					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	389 Minutes based on 717 patients(2)	178 Minutes	Low Volume: 311 Minutes Medium: 315 Minutes High: 390 Minutes Very High: 389 Minutes Overall Average: 351 Minutes	Low Volume: 218 Minutes Medium: 260 Minutes High: 298 Minutes Very High: 338 Minutes Overall Average: 279 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	86 Minutes based on 686 patients(2)	40 Minutes	Low Volume: 153 Minutes Medium: 134 Minutes High: 195 Minutes Very High: 178 Minutes Overall Average: 165 Minutes	Low Volume: 60 Minutes Medium: 89 Minutes High: 114 Minutes Very High: 132 Minutes Overall Average: 99 Minutes
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	Very High			
Immunization (IMM)					
IMM-2	Influenza Immunization	94% of 519 patients(2)	100%	95%	94%
Perinatal Care (PC)					
PC-01	Elective Delivery	3% of 177 patients	0%	3%	3%

Footnote Legend

1 . The number of cases/patients is too few to report.
2 . Data submitted were based on a sample of cases/patients.
3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Second Quarter 2014 through First Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Second Quarter 2014 through First Quarter 2015 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Address: 365 MONTAUK AVE
City, State, ZIP: NEW LONDON, CT 06320
Phone Number: (860) 442-0711
County Name: NEW LONDON

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

HCAHPS Survey Completion, Response Rate and Summary Star Rating	
Number of Completed Surveys	2178
Survey Response Rate	28
HCAHPS Summary Star Rating	3 stars

HCAHPS Composites and Individual Items

HCAHPS Composites		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	3	91	4	17	79	4	16	80	4	17	79
Composite 2 (Q5 to Q7)	Communication with Doctors	2	90	6	16	78	4	16	80	4	14	82
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	3	85	10	25	65	10	25	65	9	23	68
Composite 4 (Q13 & Q14)	Pain Management	4	88	7	22	71	7	22	71	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	3	78	19	19	62	18	18	64	18	17	65

Footnote Legend
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5 . Results are not available for this reporting period.
6 . Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
10 . Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
11 . There were discrepancies in the data collection process.
15 . The number of cases/patients is too few to report a star rating.

Star Ratings Legend
5 stars: Excellent
4 stars: Above Average
3 stars: Average
2 stars: Below Average
1 star: Poor
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Second Quarter 2014 through First Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Second Quarter 2014 through First Quarter 2015 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Hospital Environment Items		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	2	84	12	21	67	8	20	72	8	18	74
Q9	Quietness of Hospital Environment	2	77	15	35	50	14	33	53	9	29	62

Discharge Information Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Yes	%No	% Yes	%No	% Yes	%No
Composite 6 (Q19 & Q20)	Discharge Information	3	85	85	15	86	14	86	14

Care Transition Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Disagree to Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree
Composite 7 (Q23 to Q25)	Care Transition	2	80	6	45	49	5	44	51	5	43	52

HCAHPS Global Items												
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q21	Overall Rating of Hospital	Star Rating (Out of 5)	Linear Score (0-100)	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating
Overall Rating of Hospital (0= Worst Hospital 10= Best Hospital)		2	86	10	26	64	8	24	68	8	21	71
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q22	Willingness to Recommend this Hospital	Star Rating (Out of 5)	Linear Score (0-100)	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend
Willingness to Recommend this Hospital		3	86	6	29	65	5	24	71	5	24	71

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4 stars: Above Average
3 stars: Average
2 stars: Below Average
1 star: Poor
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Address: 365 MONTAUK AVE
City, State, ZIP: NEW LONDON, CT 06320
Phone Number: (860) 442-0711
County Name: NEW LONDON

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

30-Day Risk-Standardized Condition-Specific Mortality Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	No different than the National Rate	265	13.1% (10.7%, 15.8%)	14.2		in the **Nation** that Performed…	41	2474	21	1954
							in the **State** that Performed…	1	29	0	2
Chronic Obstructive Pulmonary Disease (COPD)											
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	No different than the National Rate	554	7.6% (6.0%, 9.7%)	7.7		in the **Nation** that Performed…	51	3611	89	907
							in the **State** that Performed…	1	29	0	1
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No different than the National Rate	629	11.8% (9.9%, 14.1%)	11.6		in the **Nation** that Performed…	145	3662	93	871
							in the **State** that Performed…	2	29	0	1

Footnote Legend
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7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
MORT-30-PN	Pneumonia 30-Day Mortality Rate	No different than the National Rate	512	10.6% (8.6%, 13.1%)	11.5		in the **Nation** that Performed…	176	4018	177	441
							in the **State** that Performed…	4	28	0	0
Stroke (STK)											
MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	No different than the National Rate	356	15.0% (12.5%, 18.0%)	14.8		in the **Nation** that Performed…	42	2682	79	1689
							in the **State** that Performed…	0	28	1	2

30-Day Risk-Standardized Procedure-Based Mortality Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
MORT-30-CABG	30-Day All-Cause Mortality Following Coronary Artery Bypass Graft (CABG) Surgery	N/A(5)	N/A(5)	N/A(5)	3.2		in the **Nation** that Performed…	14	1037	16	132
							in the **State** that Performed…	0	11	0	0

Footnote Legend

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Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

30-Day Risk-Standardized Condition-Specific Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	No different than the National Rate	192	16.4% (13.6%, 19.4%)	17.0		in the **Nation** that Performed…	30	2273	23	2058
							in the **State** that Performed…	0	27	0	4
Chronic Obstructive Pulmonary Disease (COPD)											
READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	No different than the National Rate	659	20.6% (18.3%, 23.3%)	20.2		in the **Nation** that Performed…	27	3730	83	823
							in the **State** that Performed…	1	28	1	1
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	Better than the National Rate	717	18.7% (16.5%, 21.1%)	22.0		in the **Nation** that Performed…	100	3766	133	779
							in the **State** that Performed…	1	29	1	1

Footnote Legend

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13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
READM-30-PN	Pneumonia 30-Day Readmission Rate	No different than the National Rate	522	17.3% (14.9%, 19.9%)	16.9		in the **Nation** that Performed…	24	4289	73	429
							in the **State** that Performed…	0	30	2	0
Stroke (STK)											
READM-30-STK	Stroke (STK) 30-Day Readmission Rate	No different than the National Rate	344	11.8% (9.5%, 14.3%)	12.7		in the **Nation** that Performed…	19	2685	58	1700
							in the **State** that Performed…	0	29	0	1

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13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

30-Day Risk-Standardized Procedure-Based Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
READM-30-CABG	30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	N/A(5)	N/A(5)	N/A(5)	14.9		in the **Nation** that Performed…	6	1040	12	141
							in the **State** that Performed…	0	11	0	0
Hip/Knee											
READM-30-HIP-KNEE	30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No different than the National Rate	740	4.7% (3.6%, 5.9%)	4.8		in the **Nation** that Performed…	49	2721	49	679
							in the **State** that Performed…	1	27	0	1

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13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

30-Day Risk-Standardized Hospital-Wide Readmission Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hospital Wide											
READM-30-HOSPWIDE	30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	Better than the National Rate	3831	13.7% (12.9%, 14.9%)	15.2		in the **Nation** that Performed…	178	4078	337	179
							in the **State** that Performed…	1	27	2	1

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13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Complication Outcome Measures: Second Quarter 2011 through First Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Risk-Standardized Complication Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Complication Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hip/Knee Complication											
COMP-HIP-KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No different than the National Rate	689	3.1% (2.2%, 4.3%)	3.1		in the **Nation** that Performed…	54	2711	45	697
							in the **State** that Performed…	1	23	5	0

Footnote Legend

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4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Payment

Reporting Period for 30-Day Condition-Specific Payment Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

30-Day Condition-Specific Payment Measures

	Hospital Quality Measures	Your Hospital's Payment Category	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Payment (Lower Limit, Upper Limit of 95% Interval Estimate)	National Average Payment		Number of Hospitals…	Greater Than National Average Payment	No Different Than National Average Payment	Less Than National Average Payment	Number of Cases Too Few To Report
PAYM-30-AMI											
PAYM-30-AMI	Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	No Different than the National Average Payment	256	$21694 ($19985, $23510)	$21791		in the **Nation** whose payment was…	368	1854	175	1944
							in the **State** whose payment was…	6	23	0	2
PAYM-30-HF											
PAYM-30-HF	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	No Different than the National Average Payment	599	$15508 ($14667, $16374)	$15223		in the **Nation** whose payment was…	731	2584	388	942
							in the **State** whose payment was…	13	17	0	1
PAYM-30-PN											
PAYM-30-PN	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	Greater than the National Average Payment	492	$15395 ($14523, $16283)	$14294		in the **Nation** whose payment was…	670	2852	684	479
							in the **State** whose payment was…	14	17	0	0

Footnote Legend

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Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2012 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Address: 365 MONTAUK AVE
City, State, ZIP: NEW LONDON, CT 06320
Phone Number: (860) 442-0711
County Name: NEW LONDON

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

AHRQ Measures – Patient Safety Indicators

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
Individual Patient Safety Indicators (PSIs)											
PSI-4	Death among surgical inpatients with serious treatable complications	No different than the National Rate	84	115.01 (71.61, 158.40)	117.75		in the **Nation** that Performed…	45	1730	65	1028
							in the **State** that Performed…	0	22	0	7
PSI-6	Iatrogenic pneumothorax, adult	No different than the National Rate	10074	0.33 (0.08, 0.58)	0.39		in the **Nation** that Performed…	1	3334	23	35
							in the **State** that Performed…	0	30	1	1
PSI-12	Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	No different than the National Rate	2032	4.84 (2.50, 7.19)	4.35		in the **Nation** that Performed…	153	2725	212	129
							in the **State** that Performed…	0	22	7	0

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5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2012 through Second Quarter 2014 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
PSI-14	Postoperative wound dehiscence	No different than the National Rate	201	1.47 (0.00, 3.27)	1.70		in the **Nation** that Performed…	0	2612	7	428
							in the **State** that Performed…	0	29	0	0
PSI-15	Accidental puncture or laceration	No different than the National Rate	10407	2.36 (1.28, 3.45)	1.81		in the **Nation** that Performed…	89	3066	199	36
							in the **State** that Performed…	0	29	2	1
Composite Patient Safety Indicator (PSI)											
PSI-90	Complication / patient safety for selected indicators (composite)	No different than the National Rate	N/A	0.98 (0.70, 1.25)	0.81		in the **Nation** that Performed…	110	3072	213	N/A
							in the **State** that Performed…	0	28	4	N/A

Footnote Legend

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7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Associated Infection Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070007 - LAWRENCE & MEMORIAL HOSPITAL

Healthcare Associated Infection

Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device or Patient Days/Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio, State Lower Limit, State Upper Limit of 95% Interval Estimate	National Standardized Infection Ratio
Healthcare Associated Infection Measures							
Central Line Associated Bloodstream Infection (ICU + select Wards)	1	1454	2.169	0.461(0.023,2.274)	No Different than National Benchmark	0.726 (0.571, 0.910)	0.547
Central Line Associated Bloodstream Infection (ICU only)	2	2186	3.689	0.542(0.091,1.791)	No Different than National Benchmark	0.455 (0.368, 0.556)	0.462
Catheter Associated Urinary Tract Infections (ICU + select Wards)	1	2312	3.933	0.254(0.013,1.254)	No Different than National Benchmark	0.562 (0.437, 0.711)	0.573
Catheter Associated Urinary Tract Infections (ICU only)	6	3929	6.337	0.947(0.384,1.969)	No Different than National Benchmark	1.339 (1.196, 1.495)	0.996
SSI-Colon Surgery	5	89	2.595	1.927(0.706,4.271)	No Different than National Benchmark	1.340 (1.141, 1.565)	1.010
SSI-Abdominal Hysterectomy	2	117	0.959	N/A(13)	N/A	0.953 (0.667, 1.323)	0.882
MRSA Bacteremia	4	62800	2.701	1.481(0.471,3.572)	No Different than National Benchmark	0.703 (0.570, 0.858)	0.883
Clostridium Difficile (C.Diff)	58	57303	45.378	1.278(0.980,1.641)	No Different than National Benchmark	1.057 (1.005, 1.112)	0.921

Footnote Legend

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8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/21/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Personnel Influenza Vaccination: Fourth Quarter 2014 through First Quarter 2015

070007 - LAWRENCE & MEMORIAL HOSPITAL

Healthcare Personnel Influenza Vaccination

Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
Healthcare Personnel Influenza Vaccination	91%	N/A	86%	84%

Footnote Legend

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3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Address: 5 PERRYRIDGE RD	Type of Facility: Short-term
City, State, ZIP: GREENWICH, CT 06830	Type of Ownership: Voluntary non-profit - Private
Phone Number: (203) 863-3000	Emergency Service Provided: Yes
County Name: FAIRFIELD	

Structural Measures (SM)		
SM-1	Participation in a Systematic Database for Cardiac Surgery	Does Not Have a Program
SM-3	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Yes
SM-4	Participation in a Systematic Clinical Database Registry for General Surgery	No
SM-5	Safe Surgery Checklist Use	Yes

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Acute Myocardial Infarction (AMI)					
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	N/A(2,7)	100%	100%	60%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	100% of 13 patients(2,3)	100%	97%	96%
Heart Failure (HF)					
HF-2	Evaluation of LVS Function	100% of 174 patients(2,3)	100%	100%	99%
Stroke (STK)					
STK-1	Venous Thromboembolism (VTE) Prophylaxis	100% of 138 patients(2)	100%	97%	97%
STK-2	Discharged on Antithrombotic Therapy	100% of 86 patients(2,3)	100%	100%	99%
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	100% of 11 patients(2,3)	100%	98%	97%
STK-4	Thrombolytic Therapy	88% of 8 patients(1,2)	100%	88%	81%
STK-5	Antithrombotic Therapy By End of Hospital Day 2	98% of 83 patients(2,3)	100%	98%	98%
STK-6	Discharged on Statin Medication	96% of 101 patients(2)	100%	97%	97%
STK-8	Stroke Education	97% of 68 patients(2)	100%	93%	94%
STK-10	Assessed for Rehabilitation	98% of 102 patients(2,3)	100%	99%	98%

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Venous Thromboembolism (VTE)					
VTE-1	Venous Thromboembolism Prophylaxis	94% of 426 patients(2)	100%	94%	93%
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	96% of 55 patients(2)	100%	96%	96%
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	98% of 59 patients(2)	100%	96%	95%
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	100% of 21 patients(2,3)	100%	98%	99%
VTE-5	Venous Thromboembolism Warfarin Therapy Discharge Instructions	98% of 43 patients(2)	100%	89%	90%
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism	0% of 8 patients(1,2)	0%	3%	5%
Pneumonia (PN)					
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	96% of 54 patients(2,3)	100%	97%	96%
Surgical Care Improvement Project (SCIP)					
SCIP-Inf-1	Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	99% of 149 patients(2,3)	100%	99%	99%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	99% of 149 patients(2,3)	100%	99%	99%
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	98% of 144 patients(2,3)	100%	98%	98%
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	94% of 70 patients(2,3)	100%	99%	98%
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	93% of 72 patients(2,3)	100%	98%	98%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	100% of 181 patients(2,3)	100%	100%	100%

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Emergency Department (ED)					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	306 Minutes based on 550 patients(2)	178 Minutes	Low Volume: 311 Minutes Medium: 315 Minutes High: 390 Minutes Very High: 389 Minutes Overall Average: 351 Minutes	Low Volume: 218 Minutes Medium: 260 Minutes High: 298 Minutes Very High: 338 Minutes Overall Average: 279 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	144 Minutes based on 549 patients(2)	40 Minutes	Low Volume: 153 Minutes Medium: 134 Minutes High: 195 Minutes Very High: 178 Minutes Overall Average: 165 Minutes	Low Volume: 60 Minutes Medium: 89 Minutes High: 114 Minutes Very High: 132 Minutes Overall Average: 99 Minutes
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	High			
Immunization (IMM)					
IMM-2	Influenza Immunization	88% of 454 patients(2)	100%	95%	94%
Perinatal Care (PC)					
PC-01	Elective Delivery	7% of 75 patients(2)	0%	3%	3%

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Second Quarter 2014 through First Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Second Quarter 2014 through First Quarter 2015 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Address: 5 PERRYRIDGE RD
City, State, ZIP: GREENWICH, CT 06830
Phone Number: (203) 863-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

HCAHPS Survey Completion, Response Rate and Summary Star Rating	
Number of Completed Surveys	552
Survey Response Rate	35
HCAHPS Summary Star Rating	4 stars

HCAHPS Composites and Individual Items

HCAHPS Composites		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	4	93	4	13	83	4	16	80	4	17	79
Composite 2 (Q5 to Q7)	Communication with Doctors	4	93	4	12	84	4	16	80	4	14	82
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	4	87	8	21	71	10	25	65	9	23	68
Composite 4 (Q13 & Q14)	Pain Management	4	90	5	20	75	7	22	71	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	3	81	16	16	68	18	18	64	18	17	65

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6 . Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
10 . Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
11 . There were discrepancies in the data collection process.
15 . The number of cases/patients is too few to report a star rating.

Star Ratings Legend
5 stars: Excellent
4 stars: Above Average
3 stars: Average
2 stars: Below Average
1 star: Poor
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Second Quarter 2014 through First Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Second Quarter 2014 through First Quarter 2015 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Hospital Environment Items		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	4	92	5	14	81	8	20	72	8	18	74
Q9	Quietness of Hospital Environment	3	82	12	27	61	14	33	53	9	29	62

Discharge Information Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Yes	%No	% Yes	%No	% Yes	%No
Composite 6 (Q19 & Q20)	Discharge Information	2	83	83	17	86	14	86	14

Care Transition Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Disagree to Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree
Composite 7 (Q23 to Q25)	Care Transition	4	83	5	40	55	5	44	51	5	43	52

HCAHPS Global Items												
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q21	Overall Rating of Hospital	Star Rating (Out of 5)	Linear Score (0-100)	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating
Overall Rating of Hospital (0= Worst Hospital 10= Best Hospital)		5	93	4	13	83	8	24	68	8	21	71
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q22	Willingness to Recommend this Hospital	Star Rating (Out of 5)	Linear Score (0-100)	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend
Willingness to Recommend this Hospital		5	94	3	10	87	5	24	71	5	24	71

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Star Ratings Legend
5 stars: Excellent
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1 star: Poor
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Address: 5 PERRYRIDGE RD
City, State, ZIP: GREENWICH, CT 06830
Phone Number: (203) 863-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

30-Day Risk-Standardized Condition-Specific Mortality Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	No different than the National Rate	147	15.0% (12.1%, 18.3%)	14.2		in the **Nation** that Performed…	41	2474	21	1954
							in the **State** that Performed…	1	29	0	2
Chronic Obstructive Pulmonary Disease (COPD)											
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	No different than the National Rate	324	6.8% (5.1%, 8.9%)	7.7		in the **Nation** that Performed…	51	3611	89	907
							in the **State** that Performed…	1	29	0	1
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No different than the National Rate	434	12.3% (10.1%, 14.8%)	11.6		in the **Nation** that Performed…	145	3662	93	871
							in the **State** that Performed…	2	29	0	1

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
MORT-30-PN	Pneumonia 30-Day Mortality Rate	No different than the National Rate	447	10.0% (7.9%, 12.4%)	11.5		in the **Nation** that Performed…	176	4018	177	441
							in the **State** that Performed…	4	28	0	0
Stroke (STK)											
MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	No different than the National Rate	267	12.9% (10.3%, 15.7%)	14.8		in the **Nation** that Performed…	42	2682	79	1689
							in the **State** that Performed…	0	28	1	2

30-Day Risk-Standardized Procedure-Based Mortality Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
MORT-30-CABG	30-Day All-Cause Mortality Following Coronary Artery Bypass Graft (CABG) Surgery	N/A(5)	N/A(5)	N/A(5)	3.2		in the **Nation** that Performed…	14	1037	16	132
							in the **State** that Performed…	0	11	0	0

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

30-Day Risk-Standardized Condition-Specific Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	No different than the National Rate	90	18.9% (15.7%, 22.6%)	17.0		in the **Nation** that Performed…	30	2273	23	2058
							in the **State** that Performed…	0	27	0	4
Chronic Obstructive Pulmonary Disease (COPD)											
READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	No different than the National Rate	377	22.0% (19.0%, 25.4%)	20.2		in the **Nation** that Performed…	27	3730	83	823
							in the **State** that Performed…	1	28	1	1
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	No different than the National Rate	509	22.8% (20.0%, 25.8%)	22.0		in the **Nation** that Performed…	100	3766	133	779
							in the **State** that Performed…	1	29	1	1

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
READM-30-PN	Pneumonia 30-Day Readmission Rate	No different than the National Rate	462	16.8% (14.2%, 19.7%)	16.9		in the **Nation** that Performed…	24	4289	73	429
							in the **State** that Performed…	0	30	2	0
Stroke (STK)											
READM-30-STK	Stroke (STK) 30-Day Readmission Rate	No different than the National Rate	256	12.8% (10.2%, 15.9%)	12.7		in the **Nation** that Performed…	19	2685	58	1700
							in the **State** that Performed…	0	29	0	1

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

30-Day Risk-Standardized Procedure-Based Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
READM-30-CABG	30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	N/A(5)	N/A(5)	N/A(5)	14.9		in the **Nation** that Performed…	6	1040	12	141
							in the **State** that Performed…	0	11	0	0
Hip/Knee											
READM-30-HIP-KNEE	30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Better than the National Rate	656	3.3% (2.5%, 4.5%)	4.8		in the **Nation** that Performed…	49	2721	49	679
							in the **State** that Performed…	1	27	0	1

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

30-Day Risk-Standardized Hospital-Wide Readmission Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hospital Wide											
READM-30-HOSPWIDE	30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	No different than the National Rate	3245	14.8% (14.0%, 15.8%)	15.2		in the **Nation** that Performed…	178	4078	337	179
							in the **State** that Performed…	1	27	2	1

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Complication Outcome Measures: Second Quarter 2011 through First Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Risk-Standardized Complication Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Complication Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hip/Knee Complication											
COMP-HIP-KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Better than the National Rate	681	1.9% (1.3%, 2.9%)	3.1		in the **Nation** that Performed…	54	2711	45	697
							in the **State** that Performed…	1	23	5	0

Footnote Legend

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Payment

Reporting Period for 30-Day Condition-Specific Payment Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

30-Day Condition-Specific Payment Measures

	Hospital Quality Measures	Your Hospital's Payment Category	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Payment (Lower Limit, Upper Limit of 95% Interval Estimate)	National Average Payment		Number of Hospitals…	Greater Than National Average Payment	No Different Than National Average Payment	Less Than National Average Payment	Number of Cases Too Few To Report
PAYM-30-AMI											
PAYM-30-AMI	Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	Greater than the National Average Payment	140	$24226 ($21901, $26737)	$21791		in the **Nation** whose payment was…	368	1854	175	1944
							in the **State** whose payment was…	6	23	0	2
PAYM-30-HF											
PAYM-30-HF	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	No Different than the National Average Payment	414	$14720 ($13795, $15700)	$15223		in the **Nation** whose payment was…	731	2584	388	942
							in the **State** whose payment was…	13	17	0	1
PAYM-30-PN											
PAYM-30-PN	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	No Different than the National Average Payment	440	$14145 ($13307, $14983)	$14294		in the **Nation** whose payment was…	670	2852	684	479
							in the **State** whose payment was…	14	17	0	0

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2012 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Address: 5 PERRYRIDGE RD
City, State, ZIP: GREENWICH, CT 06830
Phone Number: (203) 863-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

AHRQ Measures – Patient Safety Indicators

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
Individual Patient Safety Indicators (PSIs)											
PSI-4	Death among surgical inpatients with serious treatable complications	No different than the National Rate	81	97.31 (52.72, 141.89)	117.75		in the **Nation** that Performed…	45	1730	65	1028
							in the **State** that Performed…	0	22	0	7
PSI-6	Iatrogenic pneumothorax, adult	No different than the National Rate	7789	0.28 (0.02, 0.53)	0.39		in the **Nation** that Performed…	1	3334	23	35
							in the **State** that Performed…	0	30	1	1
PSI-12	Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	No different than the National Rate	2014	4.88 (2.60, 7.15)	4.35		in the **Nation** that Performed…	153	2725	212	129
							in the **State** that Performed…	0	22	7	0

Footnote Legend

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7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2012 through Second Quarter 2014 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
PSI-14	Postoperative wound dehiscence	No different than the National Rate	238	1.48 (0.00, 3.28)	1.70		in the **Nation** that Performed…	0	2612	7	428
							in the **State** that Performed…	0	29	0	0
PSI-15	Accidental puncture or laceration	No different than the National Rate	8160	1.75 (0.70, 2.80)	1.81		in the **Nation** that Performed…	89	3066	199	36
							in the **State** that Performed…	0	29	2	1
Composite Patient Safety Indicator (PSI)											
PSI-90	Complication / patient safety for selected indicators (composite)	No different than the National Rate	N/A	0.81 (0.54, 1.09)	0.81		in the **Nation** that Performed…	110	3072	213	N/A
							in the **State** that Performed…	0	28	4	N/A

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Associated Infection Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070018 - GREENWICH HOSPITAL ASSOCIATION

Healthcare Associated Infection

Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device or Patient Days/Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio, State Lower Limit, State Upper Limit of 95% Interval Estimate	National Standardized Infection Ratio
Healthcare Associated Infection Measures							
Central Line Associated Bloodstream Infection (ICU + select Wards)	0	1100	1.729	0.000(--,1.733)(8)	No Different than National Benchmark	0.726 (0.571, 0.910)	0.547
Central Line Associated Bloodstream Infection (ICU only)	0	768	1.609	0.000(--,1.862)(8)	No Different than National Benchmark	0.455 (0.368, 0.556)	0.462
Catheter Associated Urinary Tract Infections (ICU + select Wards)	2	1105	2.064	0.969(0.162,3.201)	No Different than National Benchmark	0.562 (0.437, 0.711)	0.573
Catheter Associated Urinary Tract Infections (ICU only)	0	1008	2.318	0.000(--,1.292)(8)	No Different than National Benchmark	1.339 (1.196, 1.495)	0.996
SSI-Colon Surgery	8	133	3.733	2.143(0.995,4.070)	No Different than National Benchmark	1.340 (1.141, 1.565)	1.010
SSI-Abdominal Hysterectomy	0	118	0.864	N/A(13)	N/A	0.953 (0.667, 1.323)	0.882
MRSA Bacteremia	0	54649	2.953	0.000(--,1.014)(8)	No Different than National Benchmark	0.703 (0.570, 0.858)	0.883
Clostridium Difficile (C.Diff)	25	45627	35.763	0.699(0.462,1.017)	No Different than National Benchmark	1.057 (1.005, 1.112)	0.921

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Report Run Date: 09/15/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Personnel Influenza Vaccination: Fourth Quarter 2014 through First Quarter 2015

070018 - GREENWICH HOSPITAL ASSOCIATION

Healthcare Personnel Influenza Vaccination

Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
Healthcare Personnel Influenza Vaccination	79%	N/A	86%	84%

Footnote Legend

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Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070010 - BRIDGEPORT HOSPITAL

Address: 267 GRANT STREET	Type of Facility: Short-term
City, State, ZIP: BRIDGEPORT, CT 06610	Type of Ownership: Voluntary non-profit - Private
Phone Number: (203) 384-3000	Emergency Service Provided: Yes
County Name: FAIRFIELD	

Structural Measures (SM)		
SM-1	Participation in a Systematic Database for Cardiac Surgery	Yes
SM-3	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Yes
SM-4	Participation in a Systematic Clinical Database Registry for General Surgery	Yes
SM-5	Safe Surgery Checklist Use	Yes

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Acute Myocardial Infarction (AMI)					
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	N/A(2,7)	100%	100%	60%
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	100% of 15 patients(2,3)	100%	97%	96%
Heart Failure (HF)					
HF-2	Evaluation of LVS Function	98% of 199 patients(2,3)	100%	100%	99%
Stroke (STK)					
STK-1	Venous Thromboembolism (VTE) Prophylaxis	90% of 144 patients(2)	100%	97%	97%
STK-2	Discharged on Antithrombotic Therapy	93% of 84 patients(2,3)	100%	100%	99%
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	100% of 8 patients(1,2,3)	100%	98%	97%
STK-4	Thrombolytic Therapy	78% of 9 patients(1,2)	100%	88%	81%
STK-5	Antithrombotic Therapy By End of Hospital Day 2	97% of 78 patients(2,3)	100%	98%	98%
STK-6	Discharged on Statin Medication	86% of 93 patients(2)	100%	97%	97%
STK-8	Stroke Education	100% of 44 patients(2)	100%	93%	94%
STK-10	Assessed for Rehabilitation	98% of 97 patients(2,3)	100%	99%	98%

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Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070010 - BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Venous Thromboembolism (VTE)					
VTE-1	Venous Thromboembolism Prophylaxis	89% of 426 patients(2)	100%	94%	93%
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	98% of 80 patients(2)	100%	96%	96%
VTE-3	Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	96% of 84 patients(2)	100%	96%	95%
VTE-4	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol or Nomogram	100% of 81 patients(2,3)	100%	98%	99%
VTE-5	Venous Thromboembolism Warfarin Therapy Discharge Instructions	100% of 41 patients(2)	100%	89%	90%
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism	12% of 41 patients(2)	0%	3%	5%
Pneumonia (PN)					
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	100% of 41 patients(2,3)	100%	97%	96%
Surgical Care Improvement Project (SCIP)					
SCIP-Inf-1	Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision	96% of 221 patients(2,3)	100%	99%	99%
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	97% of 221 patients(2,3)	100%	99%	99%
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	97% of 202 patients(2,3)	100%	98%	98%
SCIP-Inf-9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery being Day Zero	98% of 215 patients(2,3)	100%	99%	98%
SCIP-Card-2	Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period	97% of 115 patients(2,3)	100%	98%	98%
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	100% of 203 patients(2,3)	100%	100%	100%

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Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070010 - BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Emergency Department (ED)					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	410 Minutes based on 696 patients(2)	178 Minutes	Low Volume: 311 Minutes Medium: 315 Minutes High: 390 Minutes Very High: 389 Minutes Overall Average: 351 Minutes	Low Volume: 218 Minutes Medium: 260 Minutes High: 298 Minutes Very High: 338 Minutes Overall Average: 279 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	178 Minutes based on 692 patients(2)	40 Minutes	Low Volume: 153 Minutes Medium: 134 Minutes High: 195 Minutes Very High: 178 Minutes Overall Average: 165 Minutes	Low Volume: 60 Minutes Medium: 89 Minutes High: 114 Minutes Very High: 132 Minutes Overall Average: 99 Minutes
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	Very High			
Immunization (IMM)					
IMM-2	Influenza Immunization	84% of 531 patients(2)	100%	95%	94%
Perinatal Care (PC)					
PC-01	Elective Delivery	6% of 49 patients(2)	0%	3%	3%

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Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Second Quarter 2014 through First Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Second Quarter 2014 through First Quarter 2015 Discharges

070010 - BRIDGEPORT HOSPITAL

Address: 267 GRANT STREET
City, State, ZIP: BRIDGEPORT, CT 06610
Phone Number: (203) 384-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

HCAHPS Survey Completion, Response Rate and Summary Star Rating	
Number of Completed Surveys	756
Survey Response Rate	23
HCAHPS Summary Star Rating	3 stars

HCAHPS Composites and Individual Items

HCAHPS Composites		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	4	92	4	15	81	4	16	80	4	17	79
Composite 2 (Q5 to Q7)	Communication with Doctors	3	92	4	16	80	4	16	80	4	14	82
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	3	83	12	25	63	10	25	65	9	23	68
Composite 4 (Q13 & Q14)	Pain Management	4	88	7	21	72	7	22	71	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	2	77	20	17	63	18	18	64	18	17	65

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6 . Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
10 . Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
11 . There were discrepancies in the data collection process.
15 . The number of cases/patients is too few to report a star rating.

Star Ratings Legend
5 stars: Excellent
4 stars: Above Average
3 stars: Average
2 stars: Below Average
1 star: Poor
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Second Quarter 2014 through First Quarter 2015 Discharges

Reporting Period for HCAHPS Star Ratings: Second Quarter 2014 through First Quarter 2015 Discharges

070010 - BRIDGEPORT HOSPITAL

Hospital Environment Items		Star Rating (Out of 5)	Linear Score (0-100)	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	2	85	10	22	68	8	20	72	8	18	74
Q9	Quietness of Hospital Environment	2	77	16	32	52	14	33	53	9	29	62

Discharge Information Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Yes	%No	% Yes	%No	% Yes	%No
Composite 6 (Q19 & Q20)	Discharge Information	3	84	84	16	86	14	86	14

Care Transition Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Disagree to Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree
Composite 7 (Q23 to Q25)	Care Transition	3	81	5	45	50	5	44	51	5	43	52

HCAHPS Global Items												
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q21	Overall Rating of Hospital	Star Rating (Out of 5)	Linear Score (0-100)	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating	% 0 to 6 rating	% 7 or 8 rating	% 9 or 10 rating
Overall Rating of Hospital (0= Worst Hospital 10= Best Hospital)		3	88	9	25	66	8	24	68	8	21	71
		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q22	Willingness to Recommend this Hospital	Star Rating (Out of 5)	Linear Score (0-100)	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend	%No: Definitely or Probably Not Recommend	%Yes: Probably Recommend	%Yes: Definitely Recommend
Willingness to Recommend this Hospital		3	89	4	24	72	5	24	71	5	24	71

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15 . The number of cases/patients is too few to report a star rating.

Star Ratings Legend
5 stars: Excellent
4 stars: Above Average
3 stars: Average
2 stars: Below Average
1 star: Poor
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

Address: 267 GRANT STREET
City, State, ZIP: BRIDGEPORT, CT 06610
Phone Number: (203) 384-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

30-Day Risk-Standardized Condition-Specific Mortality Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	Better than the National Rate	331	11.5% (9.4%, 13.7%)	14.2		in the **Nation** that Performed…	41	2474	21	1954
							in the **State** that Performed…	1	29	0	2
Chronic Obstructive Pulmonary Disease (COPD)											
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	No different than the National Rate	230	6.5% (4.9%, 8.8%)	7.7		in the **Nation** that Performed…	51	3611	89	907
							in the **State** that Performed…	1	29	0	1
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No different than the National Rate	461	10.8% (8.9%, 13.1%)	11.6		in the **Nation** that Performed…	145	3662	93	871
							in the **State** that Performed…	2	29	0	1

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Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
MORT-30-PN	Pneumonia 30-Day Mortality Rate	Better than the National Rate	455	9.2% (7.3%, 11.4%)	11.5		in the **Nation** that Performed…	176	4018	177	441
							in the **State** that Performed…	4	28	0	0
Stroke (STK)											
MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	No different than the National Rate	208	15.9% (13.1%, 19.2%)	14.8		in the **Nation** that Performed…	42	2682	79	1689
							in the **State** that Performed…	0	28	1	2

30-Day Risk-Standardized Procedure-Based Mortality Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
MORT-30-CABG	30-Day All-Cause Mortality Following Coronary Artery Bypass Graft (CABG) Surgery	No different than the National Rate	36	2.7% (1.3%, 5.6%)	3.2		in the **Nation** that Performed…	14	1037	16	132
							in the **State** that Performed…	0	11	0	0

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Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

30-Day Risk-Standardized Condition-Specific Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	No different than the National Rate	346	17.6% (15.0%, 20.6%)	17.0		in the **Nation** that Performed…	30	2273	23	2058
							in the **State** that Performed…	0	27	0	4
Chronic Obstructive Pulmonary Disease (COPD)											
READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	No different than the National Rate	271	22.7% (19.5%, 26.2%)	20.2		in the **Nation** that Performed…	27	3730	83	823
							in the **State** that Performed…	1	28	1	1
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	No different than the National Rate	560	23.0% (20.2%, 26.1%)	22.0		in the **Nation** that Performed…	100	3766	133	779
							in the **State** that Performed…	1	29	1	1

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
READM-30-PN	Pneumonia 30-Day Readmission Rate	No different than the National Rate	474	17.9% (15.4%, 20.7%)	16.9		in the **Nation** that Performed…	24	4289	73	429
							in the **State** that Performed…	0	30	2	0
Stroke (STK)											
READM-30-STK	Stroke (STK) 30-Day Readmission Rate	No different than the National Rate	198	13.3% (10.7%, 16.8%)	12.7		in the **Nation** that Performed…	19	2685	58	1700
							in the **State** that Performed…	0	29	0	1

Footnote Legend

1 . The number of cases/patients is too few to report.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

30-Day Risk-Standardized Procedure-Based Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
READM-30-CABG	30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	No different than the National Rate	36	13.8% (10.3%, 18.5%)	14.9		in the **Nation** that Performed…	6	1040	12	141
							in the **State** that Performed…	0	11	0	0
Hip/Knee											
READM-30-HIP-KNEE	30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No different than the National Rate	373	4.4% (3.2%, 5.9%)	4.8		in the **Nation** that Performed…	49	2721	49	679
							in the **State** that Performed…	1	27	0	1

Footnote Legend

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5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2013 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

30-Day Risk-Standardized Hospital-Wide Readmission Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hospital Wide											
READM-30-HOSPWIDE	30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	No different than the National Rate	2934	15.8% (14.8%, 16.7%)	15.2		in the **Nation** that Performed…	178	4078	337	179
							in the **State** that Performed…	1	27	2	1

Footnote Legend

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7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Complication Outcome Measures: Second Quarter 2011 through First Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

Risk-Standardized Complication Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Complication Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hip/Knee Complication											
COMP-HIP-KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Worse than the National Rate	363	4.8% (3.3%, 6.8%)	3.1		in the **Nation** that Performed…	54	2711	45	697
							in the **State** that Performed…	1	23	5	0

Footnote Legend

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5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Payment

Reporting Period for 30-Day Condition-Specific Payment Measures: Third Quarter 2011 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

30-Day Condition-Specific Payment Measures

	Hospital Quality Measures	Your Hospital's Payment Category	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Payment (Lower Limit, Upper Limit of 95% Interval Estimate)	National Average Payment		Number of Hospitals…	Greater Than National Average Payment	No Different Than National Average Payment	Less Than National Average Payment	Number of Cases Too Few To Report
PAYM-30-AMI											
PAYM-30-AMI	Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	No Different than the National Average Payment	316	$21353 ($19891, $22899)	$21791		in the **Nation** whose payment was…	368	1854	175	1944
							in the **State** whose payment was…	6	23	0	2
PAYM-30-HF											
PAYM-30-HF	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	Greater than the National Average Payment	436	$16328 ($15354, $17388)	$15223		in the **Nation** whose payment was…	731	2584	388	942
							in the **State** whose payment was…	13	17	0	1
PAYM-30-PN											
PAYM-30-PN	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	Greater than the National Average Payment	435	$16050 ($15109, $17042)	$14294		in the **Nation** whose payment was…	670	2852	684	479
							in the **State** whose payment was…	14	17	0	0

Footnote Legend

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5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2012 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

Address: 267 GRANT STREET
City, State, ZIP: BRIDGEPORT, CT 06610
Phone Number: (203) 384-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

AHRQ Measures – Patient Safety Indicators

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
Individual Patient Safety Indicators (PSIs)											
PSI-4	Death among surgical inpatients with serious treatable complications	No different than the National Rate	78	137.57 (93.37, 181.76)	117.75		in the **Nation** that Performed…	45	1730	65	1028
							in the **State** that Performed…	0	22	0	7
PSI-6	Iatrogenic pneumothorax, adult	No different than the National Rate	8565	0.37 (0.12, 0.61)	0.39		in the **Nation** that Performed…	1	3334	23	35
							in the **State** that Performed…	0	30	1	1
PSI-12	Post-Operative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	Worse than the National Rate	1982	7.50 (5.30, 9.70)	4.35		in the **Nation** that Performed…	153	2725	212	129
							in the **State** that Performed…	0	22	7	0

Footnote Legend

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4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2012 through Second Quarter 2014 Discharges

070010 - BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
PSI-14	Postoperative wound dehiscence	No different than the National Rate	179	2.92 (1.09, 4.74)	1.70		in the **Nation** that Performed…	0	2612	7	428
							in the **State** that Performed…	0	29	0	0
PSI-15	Accidental puncture or laceration	No different than the National Rate	8914	1.64 (0.62, 2.66)	1.81		in the **Nation** that Performed…	89	3066	199	36
							in the **State** that Performed…	0	29	2	1
Composite Patient Safety Indicator (PSI)											
PSI-90	Complication / patient safety for selected indicators (composite)	No different than the National Rate	N/A	0.99 (0.73, 1.25)	0.81		in the **Nation** that Performed…	110	3072	213	N/A
							in the **State** that Performed…	0	28	4	N/A

Footnote Legend

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5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Associated Infection Measures: Second Quarter 2014 through First Quarter 2015 Discharges

070010 - BRIDGEPORT HOSPITAL

Healthcare Associated Infection

Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device or Patient Days/Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio, State Lower Limit, State Upper Limit of 95% Interval Estimate	National Standardized Infection Ratio
Healthcare Associated Infection Measures							
Central Line Associated Bloodstream Infection (ICU + select Wards)	8	4252	7.585	1.055(0.490,2.003)	No Different than National Benchmark	0.726 (0.571, 0.910)	0.547
Central Line Associated Bloodstream Infection (ICU only)	6	3841	10.026	0.598(0.243,1.245)	No Different than National Benchmark	0.455 (0.368, 0.556)	0.462
Catheter Associated Urinary Tract Infections (ICU + select Wards)	3	4677	9.830	0.305(0.078,0.831)	Better than the National Benchmark	0.562 (0.437, 0.711)	0.573
Catheter Associated Urinary Tract Infections (ICU only)	16	6090	15.270	1.048(0.620,1.665)	No Different than National Benchmark	1.339 (1.196, 1.495)	0.996
SSI-Colon Surgery	6	107	3.403	1.763(0.715,3.667)	No Different than National Benchmark	1.340 (1.141, 1.565)	1.010
SSI-Abdominal Hysterectomy	4	288	2.607	1.534(0.488,3.701)	No Different than National Benchmark	0.953 (0.667, 1.323)	0.882
MRSA Bacteremia	9	102767	6.159	1.461(0.713,2.682)	No Different than National Benchmark	0.703 (0.570, 0.858)	0.880
Clostridium Difficile (C.Diff)	101	97507	68.381	1.477(1.209,1.787)	Worse than the National Benchmark	1.057 (1.005, 1.112)	0.921

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8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 10/19/2015

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Personnel Influenza Vaccination: Fourth Quarter 2014 through First Quarter 2015

070010 - BRIDGEPORT HOSPITAL

Healthcare Personnel Influenza Vaccination

Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
Healthcare Personnel Influenza Vaccination	73%	N/A	86%	84%

Footnote Legend

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5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date Time: 09/21/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070007-LAWRENCE & MEMORIAL HOSPITAL

Address: 365 MONTAUK AVE	Type of Facility: Short-term
City, State, ZIP: NEW LONDON, CT 06320	Type of Ownership: Voluntary non-profit - Private
Phone Number: (860) 442-0711	Emergency Service Provided: Yes
County Name: NEW LONDON	

Web Based Measures										
OP-12	Does/did your facility have the ability to receive laboratory data electronically directly into your ONC certified EHR system as discrete searchable data?	No								
OP-17	Does your facility have the ability to track clinical results between visits?	No								
OP-25	Safe Surgery Checklist Use	Yes								
		Gastrointestinal	Genitourinary	Nervous System	Musculoskeletal	Cardiovascular	Eye	Skin	Respiratory	Other
OP-26	Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures	3083	416	2950	1003	255	576	39	46	101

	Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
OP-27	Influenza Vaccination Coverage among Healthcare Personnel	91%	N/A	86%	84%

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
AMI Cardiac Care					
OP-1	Median Time to Fibrinolysis	N/A(7)	18 Minutes	20 Minutes	28 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(7)	100%	67%	59%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention- Reporting Rate	N/A(7)	36 Minutes	59 Minutes	58 Minutes
OP-4	Aspirin at Arrival	96% of 27 patients	100%	99%	97%

Footnote Legend

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5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 09/21/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070007-LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
OP-5	Median Time to ECG	9 Minutes based on 26 patients	3 Minutes	7 Minutes	7 Minutes
Outpatient Imaging Efficiency (OIE)					
OP-8	MRI Lumbar Spine for Low Back Pain	49.1% of 159 patients	N/A	41.4%	45.0%
OP-9	Mammography Follow-up Rates	9.5% of 3114 patients	N/A	20.7%	8.9%
OP-10	Abdomen CT - Use of Contrast Material	4.4% of 1300 scans	N/A	5.1%	9.4%
OP-11	Thorax CT - Use of Contrast Material	0.0% of 1133 scans	N/A	0.4%	2.4%
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	5.4% of 521 patients	N/A	4.9%	5.0%
OP-14	Simultaneous use of brain Computed Tomography (CT) and sinus Computed Tomography (CT)	1.3% of 1048 patients	N/A	2.7%	2.8%
Emergency Department					
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	111 Minutes based on 388 patients	95 Minutes	Low Volume: 119 Minutes Medium: 138 Minutes High: 169 Minutes Very High: 162 Minutes Overall Average: 147 Minutes	Low Volume: 116 Minutes Medium: 142 Minutes High: 161 Minutes Very High: 173 Minutes Overall Average: 148 Minutes
OP-20	Median Time from ED Arrival to Provider Contact for ED patients	27 Minutes based on 335 patients	11 Minutes	Low Volume: 22 Minutes Medium: 20 Minutes High: 31 Minutes Very High: 29 Minutes Overall Average: 26 Minutes	Low Volume: 21 Minutes Medium: 26 Minutes High: 29 Minutes Very High: 33 Minutes Overall Average: 27 Minutes
OP-22	Patient left without being seen	1% of 83658 patients	0%	2%	2%
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	Very High			
Pain Management					

Footnote Legend

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5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 09/21/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070007-LAWRENCE & MEMORIAL HOSPITAL

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
OP-21	Median Time to Pain Management for Long Bone Fracture	44 Minutes based on 177 patients	33 Minutes	56 Minutes	54 Minutes
	Stroke				
OP-23	Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	65% of 17 patients	100%	74%	66%

Footnote Legend

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5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 09/15/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070018-GREENWICH HOSPITAL ASSOCIATION

Address: 5 PERRYRIDGE RD	Type of Facility: Short-term
City, State, ZIP: GREENWICH, CT 06830	Type of Ownership: Voluntary non-profit - Private
Phone Number: (203) 863-3000	Emergency Service Provided: Yes
County Name: FAIRFIELD	

Web Based Measures										
OP-12	Does/did your facility have the ability to receive laboratory data electronically directly into your ONC certified EHR system as discrete searchable data?	Yes								
OP-17	Does your facility have the ability to track clinical results between visits?	Yes								
OP-25	Safe Surgery Checklist Use	Yes								
		Gastrointestinal	Genitourinary	Nervous System	Musculoskeletal	Cardiovascular	Eye	Skin	Respiratory	Other
OP-26	Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures	521	546	1439	575	46	696	14	3	198

	Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
OP-27	Influenza Vaccination Coverage among Healthcare Personnel	79%	N/A	86%	84%

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
AMI Cardiac Care					
OP-1	Median Time to Fibrinolysis	N/A(5)	18 Minutes	20 Minutes	28 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(5)	100%	67%	59%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention- Reporting Rate	N/A(5)	36 Minutes	59 Minutes	58 Minutes
OP-4	Aspirin at Arrival	N/A(5)	100%	99%	97%
OP-5	Median Time to ECG	N/A(5)	3 Minutes	7 Minutes	7 Minutes

Footnote Legend

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4. Data suppressed by CMS for one or more quarters.

5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 09/15/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070018-GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
Outpatient Imaging Efficiency (OIE)					
OP-8	MRI Lumbar Spine for Low Back Pain	37.5% of 72 patients	N/A	41.4%	45.0%
OP-9	Mammography Follow-up Rates	25.0% of 2304 patients	N/A	20.7%	8.9%
OP-10	Abdomen CT - Use of Contrast Material	6.5% of 852 scans	N/A	5.1%	9.4%
OP-11	Thorax CT - Use of Contrast Material	0.4% of 730 scans	N/A	0.4%	2.4%
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	6.9% of 335 patients	N/A	4.9%	5.0%
OP-14	Simultaneous use of brain Computed Tomography (CT) and sinus Computed Tomography (CT)	2.5% of 1118 patients	N/A	2.7%	2.8%
Emergency Department					
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	166 Minutes based on 370 patients	95 Minutes	Low Volume: 119 Minutes Medium: 138 Minutes High: 169 Minutes Very High: 162 Minutes Overall Average: 147 Minutes	Low Volume: 116 Minutes Medium: 142 Minutes High: 161 Minutes Very High: 173 Minutes Overall Average: 148 Minutes
OP-20	Median Time from ED Arrival to Provider Contact for ED patients	31 Minutes based on 384 patients	11 Minutes	Low Volume: 22 Minutes Medium: 20 Minutes High: 31 Minutes Very High: 29 Minutes Overall Average: 26 Minutes	Low Volume: 21 Minutes Medium: 26 Minutes High: 29 Minutes Very High: 33 Minutes Overall Average: 27 Minutes
OP-22	Patient left without being seen	0% of 42294 patients	0%	2%	2%
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	High			
Pain Management					
OP-21	Median Time to Pain Management for Long Bone Fracture	62 Minutes based on 144 patients	33 Minutes	56 Minutes	54 Minutes

Footnote Legend

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4. Data suppressed by CMS for one or more quarters.

5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 09/15/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070018-GREENWICH HOSPITAL ASSOCIATION

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
Stroke					
OP-23	Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	N/A(5)	100%	74%	66%

Footnote Legend

**OP-1 Measure data displayed on the preview report will be available through the download process and excluded from display on Hospital Compare.*

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3. Results are based on a shorter time period than required.

4. Data suppressed by CMS for one or more quarters.

5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 10/21/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070010-BRIDGEPORT HOSPITAL

Address: 267 GRANT STREET
City, State, ZIP: BRIDGEPORT, CT 06610
Phone Number: (203) 384-3000
County Name: FAIRFIELD

Type of Facility: Short-term
Type of Ownership: Voluntary non-profit - Private
Emergency Service Provided: Yes

Web Based Measures										
OP-12	Does/did your facility have the ability to receive laboratory data electronically directly into your ONC certified EHR system as discrete searchable data?	Yes								
OP-17	Does your facility have the ability to track clinical results between visits?	No								
OP-25	Safe Surgery Checklist Use	Yes								
		Gastrointestinal	Genitourinary	Nervous System	Musculoskeletal	Cardiovascular	Eye	Skin	Respiratory	Other
OP-26	Hospital Outpatient Volume Data on Selected Outpatient Surgical Procedures	4300	1251	283	1123	242	403	1061	44	984

	Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
OP-27	Influenza Vaccination Coverage among Healthcare Personnel	73%	N/A	86%	84%

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
AMI Cardiac Care					
OP-1	Median Time to Fibrinolysis	N/A(5)	18 Minutes	20 Minutes	28 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	N/A(5)	100%	67%	59%
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention- Reporting Rate	N/A(5)	36 Minutes	59 Minutes	58 Minutes
OP-4	Aspirin at Arrival	N/A(5)	100%	99%	97%
OP-5	Median Time to ECG	N/A(5)	3 Minutes	7 Minutes	7 Minutes

Footnote Legend

**OP-1 Measure data displayed on the preview report will be available through the download process and excluded from display on Hospital Compare.*
1. The number of cases/patients is too few to report.
3. Results are based on a shorter time period than required.
4. Data suppressed by CMS for one or more quarters.
5. Results are not available for this reporting period.
7. No cases met the criteria for this measure.
13. Results cannot be calculated for this reporting period.

Report Run Date Time: 10/21/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070010-BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
Outpatient Imaging Efficiency (OIE)					
OP-8	MRI Lumbar Spine for Low Back Pain	43.6% of 39 patients	N/A	41.4%	45.0%
OP-9	Mammography Follow-up Rates	24.0% of 2245 patients	N/A	20.7%	8.9%
OP-10	Abdomen CT - Use of Contrast Material	25.1% of 553 scans	N/A	5.1%	9.4%
OP-11	Thorax CT - Use of Contrast Material	8.3% of 265 scans	N/A	0.4%	2.4%
OP-13	Cardiac imaging for preoperative risk assessment for non-cardiac low-risk surgery	4.8% of 976 patients	N/A	4.9%	5.0%
OP-14	Simultaneous use of brain Computed Tomography (CT) and sinus Computed Tomography (CT)	2.7% of 676 patients	N/A	2.7%	2.8%
Emergency Department					
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	157 Minutes based on 327 patients	95 Minutes	Low Volume: 119 Minutes Medium: 138 Minutes High: 169 Minutes Very High: 162 Minutes Overall Average: 147 Minutes	Low Volume: 116 Minutes Medium: 142 Minutes High: 161 Minutes Very High: 173 Minutes Overall Average: 148 Minutes
OP-20	Median Time from ED Arrival to Provider Contact for ED patients	44 Minutes based on 343 patients	11 Minutes	Low Volume: 22 Minutes Medium: 20 Minutes High: 31 Minutes Very High: 29 Minutes Overall Average: 26 Minutes	Low Volume: 21 Minutes Medium: 26 Minutes High: 29 Minutes Very High: 33 Minutes Overall Average: 27 Minutes
OP-22	Patient left without being seen	2% of 79845 patients	0%	2%	2%
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	Very High			
Pain Management					
OP-21	Median Time to Pain Management for Long Bone Fracture	34 Minutes based on 161 patients	33 Minutes	56 Minutes	54 Minutes

Footnote Legend

**OP-1 Measure data displayed on the preview report will be available through the download process and excluded from display on Hospital Compare.*

1. The number of cases/patients is too few to report.

3. Results are based on a shorter time period than required.

4. Data suppressed by CMS for one or more quarters.

5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date Time: 10/21/2015

Hospital Compare Preview Report: Hospital Performance – Outpatient

Reporting Period for Clinical Process Measures: Second Quarter 2014 through First Quarter 2015 Encounters

Reporting Period for Outpatient Imaging Efficiency Measures: Third Quarter 2013 through Second Quarter 2014 All Paid Medicare FFS Claims

070010-BRIDGEPORT HOSPITAL

	Hospital Quality Measures	Your Hospital Performance for All Quarters	10% of All Hospitals Submitting Data Performed Equal to or Better Than	State Performance	National Performance
Stroke					
OP-23	Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	73% of 11 patients(3)	100%	74%	66%

Footnote Legend

**OP-1 Measure data displayed on the preview report will be available through the download process and excluded from display on Hospital Compare.*

1. The number of cases/patients is too few to report.

3. Results are based on a shorter time period than required.

4. Data suppressed by CMS for one or more quarters.

5. Results are not available for this reporting period.

7. No cases met the criteria for this measure.

13. Results cannot be calculated for this reporting period.

Report Run Date: 08/04/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Percentage Summary Report
Provider: 070007
Reporting Period: Fiscal Year 2016

Data As Of: 07/28/2015

	Facility	State	National
Total Performance Score	28.178571428571	35.196728558798	40.471936058418
	Unweighted Domain Score	**Weighting**	**Weighted Domain Score**
Clinical Process of Care Domain	40.000000000000	10%	4.000000000000
Patient Experience of Care Domain	19.000000000000	25%	4.750000000000
Outcome Domain	48.571428571429	40%	19.428571428571
Efficiency Domain	0.000000000000	25%	0.000000000000

	Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net change in Base Operating DRG Payment Amount	Value-Based Incentive Payment Adjustment Factor	Exchange Function Slope
Value-Based Percentage Payment Summary - Fiscal Year 2016	1.7500000000%	1.3674983257%	-0.3825016743%	0.9961749833	2.7731271496

Calculated values were subject to rounding.
Reference the Hospital Value-Based Purchasing page on QualityNet for report information, calculations, and Hospital VBP resources.

Report Run Date: 08/04/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Clinical Process of Care Measure Detail Report
Provider: 070007
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HBVP Metrics**					
Clinical Process of Care Measures	**Numerator**	**Denominator**	**Baseline Period Rate**	**Numerator**	**Denominator**	**Performance Period Rate**	**Achievement Threshold**	**Benchmark**	**Improvements Points**	**Achievement points**	**Measure Score**	**Condition/ Procedure Score**
Acute Myocardial Infarction												
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0 cases	0 cases	-	0 cases	0 cases	-	0.91154	1.00000	-	-	-	-
Healthcare-Associated Infections												
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients	266	271	0.98155	317	329	0.96353	0.99074	1.00000	0	0	0	8
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	260	264	0.98485	322	328	0.98171	0.98086	1.00000	0	1	1	
SCIP-Inf-9 Urinary Catheter Removal on Postoperative Day 1 or Postoperative Day 2	205	221	0.92760	313	318	0.98428	0.97059	1.00000	7	5	7	
Pneumonia												
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	61	69	0.88406	79	82	0.96341	0.96552	1.00000	6	0	6	6
Preventative												
IMM-2 Influenza Immunization	472	531	0.88889	488	524	0.93130	0.90607	0.98875	4	3	4	4
Surgical Care Improvement Project												
SCIP-Card-2 Surgery Patients on Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	126	130	0.96923	115	123	0.93496	0.97727	1.00000	0	0	0	10
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	324	331	0.97885	374	374	1.00000	0.98225	1.00000	9	10	10	

Eligible Clinical Process of Care Measures: 7 out of 8
Unweighted Clinical Process of Care Domain Score: 40.000000000000
Weighted Clinical Process of Care Domain Score: 4.000000000000

Calculated values were subject to rounding.
* A dash (-) indicates that the minimum requirements were not met for calculation.

* "0 cases" indicates that no cases met the criteria for inclusion in the measure calculation.

Report Run Date: 08/04/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Patient Experience of Care Dimensions Detail Report
Provider: 070007
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012
Performance Period: 01/01/2014 - 12/31/2014

Patient Experience of Care Dimensions	Baseline Period Rate	Performance Period Rate	Floor	Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Dimension Score
Communication with Nurses	80.67%	78.12%	53.99%	77.67%	86.07%	0	1	1
Communication with Doctors	80.08%	77.46%	57.01%	80.40%	88.56%	0	0	0
Responsiveness of Hospital Staff	61.67%	63.00%	38.21%	64.71%	79.76%	0	0	0
Pain Management	71.47%	70.64%	48.96%	70.18%	78.16%	0	1	1
Communication about Medicines	61.01%	61.76%	34.61%	62.33%	72.77%	0	0	0
***Cleanliness and Quietness of Hospital Environment*[1]**	58.96%	58.73%	43.08%	64.95%	79.10%	0	0	0
Discharge Information	82.29%	85.20%	61.36%	84.70%	90.39%	3	1	3
Overall Rating of Hospital	64.25%	62.38%	34.95%	69.32%	83.97%	0	0	0

HCAHPS Base Score: 5
HCAHPS Consistency Score: 14
Unweighted Patient Experience of Care Domain Score: 19.000000000000
Weighted Patient Experience of Care Domain Score: 4.750000000000
HCAHPS Surveys Completed during the Performance period: 2234

Calculated values were subject to rounding.

[1]The ***Cleanliness and Quietness of Hospital Environment*** HCAHPS Dimension in bold italic font was used to calculate the HCAHPS Consistency Score.

Report Run Date: 08/04/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Outcome Measures Detail Report
Provider: 070007
Reporting Period: Fiscal Year 2016

Baseline Period: 10/01/2010 - 06/30/2011 **Performance Period:** 10/01/2012 - 06/30/2014	**FY 2016 Baseline Period Totals**		**FY 2016 Performance Period Totals**		**HVBP Metrics**				
Mortality Measures	**Number of Eligible Discharges**	**Baseline Period Rate**	**Number of Eligible Discharges**	**Performance Period Rate**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	67	0.840321	152	0.863598	0.847472	0.862371	9	10	10
Heart Failure (HF) 30-Day Mortality Rate	165	0.864616	399	0.893322	0.881510	0.900315	8	6	8
Pneumonia (PN) 30-Day Mortality Rate	141	0.874811	290	0.899677	0.882651	0.904181	8	8	8
Baseline Period: 10/15/2010 - 06/30/2011 **Performance Period:** 10/15/2012 - 06/30/2014	**FY 2016 Baseline Period Totals**		**FY 2016 Performance Period Totals**		**HVBP Metrics**				
AHRQ Patient Safety Measure	**Index Value**		**Index Value**		**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Complication/patient safety for selected indicators (composite)	0.515301		0.630724		0.616248	0.449988	0	0	0
Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HVBP Metrics**				
Healthcare Associated Infections Measures	**Number of Observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Number of observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Catheter-Associated Urinary Tract Infection	11	7.130	1.543	6	6.560	0.915	0.801	0.000	4	0	4
Central Line-Associated Blood Stream Infection	1	4.140	0.242	1	3.813	0.262	0.465	0.000	0	4	4
Surgical Site Infection (SSI)	N/A	N/A	-	N/A	N/A	-	N/A	N/A	N/A	N/A	0
SSI-Abdominal Hysterectomy	0	1.171	0.000	1	1.101	0.908	0.752	0.000	0	0	0
SSI-Colon Surgery	3	2.899	1.035	7	3.008	2.327	0.668	0.000	0	0	0

Eligible Outcome Measures: 7 out of 7
Unweighted Outcome Domain Score: 48.571428571429
Weighted Domain Score: 19.428571428571

Calculated values were subject to rounding.
* "N/A" indicates no data were available or submitted for this measure.
* A dash (-) indicates that the minimum requirements were not met for calculation.

Report Run Date: 08/04/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Efficiency Measure Detail Report
Provider: 070007
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HVBP Metrics**				
Efficiency Measures	**MSPB Amount (Numerator)**	**Median MSPB Amount (Denominator)**	**MSPB Measure**	**MSPB Amount (Numerator)**	**Median MSPB Amount (Denominator)**	**MSPB Measure**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Medicare Spending per Beneficiary (MSPB)	$19,162.42	$18,708.18	1.024280	$20,827.96	$20,017.29	1.040499	0.984157	0.824348	0	0	0

Eligible Efficiency Measure: 1 out of 1
Unweighted Efficiency Domain Score: 0.000000000000
Weighted Efficiency Domain Score: 0.000000000000
# of Episodes: 3027

Calculated values were subject to rounding.

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Percentage Summary Report
Provider: 070018
Reporting Period: Fiscal Year 2016

Data As Of: 07/28/2015

	Facility	State	National
Total Performance Score	33.571428571429	35.196728558798	40.471936058418
	Unweighted Domain Score	**Weighting**	**Weighted Domain Score**
Clinical Process of Care Domain	34.285714285714	10%	3.428571428571
Patient Experience of Care Domain	52.000000000000	25%	13.000000000000
Outcome Domain	42.857142857143	40%	17.142857142857
Efficiency Domain	0.000000000000	25%	0.000000000000

Value-Based Percentage Payment Summary - Fiscal Year 2016

Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net change in Base Operating DRG Payment Amount	Value-Based Incentive Payment Adjustment Factor	Exchange Function Slope
1.7500000000%	1.6292122004%	-0.1207877996%	0.9987921220	2.7731271496

Calculated values were subject to rounding.
Reference the Hospital Value-Based Purchasing page on QualityNet for report information, calculations, and Hospital VBP resources.

Report Run Date: 08/12/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Clinical Process of Care Measure Detail Report
Provider: 070018
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HBVP Metrics**					
Clinical Process of Care Measures	**Numerator**	**Denominator**	**Baseline Period Rate**	**Numerator**	**Denominator**	**Performance Period Rate**	**Achievement Threshold**	**Benchmark**	**Improvements Points**	**Achievement points**	**Measure Score**	**Condition/ Procedure Score**
Acute Myocardial Infarction												
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0 cases	0 cases	-	0 cases	0 cases	-	0.91154	1.00000	-	-	-	-
Healthcare-Associated Infections												
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients	179	181	0.98895	190	192	0.98958	0.99074	1.00000	0	0	0	6
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	166	179	0.92737	182	187	0.97326	0.98086	1.00000	6	0	6	
SCIP-Inf-9 Urinary Catheter Removal on Postoperative Day 1 or Postoperative Day 2	99	105	0.94286	87	94	0.92553	0.97059	1.00000	0	0	0	
Pneumonia												
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	85	91	0.93407	74	76	0.97368	0.96552	1.00000	6	3	6	6
Preventative												
IMM-2 Influenza Immunization	373	500	0.74600	376	466	0.80687	0.90607	0.98875	2	0	2	2
Surgical Care Improvement Project												
SCIP-Card-2 Surgery Patients on Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	84	89	0.94382	86	92	0.93478	0.97727	1.00000	0	0	0	10
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	269	279	0.96416	247	247	1.00000	0.98225	1.00000	9	10	10	

Eligible Clinical Process of Care Measures: 7 out of 8
Unweighted Clinical Process of Care Domain Score: 34.285714285714
Weighted Clinical Process of Care Domain Score: 3.428571428571

Calculated values were subject to rounding.
* A dash (-) indicates that the minimum requirements were not met for calculation.

* "0 cases" indicates that no cases met the criteria for inclusion in the measure calculation.

Report Run Date: 08/12/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Patient Experience of Care Dimensions Detail Report
Provider: 070018
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012
Performance Period: 01/01/2014 - 12/31/2014

Patient Experience of Care Dimensions	Baseline Period Rate	Performance Period Rate	Floor	Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Dimension Score
Communication with Nurses	79.39%	82.81%	53.99%	77.67%	86.07%	5	6	6
Communication with Doctors	80.26%	84.31%	57.01%	80.40%	88.56%	4	5	5
Responsiveness of Hospital Staff	64.72%	69.97%	38.21%	64.71%	79.76%	3	4	4
Pain Management	73.22%	74.52%	48.96%	70.18%	78.16%	2	5	5
Communication about Medicines	64.47%	65.17%	34.61%	62.33%	72.77%	0	3	3
Cleanliness and Quietness of Hospital Environment	67.69%	69.85%	43.08%	64.95%	79.10%	1	4	4
Discharge Information[1]	81.45%	82.12%	61.36%	84.70%	90.39%	0	0	0
Overall Rating of Hospital	80.63%	81.60%	34.95%	69.32%	83.97%	2	8	8

HCAHPS Base Score:	35
HCAHPS Consistency Score:	17
Unweighted Patient Experience of Care Domain Score:	52.000000000000
Weighted Patient Experience of Care Domain Score:	13.000000000000
HCAHPS Surveys Completed during the Performance period:	520

Calculated values were subject to rounding.

[1]The ***Discharge Information*** HCAHPS Dimension in bold italic font was used to calculate the HCAHPS Consistency Score.

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Outcome Measures Detail Report
Provider: 070018
Reporting Period: Fiscal Year 2016

Baseline Period: 10/01/2010 - 06/30/2011 **Performance Period:** 10/01/2012 - 06/30/2014	FY 2016 Baseline Period Totals		FY 2016 Performance Period Totals		HVBP Metrics				
Mortality Measures	**Number of Eligible Discharges**	**Baseline Period Rate**	**Number of Eligible Discharges**	**Performance Period Rate**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	31	0.844227	79	0.846447	0.847472	0.862371	1	0	1
Heart Failure (HF) 30-Day Mortality Rate	115	0.857723	273	0.888692	0.881510	0.900315	7	4	7
Pneumonia (PN) 30-Day Mortality Rate	148	0.892075	239	0.913359	0.882651	0.904181	9	10	10
Baseline Period: 10/15/2010 - 06/30/2011 **Performance Period:** 10/15/2012 - 06/30/2014	FY 2016 Baseline Period Totals		FY 2016 Performance Period Totals		HVBP Metrics				
AHRQ Patient Safety Measure	**Index Value**		**Index Value**		**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Complication/patient safety for selected indicators (composite)	0.483644		0.498884		0.616248	0.449988	0	7	7
Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	FY 2016 Baseline Period Totals				FY 2016 Performance Period Totals			HVBP Metrics			
Healthcare Associated Infections Measures	**Number of Observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Number of observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Catheter-Associated Urinary Tract Infection	1	2.450	0.408	1	2.463	0.406	0.801	0.000	0	5	5
Central Line-Associated Blood Stream Infection	0	1.499	0.000	1	1.693	0.591	0.465	0.000	0	0	0
Surgical Site Infection (SSI)	N/A	N/A	-	N/A	N/A	-	N/A	N/A	N/A	N/A	0
SSI-Abdominal Hysterectomy	0	0.853	-	0	0.888	-	0.752	0.000	-	-	-
SSI-Colon Surgery	3	3.734	0.803	5	3.542	1.412	0.668	0.000	0	0	0

Eligible Outcome Measures: 7 out of 7
Unweighted Outcome Domain Score: 42.857142857143
Weighted Domain Score: 17.142857142857

Calculated values were subject to rounding.
* "N/A" indicates no data were available or submitted for this measure.
* A dash (-) indicates that the minimum requirements were not met for calculation.

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Efficiency Measure Detail Report
Provider: 070018
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	FY 2016 Baseline Period Totals			FY 2016 Performance Period Totals			HVBP Metrics				
Efficiency Measures	**MSPB Amount (Numerator)**	**Median MSPB Amount (Denominator)**	**MSPB Measure**	**MSPB Amount (Numerator)**	**Median MSPB Amount (Denominator)**	**MSPB Measure**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Medicare Spending per Beneficiary (MSPB)	$18,844.66	$18,708.18	1.007295	$19,936.04	$20,017.29	0.995941	0.984157	0.824348	0	0	0

Eligible Efficiency Measure: 1 out of 1
Unweighted Efficiency Domain Score: 0.000000000000
Weighted Efficiency Domain Score: 0.000000000000
# of Episodes: 2405

Calculated values were subject to rounding.

Report Run Date: 11/18/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Percentage Summary Report
Provider: 070010
Reporting Period: Fiscal Year 2016

Data As Of: 10/27/2015

	Facility	State	National
Total Performance Score	32.500000000000	35.196728558798	40.479955798765
	Unweighted Domain Score	**Weighting**	**Weighted Domain Score**
Clinical Process of Care Domain	41.428571428571	10%	4.142857142857
Patient Experience of Care Domain	28.000000000000	25%	7.000000000000
Outcome Domain	47.142857142857	40%	18.857142857143
Efficiency Domain	10.000000000000	25%	2.500000000000

	Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net Change in Base Operating DRG Payment Amount	Value-Based Incentive Payment Adjustment Factor	Exchange Function Slope
Value-Based Percentage Payment Summary - Fiscal Year 2016	1.7500000000%	1.5772160664%	-0.1727839336%	0.9982721607	2.7731271496

Calculated values were subject to rounding.
Reference the Hospital Value-Based Purchasing page on QualityNet for report information, calculations, and Hospital VBP resources.

Report Run Date: 11/18/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Clinical Process of Care Measure Detail Report
Provider: 070010
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HBVP Metrics**					
Clinical Process of Care Measures	**Numerator**	**Denominator**	**Baseline Period Rate**	**Numerator**	**Denominator**	**Performance Period Rate**	**Achievement Threshold**	**Benchmark**	**Improvements Points**	**Achievement points**	**Measure Score**	**Condition/ Procedure Score**
Acute Myocardial Infarction												
AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0 cases	0 cases	-	0 cases	0 cases	-	0.91154	1.00000	-	-	-	-
Healthcare-Associated Infections												
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients	286	288	0.99306	287	295	0.97288	0.99074	1.00000	0	0	0	7
SCIP-Inf-3 Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	264	276	0.95652	265	272	0.97426	0.98086	1.00000	4	0	4	
SCIP-Inf-9 Urinary Catheter Removal on Postoperative Day 1 or Postoperative Day 2	274	286	0.95804	274	282	0.97163	0.97059	1.00000	3	1	3	
Pneumonia												
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	66	72	0.91667	54	55	0.98182	0.96552	1.00000	7	5	7	7
Preventative												
IMM-2 Influenza Immunization	430	521	0.82534	411	535	0.76822	0.90607	0.98875	0	0	0	0
Surgical Care Improvement Project												
SCIP-Card-2 Surgery Patients on Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period	144	150	0.96000	154	157	0.98089	0.97727	1.00000	5	2	5	15
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	292	296	0.98649	274	274	1.00000	0.98225	1.00000	9	10	10	

Eligible Clinical Process of Care Measures: 7 out of 8
Unweighted Clinical Process of Care Domain Score: 41.428571428571
Weighted Clinical Process of Care Domain Score: 4.142857142857

Calculated values were subject to rounding.
* A dash (-) indicates that the minimum requirements were not met for calculation.
* "0 cases" indicates that no cases met the criteria for inclusion in the measure calculation.

Report Run Date: 11/18/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Patient Experience of Care Dimensions Detail Report
Provider: 070010
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012
Performance Period: 01/01/2014 - 12/31/2014

Patient Experience of Care Dimensions	Baseline Period Rate	Performance Period Rate	Floor	Achievement Threshold	Benchmark	Improvement Points	Achievement Points	Dimension Score
Communication with Nurses	81.41%	81.59%	53.99%	77.67%	86.07%	0	5	5
Communication with Doctors	79.21%	80.16%	57.01%	80.40%	88.56%	1	0	1
Responsiveness of Hospital Staff	65.85%	61.75%	38.21%	64.71%	79.76%	0	0	0
Pain Management	72.92%	72.23%	48.96%	70.18%	78.16%	0	3	3
Communication about Medicines	57.28%	62.48%	34.61%	62.33%	72.77%	3	1	3
Cleanliness and Quietness of Hospital Environment[1]	56.95%	60.09%	43.08%	64.95%	79.10%	1	0	1
Discharge Information	83.99%	84.32%	61.36%	84.70%	90.39%	0	0	0
Overall Rating of Hospital	68.80%	66.35%	34.95%	69.32%	83.97%	0	0	0

HCAHPS Base Score:	13
HCAHPS Consistency Score:	15
Unweighted Patient Experience of Care Domain Score:	28.000000000000
Weighted Patient Experience of Care Domain Score:	7.000000000000
HCAHPS Surveys Completed during the Performance period:	762

Calculated values were subject to rounding.

[1]The ***Cleanliness and Quietness of Hospital Environment*** HCAHPS Dimension in bold italic font was used to calculate the HCAHPS Consistency Score.

Report Run Date: 11/18/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Outcome Measures Detail Report
Provider: 070010
Reporting Period: Fiscal Year 2016

Baseline Period: 10/01/2010 - 06/30/2011 **Performance Period:** 10/01/2012 - 06/30/2014	**FY 2016 Baseline Period Totals**		**FY 2016 Performance Period Totals**		**HVBP Metrics**				
Mortality Measures	**Number of Eligible Discharges**	**Baseline Period Rate**	**Number of Eligible Discharges**	**Performance Period Rate**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	82	0.836632	188	0.895695	0.847472	0.862371	9	10	10
Heart Failure (HF) 30-Day Mortality Rate	143	0.892556	282	0.896470	0.881510	0.900315	5	8	8
Pneumonia (PN) 30-Day Mortality Rate	125	0.897456	244	0.905713	0.882651	0.904181	9	10	10

Baseline Period: 10/15/2010 - 06/30/2011 **Performance Period:** 10/15/2012 - 06/30/2014	**FY 2016 Baseline Period Totals**	**FY 2016 Performance Period Totals**	**HVBP Metrics**				
AHRQ Patient Safety Measure	**Index Value**	**Index Value**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Complication/patient safety for selected indicators (composite)	0.703649	0.603993	0.616248	0.449988	3	1	3

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HVBP Metrics**				
Healthcare Associated Infections Measures	**Number of Observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Number of Observed Infections (Numerator)**	**Number of Predicted Infections (Denominator)**	**Standardized Infections Ratio (SIR)**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Catheter-Associated Urinary Tract Infection	16	14.385	1.112	21	15.082	1.392	0.801	0.000	0	0	0
Central Line-Associated Blood Stream Infection	8	11.270	0.710	5	9.718	0.515	0.465	0.000	2	0	2
Surgical Site Infection (SSI)	N/A	N/A	-	N/A	N/A	-	N/A	N/A	N/A	N/A	0
SSI-Abdominal Hysterectomy	2	1.727	1.158	6	2.658	2.257	0.752	0.000	0	0	0
SSI-Colon Surgery	0	3.680	0.000	9	3.694	2.436	0.668	0.000	0	0	0

Eligible Outcome Measures: 7 out of 7
Unweighted Outcome Domain Score: 47.142857142857
Weighted Domain Score: 18.857142857143

Calculated values were subject to rounding.
* "N/A" indicates no data were available or submitted for this measure.
* A dash (-) indicates that the minimum requirements were not met for calculation.

Report Run Date: 11/18/2015

Hospital Value-Based Purchasing – Value-Based Percentage Payment Summary Report
Efficiency Measure Detail Report
Provider: 070010
Reporting Period: Fiscal Year 2016

Baseline Period: 01/01/2012 - 12/31/2012 **Performance Period:** 01/01/2014 - 12/31/2014	**FY 2016 Baseline Period Totals**			**FY 2016 Performance Period Totals**			**HVBP Metrics**				
Efficiency Measures	**MSPB Amount (Numerator)**	**Median MSPB Amount (Denominator)**	**MSPB Measure**	**MSPB Amount (Numerator)**	**Median MSPB Amount (Denominator)**	**MSPB Measure**	**Achievement Threshold**	**Benchmark**	**Improvement Points**	**Achievement Points**	**Measure Score**
Medicare Spending per Beneficiary (MSPB)	$19,592.87	$18,708.18	1.047289	$20,162.13	$20,017.29	1.007236	0.984157	0.824348	1	0	1

Eligible Efficiency Measure: 1 out of 1
Unweighted Efficiency Domain Score: 10.000000000000
Weighted Efficiency Domain Score: 2.500000000000
# of Episodes: 2785

Calculated values were subject to rounding.

ATTACHMENT IV

LISTING OF PHYSICIANS PRACTICING IN COMMUNITY

Physician Practices in L&MPA Service Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Gaetano	John	M	DPM	Allegheny Foot & Ankle Ctr	914 Hartford Tpke Rte 85	Waterford	CT	06385	1457331357	Surgery	Podiatry	
Sprecace	George	A	MD	Allergy Assoc of NL	400 Bayonet St Ste LL-2	New London	CT	06320	1891792529	Medicine	Allergy & Immunology	
Balch	Eric	A	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1033164975	Anesthesia	Anesthesia	
Cameron	Alison	G	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1407827256	Anesthesia	Anesthesia	
Cecere	Joseph	A	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1528015088	Anesthesia	Anesthesia	
Daley	Kristin	A	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1811943293	Anesthesia	Anesthesia	
DeSantis	Christopher	J	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1306972831	Anesthesia	Anesthesia	
Feng	Honghui		MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1649224676	Anesthesia	Anesthesia	
Gramlich	Curt	W	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1063483808	Anesthesia	Anesthesia	
Kadian	Sudhir	K	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1366497182	Anesthesia	Anesthesia	
Lodato	Nicholas	M	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1225280498	Anesthesia	Anesthesia	
Miett	Thomas	O	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1679520134	Anesthesia	Anesthesia	
Rajput	Kanishka		MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1831373752	Anesthesia	Anesthesia	
Slater	Alexander	G	MD	Anesthesia Assoc of NL	365 Montauk Ave	New London	CT	06320	1851332308	Anesthesia	Anesthesia	
Barri	Anthony	R	MD	Barri Eye Care Ctr	489 Rte 184 Ste 100	Groton	CT	06340	1245348796	Surgery	Ophthalmology	
Antonelli	Vincent	J	DDS	Bridgeworks Family Dental Ctr	115 Bridge St	Groton	CT	06340	1497965982	Surgery	Dental	
Haronian	Howard	L	MD	Cardiology Specialists Ltd	45 Wells St Ste 102	Westerly	RI	02891	1548258635	Medicine	Cardiology	(1)
Hwang	Anita	M	MD	Cataract & Cornea Eye Spec	914 Hartford Tpke	Waterford	CT	06385	1407056559	Surgery	Ophthalmology	
Beason	William	L		Charter Oak Walk-In Med Ctr	324 Flanders Road	East Lyme	CT	06333			Family Practice	
Welsch	Robert			Charter Oak Walk-In Med Ctr	324 Flanders Road	East Lyme	CT	06333			Family Practice	
Albrecht	Richard	C		Charter Oak Walk-In Med Ctr	324 Flanders Road	East Lyme	CT	06333			General Practice	
Kitley	Timothy	A	DMD	Childrens Dentistry of GF	1527 Rte 12 PO Box 396	Gales Ferry	CT	06335	1124213517	Surgery	Pediatric Dentistry	
Cloutier	Josee	D	MD	Cloutier Family Practice LLC	10 Liberty Way Ste 10B	Niantic	CT	06357	1790860419	Medicine & Pediatrics	Family Medicine w/Pediatrics & Hospitalist	
Duke	Daniella	M	MD	Coastal Dermatology PC	55 Willow St	Mystic	CT	06355	1174594279	Medicine	Dermatology	
Campbell	Mical	S	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1083628770	Medicine	Gastroenterology	
Frese	John		MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1457316382	Medicine	Gastroenterology	
Khan	Amzad		MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1790945996	Medicine	Gastroenterology	
Ouellette	George	S	MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1285690693	Medicine	Gastroenterology	
Sapozhnikov	Eugene		MD	Coastal Digestive Diseases	234A Bank St	New London	CT	06320	1164488094	Medicine	Gastroenterology	
Monroe	John	J	MD	Community Health Ctr	1 Shaws Cove	New London	CT	06320	1508863226	Medicine	Family Medicine	
Baleswaren	Anandhi	S	MD	Community Health Ctr	481 Gold Star Hwy Ste 100	Groton	CT	06340	1346246444	Medicine	Hospitalist & Internal Medicine	
Doerwaldt	Hartmut	A	MD	Community Health Ctr	1 Shaws Cove	New London	CT	06320	1265496046	Pediatrics	Pediatrics	
McKnight	Craig	E	MD	Craig McKnight MD PhD LLC	425 Montauk Ave	New London	CT	06320	1952445272	OB-GYN	OB-GYN	
Maletz	Frank	W	MD	Crossroads Orthopaedics	196 Parkway S Ste 201	Waterford	CT	06385	1336113703	Surgery	Orthopaedic	
Noonan	Joseph	E	MD	Crossroads Orthopaedics	196 Parkway S Ste 201	Waterford	CT	06385	1144391921	Surgery	Orthopaedic	
Salkin	Jeffrey	A	MD	Crossroads Orthopaedics	196 Parkway S Ste 201	Waterford	CT	06385	1871567982	Surgery	Orthopaedic	
Burrows	Warren	B	MD	Crossroads Orthopaedics	196 Parkway S Ste 201	Waterford	CT	06385	1487628590	Surgery	Plastic-Hand Surgery	
Awwa	Bassam			CT Behavioral Health Associates	41 Faire Harbour Place	New London	CT	06320				
Lawrence	David	M	DPM	David & Debra Lawrence DPM	131 Boston Post Rd	East Lyme	CT	06333	1891729976	Surgery	Podiatry	
Lawrence	Debra	C	DPM	David & Debra Lawrence DPM	131 Boston Post Rd	East Lyme	CT	06333	1073547162	Surgery	Podiatry	
Bentz	Mary Ann	D	MD	Dermatology Assoc of SE CT	425 Montauk Ave	New London	CT	06320	1295720910	Medicine	Dermatology	
Greenwald	Alan	J	MD	Digestive Disease Assoc PC	268 Montauk Ave	New London	CT	06320	1174617419	Medicine	Gastroenterology	
Blum	Thomas	M	MD	Drs Blum & Bontempi	200 Sandy Hollow Rd	Mystic	CT	06355	1194710210	Medicine	Internal Medicine	
Bontempi	Rosemary	C	MD	Drs Blum & Bontempi	200 Sandy Hollow Rd	Mystic	CT	06355	1346235462	Medicine	Internal Medicine	
Fantl	Eugene		MD	East Lyme Pediatric Clinic	170 Flanders Rd	Niantic	CT	06357	1255337465	Pediatrics	Pediatrics	
Malik	Sajda	P	MD	East Lyme Pediatric Clinic	170 Flanders Rd	Niantic	CT	06357	1144314451	Pediatrics	Pediatrics	
Adams	Theresa	M	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1457678138	Emergency Medicine	Emergency Medicine	
Armstrong	Benjamin	D	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1346487220	Emergency Medicine	Emergency Medicine	
Bertolozzi	Peter	P	DO	EMP of New London County	365 Montauk Ave	New London	CT	06320	1588841068	Emergency Medicine	Emergency Medicine	
Bryant	Craig	A	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1861565194	Emergency Medicine	Emergency Medicine	
Cirillo	Louis	A	MD	EMP of New London County	52 Hazelnut Hill Rd	Groton	CT	06340	1780728063	Emergency Medicine	Emergency Medicine	
Cronin Vorih	Deirdre		MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1396943767	Emergency Medicine	Emergency Medicine	
Daulaire	Siri	L	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1144481805	Emergency Medicine	Emergency Medicine	
Deindorfer	Barbara	A	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1225087737	Emergency Medicine	Emergency Medicine	
Ferguson	Bernard	J	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1558335604	Emergency Medicine	Emergency Medicine	
Firman	Russell	J	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1124191465	Emergency Medicine	Emergency Medicine	
Garber	Suzanne	M	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1104110428	Emergency Medicine	Emergency Medicine	
Gianfrocco	Robert	G	DO	EMP of New London County	52 Hazelnut Hill Rd	Groton	CT	06340	1942370234	Emergency Medicine	Emergency Medicine	
Hartman	Daniel	F	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1609977784	Emergency Medicine	Emergency Medicine	
Keegan	Joshua	M	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1699096545	Emergency Medicine	Emergency Medicine	
Lehrach	Christopher	M	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1205875440	Emergency Medicine	Emergency Medicine	
Lin Monte	Melissa		DO	EMP of New London County	365 Montauk Ave	New London	CT	06320	1376793125	Emergency Medicine	Emergency Medicine	
Maheshwari	Ashok	K	MD	EMP of New London County	52 Hazelnut Hill Rd	Groton	CT	06340	1760543813	Emergency Medicine	Emergency Medicine	
Mattke	Angela	F	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1083672786	Emergency Medicine	Emergency Medicine	
Mayorga	Oliver		MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1720054661	Emergency Medicine	Emergency Medicine	
O'Donnell	Sophia	G	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1255582268	Emergency Medicine	Emergency Medicine	

Physician Practices in L&MPA Service Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Rau	Laura	D	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1821213794	Emergency Medicine	Emergency Medicine	
Sala	Christopher	J	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1215258686	Emergency Medicine	Emergency Medicine	
Singh	Deepika		MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1114123353	Emergency Medicine	Emergency Medicine	
Snediker	Daniel	G	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1982634267	Emergency Medicine	Emergency Medicine	
Sokolowski	Devin	R	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1417159765	Emergency Medicine	Emergency Medicine	
Stallard	John	D	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1184643090	Emergency Medicine	Emergency Medicine	
Stevens	Anna	L	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1598926891	Emergency Medicine	Emergency Medicine	
Terranova	George	J	MD	EMP of New London County	52 Hazelnut Hill Rd	Groton	CT	06340	1972630010	Emergency Medicine	Emergency Medicine	
Toole	Wendy	J	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1437174836	Emergency Medicine	Emergency Medicine	
Tucker	Cynthia	J	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1558571208	Emergency Medicine	Emergency Medicine	
Witt	Wendy	A	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1851365738	Emergency Medicine	Emergency Medicine	
Alfonzo	Michael	J	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1932337326	Emergency Medicine	Pediatric Emergency Medicine	
Cicero	Mark	X	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1548315823	Emergency Medicine	Pediatric Emergency Medicine	
Dodington	James	M	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1629380985	Emergency Medicine	Pediatric Emergency Medicine	
Hesse	Katherine		MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1548235088	Emergency Medicine	Pediatric Emergency Medicine	
Mackenzie	Bonnie	S	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1275730958	Emergency Medicine	Pediatric Emergency Medicine	
Siew	Lawrence	T	MD	EMP of New London County	365 Montauk Ave	New London	CT	06320	1891933727	Emergency Medicine	Pediatric Emergency Medicine	
Gautam	Vibha	G	MD	Endocrin & Osteoporosis Ctr	393 Ocean Ave	New London	CT	06320	1316042344	Medicine	Endocrinology	
Boisoneau	David	S	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1467429597	Surgery	Otolaryngology	
Dellacono	Frank	R	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1073690848	Surgery	Otolaryngology	
Gaito	Raymond	A	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1235151838	Surgery	Otolaryngology	
Mlynarski	F	G	MD	ENT Assoc of SE CT	201 Boston Post Rd	Waterford	CT	06385	1255353199	Surgery	Otolaryngology	
Falck	Francis	Y	MD	Falck Eye Ctr LLC	35 Washington St	Mystic	CT	06355	1255335113	Surgery	Ophthalmology	
Cambi	Kathryn	M	MD	Flanders Pediatrics LLC	305 Flanders Rd	East Lyme	CT	06333	1720047285	Pediatrics	Pediatrics	
Lopez	Maria	A	MD	Flanders Pediatrics LLC	305 Flanders Rd	East Lyme	CT	06333	1568402006	Pediatrics	Pediatrics	
Greenhouse	Sanford	A	MD	GF Med Group	1527 Rte 12 PO Box 355	Gales Ferry	CT	06335	1669451894	Medicine	Internal Medicine	
Hennessey	John	J	MD	GF Med Group	1527 Rte 12 PO Box 355	Gales Ferry	CT	06335	1215916564	Medicine	Internal Medicine	
Murphy-Fiengo	Mary	S	DO	GF Med Group	1527 Rte 12 PO Box 355	Gales Ferry	CT	06335	1003887001	Medicine	Internal Medicine	
Ancona	John	P	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1548359060	Pediatrics	Pediatrics	(2)
Esposito	Charles	R	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1548359078	Pediatrics	Pediatrics	(2)
Forstein	Steven	H	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1922197482	Pediatrics	Pediatrics	(2)
Holtzman	Phyllis	A	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1881783348	Pediatrics	Pediatrics	(2)
Lin	Foong-Yi		MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1427184597	Pediatrics	Pediatrics	(2)
Lovin	Jennifer	R	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1992884001	Pediatrics	Pediatrics	(2)
Rinzler	David	M	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1225127616	Pediatrics	Pediatrics	(2)
Rosenthal	Mark	A	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1144319690	Pediatrics	Pediatrics	(2)
Watson	Michelle	N	MD	GF Pediatric Group	1527 Rte 12 PO Box 608	Gales Ferry	CT	06335	1487743928	Pediatrics	Pediatrics	(2)
Curioso-Uy	Cynthia	A	MD	Gold Coast Pulmonary & Sleep	125 Shaw St	New London	CT	06320	1790783264	Medicine	Pulmonary	
Licata	Paul	J	DO	Gold Coast Pulmonary & Sleep	125 Shaw St	New London	CT	06320	1225036981	Medicine	Pulmonary	
Blefeld	Michael	E	MD	Gold Star Pediatrics	495 Rte 184 Ste 120	Groton	CT	06340	1104997923	Pediatrics	Pediatrics	
Fiftal	Carol	J	MD	Gold Star Pediatrics	495 Rte 184 Ste 120	Groton	CT	06340	1548331374	Pediatrics	Pediatrics	
Glenn	Mary	A	MD	Gold Star Pediatrics	495 Rte 184 Ste 120	Groton	CT	06340	1790845949	Pediatrics	Pediatrics	
Melchreit	Anna-Marie	L	MD	Gold Star Pediatrics	495 Rte 184 Ste 120	Groton	CT	06340	1225109051	Pediatrics	Pediatrics	
Bertman	Gary	M	MD	GP Family Care LLC	157 Montauk Ave	New London	CT	06320	1669568309	Pediatrics	Family Medicine w/Pediatrics	
Gates	Peter	J	MD	GP Family Care LLC	157 Montauk Ave	New London	CT	06320	1154416782	Pediatrics	Family Medicine w/Pediatrics	
Campos	Helar	E	MD	Helar Campos MD & Assoc	435 Montauk Ave	New London	CT	06320	1558437269	Medicine	Family Medicine	
Ecker	Robert	B	MD	Integrated Dermatology of Groton LLC	491 Gold Star Hwy Ste 310	Groton	CT	06340	1811950074	Medicine	Dermatology	
Cooper	Bruce		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1043203037	Medicine	Endocrinology & Hospitalist	
Feltes	Michael	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1689690216	Medicine	Family Medicine	
Williams	Gina	L	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1023094158	Medicine	Family Medicine	
Abdelhafiz	Gada	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1467649558	Medicine	Hospitalist	
Crispino	Carmine	R	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1861467367	Medicine	Hospitalist	
Doherty	Lauren	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1306937255	Medicine	Hospitalist	
Donovan	Kenneth	W	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1669447207	Medicine	Hospitalist	
Feder	Ingrid	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1609872845	Medicine	Hospitalist	
Frederiks	David	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1225048168	Medicine	Hospitalist	
Geronimo	Mark Dennis	V	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1215132949	Medicine	Hospitalist	
Giffault	George	K	DO	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1750357596	Medicine	Hospitalist	
Lu	Steven		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1568460186	Medicine	Hospitalist	
Malhotra	Sanjay		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1497946339	Medicine	Hospitalist	
Martin	Victor		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1881705572	Medicine	Hospitalist	
McCormick	Rachel		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1154331031	Medicine	Hospitalist	
Miller	Adriene	R	DO	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1003897737	Medicine	Hospitalist	
Nelson	John	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1376540005	Medicine	Hospitalist	
Obicheta	Chinenye	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1982888780	Medicine	Hospitalist	
Phillips	Harold	E	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1124026869	Medicine	Hospitalist	

Physician Practices in L&MPA Service Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Reardon	Claire	L	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1437343688	Medicine	Hospitalist	
Villegas	Monica	V	DO	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1255337317	Medicine	Hospitalist	
Wolff	Mirela		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1205895216	Medicine	Hospitalist	
Main	Roy	M	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1750442794	Medicine	Hospitalist & Internal Medicine	
Peraino	Robert	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1285633800	Medicine	Hospitalist & Pulmonary	
Manthous	Constantine	A	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1780643759	Medicine	Hospitalist, Internal Medicine & Pulmonary	
Felitto	Donald	J	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1831184977	Medicine	Nephrology	
Alessi	Anthony	G	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1174573612	Medicine	Neuro-Hospitalist	
Tong	Tao		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1942401815	Medicine	Neuro-Hospitalist	
Wilner	Andrew	N	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1306804257	Medicine	Neuro-Hospitalist	
Zeevi	Neer		MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1801086509	Medicine	Neuro-Hospitalist	
Crawford	William	G	MD	IPC Hospitalists of NE	365 Montauk Ave	New London	CT	06320	1114019098	Surgery	Thoracic	
Gelfand	Robert	A	MD	IPC Hosptialists of NE	365 Montauk Ave	New London	CT	06320	1952338147	Medicine	Endocrinology	
Kierstein	Jeffrey	M	DPM	Kierstein & DiFrancesca DPM PC	196 Parkway S Ste 302	Waterford	CT	06385	1841250446	Surgery	Podiatry	
Haldas	Jason	R	MD	L+M Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1275532541	Medicine	Medical Oncology & Hematology	
Hellman	Richard	M	MD	L+M Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1821097601	Medicine	Medical Oncology & Hematology	
Johnson	Vanessa	M	MD	L+M Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1326047549	Medicine	Medical Oncology & Hematology	
Newton	Benjamin	R	MD	L+M Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1265520191	Medicine	Medical Oncology & Hematology	
Rabin	Michael	S	MD	L+M Cancer Center	230 Waterford Parkway S	Waterford	CT	06385	1609883883	Medicine	Medical Oncology & Hematology	
Navin	Terence		MD	L+M Hospital Wound Care Clinic	40 Boston Post Rd	Waterford	CT	06385	1962449801	Rehab Medicine	Wound Care	(3)
Bizzarro	Matthew	J	MD	L+M Hospital/Neonatology Dept	365 Montauk Ave	New London	CT	06320	1487637203	Pediatrics	Neonatology	(4)
Citarella	Brett	V	MD	L+M Hospital/Neonatology Dept	365 Montauk Ave	New London	CT	06320	1194922146	Pediatrics	Neonatology	(4)
James	Edward	K	MD	L+M Hospital/Neonatology Dept	365 Montauk Ave	New London	CT	06320	1346258811	Pediatrics	Neonatology	(4)
Kelly	Barbara	A	MD	L+M Hospital/Neonatology Dept	365 Montauk Ave	New London	CT	06320	1942240478	Pediatrics	Neonatology	(4)
Salikooti	Saritha		MD	L+M Hospital/Neonatology Dept	365 Montauk Ave	New London	CT	06320	1588814446	Pediatrics	Neonatology	
Bortan	Alin	O	MD	L+M Infectious Disease Dept	365 Montauk Ave	New London	CT	06320	1154545754	Medicine	Infectious Disease	
Puttagunta	Sailaja		MD	L+M Infectious Disease Dept	365 Montauk Ave	New London	CT	06320	1306969282	Medicine	Infectious Disease	
Moalli	Daniel	E	MD	L+M Neurodiagnostic Lab	365 Montauk Ave Unit 4.1	New London	CT	06320	1427053958	Medicine	Neurodiagnostic	
Nordness	Robert	J	MD	L+M Occupational Health @ PHC	52 Hazelnut Hill Rd	Groton	CT	06340	1154360196	Emergency Medicine, Medicine & Rehab Medicine	Emergency Medicine, Occupational Med & Wound Care	
Deshpande	Shrikant	R	MD	L+M Occupational Health @ PHC	52 Hazelnut Hill Rd	Groton	CT	06340	1891927455	Medicine	Occupational Medicine	
Pollock	Dennis	C	MD	L+M Occupational Health @ PHC	52 Hazelnut Hill Rd	Groton	CT	06340	1609965383	Medicine	Occupational Medicine	
Ruffa	Geraldine	S	MD	L+M Occupational Health @ PHC	52 Hazelnut Hill Rd	Groton	CT	06340	1578576781	Medicine	Occupational Medicine	
Elsamra	Shady	M	MD	L+MMG Behavioral Health	365 Montauk Ave	New London	CT	06320	1144459785	Psychiatry	Psychiatry	
Mendelovicz	Naomi	M	MD	L+MMG Behavioral Health	365 Montauk Ave	New London	CT	06320	1487710141	Psychiatry	Psychiatry	
Miano	Alexander	P	MD	L+MMG Behavioral Health	194 Howard St	New London	CT	06320	1932211612	Psychiatry	Psychiatry	
Talavera-Briggs	Amarilis	M	MD	L+MMG Behavioral Health	194 Howard St	New London	CT	06320	1952499733	Psychiatry	Psychiatry	
Bagheri	Roshanak		MD	L+MMG Cardiology New London	194 Howard St	New London	CT	06320	1023222650	Medicine	Cardiology	
Cambi	Brian	C	MD	L+MMG Cardiology New London	194 Howard St	New London	CT	06320	1003033390	Medicine	Cardiology	(5)
Gaudio	Jon	C	MD	L+MMG Cardiology New London	194 Howard St	New London	CT	06320	1205885258	Medicine	Cardiology	
Ehrlich	Brian	S	MD	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1659329688	Medicine	Cardiology	
Fiengo	Mark	N	DO	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1245214220	Medicine	Cardiology	
Mena-Hurtado	Carlos	I	MD	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1205800273	Medicine	Cardiology	(5)
Milstein	Peter	S	MD	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1366482556	Medicine	Cardiology	
Mirecki	Francis	J	MD	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1083667265	Medicine	Cardiology	
Popkin	Valerie	B	MD	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1275575409	Medicine	Cardiology	
Somers	Mark	J	MD	L+MMG Cardiology Waterford	196 Parkway S Ste 103	Waterford	CT	06385	1255374864	Medicine	Cardiology	
Lincer	Robert	M	MD	L+MMG General Surgery	194 Howard St	New London	CT	06320	1851359681	Surgery	General Surgery	
Reisfeld	David	F	MD	L+MMG General Surgery	194 Howard St	New London	CT	06320	1366536526	Surgery	General Surgery	
Stanat	Christy	A	MD	L+MMG General Surgery	194 Howard St	New London	CT	06320	1942467352	Surgery	General Surgery	
Willis	Dean	N	MD	L+MMG General Surgery	194 Howard St	New London	CT	06320	1598859746	Surgery	General Surgery	
Hyppolite	Jenny		MD	L+MMG Groton	404 Thames St	Groton	CT	06340-3959	1003873332	Medicine	Internal Medicine	
Patel	Nimesh	K	DO	L+MMG Groton	404 Thames St	Groton	CT	06340	1902947658	Medicine	Internal Medicine	
Sajjad	Sepehr		MD	L+MMG Hand Center	194 Howard St	New London	CT	06320	1972772556	Surgery	Plastic-Hand Surgery	
Krasner	Alan	S	MD	L+MMG Joslin Diabetes Center	194 Howard Ave	New London	CT	06320	1932211562	Medicine	Endocrinology	
Lamberton	R	P	MD	L+MMG Joslin Diabetes Center	194 Howard St	New London	CT	06320	1205949658	Medicine	Endocrinology	
Quevedo	Stephen	F	MD	L+MMG Joslin Diabetes Center	194 Howard Ave	New London	CT	06320	1942313481	Medicine	Internal Medicine	
Coiculescu	Olivia	E	MD	L+MMG Neurology	194 Howard St	New London	CT	06320	1639338858	Medicine	Neurology	
Doherty	Patrick	F	MD	L+MMG Neurosurgery	194 Howard St	New London	CT	06320	1578620282	Surgery	Neurosurgery	
Calderon	Wilton	C	DO	L+MMG New London	194 Howard St	New London	CT	06320	1134392046	Medicine	Family Medicine	
Licare	Lisa			L+MMG New London	194 Howard Street	New London	CT	06320		Medicine	Ob-gyn	
Walcott	Charles			L+MMG Niantic	248 Flanders Road	Niantic	CT	06357		Medicine	Family Medicine	
Williams	Brian	L	MD	L+MMG Niantic	248 Flanders Rd	Niantic	CT	06357	1518945351	Medicine	Family Medicine	
Vachhani	Jitesh	K	MD	L+MMG Niantic	248 Flanders Rd	Niantic	CT	06357	1205815487	Medicine	Hospitalist	
Palker	Neil	A	MD	L+MMG Niantic	248 Flanders Rd	Niantic	CT	06357	1336280007	Medicine	Internal Medicine	
Barczak	Timothy	M	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1427032200	OB-GYN	Gynecology	

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Amdur	Henry	S	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1700920022	OB-GYN	OB-GYN	
Brown	Shereene	J	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1760626600	OB-GYN	OB-GYN	
Watson	Edward	J	MD	L+MMG Obstetrics & Gynecology	194 Howard St	New London	CT	06320	1528031804	OB-GYN	OB-GYN	
D'Mello	Suresh	C	MD	L+MMG Old Lyme	19 Halls Rd PO Box 250	Old Lyme	CT	06371	1144387838	Medicine	Family Medicine	
Graves	Jay	A	MD	L+MMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme	CT	06371	1083771745	Medicine	Family Medicine	
Nelligan	Elizabeth	K	MD	L+MMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme	CT	06371	1174663884	Medicine	Family Medicine	
Sutherland	Jennifer	L	MD	L+MMG Old Lyme	19 Halls Ave PO Box 250	Old Lyme	CT	06371	1063621829	Medicine	Family Medicine	
Ciotola	Robert	T	MD	L+MMG Primary Care Mystic	23 Clara Dr	Mystic	CT	06355	1285791046	Medicine	Family Medicine	
Parad	Adrienne	L	MD	L+MMG Primary Care Mystic	23 Clara Dr Ste 203	Mystic	CT	06355	1467659227	Medicine	Family Medicine	
Perry	Robert	J	MD	L+MMG Primary Care New London	194 Howard St	New London	CT	06320	1861404402	Medicine	Family Medicine	
DeBaets	Myriam	I	MD	L+MMG Primary Care New London	194 Howard St	New London	CT	06320	1649331919	Medicine	Hospitalist & Internal Medicine	
Carter	H Anthony		MD	L+MMG Primary Care New London	194 Howard St	New London	CT	06320	1487750733	Medicine	Internal Medicine	
Shute	Marlene		MD	L+MMG Primary Care New London	194 Howard St	New London	CT	06320	1245552306	Medicine	Internal Medicine	
Kurra	Anupama		MD	L+MMG Rehabilitation Medicine	194 Howard St	New London	CT	06320	1871728972	Rehab Medicine	Rehabilitation	
O'Keefe	Joseph	F	MD	L+MMG Rehabilitation Medicine	194 Howard St	New London	CT	06320	1538104583	Rehab Medicine	Rehabilitation	
Peters	Joseph	W	MD	L+MMG Rehabilitation Medicine	194 Howard St	New London	CT	06320	1992746325	Rehab Medicine	Rehabilitation	
Khanna	Amit		MD	L+MMG Sleep Medicine	194 Howard St	New London	CT	06320	1013012723	Medicine	Sleep Medicine	
Whelan	Tara		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379	1619273042	Medicine	Dermatology	
Whelan	Mae			L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379		Medicine	Endocrinology	(6)
Applegate	Brenda	L	MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379	1255437752	Medicine	Family Medicine	
Khalid	Saima			L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379		Medicine	Family Medicine	
Kober	William	H	MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379	1396724134	Medicine	Family Medicine	
Iovino	Brandi		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379	1639303324	Medicine	Internal Medicine	
Iovino	Louis		DO	L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379	1396825097	Medicine	Internal Medicine	
Phelan	Stephen		MD	L+MMG Stonington	91 Voluntown Rd	Pawcatuck	CT	06379	1326142332	Medicine	Internal Medicine	
Torres	Kevin	J	DO	L+MMG Primary Care	196 Parkway S Ste 103	Waterford	CT	06385	1023063849	Emergency Medicine	Emergency Medicine	
Spitz	Robert	M	MD	Montauk GYN	342 Montauk Ave	New London	CT	06320	1871575696	OB-GYN	Gynecology	
Fields	Warren	L	MD	Mystic Med Group	200 Sandy Hollow Rd	Mystic	CT	06355	1821083999	Medicine	Hospitalist & Internal Medicine	
Sullivan	James	F	MD	Mystic Med Group	200 Sandy Hollow Rd	Mystic	CT	06355	1780679472	Medicine	Hospitalist & Rheumatology	
Scarles	James		MD	Mystic Med Group	200 Sandy Hollow Rd	Mystic	CT	06355	1194710269	Medicine	Internal Medicine	
Radin	Laurence	I	MD	Neurological Group PC	350 Montauk Ave	New London	CT	06320	1508860156	Medicine	Neurology	
Lee	John	C	MD	New England Plastic Surgery	8 Vista Dr	Old Lyme	CT	06371	1568625176	Surgery	Plastic-Hand Surgery	
Gordon	Jeffrey	A	MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1609857119	Medicine	Medical Oncology & Hematology	
Govil	Mithlesh		MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1235136094	Medicine	Medical Oncology & Hematology	
Kalwar	Tricia	L	MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1982852190	Medicine	Medical Oncology & Hematology	
Lattanzi	Stephen	C	MD	New London Cancer Ctr	196 Parkway S Ste 303	Waterford	CT	06385	1801894555	Medicine	Medical Oncology & Hematology	
Allard	Elizabeth	K	MD	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	1326155367	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Fisher	Eric	J	DO	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	1730190034	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Johnson	Steven	P	MD	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	1902801434	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Rydell	Margret	K	MD	New London Family Practice	4 Shaws Cove Ste 103	New London	CT	06320	1154332427	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Stocki	Jerzy			North Stonington Med. Walk-In Ctr	82 Norwich-Westerly Road	North Stonington	CT	06359			Internal Medicine	
Pathy	Vinod	V	MD	Northeast Plastic Surgery	5 Davis Rd East	Old Lyme	CT	06371	1922299098	Surgery	Plastic-Hand Surgery	
Palazzo	Regina	M	MD	Nutmeg Pediatric Pulmonary Svs	6 Business Park Dr Ste 202	Branford	CT	06405	1801862602	Pediatrics	Pediatric Pulmonology	(5)
Basu	Arun		MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1639184377	Radiology	Diagnostic Radiology	
Blue	Todd	M	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1841227535	Radiology	Diagnostic Radiology	
Colby	Jay	M	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1659356533	Radiology	Diagnostic Radiology	
Cross	Robert	R	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1770513301	Radiology	Diagnostic Radiology	
Diffin	Daniel	C	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1649240821	Radiology	Diagnostic Radiology	
Kereshi	Tibor		MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1104897685	Radiology	Diagnostic Radiology	
Koblick	Brenda	M	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1932136629	Radiology	Diagnostic Radiology	
Manning	Thomas	J	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1316984099	Radiology	Diagnostic Radiology	
Mazzarelli	Louis		MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1114978194	Radiology	Diagnostic Radiology	
Niles	Michael	C	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1598745986	Radiology	Diagnostic Radiology	
Robbins	Sheldon	M	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1285613588	Radiology	Diagnostic Radiology	
Sitko	Ira		MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1821035502	Radiology	Diagnostic Radiology	
Sorrentino	John	R	MD	Ocean Radiology Assoc	365 Montauk Ave	New London	CT	06320	1407893183	Radiology	Diagnostic Radiology	
Antic	Anica		MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1457678641	Pathology	Pathology	
Benedict	Joseph	C	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1861424905	Pathology	Pathology	
Ejaz	Asim		MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1346403862	Pathology	Pathology	
Green	Kevin	B	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1356307334	Pathology	Pathology	
Krejci	Elise	L	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1700940285	Pathology	Pathology	
Muscato	Nicole	E	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1164579041	Pathology	Pathology	
Reyes	Victoria	G	MD	Pathology Consultants of NL	365 Montauk Ave	New London	CT	06320	1598787517	Pathology	Pathology	
Phillips	Kimberly	A	MD	Phillips Integrative Health	801 Poquonnock Rd Ste 6	Groton	CT	06340	1457359192	Medicine	Family Medicine	
McLean	Christina	M	MD	Primary Care for Women	8 Vista Dr	Old Lyme	CT	06371	1912072455	Medicine	Family Medicine	
Parekh	Anisha	R	MD	Primary Care for Women	8 Vista Dr	Old Lyme	CT	06371	1538116348	Medicine	Family Medicine	

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Satti	Mary	C	MD	Primary Care for Women	8 Vista Dr	Old Lyme	CT	06371	1376540849	Medicine	Internal Medicine	
Ehrlich	Owen	R	MD	ProHealth Ped Assoc of NL	53C Granite St	New London	CT	06320	1295835999	Pediatrics	Pediatrics	
Giserman	Bernard	A	MD	ProHealth Ped Assoc of NL	53C Granite St	New London	CT	06320	1467552166	Pediatrics	Pediatrics	
Khanna	Ekta		MD	ProHealth Ped Assoc of NL	53C Granite St	New London	CT	06320	1154586691	Pediatrics	Pediatrics	
Lebovitz	Ruth	M	MD	ProHealth Ped Assoc of NL	53C Granite St	New London	CT	06320	1497843007	Pediatrics	Pediatrics	
Salek	Allyson	A	MD	ProHealth Ped Assoc of NL	53C Granite St	New London	CT	06320	1942474739	Pediatrics	Pediatrics	
Donahue	Jennifer		MD	ProHealth Phys Womens Care	85 Poheganut Dr	Groton	CT	06340	1275647448	Medicine	Family Medicine	
McIvor	Patricia			ProHealth Phys Womens Care	85 Poheganut Drive	Groton	CT	06340			Family Practice	
Watts	Laura	A		ProHealth Phys Womens Care	85 Poheganut Drive	Groton	CT	06340			Family Practice	
Crabbe	Henry	F		Psychiatric Medicine Clinic	Five Shaw's Cove	New London	CT	06320			Psychiatry	
Romania	Anthony		MD	Romania Eye Center	82 Plaza Ct	Groton	CT	06340	1407853153	Surgery	Ophthalmology	
Hodgson	Eric	J	MD	SE CT Maternal Fetal Med Assoc	4 Shaws Cove Ste 201	New London	CT	06320	1689891673	OB-GYN	Maternal Fetal Medicine	
Neuman	Saul	D	MD	SE CT Med Assoc	447 Montauk Ave	New London	CT	06320	1316041601	Medicine	Endocrinology	
Doherty	Terrence	A	MD	SE CT Med Assoc	123 Elm St Ste 500/600	Old Saybrook	CT	06475	1255435558	Medicine	Family Medicine	
Ducey	Stephen	G	MD	SE CT Med Assoc	447 Montauk Ave	New London	CT	06320	1841394137	Medicine	Hospitalist & Internal Medicine	
Colom	William	A	MD	SE CT Med Assoc	447 Montauk Ave	New London	CT	06320	1558465849	Medicine	Internal Medicine	
Ginsberg	Jay	M	MD	SE CT Neph Assoc	88 Norwich NL Tpke 2E	Uncasville	CT	06382	1841285509	Medicine	Nephrology	
Haus	Mihkel	J	MD	SE CT Neph Assoc	88 Norwich NL Tpke 2E	Uncasville	CT	06382	1841285988	Medicine	Nephrology	
Negulescu	Mihaela	O	MD	SE CT Neph Assoc	88 Norwich NL Tpke 2E	Uncasville	CT	06382	1558473801	Medicine	Nephrology	
Peter	Thomas	C	MD	SE CT Neph Assoc	88 Norwich NL Tpke 2E	Uncasville	CT	06382	1952397549	Medicine	Nephrology	
Rasool	Altaf		MD	SE CT Neph Assoc	88 Norwich NL Tpke 2E	Uncasville	CT	06382	1013018357	Medicine	Nephrology	
Klekotka	Suzanne	J	MD	SE Pulmonary Assoc	155 Montauk Ave	New London	CT	06320	1093733875	Medicine	Internal Medicine	
Keltner	Robert	J	MD	SE Pulmonary Assoc	155 Montauk Ave	New London	CT	06320	1154436483	Medicine	Pulmonary	
Urbanetti	John	S	MD	SE Pulmonary Assoc	155 Montauk Ave	New London	CT	06320	1720181209	Medicine	Pulmonary	
Carlow	Steven	B	MD	Seacoast Ortho/Sports Med	495 Rte 184 Ste 300	Groton	CT	06340	1013935592	Surgery	Orthopaedic	
Thoms	R Justin		MD	Seacoast Ortho/Sports Med	495 Rte 184 Ste 300	Groton	CT	06340	1194987883	Surgery	Orthopaedic	
Wei	Steven	Y	MD	Seacoast Ortho/Sports Med	495 Rte 184 Ste 300	Groton	CT	06340	1225067895	Surgery	Orthopaedic	
West	John	R	MD	Seaport Dermatology	34 Water St Ste 2	Mystic	CT	06355	1487606117	Medicine	Dermatology	
Miller	Jeffrey	A	DO	Shaws Cove Orthopaedics LLC	6 Shaws Cove Ste 101	New London	CT	06320	1184692162	Surgery	Orthopaedic	
Ber	Doron	J	MD	Shoreline Allergy & Asthma	23 Clara Dr Ste 204	Mystic	CT	06355	1316924749	Medicine & Pediatrics	Allergy & Immunology & Pediatric Allergy	
Netravali	Mahesh	A	MD	Shoreline Allergy & Asthma	23 Clara Dr Ste 204	Mystic	CT	06355	1942424551	Medicine & Pediatrics	Allergy & Immunology & Pediatric Allergy	
Waggoner	Daniel	L	MD	Shoreline Allergy & Asthma	23 Clara Dr Ste 204	Mystic	CT	06355	1558406066	Medicine & Pediatrics	Allergy & Immunology & Pediatric Allergy	
Haim	Lior		MD	Shoreline Eye Group PC	741 Broad St Ext	Waterford	CT	06385	1518013358	Surgery	Ophthalmology	
Ryan	John	J	MD	Shoreline Eye Group PC	741 Broad St Ext	Waterford	CT	06385	1134192354	Surgery	Ophthalmology	
Feldman	Barry	S	MD	Shoreline Family Practice	36 Clark Ln	Waterford	CT	06385	1366555997	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Golden	David		MD	Shoreline Family Practice	36 Clark Ln	Waterford	CT	06385	1306954896	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Parad	Andrew	M	MD	Shoreline Family Practice	36 Clark Ln	Waterford	CT	06385	1053405605	Medicine & Pediatrics	Family Medicine w/Pediatrics	
Courtright	Darren	J	DPM	Shoreline Foot & Ankle Ctr	85 Poheganut Dr	Groton	CT	06340	1417937475	Surgery	Podiatry	
Marshall	Sonya	L	DPM	Shoreline Foot & Ankle Ctr	85 Poheganut Dr	Groton	CT	06340	1609059286	Surgery	Podiatry	
Lavallee	Michael	A	DO	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1447486741	OB-GYN	OB-GYN	
Levine	Jonathan	L	MD	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1497769509	OB-GYN	OB-GYN	
Mayeda	Francis	J	MD	Shoreline OB/GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1083631055	OB-GYN	OB-GYN	
Szutowska	Magdalena		MD	Shoreline OB-GYN PC	4 Shaws Cove Ste 204-205	New London	CT	06320	1730408535	OB-GYN	OB-GYN	
Duhig	Niall	J	MD	Shoreline Pulmonary Assoc LLC	415 Ocean Ave	New London	CT	06320	1578503967	Medicine	Pulmonary	
Dyer	James	A	DMD	Soundview Oral & Maxillofacial	4 Shaws Cove Ste 203	New London	CT	06320	1033125323	Surgery	Dental	
Sanfilippo	Ross	J	DMD	Soundview Oral & Maxillofacial	4 Shaws Cove Ste 203	New London	CT	06320	1154344281	Surgery	Dental	
Gaccione	Daniel	R	MD	Soundview Orthopaedic Assoc	489 Route 184 Ste 110	Groton	CT	06340	1538168117	Surgery	Orthopaedic	
Hutchins	Christopher	M	MD	Soundview Orthopaedic Assoc	489 Rte 184 Ste 110	Groton	CT	06340	1902805591	Surgery	Orthopaedic	
Agrawal	Anjali		MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1427034016	Radiology	Teleradiology	(7)
Aribandi	Manohar		MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1720052855	Radiology	Teleradiology	(7)
Aschkenasi	Carl	J	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1376612739	Radiology	Teleradiology	(7)
Chinta	Bharath Kumar		MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1033168422	Radiology	Teleradiology	(7)
Eigles	Stephen	B	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1619970787	Radiology	Teleradiology	(7)
Fox	Matthew	A	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1538370838	Radiology	Teleradiology	(7)
Goodman	Margaret	M	MD	Teleradiology Solutions	205 Church St 3rd Fl	New Haven	CT	06510	1336307537	Radiology	Teleradiology	(7)
Kalyanpur	Arjun		MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1376528315	Radiology	Teleradiology	(7)
Kamath	Sanjay	V	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1700801537	Radiology	Teleradiology	(7)
Pandit	Meenakshi		MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1679688725	Radiology	Teleradiology	(7)
Pennington	Norman	E	MD	Teleradiology Solutions	900 Chapel St Ste 620	New Haven	CT	06510	1295728251	Radiology	Teleradiology	(7)
Wable	Sumathi		MD	Teleradiology Solutions	205 Church St 3rd Fl	New Haven	CT	06510	1447345665	Radiology	Teleradiology	(7)
Lanzillo	Charles	F	MD	Thames Eye Group	200 Sandy Hollow Rd	Mystic	CT	06355	1013945344	Surgery	Ophthalmology	
Parker	Prior	L	MD	Thames Eye Group	200 Sandy Hollow Rd	Mystic	CT	06355	1326076795	Surgery	Ophthalmology	
Fraser	Richard	A	MD	Thames Urology Ctr	3 Shaws Cove Ste 206	New London	CT	06320	1164504247	Surgery	Urology	
Quinn	Anthony	D	MD	Thames Urology Ctr	3 Shaws Cove Ste 206	New London	CT	06320	1053319624	Surgery	Urology	
Schoenberger	Steven		MD	Thames Urology Ctr	3 Shaws Cove Ste 206	New London	CT	06320	1477551034	Surgery	Urology	
Auerbach	Peter	T	MD	Thameside OB/GYN Ctr	491 Rte 184 Ste 100	Groton	CT	06340	1154412674	OB-GYN	OB-GYN	

Physician Practices in L&MPA Service Area (Table 9)

Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
DiLullo	Anthony	A	MD	Thameside OB/GYN Ctr	491 Rte 184 Ste 100	Groton	CT	06340	1477667392	OB-GYN	OB-GYN	
Girard	Elisa	M	MD	Thameside OB/GYN Ctr	491 Rte 184 Ste 100	Groton	CT	06340	1700861689	OB-GYN	OB-GYN	
Jacobsen	Tricia	A	MD	Thameside OB/GYN Ctr	491 Rte 184 Ste 100	Groton	CT	06340	1154478915	OB-GYN	OB-GYN	
Schrempf	Michael	A	MD	Thameside OB/GYN Ctr	491 Rte 184 Ste 100	Groton	CT	06340	1972694495	OB-GYN	OB-GYN	
Donka	Abel	A	MD	Thompson Goldberg & Donka	22 W Main St	Niantic	CT	06357	1649322686	Medicine	Internal Medicine	
Goldberg	Robert	P	MD	Thompson Goldberg & Donka	22 W Main St	Niantic	CT	06357	1003809096	Medicine	Internal Medicine	
Thompson	David	D	MD	Thompson Goldberg & Donka	22 W Main St	Niantic	CT	06357	1477546455	Medicine	Internal Medicine	
Patterson	Bruce	H	DMD	Waterford Dental Health	177 Boston Post Rd PO Box 254	Waterford	CT	06385	1336355114	Surgery	Dental	
DiSilvestro	Paul	A	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02905	1174559603	OB-GYN	GYN Oncology	(8)
Granai	Cornelius	O	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02905	1487660296	OB-GYN	GYN Oncology	(8)
Mathews	Cara	A	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02905	1659540490	OB-GYN	GYN Oncology	(8)
Stuckey	Ashley	R	MD	Women & Infants Hospital	101 Dudley St	Providence	RI	02905	1457441321	OB-GYN	GYN Oncology	(8)
Abbed	Khalid	M	MD	Yale Medical Group	333 Cedar St TMP426	New Haven	CT	06510	1386612026	Surgery	Neurosurgery	(5)
Laurans	Maxwell	S		Yale Medical Group	333 Cedar St TMP4	New Haven	CT	06510	1861674434	Surgery	Neurosurgery	(5)
Matouk	Charles	C	MD	Yale Medical Group	333 Cedar St TMP4	New Haven	CT	06510	1053696187	Surgery	Neurosurgery	(5)
Indes	Jeffrey	E	MD	Yale Medical Group	333 Cedar St BB204	New Haven	CT	06510	1083884100	Surgery	Vascular	(5)
Ochoa Chaar	Cassius	I	MD	Yale Medical Group	333 Cedar St BB 204	New Haven	CT	06510	1669600698	Surgery	Vascular	(5)
Sumpio	Bauer	E	MD	Yale Medical Group	333 Cedar St BB204	New Haven	CT	06510	1750498671	Surgery	Vascular	(5)
Brueckner	Martina		MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1124003975	Pediatrics	Pediatric Cardiology	(5)
Fahey	John	T	MD	Yale Pediatric Cardiology	333 Cedar St LCI 302	New Haven	CT	06520	1851374086	Pediatrics	Pediatric Cardiology	(5)
Friedman	Alan	H	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1386629848	Pediatrics	Pediatric Cardiology	(5)
Greenstein	Emily	P	MD	Yale Pediatric Cardiology	333 Cedar St PO Box 208064	New Haven	CT	06520	1053560763	Pediatrics	Pediatric Cardiology	(5)
Hall	E Kevin		MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1346432820	Pediatrics	Pediatric Cardiology	(5)
Weeks	Bevin	P	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1124003686	Pediatrics	Pediatric Cardiology	(5)
Weismann	Constance	G	MD	Yale Pediatric Cardiology	333 Cedar St Box 208064	New Haven	CT	06520	1851552467	Pediatrics	Pediatric Cardiology	(5)
Attaran	Robert		MD	Yale Univ Cardiovascular Med	PO Box 208017	New Haven	CT	06520	1629270616	Medicine	Cardiology	(5)
Brennan	Joseph	J	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1528057304	Medicine	Cardiology	(5)
Cabin	Henry	S	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1881684116	Medicine	Cardiology	(5)
Cleman	Michael	W	MD	Yale Univ Cardiovascular Med	333 Cedar St PO Box 208017	New Haven	CT	06520	1023006269	Medicine	Cardiology	(5)
Curtis	Jeptha	P	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1700876273	Medicine	Cardiology	(5)
Forrest	John	K	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1386827491	Medicine	Cardiology	(5)
Giordano	Frank	J	MD	Yale Univ Cardiovascular Med	111 Goose Ln Ste 2400	Guilford	CT	06437	1366430456	Medicine	Cardiology	(5)
Henry	Glen	A		Yale Univ Cardiovascular Med	1591 Boston Post Rd	Guilford	CT	06437	1720077324	Medicine	Cardiology	(5)
Pfau	Steven	E	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06520	1114915162	Medicine	Cardiology	(5)
Remetz	Michael	S	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06520	1568450641	Medicine	Cardiology	(5)
Setaro	John	F	MD	Yale Univ Cardiovascular Med	135 College St Ste 301	New Haven	CT	06510	1932199494	Medicine	Cardiology	(5)
Abdel-Razeq	Sonya		MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1265415350	OB-GYN	Maternal Fetal Medicine	(5)
Bahtiyar	Mert	O	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1356324438	OB-GYN	Maternal Fetal Medicine	(5)
Bukowski	Radek	K	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1922167352	OB-GYN	Maternal Fetal Medicine	(5)
Campbell	Katherine	H	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1972774784	OB-GYN	Maternal Fetal Medicine	(5)
Copel	Joshua	A	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1235112392	OB-GYN	Maternal Fetal Medicine	(5)
Galerneau	France		MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1649254475	OB-GYN	Maternal Fetal Medicine	(5)
Kohari	Katherine	S	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06510	1356509996	OB-GYN	Maternal Fetal Medicine	(5)
Lipkind	Heather	S	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1033148911	OB-GYN	Maternal Fetal Medicine	(5)
Magriples	Urania		MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1740263813	OB-GYN	Maternal Fetal Medicine	(5)
Paidas	Michael	J	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1821071994	OB-GYN	Maternal Fetal Medicine	(5)
Pettker	Christian	M	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1457334542	OB-GYN	Maternal Fetal Medicine	(5)
Sfakianaki	Anna	K	MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06510	1164405239	OB-GYN	Maternal Fetal Medicine	(5)
Silasi	Michelle		MD	Yale Univ Maternal Fetal Med	333 Cedar St PO Box 208063	New Haven	CT	06520	1316122476	OB-GYN	Maternal Fetal Medicine	(5)
Bindra	Ranjit		MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1326206855	Medicine	Radiation Oncology	(5)
Decker	Roy	H	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1477673564	Medicine	Radiation Oncology	(5)
Evans	Suzanne	B	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1750400644	Medicine	Radiation Oncology	(5)
Glazer	Peter	M	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1396734166	Medicine	Radiation Oncology	(5)
Hansen	James	E	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1356501589	Medicine	Radiation Oncology	(5)
Higgins	Susan	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1962485987	Medicine	Radiation Oncology	(5)
Husain	Zain	A	MD	Yale Univ Therapeutic Rad Dept	35 Park St Smilow LL 515	New Haven	CT	06531	1134389141	Medicine	Radiation Oncology	(5)
Johung	Kimberly	L	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1255505178	Medicine	Radiation Oncology	(5)
Knowlton	Christin	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1679733422	Medicine	Radiation Oncology	(5)
Moran	Meena	S	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1841280385	Medicine	Radiation Oncology	(5)
Patel	Abhijit	A	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1942276076	Medicine	Radiation Oncology	(5)
Roberts	Kenneth	B	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1275522047	Medicine	Radiation Oncology	(5)
Wilson	Lynn	D	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1770571770	Medicine	Radiation Oncology	(5)
Yu	James	B	MD	Yale Univ Therapeutic Rad Dept	PO Box 208040	New Haven	CT	06520	1306020474	Medicine	Radiation Oncology	(5)
Amin	Hardik	P	MD	Yale-New Haven Telestroke	15 York St LCI 710 PO Box 208018	New Haven	CT	06510	1679716195	Medicine	Neurology-Telestroke	(9)
Baehring	Joachim	M	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1982686622	Medicine	Neurology-Telestroke	(9)
Dearborn	Jennifer	L	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1144457755	Medicine	Neurology-Telestroke	(9)

Physician Practices in L&MPA Service Area (Table 9)

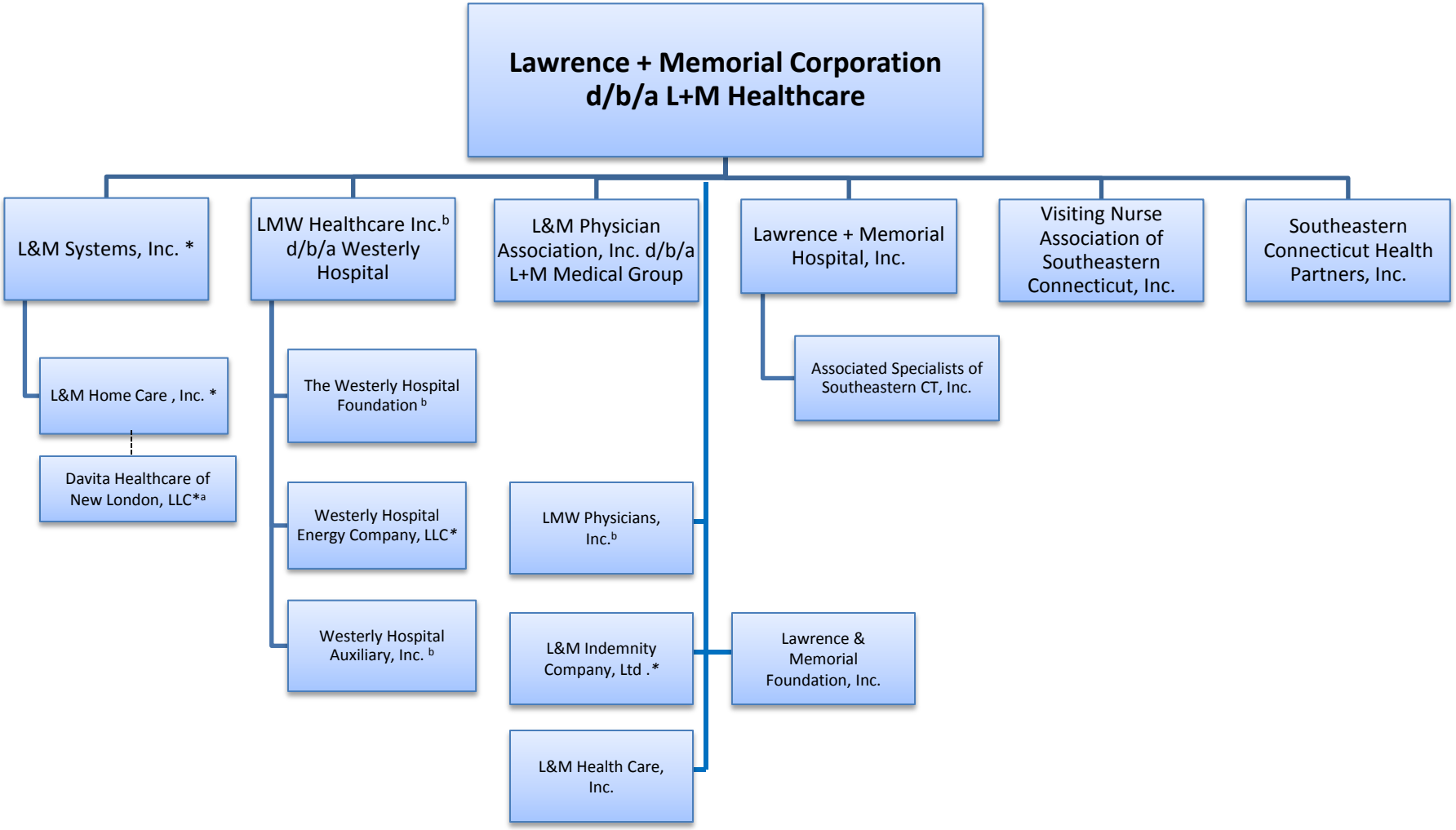
Last Name	First Name	Middle Initial	Degree	Organization Name	Address Line	City	State	Zip Code	Provider NPI	Department	Specialty	Notes
Greer	David	M	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1003807215	Medicine	Neurology-Telestroke	(9)
Hwang	David	Y	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1407983836	Medicine	Neurology-Telestroke	(9)
Loomis	Caitlin		MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1184868069	Medicine	Neurology-Telestroke	(9)
Navaratnam	Dhasakumar	S	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1528041738	Medicine	Neurology-Telestroke	(9)
Petersen	Nils	H	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1962644872	Medicine	Neurology-Telestroke	(9)
Sansing	Lauren	H	MD	Yale-New Haven Telestroke	15 York St LCI 1005	New Haven	CT	06510	1912052820	Medicine	Neurology-Telestroke	(9)
Schindler	Joseph	L	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1609857044	Medicine	Neurology-Telestroke	(9)
Sheth	Kevin	N	MD	Yale-New Haven Telestroke	333 Cedar St PO Box 208018	New Haven	CT	06520	1629184585	Medicine	Neurology-Telestroke	(9)
Allen	John	E	DMD		464 Montauk Ave	New London	CT	06320	1891871273	Surgery	Dental	
Harris	Randall	D	DDS		1527 Rte 12 PO Box 396	Gales Ferry	CT	06335	1093977811	Surgery	Dental	
Headley	Annette	L	MD		56 Whitehall Ave	Mystic	CT	06355	1295841682	Medicine	Dermatology	
Miller	Debra	R	MD		53 Granite St Ste D	New London	CT	06320	1558369215	Medicine	Dermatology	
Wolf	Eric	R	MD		495 Rte 184 Ste 108	Groton	CT	06340	1043308885	Medicine	Dermatology	
Sikand	Vijay	K	MD		41 Heritage Rd	East Lyme	CT	06333	1013914167	Medicine	Family Medicine	
Verma	Shri	K	MD		391 Ocean Ave	New London	CT	06320	1790873248	Medicine	Gastroenterology	
Azia	Gregory	S	MD		399 Ocean Ave	New London	CT	06320	1437297785	Medicine & Surgery	Gen Surgery, Gastroenterology Pulmonary & Vascular	
Deren	Michael	M	MD		125 Shaw St	New London	CT	06320	1972596534	Surgery	General & Thoracic Surgery	
Kuhn	Kris				3 Heron Road	Mystic	CT	06355			Geriatric Medicine	
Giordano	Joan		MD		183 Boston Post Rd	East Lyme	CT	06333	1144387887	Medicine	Internal Medicine	
McDermott	Edward	J	MD		25 Church St	Groton	CT	06340	1356324008	Medicine	Internal Medicine	
Yoselevsky	Melvin	A	MD		334 Montauk Ave	New London	CT	06320	1710075924	Medicine	Internal Medicine	
Simpson	Jeffrey	A	MD		345 Montauk Ave	New London	CT	06320	1275525156	OB-GYN	OB-GYN	
Famiglietti	Peter	J	MD		339 Flanders Rd Ste 109	East Lyme	CT	06333	1811994510	Surgery	Ophthalmology	
Santoro	Fred	E	MD		Flanders Plaza Ste 214 PO Box 159	East Lyme	CT	06333	1639269970	Pediatrics	Pediatrics	
Sena	Thomas		MD		196 Parkway S Ste 101	Waterford	CT	06385	1972689073	Surgery	Plastic-Hand Surgery	
Colsen	Steven	R			16 Lincoln Avenue	Pawcatuck	CT	06379			Podiatry	
Coss	Edward	W	MD		196 Parkway S Ste 201	Waterford	CT	06385	1275665564	Psychiatry	Psychiatry	
Maloney	Martin	J			400 Bayonet Street	New London	CT	06360			Psychiatry	
Ogland	Olaf	J			19 Halls Road	Old Lyme	CT	06371			Psychiatry	
Levin	Robert	E	MD		131 Boston Post Rd Ste 6	East Lyme	CT	06333	1568457166	Medicine	Rheumatology	
Degen	Kathleen				165 State Street	New London	CT	06320				

(1) Physician part of YMG: supports LMH's angioplasty program, thus clinically active part-time in CT.
(2) Physician part of NEMG.
(3) Physician leaving servicea area on 9/30/15.
(4) Physician part of YMG; coverage of LMH's NICU service provided through services agreement among LMH, YNHCH, and YSM.
(5) Physician part of YMG; provides clinical services within service area on a part-time basis through services agreements among (as applicable) LMH, LMPH, YNHH, and YSM.
(6) Physician to start 10/1/15.
(7) Physician provides teleradiology services to patient's residing within service area.
(8) Physician affiliated with W&I Hospital in Providence, RI; provides clinical services within service area on a part-time basis.
(9) Physician affiliated with YNHH; provides telehealth services to patient's residing within service area.

ATTACHMENT V

L+M HEALTHCARE ORGANIZATIONAL CHART

L+M Healthcare



Note:
** - for profit*
a – Joint Venture with Backus Dialysis Corporation and Davita
b – Rhode Island non-profit companies
[v: 24Nov015 Karen Santacroce]

ATTACHMENT VI

AUDITED FINANCIAL STATEMENTS 2015

Lawrence + Memorial Hospital

Consolidated Financial Statements and Supplemental Information
September 30, 2015 and 2014

Lawrence + Memorial Hospital
Index
September 30, 2015 and 2014

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Independent Auditor's Report

To the Board of Trustees of
Lawrence + Memorial Hospital

We have audited the accompanying consolidated financial statements of Lawrence + Memorial Hospital and its subsidiary (a subsidiary of Lawrence + Memorial Corporation, the "Hospital"), which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Hospital at September 30, 2015 and September 30, 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual organizations and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and cash flows of the individual organizations.

Hartford, Connecticut
December ___, 2015

Lawrence + Memorial Hospital
Consolidated Balance Sheets
September 30, 2015 and 2014

	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 13,362,306	$ 6,917,676
Investments	107,365,636	128,450,331
Patient accounts receivable, net of allowance for doubtful accounts of $9,766,654 and $6,293,473, respectively	37,976,959	36,373,069
Other receivables	4,131,254	4,156,260
Inventories	6,194,355	6,580,753
Due from affiliates	1,958,442	1,954,838
Prepaid expenses and other current assets	3,125,348	2,689,506
Debt service fund	1,304,613	1,304,562
Total current assets	175,418,913	188,426,995
Assets limited as to use		
Cash	183,677	182,862
Construction fund	-	561,676
Investments held in trust	926,080	925,227
Endowment investments	17,802,689	18,987,367
Funds held in trust by others	3,584,118	6,985,614
Contributions receivable	20,366	20,366
Total assets limited as to use	22,516,930	27,663,112
Deferred financing costs and other assets, net	2,187,006	2,315,752
Other receivables	19,596,372	16,536,719
Property, plant and equipment, net	150,976,973	160,857,796
	$ 370,696,194	$ 395,800,374
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 33,209,795	$ 25,786,034
Accrued vacation and sick pay	10,112,002	11,281,701
Salaries, wages, payroll taxes and amounts withheld from employees	4,908,525	5,950,567
Due to affiliates	2,512,703	2,215,430
Due to third party payors	6,711,203	5,165,225
Current portion of long-term debt	5,495,740	5,342,305
Total current liabilities	62,949,968	55,741,262
Accrued pension and other postretirement benefits	52,989,394	43,216,010
Other liabilities	23,691,278	20,601,530
Long-term debt, less current portion	102,938,747	108,587,802
Total liabilities	242,569,387	228,146,604
Net assets		
Unrestricted	103,203,168	138,173,767
Temporarily restricted	18,960,042	23,432,028
Permanently restricted	5,963,597	6,047,975
Total net assets	128,126,807	167,653,770
	$ 370,696,194	$ 395,800,374

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Consolidated Statements of Operations
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted revenues, gains and other support		
Net revenues from services to patients	$ 339,282,362	$ 337,129,192
Provision for bad debt	(12,821,337)	(14,930,302)
Net revenue less provision for bad debt	326,461,025	322,198,890
Other operating revenues	30,874,305	28,151,061
Net assets released from restriction used for operations	577,092	671,797
Total unrestricted revenues, gains and other support	357,912,422	351,021,748
Expenses		
Salaries and wages	140,605,613	143,838,674
Employee benefits	51,698,355	51,044,718
Supplies	63,622,692	59,538,141
Purchased services	29,998,356	38,647,767
Other	40,208,162	34,490,156
Interest	3,553,690	3,542,721
Depreciation and amortization	23,639,711	22,728,484
Total expenses	353,326,579	353,830,661
Income (loss) from operations	4,585,843	(2,808,913)
Nonoperating gains		
Unrestricted investment income	228,240	180,488
Income from investments and realized gains	9,708,669	8,608,113
Total nonoperating gains	9,936,909	8,788,601
Excess of revenues over expenses	14,522,752	5,979,688
Transfers to affiliated entities	(19,764,884)	(33,861,262)
Net unrealized (losses) gains on investments	(16,107,490)	31,059
Net assets released from restriction used for purchase of property, plant and equipment	140,748	139,360
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	$ (34,970,599)	$ (31,986,321)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted net assets		
Excess of revenues over expenses	$ 14,522,752	$ 5,979,688
Transfer to affiliated entities	(19,764,884)	(33,861,262)
Net unrealized gains on investment	(16,107,490)	31,059
Net assets released from restriction used for purchase of property, plant and equipment	140,748	139,360
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	(34,970,599)	(31,986,321)
Unrestricted net assets		
Beginning of year	138,173,767	170,160,088
End of year	$ 103,203,168	$ 138,173,767
Temporarily restricted net assets		
Income from investments	$ 538,194	$ 614,481
Net assets released from restriction	(4,718,825)	(811,157)
Contributions received	262,546	222,134
Change in value of irrevocable trust	683,868	111,315
Net realized and unrealized (losses) gains on investments	(1,237,769)	1,097,007
(Decrease) increase in temporarily restricted net assets	(4,471,986)	1,233,780
Temporarily restricted net assets		
Beginning of year	23,432,028	22,198,248
End of year	$ 18,960,042	$ 23,432,028
Permanently restricted net assets		
Change in value of funds held in trust by others	$ (84,378)	$ 100,721
(Decrease) increase in permanently restricted net assets	(84,378)	100,721
Permanently restricted net assets		
Beginning of year	6,047,975	5,947,254
End of year	$ 5,963,597	$ 6,047,975
Decrease in net assets	$ (39,526,963)	$ (30,651,820)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Consolidated Statements of Cash Flows
Years Ended September 30, 2015 and 2014

	2015	2014
Cash flows from operating activities		
Change in net assets	$ (39,526,963)	$ (30,651,820)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	23,639,711	22,728,484
Restricted contributions	(493,535)	(725,796)
Net unrealized losses (gains) on investments	18,243,554	(755,794)
Provision for bad debts	12,821,337	14,930,302
Decrease (increase) in funds held in trust by others	3,401,496	(212,036)
Changes in other operating accounts		
Patient accounts receivable, net	(14,425,227)	(17,399,463)
Other receivables, net	(3,034,647)	(3,021,526)
Inventories	386,398	(735,283)
Due from affiliates	(3,604)	(638,063)
Prepaid expenses and other current assets	(435,842)	(433,409)
Deferred financing costs and other assets	128,746	(539,576)
Accounts payable	6,665,372	1,274,289
Accrued vacation and sick pay	(1,169,699)	(241,571)
Salaries, wages, payroll taxes and amounts withheld from employees	(1,042,042)	1,455,110
Due to affiliates	297,273	347,698
Due to third party payors	1,545,978	1,339,131
Pension, postretirement and other liabilities	12,863,132	3,733,372
Net cash provided by (used in) operating activities	19,861,438	(9,545,951)
Cash flows from investing activities		
Purchase of property, plant and equipment, net	(13,000,499)	(21,164,013)
Purchase of investments	(28,398,638)	(58,786,901)
Sales of investments	32,984,465	70,017,433
(Increase) decrease in debt service fund	(51)	1,693
Decrease in funds held in escrow	-	2,247,255
Net cash used in investing activities	(8,414,723)	(7,684,533)
Cash flows from financing activities		
Restricted contributions	493,535	725,796
Principal payments of long term debt	(5,495,620)	(27,739,349)
Proceeds of long term debt	-	50,742,745
Net cash (used in) provided by financing activities	(5,002,085)	23,729,192
Net increase in cash and cash equivalents	6,444,630	6,498,708
Cash and cash equivalents		
Beginning of year	6,917,676	418,968
End of year	$ 13,362,306	$ 6,917,676
Supplemental disclosure of noncash activities		
Construction in process included in accounts payable	$ 914,729	$ 1,673,118
Contributed securities	$ 493,535	$ 725,796

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

1. Significant Accounting Policies and Organization

Organization
Lawrence + Memorial Hospital (the "Hospital"), a non-profit organization incorporated under the General Statutes of the State of Connecticut, is a wholly owned subsidiary of Lawrence + Memorial Corporation (the "Corporation"). The Board of the Corporation elects a Board of Directors who manages the property and affairs of the Hospital.

Principles of Consolidation
The consolidated financial statements include the accounts of the Hospital and its wholly owned subsidiary, Associated Specialists of Southeastern Connecticut, Inc. ("Associated Specialists"). All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates
The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying footnotes. Actual results could differ from those estimates and there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital's significant estimates include the collectability of patient accounts receivable, useful lives of fixed assets, estimated settlements due to third party payors, valuation of certain investments, estimated reserves for self-insurance liabilities, and benefit plan assumptions.

Regulatory Matters
The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access ("OHCA").

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital and its subsidiary in perpetuity or in funds held in trust by others whose purpose is for the funds to be maintained in perpetuity.

Donor Restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions in the accompanying consolidated statements of operations.

Cash and Cash Equivalents
The Hospital and its subsidiary consider all highly liquid investments with original maturities of three months or less at the date of purchase to be cash equivalents.

Investments
Investments in equity and debt securities are recorded at fair value in the balance sheet. Fair value is generally determined based on quoted market prices where available or net asset values provided by investment managers. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the change in net assets.

Realized and unrealized gains and losses on donor restricted endowment funds are included in temporarily restricted net assets under State law which allows the Board to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends and general economic conditions.

Investments in limited liability companies are accounted for using the equity method in instances where the limited partner's interest is more than minor (3-5%).

Fair Value Measurements
Fair value guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Hospital for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets.

- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets in active markets, quoted prices in markets that are not active, or can be corroborated by observable market data for substantially the same term of the assets.

- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

Assets Held in Trust by Others
The Hospital has been named sole or participating beneficiary in several perpetual and charitable remainder trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity from the perpetual trusts and to receive the remainder of the trust assets for the charitable remainder trusts. For perpetual trusts, the estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. The charitable remainder trusts are recorded at the present value of the estimated future distributions expected to be received over the expected term of the trust agreement. The Hospital uses appropriate credit adjusted rates. In 2015 a significant remainder trust payment of $4 million was received from the estate of a donor in accordance with the terms of

the trust document. At the time of the trust termination, the trust was recorded at $3.2 million and based on the value of the trust received; $.8 million was recorded as a change in value of irrevocable trusts in the Hospital's change in temporarily restricted net assets. The release from restriction of the $4 million for use on operations was recorded on the Corporation's Statement of Operations as all gifts and development activity is recorded at the Corporation.

Assets Limited as to Use
Assets limited as to use include assets set aside by the Board of Directors and contribution receivables for the established purpose of providing for future improvement, expansion and replacement of plant and equipment. In addition, the Hospital's interest in externally managed trusts, and unexpended bond proceeds for construction purposes are also included therein.

Property, Plant and Equipment
Property, plant and equipment are recorded at cost, or, if received as a donation, at the fair value on the date received. The Hospital provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their useful lives. American Hospital Association lives are generally used and provide for a 2-25 year life for land improvements, 5-50 year life for buildings and 2-25 year life for equipment. Lease improvements are amortized over the life of the lease.

Non operating Gains and Losses
Activities other than in connection with providing health care services are considered to be non operating.

Excess of Revenues Over Expenses
The consolidated statement of operations includes excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension-related charges other than periodic pension costs and other postretirement benefits liabilities.

Fair Value of Financial Instruments
Certain investments and other assets and liabilities are carried at amounts that approximate fair value based on current market conditions. The fair value of long-term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to the Hospital for debt of the same remaining maturities.

Medical Malpractice Self-Insurance
The Hospital purchases claims made-based professional and general liability insurance to cover medical malpractice claims from L + M Indemnity, Ltd., a wholly owned subsidiary of the Hospital's parent. The Hospital has adopted the policy of self-insuring the tail coverage portion of its malpractice insurance coverage. Management has accrued the estimate of losses anticipated to be incurred.

Income Taxes
The Hospital and its wholly owned subsidiary, Associated Specialists, are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c) (3) of the Internal Revenue Code.

Inventories
Inventory consists of supplies, both medical and general, pharmaceuticals and food products needed to sustain daily operation of patient care. Inventories are carried at the lower of cost or market under the first-in-first-out (FIFO) method.

Impairment of Long-Lived Assets
Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to dispose.

Accrued Vacation and Sick Pay
Accrued vacation is recorded as a liability as time is earned. As the time is used, the time is relieved from the liability. Accrued sick time is recorded as a percent for employees who have a balance greater than or equal to 800 hours. This payout is only upon termination of employment.

Labor action update
The Hospital's negotiations with two of its three unions, AFT Healthcare, AFT-CT, AFT, AFL-CIO, Local 5049 (registered nurses) and AFT Healthcare, AFT-CT, AFLCIO, Local 5051 (licensed practical nurses and technicians) for a new contract resulted in a 4-day strike that commenced on November 27, 2013. The Hospital brought in temporary replacement workers, and, in order to provide ongoing patient care given the threat of additional, intermittent strikes, had a lockout of employees through December 18, 2013. The lockout was lifted and employees returned to work without a contract being reached. A contract was reached and ratified and the workforce had a three year contract that was signed in February 2014. The Hospital monitored the negative impact of the strike and lockout on both revenues and expenses. This impact consisted of a reduction in net revenue of approximately $1,900,000 (unaudited) and $12,300,000 (unaudited) of replacement workers, security and reduced salary costs during 2014.

Subsequent Events
The Hospital has performed an evaluation of subsequent events through December ___, 2015, which is the date the financial statements were issued.

2. Revenues from Services to Patients and Charity Care

The following summarizes net revenues from services to patients:

	2015	2014
Gross charges from services to patients	$ 843,024,228	$ 795,287,303
Less: Charity care	5,427,817	5,449,069
Charges from services to patients, net of charity care	837,596,411	789,838,234
Deductions		
Allowances	485,513,042	450,251,022
State of Connecticut uncompensated care system	12,801,007	2,458,020
Total deductions	498,314,049	452,709,042
Net revenues from services to patients	$ 339,282,362	$ 337,129,192

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payors are different from established billing rates of the Hospital, and these differences are accounted for as allowances. The State of Connecticut has reduced Uncompensated Care Payments to all hospitals beginning July 2013 for a three year period. In 2014 and 2015, the Corporation paid cash into the State of Connecticut Uncompensated Care Pool that exceeded the amount was received from the State.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Adjustments related to prior year settlements increased the Hospital's revenues by approximately $4,119,679 in 2015 and decreased the Hospital's revenues by approximately $1,584,575 in 2014.

During 2015 and 2014, approximately 36% and 35%, respectively, of net patient service revenue was received under the Medicare program, and 12% and 11%, respectively, under the state Medicaid program. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation. Noncompliance could result in significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and reductions of funding levels could have an adverse impact on the Hospital.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines.

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

3. Investments

Investments at September 30 consist of:

	2015	2014
Investments		
Cash and cash equivalents	$ 2,475,788	$ 2,582,141
Bonds	14,797,119	20,187,600
Mutual funds	26,419,933	54,002,586
Hedge funds	57,529,962	47,442,075
Private equities	6,142,834	4,235,929
Total other investments	107,365,636	128,450,331
Funds held in trust by others		
Investments held in trust by others	3,584,118	6,985,614
Total investments held in trust by others	3,584,118	6,985,614
Endowment investments		
Cash and cash equivalents	201,141	255,829
Bonds	2,447,475	2,481,439
Mutual funds	8,553,873	10,596,174
Hedge funds	6,053,615	4,977,463
Private equities	231,641	168,351
Marketable equities	314,944	508,111
Total endowment investments	17,802,689	18,987,367
Total Investments at fair value	$ 128,752,443	$ 154,423,312

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The Hospital's financial instrument categorization is based upon the lowest level of input that is significant to the fair value measurement within the valuation hierarchy. The following table presents the financial instruments carried at fair value using the valuation hierarchy:

	2015			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 2,475,788	$ -	$ -	$ 2,475,788
Bonds	9,306,863	5,490,256	-	14,797,119
Mutual funds	26,419,933	-	-	26,419,933
Hedge funds	-	-	57,529,962	57,529,962
Private equities	-	-	6,142,834	6,142,834
Total other investments	38,202,584	5,490,256	63,672,796	107,365,636
Funds held in trust by others				
Investments held in trust by others	-	-	3,584,118	3,584,118
Total held in trust by others	-	-	3,584,118	3,584,118
Endowment investments				
Cash and cash equivalents	201,141	-	-	201,141
Bonds	1,582,765	564,931	299,779	2,447,475
Mutual funds	7,225,792	-	1,328,081	8,553,873
Hedge funds	-	-	6,053,615	6,053,615
Private equities	-	-	231,641	231,641
Marketable equities	314,944	-	-	314,944
Total endowment investments	9,324,642	564,931	7,913,116	17,802,689
	$ 47,527,226	$ 6,055,187	$ 75,170,030	$ 128,752,443

	2014			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 2,582,141	$ -	$ -	$ 2,582,141
Bonds	14,261,701	5,925,899	-	20,187,600
Mutual funds	54,002,586	-	-	54,002,586
Hedge funds	-	-	47,442,075	47,442,075
Private equities	-	-	4,235,929	4,235,929
Total other investments	70,846,428	5,925,899	51,678,004	128,450,331
Funds held in trust by others				
Investments held in trust by others	-	-	6,985,614	6,985,614
Total held in trust by others	-	-	6,985,614	6,985,614
Endowment investments				
Cash and cash equivalents	255,829	-	-	255,829
Bonds	1,560,348	608,664	312,427	2,481,439
Mutual funds	9,018,452	-	1,577,722	10,596,174
Hedge funds	-	-	4,977,463	4,977,463
Private equities	-	-	168,351	168,351
Marketable equities	508,111	-	-	508,111
Total endowment investments	11,342,740	608,664	7,035,963	18,987,367
	$ 82,189,168	$ 6,534,563	$ 65,699,581	$ 154,423,312

Fair value for Level 1 is based upon quoted prices in active markets that the Hospital has the ability to access at the measurement date. Market price data is generally obtained from exchange or dealer markets. The Hospital does not adjust the quoted price for such assets.

Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers.

Fair value for Level 3 is based on valuation techniques that use significant inputs that are unobservable as they trade infrequently or not at all and reflect assumptions based on the best information available in the circumstances.

Investments included in Level 3 primarily consist of the Hospital's ownership in alternative investments (principally limited partnership interests in hedge funds). The value of these alternative investments represents the ownership interest in the net asset value ("NAV") of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner and are based on appraisals, or other estimates that require varying degrees of judgment. If no public market exists for the investment securities, the fair value is determined by the general partner taking into consideration, among other things, the cost of the securities, prices of recent significant placements of securities of the same issuer, and subsequent developments concerning the companies to which the securities relate. Also included in Level 3 investments are charitable remainder trusts held by third parties which are recorded at the present value of the future distributions expected to be received over the term of the agreement.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The following table is a roll forward of the amounts by investment type for financial instruments classified by the Hospital within Level 3 of the fair value hierarchy defined above:

	Beginning October 1, 2014	Investment Income	Realized Gains	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2015
ıvestment pool								
edge funds	$ 54,309,686	$ 386,194	$ 822,070	$ (5,276,131)	$ (238,953)	$ 15,395,580	$ (187,009)	$ 65,211,437
rivate equities	4,404,281	667	319,946	463,808	(108,941)	1,799,667	(504,953)	6,374,475
unds held in trust	6,985,614	-	-	599,490	-	-	(4,000,986)	3,584,118
Total	$ 65,699,581	$ 386,861	$ 1,142,016	$ (4,212,833)	$ (347,894)	$ 17,195,247	$ (4,692,948)	$ 75,170,030

	Beginning October 1, 2013	Investment Income	Realized Gains	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2014
Investment pool								
Hedge funds	$ 51,695,126	$ 526,509	$ 242,582	$ 1,907,402	$ (133,494)	$ 339,590	$ (268,029)	$ 54,309,686
Private equities	1,862,538	-	386,731	262,436	(78,224)	2,047,216	(76,416)	4,404,281
Funds held in trust	6,773,578	-	-	212,036	-	-	-	6,985,614
Total	$ 60,331,242	$ 526,509	$ 629,313	$ 2,381,874	$ (211,718)	$ 2,386,806	$ (344,445)	$ 65,699,581

There were no significant transfers between levels of assets for the fiscal year ended September 30, 2015.

A summary of the investment return is presented below:

	2015	2014
Investment income	$ 1,862,864	$ 1,936,104
Realized and unrealized (losses) gains	(9,218,819)	8,085,342
Management fees and other costs	(439,538)	(680,378)
Total return on endowment investments	$ (7,795,493)	$ 9,341,068

Following is additional information related to funds whose fair value is not readily determinable as of September 30, 2015.

	Strategy	Fair Value	# of Investments	Timing to Draw Down Commitments	Redemption Terms	Redemption Restrictions
Equity securities	Global developed and emerging market equity	$ 25,921,894	2	No remaining commitments	Monthly with 10 day's notice	None
Absolute return	Long/short and long-biased equity and credit hedge funds	15,477,269	7	No remaining commitments	Annual with 90 day's notice	lock up provision of 12 months from the purchase date
Directional hedge	Long/short and long-biased equity and credit hedge funds	20,779,531	1	No remaining commitments	Quarterly with 60 day's notice	lock up provision of 25 months from the purchase date
Commodities	Commodity index	3,032,743	1	No remaining commitments	Monthly with 5 day's notice	None
Private equity	Private equity	6,374,475	9	Long term 5 years	Illiquid	Long Term 5-10 yeasrs
		$ 71,585,912				

None of the funds invested in are finite lived. Unfunded commitments at September 30, 2015 total approximately $5.4 million and relate to private equity funds. There are no liquidity restrictions in place at September 30, 2015.

4. Endowment

The Hospital's endowment consists of donor restricted endowment funds for a variety of purposes. The net assets associated with endowment funds including funds designated by the Board of Directors to function as endowments are classified and reported based on the existence or absence of donor imposed restrictions.

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The Hospital understands net asset classification guidance requires that donor restricted endowment gifts be maintained in perpetuity. Consistent with net asset classification guidance, the Hospital classified as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure. The Hospital considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund.
- The purposes of the Hospital and donor-restricted endowment fund.
- General economic conditions.
- The possible effect of inflation and deflation.
- The expected total return from income and the appreciation of investments.
- Other resources of the Hospital.
- The investment policies of the Hospital.

Changes in endowment net assets for year ended September 30:

	2015			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 16,369,375	$ 2,839,683	$ 19,209,058
Investment return				
Investment income		45,381		45,381
Net realized and unrealized gains		(1,237,769)		(1,237,769)
Total investment return	-	(1,192,388)	-	(1,192,388)
Income distribution		(140,748)		(140,748)
Endowment net assets at end of year	$ -	$ 15,036,239	$ 2,839,683	$ 17,875,922

	2014			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 15,304,434	$ 2,839,683	$ 18,144,117
Investment return				
Investment income	-	107,295	-	107,295
Net realized and unrealized gains	-	1,097,006	-	1,097,006
Total investment return	-	1,204,301	-	1,204,301
Income distribution	-	(139,360)	-	(139,360)
Endowment net assets at end of year	$ -	$ 16,369,375	$ 2,839,683	$ 19,209,058

The portion of the endowment retained either by explicit donor stipulation or by net asset classification guidance is summarized as follows:

	2015	2014
Temporarily restricted net assets		
Unspent income and appreciation on permanently restricted endowments for purchase of equipment and healthcare services	$ 15,036,239	$ 16,369,376
Total endowment funds classified as temporarily restricted net assets	$ 15,036,239	$ 16,369,376
Permanently restricted net assets		
Corpus of permanently restricted contributions for which income is to be used for purchase of equipment and healthcare services	$ 2,839,683	$ 2,839,683
Total endowment funds classified as permanently restricted net assets	$ 2,839,683	$ 2,839,683

Endowment Funds with Deficits
From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist they are classified as a reduction of unrestricted net assets.

Endowment Investment Return Objectives and Risk Parameters
The Hospital has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by the endowment while seeking to maintain the permanent nature of endowment funds. Under this policy, the return objective for the endowment assets measured over a full market cycle shall be to maximize the return against a blended index, based on the endowment's target asset allocation applied to the appropriate individual benchmarks.

Strategies Employed for Achieving Endowment Investment Objectives
To achieve its long-term rate of return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Hospital targets a diversified asset allocation to achieve its long-term objectives within prudent Hospital risk constraints.

Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives
Spending is guided by several factors most important is the value of the portfolio. Generally, the Board will approve a spending policy limiting annual expenditures for grants and operating expenses up to 4.5% of the value of the Funds' assets based on a 12 quarter rolling average for the endowment and operating funds.

Investment managers are given ample notice of the required withdrawal schedule. Appropriate liquidity is maintained to fund these withdrawals without impairing the investment process.

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30, 2015 and 2014:

	2015	2014
Funds held in trust by others	$ 482,010	$ 3,799,127
Contributions receivable	20,366	20,366
Free beds and plant replacement and expansion	15,036,239	16,369,376
Specific purpose reserves	3,421,427	3,243,159
	$ 18,960,042	$ 23,432,028

Permanently restricted net assets at September 30 are restricted to:

	2015	2014
Funds held in trust by others	$ 3,123,914	$ 3,208,292
Donor restricted endowment funds	2,839,683	2,839,683
	$ 5,963,597	$ 6,047,975

6. Property, Plant and Equipment

Property, plant and equipment consist of the following:

	2015	2014
Land and land improvements	$ 8,904,363	$ 8,846,232
Buildings	152,295,547	150,910,346
Equipment	270,848,642	265,024,485
	432,048,552	424,781,063
Less: Accumulated depreciation	(283,857,352)	(265,615,130)
	148,191,200	159,165,933
Construction in progress	2,785,773	1,691,863
	$ 150,976,973	$ 160,857,796

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

7. Long-Term Debt

	2015	2014
CHEFA Series F Revenue Bonds		
Various rate bonds, due 2016 to 2026	$ 28,065,000	$ 30,900,000
5.0% Term Bonds, due 2027 to 2031	8,705,000	8,705,000
5.0% Term Bonds, due 2032 to 2036	11,100,000	11,100,000
CHEFA Series G revenue bonds		
3.2% Term Bonds, due 2016 to 2023, option to extend with a maturity date of 2038	28,375,000	29,200,000
CHEFA H revenue bonds		
variable rate bonds, due 2023 to 2034	21,405,000	21,405,000
Tax exempt lease	8,302,654	9,963,984
Capital lease obligation	53,360	112,009
Total debt outstanding	106,006,014	111,385,993
Less: Amounts classified as current	5,495,740	5,342,305
Add: Bond premium	2,428,473	2,544,115
Total long-term portion of long-term debt	$ 102,938,747	$ 108,587,803

On September 15, 2011 the Connecticut Health and Education Facilities Authority ("CHEFA") issued $58,940,000 of Series F Bonds (the "Series F Bonds") on behalf of the Hospital and Lawrence + Memorial Corporation (collectively referred to as the "Obligated Group" under the Series F Bond agreements). The Series F Bonds are structured with a term bonds due at various dates through July 1, 2036, with annual sinking fund payments due each July 1st. Interest on the Series F Bonds is payable semiannually on the first business day of January 1 and July 1 which began on January 1, 2012.

The tax exempt lease was obtained on June 27, 2013 in the principal amount of $12,000,000. This is a seven year equipment lease on specific capital purchases that is administered through CHEFA and Bank of America-Merrill Lynch. This lease obligations will be amortized monthly through June 27, 2020 at a nominal annual interest rate of 1.759%.

On October 10, 2013 Series G was issued in a private placement offering with Bank of America-Merrill Lynch and CHEFA in the amount of $29,200,000 with an interest rate of 3.20% until October 1, 2023 with an option to extend at a negotiated rate with a maturity date of July 1, 2038.

On November 5, 2013, Series H was issued by CHEFA to refinance Series E. Series H was issued in the amount of $21,405,000 with a variable rate and a maturity date of July 1, 2034. This bond has a letter of credit guaranteed by T.D. Bank. Interest on the Series H Bonds accrues at the weekly rate and is payable on the first business day of each month commencing January 1, 2014.

Under the terms of the trust indenture for the Series F, G and H Bonds, the Obligated Group is required to meet certain financial covenants including a debt service coverage ratio and days cash on hand ratio. Members of the Obligated Group are jointly and severally obligated to provide amounts sufficient to enable the Authority to pay principal and interest on the Series F, G and H Bonds. The Bonds and bond proceeds have been allocated to the Hospital and as such, the Hospital will make future debt service payments as required under the terms of the bonds.

The bonds may be retired at an earlier date pursuant to terms of the master indenture. Payment of the bonds is collateralized by a pledge of the gross receipts, as defined and certain real property of the Hospital.

The Series H Bonds are considered variable rate demand bonds and are remarketed on a weekly basis. The Hospital maintains a letter of credit in the amount of $21,405,000 which expires on November 5, 2016. If the bonds are unable to be remarketed, the letter of credit could be utilized to purchase the bonds. The Obligated Group would then be subject to the payment terms of the letter of credit, which are monthly installments. The Series H Bonds have been successfully remarketed in the past and there have been no draws on the letter of credit.

The fair value of the outstanding bonds is $101,550,368 and $106,215,296 at September 30, 2015 and, 2014, respectively.

Principal repayments on the outstanding long term debt are as follows:

Years	Annual Principal Repayment
2016	$ 5,495,740
2017	5,730,772
2018	5,916,285
2019	6,142,340
2020 and thereafter	82,720,877
	$ 106,006,014

The Hospital made cash interest payments of $3,495,549 and $3,566,051 in fiscal year 2015 and 2014, respectively. No interest was capitalized during 2015 or 2014.

8. Pension and Other Postretirement Benefits

The Hospital has a defined benefit plan covering all employees who elected to stay in the plan. The plan is frozen to new participants as of June 30, 1999. The benefits are based on years of service and the employee's compensation during the last five years of employment.

The Hospital provides health care and life insurance benefits to its retired employees who meet certain eligibility requirements. The Hospital's policy is to fund the cost of postretirement benefits other than pension as incurred. This plan was frozen to include only those employees who retired prior to May 1, 1994.

Lawrence + Memorial Hospital
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The following table sets forth the Plans' funded status and amounts recognized in the consolidated balance sheet at September 30, 2015 and 2014 (measurement date of September 30):

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Change in benefit obligation				
Benefit obligation at beginning of year	$ 156,674,809	$ 145,789,789	$ 837,437	$ 1,000,744
Service cost	2,141,301	2,402,724	-	-
Interest cost	6,195,482	6,417,121	24,077	29,884
Employee contributions	41,451	69,839	-	-
Benefits paid	(7,608,334)	(7,015,362)	(91,218)	(95,403)
Actuarial loss (gain)	4,414,165	9,010,698	(15,972)	(97,788)
Benefit obligation at end of year	161,858,874	156,674,809	754,324	837,437
Change in plan assets				
Fair value of plan assets at beginning of year	115,176,724	105,860,348	-	-
Actual return on plan assets	(4,147,965)	9,861,899	-	-
Employee contributions	41,451	69,839		-
Employer contributions	7,400,000	6,400,000	95,403	95,403
Benefits paid	(7,608,334)	(7,015,362)	(95,403)	(95,403)
Fair value of plan assets at end of year	110,861,876	115,176,724	-	-
Funded status of the plan	(50,996,998)	(41,498,085)	(754,324)	(837,437)
Unrecognized net loss (gain) from past experience different from that assumed and effects of changes in assumptions	55,236,126	41,399,294	(443,280)	(488,085)
	4,050	79,157		-
Accrued benefit costs recognized in the consolidated balance sheet	$ 4,243,178	$ (19,634)	$ (1,197,604)	$ (1,325,522)
Components of net periodic benefit costs				
Service cost	$ 2,141,301	$ 2,402,724	$ -	$ -
Interest cost	6,195,482	6,417,121	24,077	29,884
Expected return on plan assets	(8,603,526)	(7,920,200)	-	-
Amortization of net loss/(gain)	3,328,824	2,676,330	(60,777)	(66,454)
Net amortization and deferral	75,107	111,153	-	-
Benefit cost	$ 3,137,188	$ 3,687,128	$ (36,700)	$ (36,570)

The net actuarial loss of approximately $4.4 million is due to a loss of approximately $7.5 million due to a change in mortality table offset by gains due to decrease in discount rate and other changes in assumptions.

The weighted average assumptions used to determine the net benefit cost at the beginning of the year are as follows:

	2015	2014
Discount rate	4.05 %	4.51 %
Average rate of compensation increases	2.50 %	2.50 %
Expected return on assets	7.50 %	7.50 %

The weighted average assumptions used to determine the benefit obligation at the end of the year are as follows:

	2015	2014
Discount rate	4.10 %	4.05 %
Average rate of compensation increases	2.50 %	2.50 %

The Plan's asset allocations as of September 30 are as follows:

Asset Category	2015	2014
Cash	2 %	2 %
Bonds	32	24
Mutual funds	26	45
Hedge funds	40	29
Total	100 %	100 %

The expected rate of return on assets is calculated based on past experience.

Expected benefits to be paid under the plans are as follows:

Fiscal Years Beginning October 1,	Expected Benefits
2015	$ 7,940,500
2016	8,280,197
2017	8,395,891
2018	8,784,310
2019	9,069,440
Expected aggregate for 5 fiscal years beginning 2020	49,712,011

Annual employer contributions are determined by the Hospital based upon calculations prepared by the plan's actuary. Expected contributions to the plans for 2016 are approximately (unaudited):

Pension	$ 7,940,000
Retiree health	89,642

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) for participants is assumed to be 8% in 2015 reducing to 5.0% by the year 2020 and remaining at that level thereafter. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a one percentage point increase in the assumed health care cost trend rate would increase the accumulated post-retirement benefit obligation and service cost plus interest cost by approximately $49,000 and $56,000, respectively, at September 30, 2015 and 2014. A one percentage point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $45,000 and $51,000, respectively, at September 30, 2015 and 2014.

Plan Assets

The defined benefit plan assets are valued utilizing the same fair value hierarchy as the Hospital's investments as described in Note 1.

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2015:

	Level 1	Level 2	Level 3	2015
Investments, at fair value				
Cash	$ 2,345,782	$ -	$ -	$ 2,345,782
Bonds	35,027,573	-	-	35,027,573
Mutual funds	24,119,636	4,946,910	-	29,066,546
Hedge funds	-	-	44,421,975	44,421,975
Total investments, at fair value	$ 61,492,991	$ 4,946,910	$ 44,421,975	$ 110,861,876

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2014:

	Level 1	Level 2	Level 3	2014
Investments, at fair value				
Cash	$ 2,417,830	$ -	$ -	$ 2,417,830
Bonds	27,571,791	-	-	27,571,791
Mutual funds	46,557,396	5,171,869	-	51,729,265
Hedge funds	-	-	33,457,838	33,457,838
Total investments, at fair value	$ 76,547,017	$ 5,171,869	$ 33,457,838	$ 115,176,724

There were transfers between levels during 2015 and no transfers during 2014.

The table below represents the change in fair value measurements for Level 3 investments held by the plan for the years ended September 30:

	2015	2014
Beginning balances	$ 33,457,838	$ 31,893,958
Realized gains	554,617	4,588,368
Fees	(204,757)	(79,614)
Unrealized losses	(3,485,723)	(2,944,874)
Purchases	14,100,000	-
Sales	-	-
Ending balances	$ 44,421,975	$ 33,457,838

The investment objective for the pension and post retirement plans seeks a positive long-term total return after inflation to meet the Hospital's current and future plan obligations.

Asset allocations combine tested theory and informed market judgment to balance investment risks with the need for high returns.

The Hospital's 401(k) plan covers eligible employees who elect to participate. Eligible employees may contribute a percentage of their salary. The Hospital matches 100% of the first 4% of gross pay deferred by employees for those employees who do not participate in the defined benefit plan. Contributions charged to operations were approximately $3,416,963 and $3,296,282 for 2015 and 2014, respectively.

9. Functional Expenses

The Hospital provides general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses by function are as follows:

	2015	2014
Health care services	$ 249,259,940	$ 258,736,071
General and administrative	104,066,639	95,094,590
	$ 353,326,579	$ 353,830,661

10. Contingencies

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position, results of operations, changes in net assets or cash flows.

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Assets				
Current assets				
Cash and cash equivalents	$ 13,348,901	$ 13,405	$ -	$ 13,362,306
Investments	107,365,636	-	-	107,365,636
Patient accounts receivable, net	37,925,784	51,175	-	37,976,959
Other receivables	4,131,254	-	-	4,131,254
Inventories	6,194,355	-	-	6,194,355
Due from affiliates	2,065,142	-	(106,700)	1,958,442
Prepaid expenses and other current assets	3,125,348	-	-	3,125,348
Debt service fund	1,304,613	-	-	1,304,613
Total current assets	175,461,033	64,580	(106,700)	175,418,913
Assets limited as to use				
Cash	183,677	-	-	183,677
Construction funds	-	-	-	-
Investments held in trust	926,080	-	-	926,080
Endowment investments	17,802,689	-	-	17,802,689
Funds held in trust by others	3,584,118	-	-	3,584,118
Contributions receivable	20,366	-	-	20,366
Total assets limited as to use	22,516,930	-	-	22,516,930
Other assets				
Deferred financing costs	2,187,006	-	-	2,187,006
Other receivables	19,596,372	-	-	19,596,372
Property, plant and equipment	150,976,973	-	-	150,976,973
Total assets	$ 370,738,314	$ 64,580	$ (106,700)	$ 370,696,194

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Liabilities				
Current liabilities				
Accounts payable	$ 32,897,000	$ 312,795	$ -	$ 33,209,795
Accrued vacation and sick pay	10,112,002	-	-	10,112,002
Salaries, wages, payroll taxes and amounts withheld from employees	4,908,525	-	-	4,908,525
Due to affiliates	2,512,703	106,700	(106,700)	2,512,703
Due to third party payors	6,711,203	-	-	6,711,203
Current portion of long-term debt	5,495,740	-	-	5,495,740
Total current liabilities	62,637,173	419,495	(106,700)	62,949,968
Accrued pension and other postretirement benefits	52,989,394	-	-	52,989,394
Other liabilities	23,691,278	-	-	23,691,278
Long-term debt, less current portion	102,938,747	-	-	102,938,747
Total liabilities	242,256,592	419,495	(106,700)	242,569,387
Net assets				
Unrestricted	103,558,083	(354,915)	-	103,203,168
Temporarily restricted	18,960,042	-	-	18,960,042
Permanently restricted	5,963,597	-	-	5,963,597
Total net assets	128,481,722	(354,915)	-	128,126,807
	$ 370,738,314	$ 64,580	$ (106,700)	$ 370,696,194

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Assets				
Current assets				
Cash and cash equivalents	$ 6,917,676	$ -	$ -	$ 6,917,676
Investments	128,450,331	-	-	128,450,331
Patient accounts receivable, net	36,289,187	83,882	-	36,373,069
Other receivables	4,156,260	-	-	4,156,260
Inventories	6,580,753	-	-	6,580,753
Due from affiliates	2,064,619	-	(109,781)	1,954,838
Prepaid expenses and other current assets	2,689,506	-	-	2,689,506
Debt service fund	1,304,562	-	-	1,304,562
Total current assets	188,452,894	83,882	(109,781)	188,426,995
Assets limited as to use				
Cash	182,862	-	-	182,862
Construction funds	561,676	-	-	561,676
Investments held in trust	925,227	-	-	925,227
Endowment investments	18,987,367	-	-	18,987,367
Funds held in trust by others	6,985,614	-	-	6,985,614
Contributions receivable	20,366	-	-	20,366
Funds held in escrow by agreement with State of Connecticut Health and Educational Facilities Authority and trustees	-	-	-	-
Total assets limited as to use	27,663,112	-	-	27,663,112
Other assets				
Deferred financing costs	2,315,752	-	-	2,315,752
Other receivables	16,536,719	-	-	16,536,719
Property, plant and equipment	160,857,796	-	-	160,857,796
Total assets	$ 395,826,273	$ 83,882	$ (109,781)	$ 395,800,374

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Liabilities				
Current liabilities				
Accounts payable	$ 25,518,874	$ 267,160	$ -	$ 25,786,034
Accrued vacation and sick pay	11,241,300	40,401	-	11,281,701
Salaries, wages, payroll taxes and amounts withheld from employees	5,728,350	222,217	-	5,950,567
Due to affiliates	2,215,430	109,781	(109,781)	2,215,430
Due to third party payors	5,165,225	-	-	5,165,225
Current portion of long-term debt	5,342,305	-	-	5,342,305
Total current liabilities	55,211,484	639,559	(109,781)	55,741,262
Accrued pension and other postretirement benefits	43,216,010	-	-	43,216,010
Other liabilities	20,601,530	-	-	20,601,530
Long-term debt, less current portion	108,587,802	-	-	108,587,802
Total liabilities	227,616,826	639,559	(109,781)	228,146,604
Net assets				
Unrestricted	138,729,444	(555,677)	-	138,173,767
Temporarily restricted	23,432,028	-	-	23,432,028
Permanently restricted	6,047,975	-	-	6,047,975
Total net assets	168,209,447	(555,677)	-	167,653,770
	$ 395,826,273	$ 83,882	$ (109,781)	$ 395,800,374

Lawrence + Memorial Hospital
Consolidating Statement of Operations
September 30, 2015

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Net revenues from services to patients	$ 337,821,155	$ 1,461,207	$ -	$ 339,282,362
Provision for bad debt	(12,798,310)	(23,027)	-	(12,821,337)
Net revenue less provision for bad debt	325,022,845	1,438,180	-	326,461,025
Other operating revenues	30,854,159	57,404	(37,258)	30,874,305
Net assets released from restriction used for operation	577,092	-	-	577,092
	356,454,096	1,495,584	(37,258)	357,912,422
Operating expenses				
Salaries and wages	140,640,103	(34,490)	-	140,605,613
Employee benefits	51,694,855	15,075	(11,575)	51,698,355
Supplies	63,622,692	-	-	63,622,692
Purchased services	29,627,730	370,626	-	29,998,356
Other	37,349,172	2,884,673	(25,683)	40,208,162
Interest	3,553,690	-	-	3,553,690
Depreciation and amortization	23,639,711	-	-	23,639,711
Total expenses	350,127,953	3,235,884	(37,258)	353,326,579
Income (loss) from operations	6,326,143	(1,740,300)	-	4,585,843
Nonoperating gains				
Unrestricted investment income	228,240	-		228,240
Income from investments and realized gains	9,708,669	-		9,708,669
	9,936,909	-	-	9,936,909
Excess (deficit) of revenues over expenses	16,263,052	(1,740,300)	-	14,522,752
Transfers to affiliate entities	(21,705,946)	1,941,062	-	(19,764,884)
Net unrealized losses on investments	(16,107,490)	-	-	(16,107,490)
Net assets released from restriction used for purchase of property, plant and equipment	140,748	-	-	140,748
Pension related changes other than periodic pension costs	(13,761,725)	-	-	(13,761,725)
(Decrease) increase in unrestricted net assets	$ (35,171,361)	$ 200,762	$ -	$ (34,970,599)

Lawrence + Memorial Hospital
Consolidating Statement of Operations
September 30, 2014

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Net revenues	$ 333,751,931	$ 3,377,261	$ -	$ 337,129,192
Provision for bad debt	(14,966,698)	36,396	-	(14,930,302)
Net revenue less provision for bad debt	318,785,233	3,413,657	-	322,198,890
Other operating revenues	29,607,174	319,074	(1,775,187)	28,151,061
Net assets released from restriction	671,797	-	-	671,797
	349,064,204	3,732,731	(1,775,187)	351,021,748
Operating expenses				
Salaries and wages	142,343,619	1,610,637	(115,582)	143,838,674
Employee benefits	50,942,363	361,785	(259,430)	51,044,718
Supplies	59,512,480	25,661	-	59,538,141
Purchased services	37,964,369	1,604,552	(921,154)	38,647,767
Other	31,491,444	3,477,733	(479,021)	34,490,156
Interest	3,542,721	-	-	3,542,721
Depreciation and amortization	22,728,484	-	-	22,728,484
	348,525,480	7,080,368	(1,775,187)	353,830,661
Income/(loss) from operations	538,724	(3,347,637)	-	(2,808,913)
Nonoperating gains				
Unrestricted income	180,488	-	-	180,488
Income from investments	8,608,113	-	-	8,608,113
	8,788,601	-	-	8,788,601
Excess of revenues over expenses	9,327,325	(3,347,637)	-	5,979,688
Transfers from affiliate	(37,512,132)	3,650,870	-	(33,861,262)
Net unrealized gains on investments	31,059	-	-	31,059
Net assets released from restriction used for purchase of property, plant and equipment	139,360	-	-	139,360
Donated equipment	6,350	-	-	6,350
Pension related changes other than periodic pension costs	(4,281,516)	-	-	(4,281,516)
(Decrease)/increase in unrestricted net assets	$ (32,289,554)	$ 303,233	$ -	$ (31,986,321)

Lawrence + Memorial Corporation and Subsidiaries

Consolidated Financial Statements and Supplemental Information
September 30, 2015 and 2014

Lawrence + Memorial Corporation and Subsidiaries
Index
September 30, 2015 and 2014

Independent Auditor's Report

To the Board of Trustees of
Lawrence + Memorial Corporation

We have audited the accompanying consolidated financial statements of Lawrence + Memorial Corporation (the "Corporation") and its subsidiaries, which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the financial statements of Visiting Nurse Association of Southeastern Connecticut, Inc., a wholly owned subsidiary, which statements reflect total assets of $22,422,239 and $20,659,633 as of September 30, 2015 and September 30, 2014, respectively, and total revenues of $17,255,595 and $16,156,841 for the years then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Visiting Nurse Association of Southeastern Connecticut, Inc., is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Corporation's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Lawrence + Memorial Corporation (the "Corporation") and its subsidiaries at September 30, 2015 and September 30, 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual organizations and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, and changes in net assets of the individual organizations.

Hartford, Connecticut
December ___, 2015

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Balance Sheets
September 30, 2015 and 2014

	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 24,264,612	$ 16,480,529
Investments	162,278,643	184,426,039
Patient accounts receivable, net of allowance for doubtful accounts of $14,627,346 and $10,334,227, respectively	50,993,988	47,482,954
Other receivables	5,950,946	5,792,415
Inventories	8,154,843	8,393,007
Prepaid expenses and other current assets	3,810,426	3,748,725
Debt service fund	1,304,613	1,304,562
Total current assets	256,758,071	267,628,231
Assets limited as to use		
Cash	183,677	182,862
Construction fund	-	561,676
Investments held in trust	926,080	925,227
Endowment investments	35,458,701	36,641,428
Funds held in trust by others	7,633,141	11,348,610
Contributions receivable	2,916,786	3,520,787
Total assets limited as to use	47,118,385	53,180,590
Intangible assets, net	2,604,375	2,978,625
Other receivables	2,818,554	2,580,786
Deferred financing costs and other assets, net	2,187,006	2,315,752
Property, plant and equipment, net	196,288,742	206,850,299
	$ 507,775,133	$ 535,534,283
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 37,172,933	$ 36,357,188
Accrued vacation and sick pay	13,689,948	14,223,728
Salaries, wages, payroll taxes and amounts withheld from employees	9,618,789	10,671,516
Due to third party payors	8,275,846	7,257,949
Other current liabilities	655,581	582,553
Current portion of long-term debt	5,495,740	5,476,980
Total current liabilities	74,908,837	74,569,914
Accrued pension and other postretirement benefits	53,468,405	43,588,661
Other liabilities	31,629,767	26,410,901
Long-term debt less current portion	102,938,747	108,587,802
Total liabilities	262,945,756	253,157,278
Net assets		
Unrestricted	209,208,824	241,902,500
Temporarily restricted	20,286,597	24,770,687
Permanently restricted	15,333,956	15,703,818
Total net assets	244,829,377	282,377,005
	$ 507,775,133	$ 535,534,283

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Statements of Operations
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted revenues, gains and other support		
Net revenues from services to patients	$ 455,763,829	$ 453,529,100
Provision for bad debt	(16,683,423)	(20,298,386)
Net revenue less provision for bad debt	439,080,406	433,230,714
Other operating revenues	16,375,817	20,795,287
Net assets released from restriction used for operations	4,831,645	876,203
Total unrestricted revenues, gains and other support	460,287,868	454,902,204
Operating expenses		
Salaries and wages	212,124,691	213,467,507
Employee benefits	59,040,657	59,185,837
Supplies	76,774,253	71,998,110
Purchased services	39,607,243	54,475,011
Other	50,232,174	43,427,170
Interest	3,553,690	3,554,919
Depreciation and amortization	28,953,704	27,479,122
Total expenses	470,286,412	473,587,676
Loss from operations	(9,998,544)	(18,685,472)
Nonoperating gains		
Unrestricted investment income	228,240	180,488
Nonoperating expenses	(1,527,184)	-
Income from investments and realized gains	13,131,917	9,832,164
Inherent contribution received from purchase of Westerly Hospital	-	5,284,752
Total nonoperating gains	11,832,973	15,297,404
Excess (deficit) of revenues over expenses	1,834,429	(3,388,068)
Net unrealized (losses) gains on investments	(20,907,128)	2,028,088
Net assets released from restrictions used for purchase of property, plant and equipment	140,748	1,006,500
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	$ (32,693,676)	$ (4,628,646)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted net assets		
Excess (deficit) of revenues over expenses	$ 1,834,429	$ (3,388,068)
Net unrealized (losses) gains on investments	(20,907,128)	2,028,088
Net assets released from restrictions used for purchase of property, plant and equipment	140,748	1,006,500
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	(32,693,676)	(4,628,646)
Beginning of year unrestricted net assets	241,902,500	246,531,146
End of year unrestricted net assets	$ 209,208,824	$ 241,902,500
Temporarily restricted net assets		
Income from investments	$ 549,250	$ 677,343
Net assets released from restrictions	(4,972,392)	(1,882,704)
Contributions received	474,954	421,640
Change in value of funds held in trust by others	683,868	111,315
Net realized and unrealized (losses) gains on investments	(1,219,770)	1,288,111
(Decrease) increase in temporarily restricted net assets	(4,484,090)	615,705
Temporarily restricted net assets		
Beginning of year	24,770,687	24,154,982
End of year	$ 20,286,597	$ 24,770,687
Permanently restricted net assets		
Income from investments	$ 17,103	$ 20,569
Contributions received	77,827	80,074
Change in value of funds held in trust by others	(398,351)	280,866
Net realized and unrealized (losses) gains on investments	(66,441)	32,831
(Decrease) increase in permanently restricted net assets	(369,862)	414,340
Permanently restricted net assets		
Beginning of year	15,703,818	15,289,478
End of year	15,333,956	15,703,818
Decrease in net assets	$ (37,547,628)	$ (3,598,601)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended September 30, 2015 and 2014

	2015	2014
Cash flows from operating activities		
Change in net assets	$ (37,547,628)	$ (3,598,601)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	28,953,704	27,479,122
Net unrealized and realized losses (gains) on investments	23,070,838	(2,963,155)
Inherent contribution received from purchase of Westerly Hospital	-	(4,940,302)
Provision for bad debts	16,683,423	20,298,386
Decrease (increase) in funds held in trust by others	3,715,469	(392,181)
Decrease in contributions receivable	604,001	(817,794)
Restricted contributions	(1,024,204)	(1,164,969)
Changes in other operating accounts		
Patient accounts receivable, net	(20,194,457)	(20,461,592)
Other receivables, net	(396,299)	(504,322)
Inventories	238,164	(891,853)
Prepaid expenses and other current assets	(61,701)	(191,218)
Deferred financing costs and other assets	128,746	(539,576)
Accounts payable	57,356	(3,713,678)
Accrued vacation and sick pay	(533,780)	1,643,021
Salaries, wages, payroll taxes and amounts withheld from employees	(1,052,727)	569,862
Due to third party payors	1,017,897	1,386,968
Amortization on Intangibles	374,250	-
Pension, postretirement and other liabilities	15,171,638	5,674,664
Net cash provided by operating activities	29,204,690	16,872,782
Cash flows from investing activities		
Purchase of property, plant and equipment, net	(17,633,758)	(25,715,324)
Purchases of investments	(61,391,317)	(70,459,536)
Sales of investments	62,210,610	77,121,334
Decrease in debt service fund	(51)	1,693
Decrease in funds held in escrow	-	2,247,255
Net cash used in investing activities	(16,814,516)	(16,804,578)
Cash flows from financing activities		
Restricted contributions	1,024,204	1,164,969
Principal payments of long term debt	(5,630,295)	(28,364,994)
Proceeds of long term debt	-	32,080,103
Net cash (used in) provided by financing activities	(4,606,091)	4,880,078
Net increase in cash and cash equivalents	7,784,083	4,948,282
Cash and cash equivalents		
Beginning of year	16,480,529	11,532,247
End of year	$ 24,264,612	$ 16,480,529
Supplemental disclosure of noncash activities		
Construction in process included in accounts payable	$ 914,729	$ 1,673,118
Contributed securities	1,024,204	1,164,969

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

1. Significant Accounting Policies and Organization

Organization
Lawrence + Memorial Corporation (the "Corporation") is a not-for-profit organization incorporated under the Nonstock Corporation Act of the State of Connecticut. The Corporation is organized exclusively for public welfare, charitable, scientific, literary and education purposes, including the furtherance of the welfare, programs and activities of Lawrence + Memorial Hospital (the "Hospital"), a nonprofit organization incorporated under the General Statutes of the State of Connecticut.

Yale New Haven Health System Affiliation
On July 17, 2015, the Corporation and Yale New Haven Health System ("YNHHS") announced they have approved a definitive agreement to affiliate, pending regulatory approvals. The definitive agreement, approved by both Boards of Directors, is based on the mutual belief that an affiliation would enhance healthcare quality, access and efficiency. Under the agreement, the Corporation will become a corporate member of YNHHS, joining Bridgeport, Greenwich and Yale-New Haven Hospitals as a full member of YNHHS. The affiliation will require review and approval by Connecticut and Rhode Island state agencies. The process is expected to be completed by Summer 2016. The Corporation incurred approximately $1.5 million in legal and other professional expenses in connection with due diligence as a result of this agreement which has been recorded as nonoperating expenses within the Consolidated Statement of Operations.

The following entities are subsidiaries of the Corporation: Lawrence + Memorial Hospital ("L+M"), L& M Physician Association Inc., L&M Systems, Inc., VNA of Southeastern Connecticut, L&M Healthcare, L&M Indemnity Ltd, VNA of Southeastern Connecticut Inc. and LMW Healthcare Inc. (Westerly Hospital).

Acquisition of Westerly Hospital
On June 1, 2013, the Corporation and its subsidiary, LMW Healthcare, Inc. ("LMW") completed the acquisition of certain assets and liabilities of Westerly Hospital, a 125-bed general acute care hospital located in Westerly, Rhode Island on a 10.6 acre campus. The acquisition was the culmination of a process that included the appointment of W. Mark Russo, Esq. as the special master (the "Special Master") for Westerly Hospital and its affiliates by the Rhode Island Superior Court for the County of Washington (the "RI Court") in December 2011, due to the deteriorating financial condition of Westerly Hospital. The Special Master was granted authority by the RI Court to negotiate the sale of the assets of Westerly Hospital and its affiliates.

The Corporation formed LMW as a Rhode Island nonprofit corporation, and in June 2012, LMW entered into an Asset Purchase Agreement (the "Purchase Agreement") with the Special Master for Westerly Hospital and its affiliates, which was approved by the RI Court in September 2012. The Corporation guaranteed LMW's commitments under the Purchase Agreement. Pursuant to the Purchase Agreement and upon the successful completion of regulatory review by various Rhode Island agencies, the Corporation acquired certain assets and liabilities of Westerly Hospital and its affiliates, in order to expand its care and operations to the Westerly, Rhode Island community. The acquisition of the Westerly Hospital furthers the Corporation and Lawrence + Memorial Hospital's strategy of improving the depth and breadth of services available to all residents in the eastern Connecticut and western Rhode Island regions, without regard to ability to pay. Lawrence + Memorial Hospital expects to reduce unnecessary duplication of effort and costs with Westerly Hospital, while maintaining community access to essential services in the Westerly service area.

The purchase price of $16,098,758 was paid in cash. The transaction resulted in an inherent contribution of $12,011,469 which has been appropriately allocated to the three net asset classes within the statement of changes in net assets in 2013. The inherent contribution is a result of the value of net assets being acquired exceeding the purchase price. The purchase price allocation was preliminary and has been adjusted as additional information was obtained in 2014. An additional $5.3 million in inherent contribution was recorded in 2014, principally due to $3.1 million better experience on accounts receivable collections and $1.8 million in favorable final settlement of assumed accounts payable liabilities.

L&M Healthcare has an affiliation agreement effective January 31, 1999 (the "Agreement") with the Hospice of Southeastern Connecticut, Inc. (the "Hospice"). The Agreement gives L&M Healthcare a membership of the Hospice with one other not-for-profit healthcare organization. L&M Healthcare does not have an equity investment in the Hospice because the affiliation agreement does not require L&M Healthcare to provide capital to the Hospice and L&M Healthcare is not entitled to any of the net assets of the Hospice should the relationship terminate or the Hospice dissolve. The Corporation and its subsidiaries have never given capital to the Hospice and the Hospice has never made capital distributions to the Corporation or its subsidiaries.

L & M Physician Association, Inc. ("LMPA") was formed exclusively for the charitable purpose of benefiting, supporting, and furthering the charitable activities of Lawrence + Memorial Hospital by engaging physicians to provide physician services to the Hospital, organizations affiliated with the Hospital and communities they serve for purpose of practicing medicine and health care services.

Principles of Consolidation
The consolidated financial statements include the accounts of the Corporation and its wholly owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying footnotes. Actual results could differ from those estimates and there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Corporation's significant estimates include the collectability of patient accounts receivable, useful lives of fixed assets, settlements due to third party payors, estimated reserves for self-insurance liabilities, and benefit plan assumptions.

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation and its subsidiaries in perpetuity or in funds held in trust by others whose purpose is for the funds to be maintained in perpetuity.

Donor Restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of operations as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions in the accompanying consolidated statements of operations.

Cash and Cash Equivalents
The Corporation and its subsidiaries consider all highly liquid investments with original maturities of three months or less at the date of purchase to be cash equivalents.

Investments
Investments in equity and debt securities are recorded at fair value in the balance sheet. Fair value is generally determined based on quoted market prices where available or net asset values provided by investment managers. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the change in net assets. Under accounting principles generally accepted in the United States of America, an “other than temporary impairment” is recognized if the Corporation does not expect the fair value of a security to recover above cost or amortized cost. Once an “other than temporary impairment” charge has been recorded, a new cost basis is established.

The Corporation continues to review its securities for appropriate valuation on an ongoing basis. The Corporation determined that none of their investments were impaired as of September 30, 2015 or 2014.

Realized and unrealized gains and losses on donor restricted endowment funds are included in temporarily restricted net assets under State law which allows the Board to appropriate as much of the net appreciation of investments as is prudent considering the Corporation’s long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions.

Investments in limited liability companies are accounted for using the equity method in instances where the limited partner’s interest is more than minor (3-5%).

Fair Value Measurements
Fair value guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Corporation for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

Level 1 Quoted prices in active markets for identical assets.

Level 2 Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets in active markets, quoted prices in markets that are not active, or can be corroborated by observable market data for substantially the same term of the assets.

Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

Assets Held in Trust by Others
The Hospital has been named sole or participating beneficiary in several perpetual and charitable remainder trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity from the perpetual trusts and to receive the remainder of the trust assets for the charitable remainder trusts. For perpetual trusts, the estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. The charitable remainder trusts are recorded at the present value of the estimated future distributions expected to be received over the expected term of the trust agreement. The Hospital uses appropriate credit adjusted rates to discount amounts. In 2015 a significant remainder trust payment of $4 million was received from the estate of a donor in accordance with the terms of the trust documents. At the time of the trust termination, the trust was recorded at $3.2 million and based on the value of the trust received; $.8 million was recorded as a change in value of irrevocable trusts on the Hospital's change in temporarily restricted net assets. The release from restriction of the $4 million for use on operations was recorded on the Corporation's Statement of Operations as all gifts and development activity is recorded at the Corporation.

Assets Limited as to Use
Assets limited as to use include assets set aside by the Board of Directors, contribution receivables and for the established purpose of providing for future improvement, expansion and replacement of plant and equipment. In addition, the Corporation's interest in externally managed trusts, unexpended bond proceeds for construction purposes, and assets held by trustees are also included therein.

Property, Plant and Equipment
Property, plant and equipment are recorded at cost, or if received as a donation, at the fair value on the date received. The Corporation provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their estimated useful lives. American Hospital Association lives are generally used and provide for a 2-25 year life for land improvements, 5-50 year life for buildings and a 2-25 year life for equipment. Lease improvements are amortized over the life of the lease.

Nonoperating Gains and Losses
Activities other than in connection with providing health care services are considered to be nonoperating.

Excess of Revenues over Expenses
The consolidated statements of operations include nonoperating expenses in connection with the affiliation with Yale New Haven Health Systems in excess of revenues over expenses. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension-related charges other than periodic pension costs and other postretirement benefits liabilities.

Fair Value of Financial Instruments
Investments and other assets and liabilities are carried at amounts that approximate fair value based on current market conditions. The fair value of long term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to the Corporation and its Subsidiaries for debt of the same remaining maturities.

Medical Malpractice Self-Insurance
The Corporation purchases claims made professional and general liability insurance to cover medical malpractice claims from L&M Indemnity Ltd, a wholly owned subsidiary of the Corporation. The Hospitals, LMPA and VNA have adopted the policy of self-insuring the tail portion of its malpractice insurance coverage. Management accrues its best estimate of losses as incidents which give rise to potential losses occur.

Income Taxes
The Corporation and its subsidiaries are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c)(3) of the Internal Revenue Code, except for L&M Systems. L&M Systems provides for taxes based on current taxable income and the future tax consequences of temporary differences between financial and income tax reporting. Such amounts are not material to the consolidated financial statements.

Inventories
Inventory consists of supplies, both medical and general, pharmaceuticals and food products needed to sustain daily operation of patient care. Inventories are carried at the lower of cost or market under the first-in-first-out (FIFO) method.

Impairment of Long-Lived Assets
Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to dispose.

Accrued Vacation and Sick Pay
Accrued vacation is recorded as a liability as time is earned. As the time is used, the time is relieved from the liability. Accrued sick time is recorded as a percent for employees who have a balance greater than or equal to 800 hours. The payout is only upon termination of employment.

Labor Action Update

The Hospital's negotiations with two of its three unions, AFT Healthcare, AFT-CT, AFT, AFL-CIO, Local 5049 (registered nurses) and AFT Healthcare, AFT-CT, AFLCIO, Local 5051 (licensed practical nurses and technicians) for a new contract resulted in a 4-day strike that commenced on November 27, 2013. The Hospital brought in temporary replacement workers, and, in order to provide ongoing patient care given the threat of additional, intermittent strikes, had a lockout of employees through December 18, 2013. The lockout was lifted and employees returned to work without a contract being reached. A contract was reached and ratified and the workforce had a three year contract that was signed in February 2014. The Hospital monitored the negative impact of the strike and lockout on both revenues and expenses. This impact consisted of a reduction in net revenue of approximately $1,900,000 (unaudited) and $12,300,000 (unaudited) of replacement workers, security and reduced salary costs during 2014.

Subsequent Events

The Corporation has performed an evaluation of subsequent events through December __, 2015, which is the date the financial statements were issued.

2. Revenues From Services to Patients and Charity Care

The following summarizes net revenues from services to patients:

	2015	2014
Gross charges from services to patients	$ 1,138,758,476	$ 1,078,626,933
Less: Charity care	6,124,509	6,782,933
Charges from services to patients, net of charity care	1,132,633,967	1,071,844,000
Deductions		
Allowances	664,069,131	615,856,880
State of Connecticut uncompensated care system	12,801,007	2,458,020
Total deductions	676,870,138	618,314,900
Net revenues from services to patients	$ 455,763,829	$ 453,529,100

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payors are different from established billing rates of the Corporation, and these differences are accounted for as allowances. The State of Connecticut has reduced Uncompensated Care Payments to all hospitals beginning July 2013 for a three year period. In 2014 and 2015, the Corporation paid cash into the State of Connecticut Uncompensated Care Pool that exceeded the amount was received from the State.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Adjustments related to prior year settlements increased the Hospital's revenues by approximately $4,119,679 in 2015 and decreased the Hospital's revenue by approximately$1,584,575 in 2014.

During 2015 and 2014, approximately 36% and 35%, respectively, of net patient service revenue was received under the Medicare program, and 12% and 11%, respectively, under the state Medicaid program. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation. Non compliance could result in significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and reductions of funding levels could have an adverse impact on the Hospital.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines.

3. Investments

Investments included in current assets consist of the following:

	2015	2014
Investments		
Cash and cash equivalents	$ 4,347,663	$ 6,293,794
Bonds	37,080,980	40,097,819
Mutual funds	39,711,437	72,596,528
Hedge funds	70,852,615	57,360,354
Private equities	6,682,428	4,535,516
Marketable equities	3,603,520	3,542,028
Total investments	$ 162,278,643	$ 184,426,039
Funds held in trust by others		
Investments held in trust by others	7,633,141	11,348,610
Total funds held in trust by others	7,633,141	11,348,610
Endowment investments		
Cash and cash equivalents	$ 4,410,185	$ 4,307,512
Bonds	5,312,210	5,061,901
Mutual funds	11,438,208	14,191,010
Hedge funds	7,603,385	6,263,387
Private equities	288,434	209,627
Marketable equities	6,406,279	6,607,991
Total endowment investments	35,458,701	36,641,428
Total investments at fair value	$ 205,370,485	$ 232,416,077

Lawrence + Memorial Corporation and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The Corporation's financial instrument categorization is based upon the lowest level of input that is significant to the fair value measurement within the valuation hierarchy. The following table presents the financial instruments carried at fair value using the by the fair value guidance valuation hierarchy defined above:

	2015			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 4,347,663	$ -	$ -	$ 4,347,663
Bonds	30,675,681	6,405,299	-	37,080,980
Mutual funds	39,711,437	-	-	39,711,437
Hedge funds	-	-	70,852,615	70,852,615
Private equities	-	-	6,682,428	6,682,428
Marketable equities	3,603,520	-	-	3,603,520
Total investments	78,338,301	6,405,299	77,535,043	162,278,643
Funds held in trust by others				
Investments held in trust by others	-	-	7,633,141	7,633,141
Total held in trust by others	$ -	$ -	$ 7,633,141	$ 7,633,141
Endowment investments				
Cash and cash equivalents	$ 4,410,185	$ -	$ -	$ 4,410,185
Bonds	3,435,383	1,577,048	299,779	5,312,210
Mutual funds	10,110,127	-	1,328,081	11,438,208
Hedge funds	-	-	7,603,385	7,603,385
Private equities	-	-	288,434	288,434
Marketable equities	6,406,279	-	-	6,406,279
Total endowment investments	24,361,974	1,577,048	9,519,679	35,458,701
Total Investments at fair value	$ 102,700,275	$ 7,982,347	$ 94,687,863	$ 205,370,485

Lawrence + Memorial Corporation and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

	2014			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 6,293,794	$ -	$ -	$ 6,293,794
Bonds	33,184,269	6,913,550	-	40,097,819
Mutual funds	72,596,528	-	-	72,596,528
Hedge funds	-	-	57,360,354	57,360,354
Private equities	-	-	4,535,516	4,535,516
Marketable equities	3,542,028	-	-	3,542,028
Total investments	115,616,619	6,913,550	61,895,870	184,426,039
Funds held in trust by others				
Investments held in trust by others	-	-	11,348,610	11,348,610
Total held in trust by others	-	-	11,348,610	11,348,610
Endowment investments				
Cash and cash equivalents	4,307,512	-	-	4,307,512
Bonds	3,300,408	1,449,067	312,427	5,061,902
Mutual funds	12,613,287	-	1,577,722	14,191,009
Hedge funds	-	-	6,263,387	6,263,387
Private equities	-	-	209,627	209,627
Marketable equities	6,607,991	-	-	6,607,991
Total endowment investments	26,829,198	1,449,067	8,363,163	36,641,428
Total Investments at fair value	$ 142,445,817	$ 8,362,617	$ 81,607,643	$ 232,416,077

Fair value for Level 1 is based upon quoted prices in active markets that the Corporation has the ability to access at the measurement date. Market price data is generally obtained from exchange or dealer markets. The Corporation does not adjust the quoted price for such assets.

Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers.

Fair value for Level 3 is based on valuation techniques that use significant inputs that are unobservable as they trade infrequently or not at all and reflect assumptions based on the best information available in the circumstances.

Investments included in Level 3 primarily consist of the Corporations ownership in alternative investments (principally limited partnership interests in hedge funds). The value of these alternative investments represents the ownership interest in the net asset value (“NAV”) of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner and are based on appraisals, or other estimates that require varying degrees of judgment. If no public market exists for the investment securities, the fair value is determined by the general partner taking into consideration, among other things, the cost of the securities, prices of recent significant placements of securities of the same issuer, and subsequent developments concerning the companies to which the securities relate. Also included in Level 3 investments are charitable remainder trusts held by third parties which are recorded at the present value of the future distributions expected to be received over the term of the agreement and investments in for-profit companies.

Lawrence + Memorial Corporation and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Corporation believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The following table is a roll forward of the amounts by investment type for financial instruments classified by the Corporation within Level 3 of the fair value hierarchy defined above:

	Beginning October 1, 2014	Investment Income	Realized Gains	Unrealized (Losses)/gains	Investment Fees	Purchases	Sales	Ending September 30, 2015
Investment pool								
Hedge funds	$ 65,555,889	$ 458,045	$ 966,260	$ (6,421,508)	$ (295,818)	$ 20,216,000	$ (187,009)	$ 80,291,859
Private equities	4,703,144	667	330,143	534,090	(116,790)	1,821,362	(509,753)	6,762,863
Funds held in trust	11,348,610	102,675	393,314	(22,441)	(51,916)	41,181	(4,178,282)	7,633,141
	$ 81,607,643	$ 561,387	$ 1,689,717	$ (5,909,859)	$ (464,524)	$ 22,078,543	$ (4,875,044)	$ 94,687,863

	Beginning October 1, 2013	Investment Income	Realized Gains/(losses)	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2014
Investment pool								
Hedge funds	$ 62,386,880	$ 624,650	$ 270,868	$ 2,318,323	$ (158,389)	$ 381,586	$ (268,029)	$ 65,555,889
Private equities	1,996,835	-	387,382	311,627	(86,266)	2,169,982	(76,416)	4,703,144
Funds held in trust	10,956,429	141,409	(38,835)	344,380	(51,515)	-	(3,258)	11,348,610
	$ 75,340,144	$ 766,059	$ 619,415	$ 2,974,330	$ (296,170)	$ 2,551,568	$ (347,703)	$ 81,607,643

There were no significant transfers of assets between levels for the year ended September 30, 2015.

A summary of the investment return is presented below:

	2015	2014
Investment income	$ 3,232,345	$ 3,138,334
Realized and unrealized (losses) gains	(12,237,230)	10,268,410
Management fees and other costs	(671,327)	(754,021)
Total return on investments	$ (9,676,212)	$ 12,652,723

Following is additional information related to funds whose fair value is not readily determinable as of September 30, 2015.

	Strategy	Fair Value	Number of Investments	Timing to Draw Down Commitments	Redemption Terms	Redemption Restrictions
Equity securities	Global developed and emerging market equity	$ 32,433,821	2	No remaining commitments	Monthly with 10 day's notice	None
Absolute return	Long/short and long-biased equity and credit hedge funds	18,245,530	2	No remaining commitments	Annual with 90 day's notice	lock up provision of 12 months from the purchase date
Directional hedge	Long/short and long-biased equity and credit hedge funds	25,691,083	1	No remaining commitments	Quarterly with 60 day's notice	lock up provision of 25 months from the purchase date
Commodities	Commodity index	3,713,426	1	No remaining commitments	Monthly with 5 day's notice	None
Private equity	Private equity	6,970,862	9	Long term 5	Illiquid	Long Term 5-10 years
		$ 87,054,722				

None of the funds invested in are finite lived. Unfunded commitments at September 30, 2015 total approximately $5.5 million and relate to private equity funds. There are no liquidity restrictions in place at September 30, 2015.

4. Endowments

The Corporation's endowments consist of donor restricted endowment funds for a variety of purposes. The net assets associated with endowment funds including funds designated by the Board of Directors to function as endowments are classified and reported based on the existence or absence of donor imposed restrictions.

The Corporation understands net asset classification guidance to require that donor restricted endowment gifts be maintained in perpetuity. Consistent with net asset classification guidance, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure. The Corporation considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund.
- The purposes of the Corporation and donor-restricted endowment fund.
- General economic conditions.
- The possible effect of inflation and deflation.
- The expected total return from income and the appreciation of investments.
- Other resources of the Corporation.
- The investment policies of the Corporation.

Changes in endowment net assets for the year ended September 30:

	2015			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 10,480,208	$ 17,497,079	$ 7,382,529	$ 35,359,816
Investment return				
Investment income	382,283	105,090	17,103	504,476
Net realized and unrealized gains (losses)	151,631	(1,268,480)	(66,441)	(1,183,290)
Contributions	87,352	-	77,827	165,179
Total investment return	621,266	(1,163,390)	28,489	(513,635)
Income distribution	-	(140,748)	-	(140,748)
Endowment net assets at end of year	$ 11,101,474	$ 16,192,941	$ 7,411,018	$ 34,705,433

Lawrence + Memorial Corporation and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

	2014			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 9,257,584	$ 16,178,222	$ 7,249,055	$ 32,684,861
Addition of Westerly Hospital Endowment Net Assets	18,975	-	-	18,975
Investment return				
Investment income	304,778	170,106	20,569	495,453
Net realized and unrealized gains	715,724	1,288,111	32,832	2,036,667
Contributions	183,147	-	80,073	263,220
Total investment return	1,203,649	1,458,217	133,474	2,795,340
Income distribution	-	(139,360)	-	(139,360)
Endowment net assets at end of year	$ 10,480,208	$ 17,497,079	$ 7,382,529	$ 35,359,816

Endowment funds classified as permanently and temporarily restricted net assets:

The portion of the endowment retained either by explicit donor stipulation or by net asset classification guidance is summarized as follows:

	2015	2014
Temporarily restricted net assets		
Unspent income and appreciation on permanently restricted endowments for purchase of equipment and healthcare services	$ 16,192,941	$ 17,497,079
Total endowment funds classified as temporarily restricted net assets	$ 16,192,941	$ 17,497,079
Permanently restricted net assets		
Corpus of permanently restricted contributions for which income is to be used for purchase of equipment and healthcare services	$ 7,411,018	$ 7,382,529
Total endowment funds classified as permanently restricted net assets	$ 7,411,018	$ 7,382,529

Endowment Funds With Deficits

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist they are classified as a reduction of unrestricted net assets. The Corporation analyzed the endowments and notes there are no deficits as of September 30, 2015 and 2014.

Endowment Investment Return Objectives and Risk Parameters

The Corporation has adopted endowment investment and spending policies that attempt to provide predictable stream of funding to programs supported by the endowment while seeking to maintain the permanent nature of endowment funds. Under this policy, the return objective for the endowment assets measured over a full market cycle shall be to maximize the return against a blended index, based on the endowment's target asset allocation applied to the appropriate individual benchmarks.

Strategies Employed for Achieving Endowment Investment Objectives
To achieve its long-term rate of return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Corporation targets a diversified asset allocation to achieve its long-term objectives within prudent Corporation risk constraints.

Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives
Spending is guided by several factors most important is the value of the portfolio. Generally, the Board will approve a spending policy limiting annual expenditures for grants and operating expenses up to 4.5% of the value of the Funds' assets based on a 12 quarter rolling average for the endowment, and operating funds.

Investment managers are given ample notice of the required withdrawal schedule. Appropriate liquidity is maintained to fund these withdrawals without impairing the investment process.

5. Temporary and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30, 2015 and 2014:

	2015	2014
Temporarily restricted net assets		
Funds held in trust by others	$ 482,010	$ 3,799,127
Contributions receivable	20,366	20,366
Free beds and plant replacement and expansion	15,036,239	16,369,376
Specific purpose reserves	4,747,982	4,581,818
	$ 20,286,597	$ 24,770,687

Permanently restricted net assets at September 30, 2015 and 2014 are restricted to:

	2015	2014
Permanently restricted net assets		
Funds held in trust by others	$ 7,172,936	$ 7,571,288
Donor restricted endowment funds	8,161,020	8,132,530
	$ 15,333,956	$ 15,703,818

6. Property, Plant and Equipment

Property, plant and equipment consists of the following:

	2015	2014
Land and land improvements	$ 23,444,067	$ 23,323,273
Buildings	173,682,838	171,045,151
Equipment	293,448,847	284,414,885
	490,575,752	478,783,309
Less: Accumulated depreciation	(297,167,005)	(274,060,791)
	193,408,747	204,722,518
Construction in progress	2,879,995	2,127,781
	$ 196,288,742	$ 206,850,299

7. Long-Term Debt

	2015	2014
CHEFA Series F Revenue Bonds		
Various rate bonds, due 2016 to 2026	$ 28,065,000	$ 30,900,000
5.0% Term Bonds, due 2027 to 2031	8,705,000	8,705,000
5.0% Term Bonds, due 2032 to 2036	11,100,000	11,100,000
CHEFA Series G revenue bonds		
3.2% Term Bonds, due 2016 to 2023, option to extend 2038	28,375,000	29,200,000
CHEFA Series H revenue bonds		
Variable rate bonds, due 2023-2034	21,405,000	21,405,000
Tax exempt lease	8,302,654	9,963,984
Capital lease obligation	53,360	246,684
Total debt outstanding	106,006,014	111,520,668
Less: Amounts classified as current	5,495,740	5,476,980
Add: Bond premium	2,428,473	2,544,114
Total long-term portion of long-term debt	$ 102,938,747	$ 108,587,802

On September 15, 2011 the Connecticut Health and Education Facilities Authority ("CHEFA") issued $58,940,000 of Series F Bonds (the "Series F Bonds") on behalf of the Hospital and Lawrence + Memorial Corporation (collectively referred to as the "Obligated Group" under the Series F Bond agreements). The Series F Bonds are structured with a term bonds due at various dates through July 1, 2036, with annual sinking fund payments due each July 1st. Interest on the Series F Bonds is payable semiannually on the first business day of January 1 and July 1 which began on January 1, 2012.

The tax exempt lease was obtained on June 27, 2013 in the principal amount of $12,000,000. This is a seven year equipment lease on specific capital purchases that is administered through CHEFA and Bank of America-Merrill Lynch. This lease obligation will be amortized monthly through June 27, 2020 at a nominal annual interest rate of 1.759%.

On October 10, 2013 Series G was issued in a private placement offering with Bank of America-Merrill Lynch and CHEFA in the amount of $29,200,000 with an interest rate of 3.20% until October 1, 2023 with an option to extend at a negotiated rate with a maturity date of July 1, 2038.

On November 5, 2013, Series H was issued by CHEFA to refinance Series E. Series H was issued in the amount of $21,405,000 with a variable rate and a maturity date of July 1, 2034. This bond has a letter of credit guaranteed by T.D. Bank. Interest on the Series H Bonds accrues at the weekly rate and is payable on the first business day of each month commencing January 1, 2014.

Under the terms of the trust indenture for the Series F, G and H Bonds, the Obligated Group is required to meet certain financial covenants including a debt service coverage ratio and days cash on hand ratio. Members of the Obligated Group are jointly and severally obligated to provide amounts sufficient to enable the Authority to pay principal and interest on the Series F, G and H Bonds. The Bonds and bond proceeds have been allocated to the Hospital and as such, the Hospital will make future debt service payments as required under the terms of the bonds.

The bonds may be retired at an earlier date pursuant to terms of the master indenture. Payment of the bonds is collateralized by a pledge of the gross receipts, as defined and certain real property of the Hospital.

The Series H Bonds are considered variable rate demand bonds and are remarketed on a weekly basis. The Hospital maintains a letter of credit in the amount of $21,405,000 which expires on November 5, 2016. If the bonds are unable to be remarketed, the letter of credit could be utilized to purchase the bonds. The Obligated Group would then be subject to the payment terms of the letter of credit, which are monthly installments. The Series H Bonds have been successfully remarketed in the past and there have been no draws on the letter of credit.

The Corporation had a line of credit with Bank of America-Merrill Lynch for $13,802,758. This was taken as a bridge loan prior to issuance of Series G private Placement. The proceeds of Series G were used to pay off this line of credit on October 10, 2013. LMW Healthcare had a line of credit with Washington Trust for $4,860,642. This line was reissued at time of closing but was paid off in November 2013.

The fair value of the outstanding bonds is $101,550,368 and $106,215,296 at September 30, 2015 and September 30, 2014, respectively.

Principal repayments on the outstanding long term debt are as follows:

Years	Annual Principal Repayment
2016	$ 5,495,740
2017	5,730,772
2018	5,916,285
2019	6,142,340
2020 and thereafter	82,720,877
	$ 106,006,014

Cash interest payments of $3,495,549 and $3,566,051 were made in fiscal year 2015 and 2014, respectively. No interest was capitalized during 2015 and 2014.

Lawrence + Memorial Corporation and Subsidiaries
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

8. Pension and Other Postretirement Benefits

The Hospital has a defined benefit plan covering all employees who elected to stay in the Plan. The Plan is frozen to new participants as of June 30, 1999. The benefits are based on years of service and the employee's compensation during the last five years of employment.

The Hospital provides health care and life insurance benefits to its retired employees who meet certain eligibility requirements. The Hospital's policy is to fund the cost of postretirement benefits other than pensions as incurred. This plan was frozen to include only those employees who retired prior to May 1, 1994.

The following table sets forth the Hospital's plans' funded status and amounts recognized in the consolidated balance sheet at September 30, 2015 and 2014 (measurement date of September 30):

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Change in benefit obligation				
Benefit obligation at beginning of year	$ 156,674,809	$ 145,789,789	$ 837,437	$ 1,000,744
Service cost	2,141,301	2,402,724	-	-
Interest cost	6,195,482	6,417,121	24,077	29,884
Employee contributions	41,451	69,839	-	-
Benefits paid	(7,608,334)	(7,015,362)	(91,218)	(95,403)
Actuarial (gain) loss	4,414,165	9,010,698	(15,972)	(97,788)
Benefit obligation at end of year	161,858,874	156,674,809	754,324	837,437
Change in plan assets				
Fair value of plan assets at beginning of year	115,176,724	105,860,348	-	-
Actual return on plan assets	(4,147,965)	9,861,899	-	-
Employee contributions	41,451	69,839	-	-
Employer contributions	7,400,000	6,400,000	91,218	95,403
Benefits paid	(7,608,334)	(7,015,362)	(91,218)	(95,403)
Fair value of plan assets at end of year	110,861,876	115,176,724	-	-
Funded status of the plan	(50,996,998)	(41,498,085)	(754,324)	(837,437)
Unrecognized net loss (gain) from past experience different from that assumed and effects of changes in assumptions	55,236,126	41,399,294	(443,280)	(488,085)
Unrecognized prior service cost	4,050	79,157	-	-
Accrued benefit costs recognized in the statements of operations	$ 4,243,178	$ (19,634)	$ (1,197,604)	$ (1,325,522)
Components of net periodic benefit costs				
Service cost	$ 2,141,301	$ 2,402,724	$ -	$ -
Interest cost	6,195,482	6,417,121	24,077	29,884
Expected return on plan assets	(8,603,526)	(7,920,200)	-	-
Amortization of net loss (gain)	3,328,824	2,676,330	(60,777)	(66,454)
Net amortization and deferral	75,107	111,153	-	-
Benefit cost	$ 3,137,188	$ 3,687,128	$ (36,700)	$ (36,570)

The net actuarial loss of approximately $4.4 million is due to a loss of approximately $7.5 million due to a change in mortality table offset by gains due to decrease in discount rate and other changes in assumptions.

The weighted average assumptions used to determine the net benefit cost at the beginning of the year are as follows:

	2015	2014
Discount rate	4.05 %	4.51 %
Average rate of compensation increases	2.50 %	2.50 %
Expected return on assets	7.50 %	7.50 %

The weighted average assumptions used to determine the benefit obligation at the end of the year are as follows:

	2015	2014
Discount rate	4.10 %	4.05 %
Average rate of compensation increases	2.50 %	2.50 %

The Plan's asset allocations as of September 30 are as follows:

Asset Category	2015	2014
Cash	2 %	2 %
Bonds	32	24
Mutual funds	26	45
Hedge funds	40	29
	100 %	100 %

The expected rate of return on plan assets is calculated based on past experience.

Expected benefits to be paid under the Hospital's plans are as follows:

Fiscal Years Beginning October 1,	Expected Benefits
2015	$ 7,940,500
2016	8,280,197
2017	8,395,891
2018	8,784,310
2019	9,069,440
Expected aggregate for 5 fiscal years beginning 2020	49,712,011

Annual employer contributions are determined by the Hospital based upon calculations prepared by the plan's actuary. Expected contributions to the plans for 2016 are approximately (unaudited):

Pension	$ 7,940,000
Retiree health	89,642

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) for participants is assumed to be 8.0% in 2015 reducing to 5.0% by the year 2020 and remaining at that level thereafter. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a one percentage point increase in the assumed health care cost trend rate would increase the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $49,000 and $56,000, respectively, at September 30, 2015 and 2014. A one percentage point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $45,000 and $51,000, respectively, at September 30, 2015 and 2014.

Plan Assets

The defined benefit plan assets are valued utilizing the same fair value hierarchy as the Hospital's investments as described in Note 1.

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2015:

	Level 1	Level 2	Level 3	2015
Investments, at fair value				
Cash	$ 2,345,782	$ -	$ -	$ 2,345,782
Bonds	35,027,573	-	-	35,027,573
Mutual funds	24,119,636	4,946,910	-	29,066,546
Hedge funds	-	-	44,421,975	44,421,975
Total investments, at fair value	$ 61,492,991	$ 4,946,910	$ 44,421,975	$ 110,861,876

The following table summarizes the fair values of investments by major type held by the staff pension health plan at September 30, 2014:

	Level 1	Level 2	Level 3	2014
Investments, at fair value				
Cash	$ 2,417,830	$ -	$ -	$ 2,417,830
Bonds	27,571,791	-	-	27,571,791
Mutual funds	46,557,396	5,171,869	-	51,729,265
Hedge funds	-	-	33,457,838	33,457,838
Total investments, at fair value	$ 76,547,017	$ 5,171,869	$ 33,457,838	$ 115,176,724

There were transfers between levels during 2015 but no transfers in 2014.

The table below represents the change in fair value measurements for Level 3 investments held by the plans for the years ended September 30.

	2015	2014
Beginning balances	$ 33,457,838	$ 31,893,958
Realized gains	554,617	4,588,368
Fees	(204,757)	(79,614)
Unrealized losses	(3,485,723)	(2,944,874)
Purchases	14,100,000	-
Ending balances	$ 44,421,975	$ 33,457,838

The investment objective for the pension and post retirement plans seeks a positive long-term total return after inflation to meet the Hospital's current and future plan obligations.

Asset allocations combine tested theory and informed market judgment to balance investment risks with the need for high returns.

The Hospital's 401(k) plan covers eligible employees who elected to participate. Eligible employees may contribute a percentage of their salary. The Hospital matches 100% of the first 4% of gross pay deferred by employees for those employees who do not participate in the defined benefit plan. Plan contributions charged to operations were approximately $4,764,785 and $4,584,389 for 2015 and 2014, respectively.

The VNA has a defined contribution pension plan which covers substantially all of its employees who have met specified age and length of service requirements. Contributions to the Plan are based on 5% of eligible salaries and totaled approximately $504,943 and $463,475 for the years ended September 30, 2015 and 2014, respectively.

9. Functional Expenses

The Corporation and its subsidiaries provide general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses by function are as follows:

	2015	2014
Health care services	$ 347,731,294	$ 348,719,365
General and administrative	122,555,118	124,868,311
	$ 470,286,412	$ 473,587,676

10. Commitments and Contingencies

The Corporation and its subsidiaries are parties to various lawsuits incidental to their business. Management believes that the lawsuits will not have a material adverse effect on their financial position, results of operations, and changes in net assets or cash flows.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 13,362,306	$ 79,026	$ -	$ 13,441,332	$ -	$ 1,742,691	$ 3,358,523	$ 2,300,545	$ 3,421,521	$ -	$ 24,264,612
Investments	107,365,636	28,697,270	-	136,062,906	-	-	18,604,941	7,476,983	133,813	-	162,278,643
Patient accounts receivable,net	37,976,959	-	-	37,976,959	-	997,949	-	3,417,751	8,601,329	-	50,993,988
Other receivables	4,131,254	-	-	4,131,254	24,500	55,407	1,241,613	498,172	-	-	5,950,946
Inventories	6,194,355	-	-	6,194,355	-	-	-	-	1,960,488	-	8,154,843
Due from affiliates	1,958,442	24,500	(1,958,442)	24,500	2,512,703	-	-	-	-	(2,537,203)	-
Prepaid expenses and other current assets	3,125,348	-	-	3,125,348	-	84,040	16,143	339,100	245,795	-	3,810,426
Debt service fund	1,304,613	-	-	1,304,613	-	-	-	-	-	-	1,304,613
Total current assets	175,418,913	28,800,796	(1,958,442)	202,261,267	2,537,203	2,880,087	23,221,220	14,032,551	14,362,946	(2,537,203)	256,758,071
Assets limited as to use											
Cash	183,677	-	-	183,677	-	-	-	-	-	-	183,677
Investments held in trust	926,080	-	-	926,080	-	-	-	-	-	-	926,080
Endowment investments	17,802,689	3,387,752	-	21,190,441	-	-	-	6,777,246	7,491,014	-	35,458,701
Investment in subsidiaries	-	19,281,447	-	19,281,447	-	-	-	-	-	(19,281,447)	-
Funds held in trust by others	3,584,118	-	-	3,584,118	-	-	-	-	4,049,023	-	7,633,141
Contributions receivable	20,366	2,146,420	-	2,166,786	-	-	-	-	750,000	-	2,916,786
Total assets limited as to use	22,516,930	24,815,619	-	47,332,549	-	-	-	6,777,246	12,290,037	(19,281,447)	47,118,385
Other assets											
Intangible assets, net	-	-	-	-	-	-	-	-	2,604,375	-	2,604,375
Other receivables	19,596,372	-	-	19,596,372	-	2,668,056	287,916	9,462	770,142	(20,513,394)	2,818,554
Deferred financing costs and other assets, net	2,187,006	-	-	2,187,006	-	-	-	-	-	-	2,187,006
Property, plant and equipment											
Land improvements	8,904,363	12,330,635	-	21,234,998	-	-	-	330,275	1,878,794	-	23,444,067
Buildings/leasehold improvements	152,295,547	-	-	152,295,547	-	1,062,737	-	2,285,699	18,038,855	-	173,682,838
Equipment/furniture	270,848,642	17,010	-	270,865,652	-	1,178,352	-	1,016,108	20,388,735	-	293,448,847
Accumulated depreciation	(283,857,352)	(166,376)	-	(284,023,728)	-	(1,200,400)	-	(2,029,102)	(9,913,775)	-	(297,167,005)
Construction in progress	2,785,773	-	-	2,785,773	-	-	-	-	94,222	-	2,879,995
Property, plant and equipment, net	150,976,973	12,181,269	-	163,158,242	-	1,040,689	-	1,602,980	30,486,831	-	196,288,742
	$ 370,696,194	$ 65,797,684	$ (1,958,442)	$ 434,535,436	$ 2,537,203	$ 6,588,832	$ 23,509,136	$ 22,422,239	$ 60,514,331	$ (42,332,044)	$ 507,775,133

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Liabilities and Net Assets											
Current liabilities											
Accounts payable	$ 33,209,795	$ 88,903	$ -	$ 33,298,698	$ -	$ 201,568	$ 93,932	$ 244,438	$ 3,334,297	$ -	$ 37,172,933
Accrued vacation and sick pay	10,112,002	-	-	10,112,002	-	1,500,450	-	691,888	1,385,608	-	13,689,948
Salaries, wages, payroll taxes and amounts withheld from employees	4,908,525	-	-	4,908,525	-	2,790,267	-	659,774	1,260,223	-	9,618,789
Due to affiliates	2,512,703	1,941,981	(1,958,442)	2,496,242	40,961	-	-	-	-	(2,537,203)	-
Due to third party payors	6,711,203	-	-	6,711,203	-	-	-	240,000	1,324,643	-	8,275,846
Other current liabilities	-	-	-	-	-	-	513,215	142,366	-	-	655,581
Current portion of long-term debt	5,495,740	-	-	5,495,740	-	-	-	-	-	-	5,495,740
Total current liabilities	62,949,968	2,030,884	(1,958,442)	63,022,410	40,961	4,492,285	607,147	1,978,466	7,304,771	(2,537,203)	74,908,837
Accrued pension and other postretirement benefits	52,989,394	-	-	52,989,394	-	-	-	-	479,011	-	53,468,405
Other liabilities	23,691,278	-	-	23,691,278	-	4,855,295	22,147,795	258,790	2,757,900	(22,081,291)	31,629,767
Long-term debt less current portion	102,938,747	-	-	102,938,747	-	-	-	-	-	-	102,938,747
Total liabilities	242,569,387	2,030,884	(1,958,442)	242,641,829	40,961	9,347,580	22,754,942	2,237,256	10,541,682	(24,618,494)	262,945,756
Net assets											
Unrestricted	103,203,168	63,657,520	-	166,860,688	2,496,242	(2,758,748)	754,194	20,157,983	39,412,015	(17,713,550)	209,208,824
Temporarily restricted	18,960,042	109,280	-	19,069,322	-	-	-	-	1,217,275	-	20,286,597
Permanently restricted	5,963,597	-	-	5,963,597	-	-	-	27,000	9,343,359	-	15,333,956
Total net assets	128,126,807	63,766,800	-	191,893,607	2,496,242	(2,758,748)	754,194	20,184,983	49,972,649	(17,713,550)	244,829,377
	$ 370,696,194	$ 65,797,684	$ (1,958,442)	$ 434,535,436	$ 2,537,203	$ 6,588,832	$ 23,509,136	$ 22,422,239	$ 60,514,331	$ (42,332,044)	$ 507,775,133

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 6,917,676	$ 334,893	$ -	$ 7,252,569	$ -	$ 1,901,701	$ 950,345	$ 1,675,245	$ 4,700,669	$ -	$ 16,480,529
Investments	128,450,331	31,541,423	-	159,991,754	-	-	16,769,765	7,523,944	140,576	-	184,426,039
Patient accounts receivable,net	36,373,069	-	-	36,373,069	-	2,378,629	-	2,740,706	5,990,550	-	47,482,954
Other receivables	4,156,260	-	-	4,156,260	24,500	289,393	1,322,262	-	-	-	5,792,415
Inventories	6,580,753	-	-	6,580,753	-	-	-	-	1,812,254	-	8,393,007
Due from affiliates	1,954,838	24,500	(1,954,838)	24,500	2,215,430	-	-	-	-	(2,239,930)	-
Prepaid expenses and other current assets	2,689,506	-	-	2,689,506	-	545,698	16,143	438,951	58,427	-	3,748,725
Debt service fund	1,304,562	-	-	1,304,562	-	-	-	-	-	-	1,304,562
Total current assets	188,426,995	31,900,816	(1,954,838)	218,372,973	2,239,930	5,115,421	19,058,515	12,378,846	12,702,476	(2,239,930)	267,628,231
Assets limited as to use											
Cash	182,862	-	-	182,862	-	-	-	-	-	-	182,862
Construction funds	561,676	-	-	561,676	-	-	-	-	-	-	561,676
Investments held in trust	925,227	-	-	925,227	-	-	-	-	-	-	925,227
Endowment investments	18,987,367	3,565,739	-	22,553,106	-	-	-	6,654,619	7,433,703	-	36,641,428
Investment in subsidiaries	-	19,281,447	-	19,281,447	-	-	-	-	-	(19,281,447)	-
Funds held in trust by others	6,985,614	-	-	6,985,614	-	-	-	-	4,362,996	-	11,348,610
Contributions receivable	20,366	2,750,421	-	2,770,787	-	-	-	-	750,000	-	3,520,787
Total assets limited as to use	27,663,112	25,597,607	-	53,260,719	-	-	-	6,654,619	12,546,699	(19,281,447)	53,180,590
Other assets											
Intangible assets, net	-			-	-	-	-	-	2,978,625	-	2,978,625
Other receivables	16,536,719	-	-	16,536,719	-	2,137,101	287,916	-	-	(16,380,950)	2,580,786
Deferred financing costs and other assets, net	2,315,752	-	-	2,315,752	-	-	-	-	-	-	2,315,752
Property, plant and equipment											
Land improvements	8,846,232	12,330,635	-	21,176,867	-	-	-	330,275	1,816,131	-	23,323,273
Buildings/leasehold improvements	150,910,346	-	-	150,910,346	-	1,046,733	-	2,238,496	16,849,576	-	171,045,151
Equipment/furniture	265,024,485	17,010	-	265,041,495	-	976,188	-	994,431	17,402,771	-	284,414,885
Accumulated depreciation	(265,615,130)	(104,684)	-	(265,719,814)	-	(973,022)	-	(1,937,034)	(5,430,921)	-	(274,060,791)
Construction in progress	1,691,863	-	-	1,691,863	-	-	-	-	435,918	-	2,127,781
Property, plant and equipment, net	160,857,796	12,242,961	-	173,100,757	-	1,049,899	-	1,626,168	31,073,475	-	206,850,299
	$ 395,800,374	$ 69,741,384	$ (1,954,838)	$ 463,586,920	$ 2,239,930	$ 8,302,421	$ 19,346,431	$ 20,659,633	$ 59,301,275	$ (37,902,327)	$ 535,534,283

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Liabilities and Net Assets											
Current liabilities											
Accounts payable	$ 25,786,034	$ 115,809	$ -	$ 25,901,843	$ -	$ 343,515	$ 197,453	$ 1,615,548	$ 8,298,829	$ -	$ 36,357,188
Accrued vacation and sick pay	11,281,701	-	-	11,281,701	-	1,595,316	-	-	1,346,711	-	14,223,728
Salaries, wages, payroll taxes and amounts withheld from employees	5,950,567	-	-	5,950,567	-	3,536,119	-	-	1,184,830	-	10,671,516
Due to affiliates	2,215,430	1,912,595	(1,954,838)	2,173,187	66,743	-	-	-	-	(2,239,930)	-
Due to third party payors	5,165,225	-	-	5,165,225	-	-	-	234,000	1,858,724	-	7,257,949
Other current liabilities	-	-	-	-	-	-	428,096	154,457	-	-	582,553
Current portion of long-term debt	5,342,305	-	-	5,342,305	-	-	-	-	134,675	-	5,476,980
Total current liabilities	55,741,262	2,028,404	(1,954,838)	55,814,828	66,743	5,474,950	625,549	2,004,005	12,823,769	(2,239,930)	74,569,914
Accrued pension and other postretirement benefits	43,216,010	-	-	43,216,010	-	-	-	-	372,651	-	43,588,661
Other liabilities	20,601,530	-	-	20,601,530	-	3,744,380	17,719,560	-	2,135,400	(17,789,969)	26,410,901
Long-term debt less current portion	108,587,802	-	-	108,587,802	-	-	-	-	-	-	108,587,802
Total liabilities	228,146,604	2,028,404	(1,954,838)	228,220,170	66,743	9,219,330	18,345,109	2,004,005	15,331,820	(20,029,899)	253,157,278
Net assets											
Unrestricted	138,173,767	67,562,541	-	205,736,308	2,173,187	(916,909)	1,001,322	18,628,628	33,152,392	(17,872,428)	241,902,500
Temporarily restricted	23,432,028	150,439	-	23,582,467	-	-	-	-	1,188,220	-	24,770,687
Permanently restricted	6,047,975	-	-	6,047,975	-	-	-	27,000	9,628,843	-	15,703,818
Total net assets	167,653,770	67,712,980	-	235,366,750	2,173,187	(916,909)	1,001,322	18,655,628	43,969,455	(17,872,428)	282,377,005
	$ 395,800,374	$ 69,741,384	$ (1,954,838)	$ 463,586,920	$ 2,239,930	$ 8,302,421	$ 19,346,431	$ 20,659,633	$ 59,301,275	$ (37,902,327)	$ 535,534,283

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Statement of Operations
Year Ended September 30, 2015

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Net revenues from services to patients	$ 339,282,362	$ -	$ -	$ 339,282,362	$ -	$ 29,975,826	$ -	$ 13,160,152	$ 73,345,489	$ -	$ 455,763,829
Provision for bad debt	(12,821,337)	-	-	(12,821,337)	-	(886,077)	-	(73,656)	(2,902,353)	-	(16,683,423)
Net revenue less provision for bad debt	326,461,025	-	-	326,461,025	-	29,089,749	-	13,086,496	70,443,136	-	439,080,406
Other operating revenues	30,874,305	963,970	-	31,838,275	555,885	8,944,425	6,145,615	4,169,099	2,355,099	(37,632,581)	16,375,817
Net assets released from restriction used for operations	577,092	4,254,553	-	4,831,645	-	-	-	-	-	-	4,831,645
	357,912,422	5,218,523	-	363,130,945	555,885	38,034,174	6,145,615	17,255,595	72,798,235	(37,632,581)	460,287,868
Operating expenses											
Salaries and wages	140,605,613	-	-	140,605,613	-	37,208,008	-	11,408,447	28,970,058	(6,067,435)	212,124,691
Employee benefits	51,698,355	-	-	51,698,355	-	6,855,301	-	2,680,705	6,892,411	(9,086,115)	59,040,657
Supplies	63,622,692	253,939	-	63,876,631	-	1,600,252	-	354,796	10,942,574	-	76,774,253
Purchased services	29,998,356	391,508	-	30,389,864	14,206	4,338,255	188,964	446,565	15,254,539	(11,025,150)	39,607,243
Other	40,208,162	34,629	-	40,242,791	218,624	9,708,321	7,204,478	873,982	3,261,737	(11,277,759)	50,232,174
Interest	3,553,690	-	-	3,553,690	-	-	-	-	416,000	(416,000)	3,553,690
Depreciation and amortization	23,639,711	61,692	-	23,701,403	-	227,378	-	92,068	4,932,855	-	28,953,704
Total expenses	353,326,579	741,768	-	354,068,347	232,830	59,937,515	7,393,442	15,856,563	70,670,174	(37,872,459)	470,286,412
Income (loss) from operations	4,585,843	4,476,755	-	9,062,598	323,055	(21,903,341)	(1,247,827)	1,399,032	2,128,061	239,878	(9,998,544)
Nonoperating gains											
Unrestricted investment income	228,240	-	-	228,240	-	-	-	-	-	-	228,240
Nonoperating expenses	-	(1,527,184)	-	(1,527,184)	-	-	-	-	-	-	(1,527,184)
Income from investments and realized gains	9,708,669	2,175,070	-	11,883,739	-	-	205,148	807,251	235,779	-	13,131,917
	9,936,909	647,886	-	10,584,795	-	-	205,148	807,251	235,779	-	11,832,973
Excess (deficit) of revenues over expenses	14,522,752	5,124,641	-	19,647,393	323,055	(21,903,341)	(1,042,679)	2,206,283	2,363,840	239,878	1,834,429
Net unrealized (losses) on investments	(16,107,490)	(3,912,099)	-	(20,019,589)	-	-	(204,449)	(676,928)	(6,162)	-	(20,907,128)
Transfer to affiliated entities	(19,764,884)	(5,117,563)	-	(24,882,447)	-	20,061,502	1,000,000	-	3,820,945	-	-
Net assets released from restrictions used for purchases of property and equipment	140,748	-	-	140,748	-	-	-	-	-	-	140,748
Donated equipment	-	-	-	-	-	-	-	-	81,000	(81,000)	-
Pension related changes other than periodic pension costs	(13,761,725)	-	-	(13,761,725)	-	-	-	-	-	-	(13,761,725)
Decrease in unrestricted net assets	$ (34,970,599)	$ (3,905,021)	$ -	$ (38,875,620)	$ 323,055	$ (1,841,839)	$ (247,128)	$ 1,529,355	$ 6,259,623	$ 158,878	$ (32,693,676)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Statement of Operations
Year Ended September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Net revenues from services to patients	$ 337,129,192	$ -	$ -	$ 337,129,192	$ -	$ 29,333,784	$ -	$ 12,091,733	$ 74,974,391	$ -	$ 453,529,100
Provision for bad debt	(14,930,302)	-	-	(14,930,302)	-	(534,484)	-	(75,000)	(4,758,600)	-	(20,298,386)
Net revenue less provision for bad debt	322,198,890	-	-	322,198,890	-	28,799,300	-	12,016,733	70,215,791	-	433,230,714
Other operating revenues	28,151,061	2,958,303	-	31,109,364	486,265	4,787,661	5,376,504	4,140,108	2,963,560	(28,068,175)	20,795,287
Net assets released from restriction used for operations	671,797	204,406	-	876,203	-	-	-	-	-	-	876,203
	351,021,748	3,162,709	-	354,184,457	486,265	33,586,961	5,376,504	16,156,841	73,179,351	(28,068,175)	454,902,204
Operating expenses											
Salaries and wages	143,838,674	-	-	143,838,674	-	37,356,344	-	10,811,798	28,074,499	(6,613,808)	213,467,507
Employee benefits	51,044,718	-	-	51,044,718	-	6,483,081	-	2,598,219	6,454,031	(7,394,212)	59,185,837
Supplies	59,538,141	206,897	-	59,745,038	-	1,334,391	-	330,396	10,588,285	-	71,998,110
Purchased services	38,647,767	518,743	-	39,166,510	19,330	3,462,524	334,538	480,267	15,344,077	(4,332,235)	54,475,011
Other	34,490,156	42,546	-	34,532,702	122,200	7,849,748	5,486,160	937,952	4,066,583	(9,568,175)	43,427,170
Interest	3,542,721	8,500	-	3,551,221	-	-	-	-	419,698	(416,000)	3,554,919
Depreciation and amortization	22,728,484	61,692	-	22,790,176	-	234,268	-	107,318	4,347,360	-	27,479,122
Total expenses	353,830,661	838,378	-	354,669,039	141,530	56,720,356	5,820,698	15,265,950	69,294,533	(28,324,430)	473,587,676
(Loss) from operations	(2,808,913)	2,324,331	-	(484,582)	344,735	(23,133,395)	(444,194)	890,891	3,884,818	256,255	(18,685,472)
Nonoperating gains											
Unrestricted investment income	180,488	-	-	180,488	-	-	-	-	-	-	180,488
Income from investments and realized gains	8,608,113	355,103	-	8,963,216	-	-	203,572	652,017	13,359	-	9,832,164
Inherent contribution received from purchase of Westerly Hospital	-	-	-	-	-	-	-	-	5,284,752	-	5,284,752
	8,788,601	355,103	-	9,143,704	-	-	203,572	652,017	5,298,111	-	15,297,404
(Deficit) excess of revenues over expenses	5,979,688	2,679,434	-	8,659,122	344,735	(23,133,395)	(240,622)	1,542,908	9,182,929	256,255	(3,388,068)
Net unrealized gains on investments	31,059	1,515,218	-	1,546,277	-	-	(88,647)	570,458	-	-	2,028,088
Transfer to affiliated entities	(33,861,262)	12,237,912	-	(21,623,350)	(16,465)	20,865,372	-	-	774,443	-	-
Net assets released from restrictions used for purchases of property and equipment	139,360	867,140	-	1,006,500		-	-	-	-	-	1,006,500
Donated equipment	6,350	-	-	6,350		-	-	-	-	-	6,350
Pension related changes other than periodic pension costs	(4,281,516)	-	-	(4,281,516)		-	-	-	-	-	(4,281,516)
Decrease in unrestricted net assets	$ (31,986,321)	$ 17,299,704	$ -	$ (14,686,617)	$ 328,270	$ (2,268,023)	$ (329,269)	$ 2,113,366	$ 9,957,372	$ 256,255	$ (4,628,646)

The accompanying notes are an integral part of these consolidated financial statements.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidated Financial Statements and
Supplementary Information

September 30, 2015 and 2014

(With Independent Auditors' Report Thereon)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Table of Contents

KPMG LLP
345 Park Avenue
New York, NY 10154-0102

Independent Auditors' Report

The Board of Trustees

Yale-New Haven Health Services Corporation
d/b/a Yale New Haven Health System and Subsidiaries:

We have audited the accompanying consolidated financial statements of Yale-New Haven Health Services Corporation, d/b/a Yale New Haven Health System and Subsidiaries, which comprise the consolidated balance sheet as of September 30, 2015, and the related consolidated statements of operations and changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the 2015 consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Yale-New Haven Health Services Corporation as of September 30, 2015, and the consolidated results of their operations and their cash flows for the year then ended in accordance with U.S. generally accepted accounting principles.

KPMG

Other Matters

The accompanying consolidated financial statements of Yale-New Haven Health Services Corporation as of September 30, 2014 and for the year then ended were audited by other auditors whose report thereon dated December 23, 2014, expressed an unmodified opinion on those consolidated financial statements.

Our audit was performed for the purpose of forming an opinion on the 2015 consolidated financial statements as a whole. The accompanying consolidating balance sheet and consolidating statement of operations and changes in net assets are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statement as a whole.

KPMG LLP

December 23, 2015

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidated Balance Sheets

September 30, 2015 and 2014

(In thousands)

Assets		2015	2014
Current assets:			
Cash and cash equivalents	$	194,946	161,059
Short-term investments		1,160,670	1,040,882
Accounts receivable for services to patients, less allowance for uncollectible accounts of approximately $313,860 in 2015, and $272,684 in 2014		405,694	368,342
Professional liabilities insurance recoveries receivable – current portion		32,170	35,271
Other current assets		91,540	72,812
Amounts on deposit with trustee in debt service fund		5,465	4,641
Total current assets		1,890,485	1,683,007
Assets limited as to use		206,319	233,550
Long-term investments		420,800	394,904
Deferred financing costs, less accumulated amortization		10,494	10,993
Professional liabilities insurance recoveries receivable – noncurrent		85,394	86,652
Goodwill		114,308	114,352
Other assets		211,155	188,102
Property, plant, and equipment, net		1,388,747	1,455,574
Construction in progress		157,101	66,043
		1,545,848	1,521,617
Total assets	$	4,484,803	4,233,177

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets		2015	2014
Current liabilities:			
Accounts payable and accrued expenses	$	499,883	451,030
Current portion of long-term debt		16,881	19,493
Current portion of capital lease obligation		2,050	2,963
Professional liabilities – current portion		32,170	35,271
Other current liabilities		92,866	58,800
Total current liabilities		643,850	567,557
Long-term debt, net of current portion		906,150	917,111
Long-term capital lease obligations, net of current portion		107,159	70,998
Accrued pension and postretirement benefit obligations		339,901	321,442
Professional liabilities – noncurrent		148,303	173,806
Other long-term liabilities		304,801	271,261
Deferred revenue		42,720	44,378
Total liabilities		2,492,884	2,366,553
Net assets:			
Unrestricted		1,750,995	1,644,056
Temporarily restricted		147,568	141,712
Permanently restricted		93,356	80,856
Total net assets, including noncontrolling interest		1,991,919	1,866,624
Commitments and contingencies			
Total liabilities and net assets	$	4,484,803	4,233,177

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidated Statements of Operations and Changes in Net Assets

Years ended September 30, 2015 and 2014

(In thousands)

	2015	2014
Operating revenue:		
Net patient service revenue	$ 3,574,213	3,411,435
Less provision for bad debts, net	(81,528)	(123,743)
Net patient service revenue, less provision for bad debts, net	3,492,685	3,287,692
Other revenue	109,595	106,994
Total operating revenue	3,602,280	3,394,686
Operating expenses:		
Salaries and benefits	1,858,472	1,744,137
Supplies and other	1,344,217	1,251,717
Depreciation and amortization	185,944	192,072
Insurance	29,803	9,731
Interest	24,188	26,917
Total operating expenses	3,442,624	3,224,574
Income from operations	159,656	170,112
Nonoperating gains (losses), net:		
Income from investments, donations, and other, net	14,113	84,024
Change in fair value of swap, including counterparty payments	(29,678)	(17,204)
Loss on refunding of long-term debt	—	(32,631)
Excess of revenue over expenses	144,091	204,301
Other changes in unrestricted net assets:		
Other changes in net assets	(382)	(215)
Net assets released from restrictions for purchases of fixed assets	7,342	3,947
Pension and postretirement related changes other than net periodic benefit cost	(44,112)	(75,259)
Increase in unrestricted net assets	106,939	132,774

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidated Statements of Operations and Changes in Net Assets

Years ended September 30, 2015 and 2014

(In thousands)

	2015	2014
Temporarily restricted net assets:		
Income from investments	2,234	1,389
Net realized and unrealized gains on investments	1,335	13,172
Bequests and contributions	30,336	20,859
Net assets released from restrictions for purchases of fixed assets	(5,950)	(3,947)
Net assets released from restrictions for operations	(21,196)	(13,178)
Net assets released from restrictions for clinical programs	(1,477)	(5,882)
Other changes in net assets	574	741
Increase in temporarily restricted net assets	5,856	13,154
Permanently restricted net assets:		
Bequests and contributions	15,175	5,372
Net assets released from restrictions for purchases of fixed assets	(1,392)	—
Net realized and unrealized losses on investments	(1)	46
Change in beneficial interest in perpetual trusts	(1,282)	5,259
Increase in permanently restricted net assets	12,500	10,677
Increase in net assets	125,295	156,605
Net assets at beginning of year	1,866,624	1,710,019
Net assets at end of year	$ 1,991,919	1,866,624

See accompanying notes to consolidated financial statements.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidated Statements of Cash Flows

Years ended September 30, 2015 and 2014

(In thousands)

	2015	2014
Operating activities:		
Increase in net assets	$ 125,295	156,605
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation	185,944	192,072
Net realized and change in net unrealized gains and losses on investments	(27,967)	(101,335)
Change in fair value of interest rate swap agreements	5,566	1,455
Loss on refunding of long-term debt	—	32,631
Amortization of long-term debt premium	(2,807)	(1,758)
Provisions for bad debts, net	81,538	123,743
Amortization of deferred financing costs	499	(413)
Change in perpetual trusts	1,302	(6,212)
Bequests and contributions, net of pledges	(45,511)	(26,231)
Pension and postretirement related changes other than net periodic benefit cost	44,112	75,259
Changes in operating assets and liabilities:		
Accounts receivable, net	(118,890)	(157,111)
Other assets	(41,737)	(53,367)
Accounts payable and accrued expenses	48,853	(23,070)
Professional insurance recoveries and liabilities	(24,245)	754
Other liabilities	34,729	45,572
Net cash provided by operating activities	266,681	258,594
Investing activities:		
Net acquisitions of property, plant, and equipment	(169,932)	(115,888)
Capitalized interest	—	190
Net purchases of investments	(218,679)	(190,238)
Net sales of investments	100,962	10,765
Amounts deposited with trustee in debt service fund	(824)	2,535
Assets limited as to use	25,929	(52,867)
Net cash used in investing activities	(262,544)	(345,503)
Financing activities:		
Proceeds from issuance of long-term debt	—	619,183
Proceeds from notes payable	8,345	—
Payments of long-term debt	(14,927)	(490,610)
Payments on bank line of credit payable	—	(25,000)
Payments of notes payable	(4,185)	(3,213)
Payments on capital lease obligations	(4,995)	(2,645)
Cost of issuance of long-term debt	—	(6,825)
Bequests and contributions, net of pledges	45,512	26,231
Net cash provided by financing activities	29,750	117,121
Net increase in cash and cash equivalents	33,887	30,212
Cash and cash equivalents at beginning of year	161,059	130,847
Cash and cash equivalents at end of year	$ 194,946	161,059

See accompanying notes to consolidated financial statements.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Notes to Consolidated Financial Statements

September 30, 2015 and 2014

(1) Organization and Significant Accounting Policies

Yale-New Haven Health Services Corporation (Y-NHHSC), formed in 1983, was incorporated under the Connecticut Nonstock Corporation Act to coordinate the activities of the members of the Yale-New Haven Health Services Corporation, d/b/a Yale New Haven Health System and Subsidiaries (collectively, the System), and is an integrated regional health care delivery system. The System currently includes the following entities:

Y-NHHSC is the parent company of Yale-New Haven Hospital and Subsidiaries (Y-NHH), Bridgeport Hospital and Subsidiaries (BH), Greenwich Health Care Service, Inc. (GHCS), Northeast Medical Group, Inc. (NEMG), and Y-NHH-MSO, Inc. (MSO).

Y-NHHSC is the sole member of Yale-New Haven Hospital, Inc. Y-NHH and its subsidiaries operate autonomously with a separate board, management, and medical staff. Y-NHHSC must approve the strategic plans, operating budgets, capital budgets and board appointments of Y-NHH. Y-NHH is the parent of:

Yale-New Haven Care Continuum Corporation (YNHCCC), a Connecticut nonstock corporation, is a wholly owned subsidiary of Y-NHH. YNHCCC provides long-term care for those unable to live independently and short-term rehabilitation for patients who have experienced elective surgery, an injury or a traumatic major illness. Its services include respite care for family members and caregivers, recovery for victims of strokes, orthopedic recovery services, medications and diagnostic services (such as radiological services).

Yale-New Haven Ambulatory Services Corporation and Subsidiaries (ASC), a Connecticut nonstock, taxable corporation, is a wholly owned subsidiary of Y-NHH, and is 51% owner of Shoreline Surgery Center, LLC (SSC) and SSC II, LLC.

York Enterprises, Inc. and Subsidiaries (York) is a Connecticut corporation formed for the purpose of initiating or acquiring business entities. Currently, York has two subsidiaries: Medical Center Pharmacy and Home Care, Inc. (MCP) and Medical Center Realty, Inc. (MCR). MCP is a Connecticut stock, for-profit company, which operated a retail pharmacy with multiple locations until February 2011. MCR is a Connecticut stock, for-profit company, which owns or holds leases on the System's affiliated commercial space. York is the sole shareholder of MCP and MCR.

Caritas Insurance Company, Ltd. (Caritas) is a Vermont-domiciled, captive insurance company licensed under Chapter 141 of Title 8 of the Vermont Statutes Annotated. Caritas is a tax-exempt supporting organization having Y-NHH as its sole shareholder. Caritas provides excess professional liability coverage and general liability coverage. Prior to the 2012 acquisition of the stock of Caritas by Y-NHH from the Hospital of Saint Raphael (HSR), Caritas was a wholly owned subsidiary of HSR. Caritas was dissolved on December 15, 2014 and the insurance liabilities were transferred to Medical Centre Insurance Company, Ltd (see note 10).

(Continued)

Lukan Indemnity Company, Ltd. (Lukan) is a Bermuda-domiciled captive insurance company that provides primary professional liability coverage. Prior to the 2012 acquisition of the stock of Lukan by Y-NHH from HSR, Lukan was a wholly owned subsidiary of HSR. Lukan was dissolved on March 31, 2015 and the insurance liabilities were transferred to Medical Centre Insurance Company, Ltd (see note 10).

Y-NHHSC is the sole member of Bridgeport Hospital. BH and its subsidiaries operate autonomously with a separate board management, and medical staff. Y-NHHSC must approve the strategic plans, operating budgets, capital budgets and board appointments of BH. BH is the sole member of the following not-for-profit, nonstock corporations:

Bridgeport Hospital Foundation, Inc. (the Foundation) solicits contributions for the benefit of BH and all other tax-exempt health care organizations associated with BH.

Southern Connecticut Health System Properties, Inc. (Properties) is a real estate holding company, which sold primarily all of its assets to BH during 1998.

NEMG is a tax-exempt medical foundation that provides physician-related services to Bridgeport, Greenwich, and Yale-New Haven Hospitals and their surrounding communities. NEMG operates autonomously with a separate board, management, and medical staff. Y-NHHSC must approve the strategic plans, operating budgets, capital budgets, and board appointments of NEMG.

Concurrent with the issuance of the Connecticut Health and Educational Facilities Authority (CHEFA) Revenue Bonds, Yale-New Haven Health Obligated Group Issue, Series A, B, C, D and E dated May 20, 2014, six members of the System were combined to form an Obligated Group. The Obligated Group comprises of Y-NHHSC, Y-NHH, YNHCCC, BH, the Foundation and NEMG. The members of the Obligated Group have adopted certain governance provisions in their certificates of incorporation and by-laws pursuant to which Y-NHHSC retains the authority to directly take certain actions on behalf of each Obligated Group member without the approval of the board of trustees of the applicable Obligated Group member, including the incurrence of indebtedness on behalf of each Obligated Group member, the management and control of the liquid assets of each, and the appointment of the president and chief executive officer of each Obligated Group member. GHCS and its subsidiaries are part of the System, but they are not members of the Obligated Group.

GHCS is the parent corporation of a group of wholly owned subsidiaries, including Greenwich Hospital, The Perryridge Corporation Greenwich Health Care Services, Inc. (GHSI), the Greenwich Hospital Endowment Fund, Inc., and Greenwich Ambulatory Surgery Center, LLC (GASC). GHCS and its subsidiaries are Section 501(c)(3) not-for-profit organizations, and are exempt from federal income taxes under Section 501(a) of the Code. Greenwich Hospital, a nonstock Connecticut corporation, is a wholly owned subsidiary of GHCS (the sole member), providing health care services to the lower Fairfield County and Westchester County, New York communities. GHCS and its subsidiaries have continued to operate autonomously with a separate board, management and medical staff. Y-NHHSC must approve the strategic plans, operating budgets, capital budgets and board appointments of GHCS. GHCS dissolved its wholly owned subsidiary, Greenwich Health Services, Inc., a Connecticut business corporation during fiscal 2015. The activity and eliminations

(Continued)

for Greenwich Pathology Associates, LLC, Greenwich Clinical Pathology Associates, LLC, Greenwich Fertility and IVF center, P.C., Occupational Health of New Jersey and Occupational Health of New York are now reported as part of Greenwich Hospital.

Y-NHHSC must approve the strategic plans, operating budgets, capital budgets, any transfer of assets, and Board of Director appointments of GHCS and its subsidiaries.

MSO, a for-profit stock corporation, was formed to manage physician practices and provide third-party administration services on certain managed care contracts. The capital stock of MSO consists of 20,000 shares of common stock, par value of one one-hundredth of a dollar per share. The Board of Directors of MSO is appointed by Y-NHHSC, the sole shareholder, who controls MSO's operations.

(a) Acquisition

On June 1, 2014, NEMG and Y-NHHSC acquired certain assets of PriMed, LLC (PriMed), a physician practice for approximately $54.2 million. YNHHSC contributed the entire purchase price. PriMed is a multi-specialty group of approximately 120 providers in 36 locations across Fairfield County and New Haven County, Connecticut. PriMed also is the sole member of a gastroenterology surgery center, the Fairfield County Endoscopy Center, and offers a number of ancillary services, such as a sleep laboratory, cardiac diagnostic testing, physical therapy and nutritional counseling. Under the terms of the transaction, NEMG and Y-NHHSC acquired substantially all the assets of PriMed and a 40% interest in the gastroenterology surgery center. Y-NHHSC deposited $5.5 million into escrow to fund the purchase of the remaining 60% membership interest in the gastroenterology surgery center. This purchase was completed in May 2015. Also at acquisition, Y-NHHSC recorded a liability of $5 million for the amounts to be paid to PriMed physicians contingent on their continued service in the three years following the acquisition closing date as per the agreement.

(b) Principles of Consolidation

The accompanying consolidated financial statements present the accounts and transactions of the System and its subsidiaries. All significant intercompany revenue and expenses and inter-company balance sheet accounts have been eliminated in consolidation.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets, including estimated collectibles for accounts receivable for services to patients, and liabilities, including estimated net settlements with third-party payors and professional liabilities, and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the amounts of revenue and expenses reported during the reporting period. Actual results could differ from those estimates.

During the years ended September 30, 2015 and 2014 the System recorded a favorable change in estimate of approximately $29.8 million and $11.9 million, respectively. Included in the change are amounts related to third-party payor settlements.

(Continued)

(d) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the System has been limited by donors to a specific time period or purpose, and appreciation on permanently restricted net assets. Permanently restricted net assets have been restricted by donors to be maintained by the System in perpetuity. The System is a partial beneficiary to various perpetual trust agreements. Assets recorded under these agreements are recognized at fair value. The investment income generated from the trusts is unrestricted, and the assets are classified as permanently restricted by the donor.

Certain restricted funds investments are pooled with certain unrestricted investments to facilitate their management. Investment income is allocated to both restricted and unrestricted funds participating in the investment pool on pro rata basis based on the market value of the fund. The Board of Trustees approves spending for certain pooled funds based on the spending policy. Realized gains and losses from the sale of securities are computed using the average cost method and the first-in, first-out method.

Contributions, including unconditional promises to give, are recognized as revenue in the period received. Conditional promises to give are not recognized until the conditions on which they depend are substantially met. Contributions receivable to be received after one year are discounted at a discount rate commensurate with the risks involved. Amortization of the discount is recognized as revenue, and is classified as either unrestricted or temporarily restricted in accordance with donor-imposed restrictions, if any, on the contributions.

(e) Capital Campaign and Pledges Receivable

Contributions and pledges receivable, included in other current assets and other assets in the accompanying consolidated balance sheets at September 30, 2015 and 2014, are expected to be received as follows (in thousands):

	September 30	
	2015	**2014**
Less than one year	$ 4,379	5,164
One to five years	3,415	4,298
Thereafter	60	—
	7,854	9,462
Less unamortized discount on contributions receivable (0.01% to 4.2%)	(232)	(208)
	7,622	9,254
Allowance for uncollectible contributions	(229)	(277)
Contributions receivable, net	$ 7,393	8,977

(Continued)

Excluded from contributions receivable are certain items, primarily letters of intent, which are not legally binding and gifts conditional on events that have not yet occurred.

(f) Donor Restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. All gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets.

(g) Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid financial instruments with original maturities of three months or less when purchased, which are not classified as assets limited as to use, and which are not maintained in the short-term or long-term investment portfolios.

Cash and cash equivalents are maintained with domestic financial institutions with deposits which exceed federally insured limits. It is the System's policy to monitor the financial strength of these institutions.

(h) Accounts Receivable

Patient accounts receivable result from the health care services provided by the System. Additions to the allowance for uncollectible accounts result from the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance for uncollectible accounts.

The amount of the allowance for uncollectible accounts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in Medicare and Medicaid health care coverage, and other collection indicators. Management periodically assesses the adequacy of this allowance based upon historical collection and write-off experience by payor category. The results of these reviews are used to modify, as necessary, the provision for bad debts and to establish appropriate allowances for uncollectible patient accounts receivable. After satisfaction of amounts due from insurance, The System follows established guidelines for placing certain patient balances with collection agencies, subject to certain restrictions on collection efforts as determined by the System policy. See note 2 for additional information relative to third-party payor programs.

Net patient accounts receivable has been adjusted to the estimated amounts expected to be collected. These estimated amounts are subject to further adjustments upon review by third-party payors. Such receivables do not bear interest.

(i) Loan Receivable

On September 2014, Y-NHH entered into a term loan agreement as part of a transaction with a health care provider more fully described in note 11. The term loan agreement has a term that coincides with an agreement for Y-NHH to lease an Inpatient Rehabilitation Unit (IRU). The term of

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the IRU Lease Agreement is five years and provides Y-NHH with two five-year renewal options at the end of each term.

The term loan bears interest of 6.5% annually that is payable monthly. The loan is collateralized by certain property owned by a subsidiary of the health care provider.

(j) Investments

The System has designated its investment portfolio as trading. Investment income or loss (including realized gains and losses on investments, interest, and dividends) and the change in net unrealized gains and losses are included in the excess of revenue over expenses unless the income or loss is restricted by donor or law.

Investments in equity securities with readily determinable fair values and investments in debt securities are measured at fair value (quoted market prices) in the accompanying consolidated balance sheets.

Certain alternative investments (nontraditional, not-readily-marketable assets) are structured such that the System holds limited partnership interests or pooled units and are accounted for utilizing net asset value per unit for measurement of the units' fair value. Individual investment holdings within the alternative investments may, in turn, include investments in both nonmarketable and market-traded securities. Fund of funds investments are primarily based on financial data supplied by the underlying investee funds. Values may be based on historical cost, appraisals, or other estimates that require varying degrees of judgment. The investments may indirectly expose the System to securities lending, short sales of securities, and trading in futures and forwards contracts, options, swap contracts and other derivative products. While these financial instruments may contain varying degrees of risk, the System's risk with respect to such transactions is limited to its capital balance in each investment. The financial statements of the investees are audited annually by independent auditors. Future funding commitments for alternative investments aggregated approximately $6.4 million at September 30, 2015.

The System maintains the Yale New Haven Health System Investment Trust (the Trust), a unitized Delaware Investment Trust created to pool assets for investment by the Health System nonprofit entities. The Trust is comprised of two pools: the Long-Term Investment Pool (L-TIP) and the Intermediate-Term Investment Pool (I-TIP). Governance of the Trust is performed by the Yale New Haven Health System Investment Committee.

Under the terms of the investment management agreement with the Trust, withdrawals of investments in the L-TIP can be made annually by each Hospital on July 1. Amounts withdrawn are subject to a schedule that allows larger withdrawals with longer notice periods. As of September 30, 2015, each Hospital can withdrawal 100% of its investment in the L-TIP on July 1, 2016. Withdrawals of investments in the I-TIP in any amount can be made quarterly with 30 days advance notice.

The Trust has entered into an agreement with Yale University (the University). The University's investment office (the Investment Management Agreement) which allows the University to manage a

(Continued)

portion of the Trust's investments as part of the University's Endowment Pool (the Pool). The Trust transferred approximately $50.0 million and $100.0 million to the University in exchange for units in the Pool for years ended September 30, 2015 and 2014, respectively. The Trust's interest in the Pool is reported at fair value based on the net asset value per units held. The Pool invests in domestic equity, foreign equity, absolute return, private equity, real assets, fixed income, and cash.

Under the terms of the investment management agreement with the University, withdrawals of the Trust's investment in the Pool can be made annually by the Trust on July 1. For withdrawals of amounts less than $150.0 million, or 75% of the Trust's investment in the Pool, $100.0 million, or 50% of the Trust's investment in the Pool, and $50.0 million, or 25% of the Trust's investment in the Pool, the advance notice period is set to a maximum of 180 days, 90 days, and 30 days, respectively, prior to the University's fiscal year ending June 30. For withdrawals greater than $150.0 million or more than 75% of the Trust's investment in the Pool, the advance notice period is set to a maximum of 270 days prior to the University's fiscal year end of June 30.

In March 2006, Y-NHH entered into an arrangement with the University, whereby the University will manage certain Board-designated assets of Y-NHH. These Board-designated assets are commingled in the University's endowment pool. As of September 30, 2015 and 2014, the carrying value of assets managed by the University under this agreement was approximately $10.6 million and $10.4 million, respectively. Because of the limitations on their use, the assets are separately classified from assets invested under the Investment Management Agreement.

In 2011, the investment management agreement between the Trust and the University was modified to allow the Trust to obtain a cash advance, up to a maximum of $75 million, on a monthly basis. For these advances, interest of U.S. Prime rate, plus 2% will be paid by the Trust. Repayments on the advances are made by the Trust by way of redemptions of a sufficient number of Trust's units in the Endowment using the June 30th unit valuation. No advances have been requested or taken by the Trust.

Short-term investments represent those securities that are available for the System's operations, and can be converted to cash within one year.

(k) Inventories

Inventories (included in other current assets) are stated at the lower of cost or market. The System values its inventories using the first-in, first-out method, with the exception of Y-NHH's pharmacy inventories, which are valued at average cost.

(l) Assets Limited as to Use

Assets so classified represent assets held by trustees under indenture agreements, beneficial interest in perpetual trusts. Amounts required to meet current liabilities are reported as current assets. These funds consist primarily of U.S. government securities, equities, debt securities, mutual funds and money market funds.

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(m) Perpetual Trusts

The System is the beneficiary of certain perpetual trusts held and administered by others. The present values of the estimated future cash receipts, which are measured based on the fair value of the assets held by the trust, are recognized as assets and contribution revenue at the dates the trusts are established. Beneficial interest in perpetual trusts is recorded as permanently restricted net assets and is adjusted for any changes in the fair value of the trusts. Income distributions received from the trusts are recorded as temporarily restricted contributions when received.

(n) Interest Rate Swap Agreements

The System utilizes interest rate swap agreements to reduce risks associated with changes in interest rates. Interest rate swap agreements are reported at fair value. The System is exposed to credit loss in the event of nonperformance by the counterparties to its interest rate swap agreements. The System is also exposed to the risk that the swap receipts may not offset its variable rate debt service. To the extent these variable rate payments do not equal variable interest payments on the bonds, there will be a net loss or net benefit to the System.

(o) Benefits and Insurance

The System is effectively self-insured for medical, dental, hospitalization, and prescription drug benefits provided to employees and has a stop loss arrangement to limit exposure for these self-insured benefits. Y-NHH and Y-NHHSC make annual contributions to the Y-NHHSC Voluntary Employee Beneficiary Association (VEBA) plan to fund medical, dental, hospitalization, group term life insurance and prescription drug benefits. Annually, premiums are set to reflect the estimated cost of benefits. During the years ended September 30, 2015 and 2014, Y-NHH and Y-NHHSC made actuarially determined contributions, net of premium adjustments, to the VEBA plan of approximately $179.7 million and $172.6 million, respectively.

(p) Professional Liability Insurance

The System is effectively self-insured for workers' compensation claims. The System has a stop loss arrangement to limit exposure for workers' compensation claims. Estimated amounts are accrued for claims, including claims incurred but not reported (IBNR). At September 30, 2015 and 2014, the estimated discounted liabilities for self-insured workers' compensation claims and IBNR aggregated approximately $31.4 million and $29.4 million, respectively, discounted at 2.0% and 2.5%, respectively, and are included in other long-term liabilities in the accompanying consolidated balance sheets.

The System records the actuarially determined liabilities for IBNR professional and general liabilities (see note 10).

(q) Property, Plant and Equipment

Property, plant and equipment purchased are carried at cost, and those acquired by gifts and bequests are carried at fair value established at the date of contribution. The carrying amounts of assets and the related accumulated depreciation are removed from the accounts when such assets are disposed

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of, and any resulting gain or loss is included in income from operations. Depreciation of property, plant and equipment is computed by the straight-line method in amounts sufficient to depreciate the cost of the assets over their estimated useful lives, ranging from 3 to 50 years. The cost of additions and improvements are capitalized, and expenditures for repairs and maintenance, including the cost of replacing minor items not considered substantial enhancements, are expensed as incurred.

Leases are classified as capital leases or operating leases in accordance with the terms of the underlying lease agreements. Lease payments under operating leases are charged directly to rental expense, and are included in supplies and other expenses in the accompanying consolidated statements of operations.

(r) Goodwill

Goodwill is not amortized but instead tested at least annually for impairment or more frequently when events or changes in circumstances indicate that the assets might be impaired. This impairment test is performed at the reporting unit level. The System evaluates goodwill at the entity level as management has determined that the System's operation comprise a single reporting entity. Goodwill is considered to be impaired if the carrying value of the reporting unit, including goodwill, exceeds the reporting unit's fair value. Reporting unit fair value is estimated using both income (discounted cash flows) and market approaches.

The discounted cash flow approach requires the use of assumptions and judgments, including estimates of future cash flows and the selection of discount rates. The market approach relies on comparisons to publicly traded stocks or to sales of similar companies. The System has determined that no goodwill impairment exists at September 30, 2015 or 2014.

(s) Deferred Revenue

Deferred revenue includes amounts which have been received that relate to future years. Amounts will be reduced as revenue is earned.

(t) Derivative Contracts

In the normal course of business, the System procures fuel and has entered into forward delivery agreements and commodity contracts. Substantially all of the System's contracts to procure fuel are designated as, and qualify as, normal purchases; accordingly, such contracts are not accounted for as derivative contracts.

(u) Excess of Revenue Over Expenses

In the accompanying consolidated statements of operations and changes in net assets, excess of revenue over expenses is the performance indicator. Peripheral or incidental transactions are included in excess of revenue over expenses. Those gains and losses deemed by management to be closely related to ongoing operations are included in other revenue; other gains and losses are classified as nonoperating.

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Contributions of, or restricted to, property, plant and equipment, and pension and other postretirement related changes other than net periodic benefit cost are excluded from the performance indicator, but are included in the change in net assets.

(v) Income Taxes

Most entities within the System are not-for-profit corporations as described in Section 501(c)(3) of the Code, and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. Provisions for income taxes and deferred taxes, which are not material to the consolidated financial statements, have been made for the taxable entities listed above under the description of the System.

There are certain transactions that could be deemed "Unrelated Business Income" and would result in a tax liability. Management reviews transactions to estimate potential tax liabilities using a threshold of more likely than not that the position will be sustainable based on the merits of the position. It is management's estimation that there are no material tax liabilities that need to be recorded.

(w) Operating Expenses

Y-NHH records amounts received from the University, area hospitals, and other local health care providers for costs incurred on behalf of those organizations as reductions to expenses. These costs consist mainly of salaries and benefits. For the years ended September 30, 2015 and 2014, Y-NHH recorded approximately $55.0 million and $60.5 million, respectively, as reductions to expenses.

(x) Deferred Financing Costs

The System capitalizes costs incurred in connection with the issuance of long-term debt, and amortizes these costs over the life of the respective obligations using the effective interest method (note 8). The accumulated amortization of deferred financing costs was approximately $1.1 million and $0.6 million for September 30, 2015 and 2014, respectively. See note 8 for additional information relative to debt-related matters.

(y) Impairment of Assets

The System reviews property, plant, and equipment, and intangible assets for impairment whenever events or changes in circumstances indicate that the carrying amount of the assets may not be recoverable. If such impairment indicators are present, the System recognizes a loss on the basis of whether these amounts are fully recoverable. There was no impairment recognized in 2015 and 2014.

(z) Reclassifications

Certain reclassifications have been made to the year ended September 30, 2014, balances previously reported in the consolidated financial statements in order to conform with the year ended September 30, 2015, presentation.

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(aa) New Accounting Pronouncements

In May 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2015-07, *Fair Value Measurement (Topic 820) – Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)*, which removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using the net asset value per share practical expedient. ASU 2015-07 also removes the requirement to make certain disclosures for all investments that are eligible to be measured at fair value using the net asset value per share practical expedient. Reporting entities will be required to disclose the amount of investments measured at net asset value (or its equivalent) using the practical expedient to reconcile total investments in the fair value hierarchy to total investments measured at fair value. ASU 2015-07 is effective for public business entities for fiscal years beginning after December 15, 2015, and interim periods within those fiscal years. The effective date for all other entities is fiscal years beginning after December 15, 2016, and interim periods within those fiscal years. Early adoption is permitted. Management has adopted and applied ASU 2015-07 retrospectively to all periods presented.

In April, 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*. ASU No. 2015-03 is intended to simplify the presentation of debt issuance costs, requiring them to be presented as a direct reduction from the carrying value of the related debt liability. This guidance is effective for fiscal years beginning after December 15, 2015 and management is currently evaluating the effect of this guidance on its consolidated financial statements.

(2) Accounts Receivable for Services to Patients and Net Patient Service Revenue

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. The difference is accounted for as allowances. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, fee-for-service, discounted charges, and per diem payments. Net patient service revenue is affected by the State of Connecticut Disproportionate Share program and is reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered, and includes estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known, or as years are no longer subject to such audits, reviews, and investigation.

Third-party payor receivables included in other receivables were $5.0 million and $8.0 million at September 30, 2015 and 2014, respectively. Third-party payor liabilities included in other current liabilities were $76.2 million and $47.4 million at September 30, 2015 and 2014, respectively. Third-party payor liabilities include in other long-term liabilities were $70.5 million and $76.9 million at September 30, 2015 and 2014, respectively.

The System has established estimates, based on information presently available, of amounts due to or from Medicare, Medicaid, and third-party payors for adjustments to current and prior year payment rates, based

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on System-specific data. Such amounts are included in the accompanying consolidated balance sheets. Additionally, certain payors' payment rates for various years have been appealed by the System. If the appeals are successful, additional income applicable to those years might be realized.

Revenue from Medicare and Medicaid programs accounted for approximately 29% and 11%, respectively, of the System's consolidated net patient service revenue for the years ended September 30, 2015, and approximately 32% and 11%, respectively, of the System's consolidated net patient service revenue for the years ended September 30, 2014. Inpatient discharges relating to Medicare and Medicaid programs accounted for approximately 36% and 27%, respectively for the year ended September 30, 2015 and 37% and 27%, respectively, for the year ended September 30, 2014. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and are subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by material amounts in the near term.

The System believes that it is in compliance with all applicable laws and regulations, and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing, except as disclosed in note 11. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and the reduction of funding levels could have an adverse impact on the System. Cost reports for the System's hospitals, which serve as the basis for final settlement with government payors have been settled by final settlement for various years ranging through 2012 for Medicare and through 2013 for Medicaid. Other years remain open for settlement.

The significant concentrations of accounts receivable for services to patients include 36% from Medicare, 16% from Medicaid, and 48% from nongovernmental payors at September 30, 2015 and 37% from Medicare, 13% from Medicaid, and 50% from nongovernmental payors at September 30, 2014.

Patient service revenue for the years ended September 30, 2015 and 2014, net of contractual allowances and discounts (but before the provision for bad debts), recognized from these major payor sources based on primary insurance designation, is as follows:

		2015	2014
		(In thousands)	
Third-party	$	3,465,982	3,276,256
Self-pay		108,231	135,179
Total all payors	$	3,574,213	3,411,435

Deductibles and copayments under third-party payment programs within the third-party payor amount above are the patient's responsibility and the System considers these amounts in its determination of the provision for bad debts based on collection experience. Accounts receivable are also reduced by an allowance for doubtful accounts. In evaluating the collectibility of accounts receivable, the System analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for uncollectible accounts and provision for bad debts. Management regularly

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reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts.

The System's allowance for doubtful accounts totaled approximately $313.9 million and $272.7 million at September 30, 2015 and 2014, respectively. The allowance for doubtful accounts for self-pay patients was approximately 66.0% and 81.8% of self-pay accounts receivable as of September 30, 2015 and 2014, respectively. Substantially all write-offs are related to self-pay patients.

(3) Uncompensated Care and Community Benefit Expense

The System's commitment to community service is evidenced by services provided to the poor and benefits provided to the broader community. Services provided to the poor include services provided to persons who cannot afford health care because of inadequate resources, and/or who are uninsured or underinsured.

The System makes available free care programs for qualifying patients. In accordance with the established policies of the System, during the registration, billing, and collection process, a patient's eligibility for free care funds is determined. For patients who were determined by the System to have the ability to pay but did not, the uncollected amounts are the provision for bad debts. For patients who do not avail themselves of any free care program, and whose ability to pay cannot be determined by the System, care given but not paid for is classified as charity care. During the year ended September 30, 2014, the System amended it Charity Care policy. Based upon the policy change, the System experienced increased charity care write offs during the years ended September 30, 2015 and 2014.

Together, charity care and provision for bad debts represent uncompensated care. The estimated cost of total uncompensated care is approximately $154.7 million and $184.9 million for the years ended September 30, 2015 and 2014, respectively. The estimated cost of uncompensated care is based on the ratio of cost to charges, as determined by claims activity.

The estimated cost of charity care provided was $108.4 million and $115.8 million for the years ended September 30, 2015 and 2014, respectively. The estimated cost of charity care is based on the ratio of cost to charges. The allocation between bad debt and charity care is determined based on management's analysis on the previous 12 months of hospital data. This analysis calculates the actual percentage of accounts written off or designated as bad debt versus charity care while taking into account the total costs incurred by the System for each account analyzed.

For the years ended September 30, 2015 and 2014, provision for bad debts, at charges, was $81.5 million and $123.7 million, respectively. For the years ended September 30, 2015 and 2014, provision for bad debt at cost was approximately $46.3 million and $69.1 million, respectively. The provision for bad debts is multiplied by the ratio of cost to charges for purposes of inclusion in the total uncompensated care amount identified above.

The Connecticut Disproportionate Share Hospital Program (CDSHP) was established to provide funds to hospitals for the provision of uncompensated care and is funded, in part, by an assessment on hospital net patient service revenue. During the years ended September 30, 2015 and 2014, the System received $14.6 million and $42.2 million, respectively, in CDSHP distributions, of which approximately

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$10.4 million and $27.8 million was related to charity care. The System made payments into the CDSHP of $122.4 million and $102.5 million for the years ended September 30, 2015 and 2014, respectively, for the assessment.

The State of Connecticut implemented changes to the hospital funding levels for the CDSHP in their fiscal 2016 biennium budget. As a result of these budget changes, the funding for this program was reduced effective July 1, 2015. The reduction in funding was approximately $13.2 million for the period July 1, 2015 to September 30, 2015 and the funding has been eliminated for the state fiscal year 2016 in the amount of $52.8 million.

Additionally, the System provides benefits for the broader community which includes services provided to other needy populations that may not qualify as poor but need special services and support. Benefits include the cost of health promotion and education of the general community, interns and residents, health screenings and medical research. The benefits are provided through the community health centers, some of which service non-English speaking residents, disabled children and various community support groups. The System voluntarily assists with the direct funding of several City of New Haven programs, including an economic development program and a youth initiative program.

In addition to the quantifiable services defined above, the System provides additional benefits to the community through its advocacy of community service by employees. The System's employees serve numerous organizations through board representation, membership in associations and other related activities. The System also solicits the assistance of other health care professionals to provide their services at no charge through participation in various community seminars and training programs.

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(4) Investments and Assets Limited as to Use

The composition of investments, including investments held by the Trust, amounts on deposit with trustee in debt service fund, and assets limited as to use is set forth in the following table (in thousands):

	September 30	
	2015	2014
Money market funds	$ 130,047	212,529
U.S. equity securities	104,792	97,735
International equity securities[a]	105,476	116,635
Fixed income:		
U.S. government	417,835	301,674
International government[b]	97,707	86,160
Corporate bonds	4,945	27,097
Mortgage backed securities	—	24
Commodities	1,595	2,716
Hedge funds:		
Absolute return[c]	21,909	22,310
Long/short equity[d]	6,936	2,460
Private equity	7,489	8,272
Real estate[e]	8,278	11,285
Interest in Yale University endowment pool[f]	855,264	752,731
Perpetual trusts[g]	30,981	32,349
Total	$ 1,793,254	1,673,977

[a] Investments with external international equity and bond managers that are domiciled in the United States. Investment managers may invest in American or Global Depository Receipts (ADR, GDR) or in direct foreign securities.

[b] Investments with external commodities futures manager.

[c] Investment with external multi-strategy fund of funds manager investing in publicly traded equity and credit holdings which may be long or short positions.

[d] Investment with an external long-short equity fund of funds manager with underlying portfolio investments consisting of publicly traded equity positions.

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(e) Investments with external direct real estate managers and fund of funds managers. Investment vehicles include both closed end Real Estate Investment Trusts (REITs) and limited partnerships.

(f) Yale University Endowment Pool maintains a diversified investment portfolio, through the use of external investment managers operating in a variety of investment vehicles, including separate accounts, limited partnerships, and commingled funds. The pool combines an orientation to equity investments with an allocation to nontraditional asset classes such as an absolute return, private equity, and real assets.

(g) Investments consist of several domestic and international equity and fixed income mutual funds, REITs, commodities and money market funds. There is also an investment in a hedge fund of funds.

(5) Property, Plant and Equipment

Property, plant and equipment is as follows (in thousands):

	September 30	
	2015	2014
Land, buildings and improvements	$ 1,617,826	1,562,723
Equipment	1,264,862	1,267,165
Assets recorded under capital leases	57,345	70,262
	2,940,033	2,900,150
Less accumulated depreciation and amortization	1,551,286	1,444,576
Property, plant, and equipment, net	1,388,747	1,455,574
Construction in progress (note 8 (n))	157,101	66,043
	$ 1,545,848	1,521,617

(6) Endowment

The System's endowment includes donor-restricted endowment funds. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor- imposed restrictions.

The System has interpreted the Connecticut Uniform Prudent Management of Institutional Funds Act (CUPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, the System classifies as permanently restricted net assets: (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment related to the System's beneficial interest in perpetual trusts made in accordance with the direction of the applicable donor gift instrument at the time of the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund

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that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by the System in a manner consistent with the standard of prudence prescribed by CUPMIFA. In accordance with CUPMIFA, the System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (1) the duration and preservation of the fund; (2) the purposes of the System and the donor-restricted endowment fund; (3) general economic conditions; (4) the possible effect of inflation and deflation; (5) the expected total return from income and the appreciation of investments; (6) other resources of the System; and (7) the investment and spending policies of the System.

Changes in endowment net assets for the year ended September 30, 2015, are as follows (in thousands):

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets at beginning of year	$ 47,947	73,543	80,856	202,346
Investment returns:				
Investment (loss) income	(865)	151	—	(714)
Net appreciation (realized and unrealized)	452	3,278	(1)	3,729
Total investment returns	(413)	3,429	(1)	3,015
Appropriation of endowment assets for expenditure	(2,820)	(7,826)	(1,392)	(12,038)
Other changes:				
Contributions	—	6,130	15,175	21,305
Change in value of beneficial interest trusts	—	—	(1,282)	(1,282)
Endowment net assets at end of year	$ 44,714	75,276	93,356	213,346

(Continued)

Changes in endowment net assets for the year ended September 30, 2014, are as follows (in thousands):

	Unrestricted	Temporarily restricted	Permanently restricted	Total
Endowment net assets at beginning of year	$ 43,893	71,899	70,179	185,971
Investment returns:				
Investment (loss) income	(554)	688	—	134
Net appreciation (realized and unrealized)	7,156	10,677	46	17,879
Total investment returns	6,602	11,365	46	18,013
Appropriation of endowment assets for expenditure	(2,548)	(10,942)	—	(13,490)
Other changes:				
Contributions	—	1,221	5,373	6,594
Change in value of beneficial interest trusts	—		5,258	5,258
Endowment net assets at end of year	$ 47,947	73,543	80,856	202,346

	September 30	
	2015	2014
	(In thousands)	
The portion of perpetual endowment funds subject to a time restriction under CUPMIFA:		
Without purpose restrictions	$ 8,666	8,357
With purpose restrictions	66,610	65,186
Total endowment funds classified as temporarily restricted net assets	$ 75,276	73,543

(a) Return Objectives and Risk Parameters

The System has adopted investment and spending policies for endowed assets that attempt to provide a predictable stream of funding to programs supported by its endowment. Endowment assets include those assets of donor-restricted funds that the organization must hold in perpetuity. Under these policies, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce results that over time provide a rate of return that meets the spending policy objectives adjusted for inflation. Actual returns in any given year may vary from this amount.

(b) Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the System relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and

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current yield (interest and dividends) The System targets a diversified asset allocation that place greater emphasis on equity-based investments to achieve its long-term rate of return objectives within prudent risk constraints.

(c) Spending Policy and How the Investment Objectives Relate to Spending Policy

BH and Y-NHH have a policy of appropriating for distribution each year based on a combination of the weighted average of the prior year spending adjusted for inflation and the amount that would have been spent using a predetermined percentage (5.25% for Y-NHH and 5.0% for BH) of the current market value of the endowment fund. In establishing this policy, BH and Y-NHH have considered the long-term expected return on its endowment.

GHCS has a policy of appropriating funds for distribution each year based on the greater of $800,000 or 5% of the average market value of its investments for the prior 12 quarters. In establishing this policy, GHCS considered the long-term expected return on its endowment.

From time to time, the fair value of assets associated with permanently restricted endowment funds may fall below the level determined under Connecticut UPMIFA.

(7) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes (in thousands):

	September 30	
	2015	2014
Specific hospital operations, teaching, research, indigent and free care, and training	$ 125,467	123,058
Plant improvement and expansion	22,101	18,654
	$ 147,568	141,712

Permanently restricted net assets of approximately $93.4 million and $80.9 million at September 30, 2015 and 2014, respectively, consist of donor restricted endowment principal and beneficial interests in perpetual trusts. The income generated from permanently restricted funds is expendable for purposes designated by donors, including research, free care, health care, and other services.

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

(8) Debt

A summary of long-term debt and capital lease obligations is as follows (in thousands):

	September 30 2015	2014
Revenue bonds financed with the State of Connecticut Health and Educational Facilities Authority (CHEFA):		
Tax-exempt		
Series C (Greenwich Hospital) maturing July 1, 2026 (variable interest rates with an average rate of approximately 3.22% for fiscal 2015) (a)	$ 35,105	37,710
Series D (BH), maturing July 1, 2025, fixed interest ranging from 2.00% to 5.00% (b)	29,780	32,110
Series E (BH), 3.47% effective interest rate (c)	34,982	35,971
Series N (Y-NHH), 4.27% effective interest rate (d)	44,815	44,815
Series O (Y-NHH), 2.84% effective interest rate (d)	50,000	50,000
Series A (Y-NHH), 3.77% effective interest rate (e)	102,300	102,300
Series B (Y-NHH), 2.30% effective interest rate (e)	168,275	168,275
Series C (Y-NHH), 3.11% effective interest rate (f)	77,235	83,625
Series D (Y-NHH), 3.68% effective interest rate (f)	108,275	108,275
Series E (Y-NHH), 3.47% effective interest rate (c)	43,728	44,963
Series 2013 taxable bonds (Y-NHH), 4.13% effective rate (g)	132,000	132,000
Series 2014 taxable bonds (Y-NHH), 4.37% effective rate (j)	50,725	50,725
Loans payable:		
Note payable (Y-NHH), 5.4% effective interest rate (i)	8,309	—
Term loan – November 2010 (BH), 3.22% fixed interest rate (j)	3,674	4,317
Term loan June, 2012 (BH), 1.66% fixed interest rate (k)	1,977	3,082
Note payable (BH), 6.9% fixed interest rate (l)	2,101	6,250
Capital lease obligation at an imputed interest of 6.0% – November 2010, (Y-NHH) (m)	48,853	50,682
Capital lease obligation (BH) (n)	60,774	20,207
Capital lease obligations (York), at varying rates of imputed interest of 6.25%, collateralized by leased equipment	—	3,119
	1,002,908	978,426
Add premium	29,332	32,139
Less current portion	(18,931)	(22,456)
	$ 1,013,309	988,109

a) On May 6, 2008, CHEFA issued $53.6 million of its Revenue Bonds on behalf of GH, Series C, consisting of variable rate demand bonds. The proceeds were utilized for the refunding of outstanding revenue bonds. Principal amounts related to the Series C revenue bonds mature annually

(Continued)

each July 1 through fiscal 2026. The Series C bonds are required to be supported by a letter of credit, which has been executed with Bank of America. The letter of credit is scheduled to expire in May 2018.

b) In May 2012, the BH Series D tax-exempt revenue bonds were issued through CHEFA under a Master Trust Indenture for approximately $36.4 million, with coupons ranging from 2.0% to 5.0%, and a final maturity of July 2025. The proceeds, including a premium of approximately $4.1 million, were held in an escrow account and used for the retirement of the outstanding tax-exempt revenue bonds and to pay for certain bond issuance costs of approximately $0.8 million. The bond premium is being amortized using the effective interest method and is included in interest expense in the accompanying consolidated statement of operations and changes in net assets.

c) In June 2014, the Obligated Group issued Series E revenue bonds totaling approximately $80.9 million. The Series E revenue bonds were issued as fixed rate bonds with an effective interest rate of 3.47%. The proceeds included a premium of approximately $10.1 million. The proceeds were used to finance costs for the installation of machinery and equipment and various renovations and improvements to the infrastructures at BH and Y-NHH. The premium is being amortized and included in capitalized interest. Upon completion of these projects, the bond premium will be amortized as interest expense in the accompanying consolidated statement of operations and changes in net assets.

d) In January 2013, Y-NHH issued Series N and Series O revenue bonds totaling approximately $100.0 million. The Series N revenue bonds were issued as fixed rate bonds with an effective interest rate of 4.27%. The Series O revenue bonds were issued as VRDBs with an effective interest rate of 2.84% at September 30, 2013. The proceeds, including a premium of approximately $5.2 million for the Series N revenue bonds, were used to refinance a line of credit. The bond premium is being amortized as interest expense in the accompanying consolidated statements of operations and changes in net assets.

e) In June 2014, the Obligated Group issued Series A revenue bonds totaling approximately $102.3 million and Series B revenue bonds totaling approximately $168.3 million. The Series A revenue bonds were issued as fixed rate bonds with an effective interest rate of 3.77%. The Series B revenue bonds were issued as floating rate notes with an effective interest rate of 2.30%. The proceeds from the Series A revenue bonds, including a premium of approximately $14.8 million, and the proceeds from the Series B revenue bonds, were used to defease certain Y-NHH revenue bonds. The bond premium is being amortized as interest expense using the effective interest method in the consolidated statements of operations and changes in net assets.

f) In June 2014, the Obligated Group issued Series C revenue bonds totaling approximately $83.6 million and Series D revenue bonds totaling approximately $108.3 million. The Series C revenue bonds were issued as VRDBs with an effective interest rate of 3.11%. The proceeds from the Series C issuance were used to refund certain Y-NHH revenue bonds. The Series D revenue bonds were issued as VRDBs with an effective interest rate of 3.68%. The proceeds from the Series D issuance were used to refund certain Y-NHH revenue bonds.

(Continued)

As a result of the above transactions, Y-NHH incurred a loss on extinguishment of debt totaling approximately $32.6 million during the fiscal year ended September 30, 2014.

g) In January 2013, Y-NHH issued Series 2013 taxable bonds totaling approximately $132.0 million. The Series 2013 taxable bonds were issued as fixed rate bonds with an effective interest rate of 4.13%. The proceeds were used to finance and refinance the costs of certain projects and activities in furtherance of Y-NHH's tax exempt purpose, including the refinancing of certain existing indebtedness.

h) In June 2014, the Obligated Group issued Series 2014 taxable bonds totaling approximately $50.7 million. The Series 2014 taxable bonds were issued as fixed rate bonds with an effective interest rate of 4.37%. The proceeds were used to finance the costs of certain projects and activities in furtherance of the System's tax-exempt purpose.

i) In connection with the May 2015 purchase of a parcel of real estate, Y-NHH assumed a note payable with an effective interest rate of 5.46%. The note payable has a term of three years and matures in May 2017.

j) In November 2010, BH obtained a $6.6 million term loan from the CHEFA. The proceeds of the loan are to be used for the purchase and installation of energy savings equipment and various renovations and improvements to the infrastructure of BH. The loan is to be paid in monthly installments over ten years at a fixed interest rate of 3.22%.

k) In June 2012, BH obtained a $5.5 million term loan from CHEFA. The loan is to be paid in monthly installments over five years at a fixed rate of 1.66% with the proceeds to be used for medical and cafeteria equipment. The loan is secured by the equipment purchased with the proceeds of the loan.

l) In December 2012, in connection with the purchase of a radiology practice, BH entered into a note payable with the seller in the amount of $15.1 million. The note is to be repaid in monthly installments over five years.

m) Y-NHH entered into a contract to lease space in a building adjacent to Y-NHH. Y-NHH's rental obligation commenced in December 2009. This capital lease has a term of 20 years from the commencement date with the option to extend the lease for four successive terms of ten years. Rental payments increase by 5% every five years. Y-NHH is also subject to additional rent for its share of expenses, as defined in the contract. Y-NHH has the option to purchase the property at the end of the fifth, tenth, or twentieth year or at the end of each of the first three ten-year extension periods.

n) BH entered into an arrangement with a developer to construct a 120,000 square foot medical office building and adjacent garage in Fairfield County, CT. The arrangement contains provisions for BH to begin leasing the property for a 25-year period beginning in April 2016. Management has evaluated the terms of the arrangement and will be recording the project as a capital lease. Upon completion, the total estimated capital lease obligation will approximate $102.0 million. At September 30, 2015 and 2014, construction costs totaled approximately $60.8 million and $20.2 million, respectively, and are included in construction in process in the accompanying consolidated balance sheet.

(Continued)

Required monthly payments on the revenue bonds by the System to a trustee are in amounts sufficient to provide for the payments of principal, interest, and sinking fund installments, as well as required payments to certain reserve funds held by the trustee, in accordance with the terms of the agreements, and certain other annual costs of CHEFA.

Arbitrage rules apply to tax-exempt debt issued after August 31, 1986. The rules require that, in specified circumstances, earnings from the investment of tax-exempt bond proceeds which exceed the yield on the bonds must be remitted to the Federal government.

The GH Series C, Y-NHH Series C, Y-NHH Series D and Y-NHH Series O VRDBs are required to be supported by letter of credit facilities (LOCs) which have been executed with three financial institutions. These LOCs are scheduled to expire on May 7, 2018, December 31, 2017, June 23, 2017, and February 14, 2018, respectively.

The Hospitals maintain the bank letters of credit to ensure the availability of funds to purchase any bonds tendered by bondholders that the remarketing agents are unable to remarket to new bondholders. Draws related to such tenders under the letters of credit will become Bank Bonds. As Bank Bonds, they can still be remarketed by the remarketing agents. If not remarketed successfully as Bank Bonds, the Hospitals will have the opportunity to refinance them, depending upon which bond series, during a period of from 90 to 367 days from initial draw date. If the Bank Bonds are not refunded and remain outstanding exceeding such period from initial draw date, GH will be required to make monthly payments over three years and Y-NHH will be required to make quarterly payments over five years. There were no draws under the letters of credit as of September 30, 2015.

The terms of the various financing arrangements between CHEFA and the System, the financial institutions providing the LOCs and the System, and the bank and the System provide for financial covenants regarding the System's debt service coverage ratio, liquidity ratio, and debt to capitalization ratio, among others.

Assets recorded under the capital lease obligations totaled approximately $118.1 million and $90.4 million as of September 30, 2015 and 2014, respectively. Accumulated depreciation for the capital lease obligations totaled approximately $10.1 million and $19.3 million at September 30, 2015 and 2014, respectively.

Capitalized interest at September 30, 2015 and 2014 totaled approximately $30.9 million and $29.9 million, respectively.

For the years ended September 30, 2015 and 2014, the System paid approximately $23.4 million and $25.5 million, respectively, for interest related to long-term debt and capital lease obligations.

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

Scheduled principal payments on all long-term debt, including capital lease obligations, are as follows (in thousands):

	Debt	Capital lease obligations
Year ending September 30:		
2016	$ 16,472	8,633
2017	25,897	13,052
2018	15,829	13,052
2019	17,601	13,053
2020	18,290	13,235
Thereafter	799,193	177,133
	$ 893,282	238,158
Less interest		(128,949)
		$ 109,209

The following table summarizes the System's interest rate swap agreements (in thousands):

Swap type	Expiration date	System receives	System pays	Notional amount at September 30 2015	Notional amount at September 30 2014
Series O – fixed to floating	July 1, 2053	67% of LIBOR	2.84%	$ 50,000	50,000
Series B – fixed to floating	July 1, 2049	67% of LIBOR	2.31%	100,965	100,965
Series B – fixed to floating	July 1, 2049	LIBOR	2.29%	67,310	67,310
Series C – fixed to floating (Y-NHH)	July 1, 2025	LIBOR	3.11%	51,592	55,861
Series D – fixed to floating	July 1, 2036	LIBOR	3.68%	44,505	44,505
Series C – fixed to floating (Greenwich Hospital)	July 1, 2026	LIBOR	3.10%	24,000	25,700
				$ 338,372	344,341

The swap agreements fix the interest rate at a level viewed as desirable by the System. Such agreements expose the System to credit risk in the event of nonperformance by the counterparties, some of which is collateralized. At September 30, 2015 and 2014, the fair value of the swap agreements based on current interest rates was approximately $54.7 million and $36.1 million, respectively, representing a payable to the counterparties (recorded in other long-term liabilities).

For the Y-NHH Series O swap, there was an unfavorable change in fair value of $0.7 million and $0.6 million for the years ended September 30, 2015 and 2014, respectively, which was recorded in excess of revenue over expenses. No collateral was required under the Series O swap agreement for the years ended September 30, 2015 and 2014.

(Continued)

In June 2014, Y-NHHSC, on behalf of the Obligated Group, entered into LIBOR swap rate locks with two counter parties (the Series B swaps). For the Series B swaps, there was an unfavorable change in fair value of approximately $13.2 million and $7.1 for the years ended September 30, 2015 and 2014, respectively, which was recorded in excess of revenue over expenses. No collateral was required under the Series B swap agreements for the years ended September 30, 2015 and 2014.

For the Y-NHH Series C swap, there was a favorable change in fair value of approximately $0.5 million and $1.0 million, respectively, for the years ended September 30, 2015 and 2014 which was recorded in excess of revenue over expenses. No collateral was required under the Y- NHH Series C swap agreement for the years ended September 30, 2015 and 2014.

For the Y-NHH Series D swap, there was an unfavorable change in fair value of approximately $4.2 million and $2.2 million for the years ended September 30, 2015 and 2014, respectively, which was recorded in excess of revenue over expenses. No collateral was required under the Series D swap agreement for the years ended September 30, 2015 and 2014.

In connection with its Series C revenue bonds, GH entered into an interest rate swap agreement (the GH swap) with a financial institution. Under the terms of the GH swap, GH will receive variable interest payments and pay fixed interest payments on a notional value of approximately $24.0 million.

For the GH swap, there was a favorable change in fair value of approximately $0.3 million for the years ended September 30, 2015 and 2014 which was recorded in excess of revenue over expenses. The terms of the swap agreement have not required GH to collateralize funds to be held by the financial institution as of September 30, 2015 and 2014.

(9) Pensions and Postretirement Benefits

The System has qualified and nonqualified defined benefit pension plans covering substantially all employees and executives. The benefits provided are based on age, years of service, and compensation. The System's policy is to fund the pension benefits with at least the minimum amounts required by the Employee Retirement Income Security Act of 1974.

The System also sponsors contributory 403(b) plans and 401(k) plans covering substantially all employees. Employer contributions for certain 403(b), made to a matching 401(a) plan, and 401(k) plans are determined based on employee contributions and years of service. The System contributed approximately $62.0 million and $51.3 million for the years ended September 30, 2015 and 2014, respectively. Amounts due to the defined contribution plans amounted to $28.7 million and $21.7 million at September 30, 2015 and 2014, respectively, and is included in accrued expenses in the accompanying balance sheets.

Y-NHH maintains a Section 457 Nonqualified deferred compensation plan. Contributions are made on a pre-tax basis. The balances recorded at September 30, 2015 and 2014 in other assets and other long-term liabilities were approximately $34.4 million and $32.5 million, respectively.

On June 30, 2006, BH froze its defined benefit plan. On October 1, 2006, BH instituted a defined contribution plan.

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Effective as of December 31, 2006, GH amended its defined benefit pension plan to freeze benefits for employees who were under age 50 with less than five years of service. Effective January 1, 2007, GH began providing a matching contribution and a length of service contribution, in addition to its incentive contribution, for its defined contribution plan for all employees no longer accruing benefits under the defined benefit plan. Employees who were age 50 or older with five years of service continue to accumulate benefits under the defined benefit plan, and do not participate in the defined contribution plan.

Effective September 30, 2013, the Y-NHH qualified defined benefit pension plan and the 401(a) plan were amended to reduce the percentage of compensation contributed by Y-NHH to the qualified defined benefit pension plan and to increase the percentage of compensation contributed by Y-NHH to the 401(a) plan for the plan years commencing after December 1, 2013.

Y-NHH and GH also provide certain health care and life insurance benefits upon retirement to substantially all their employees. Y-NHH's and GH's policy is to fund these annual costs as they are incurred from the general assets of Y-NHH and GH. The estimated cost of these postretirement benefits is actuarially determined and accrued over the employees' service periods.

Included in unrestricted net assets at September 30, 2015 and 2014 are the following amounts that have not yet been recognized in net periodic pension cost: unrecognized prior service credit of approximately $20.4 million and $22.4 million, respectively, and unrecognized actuarial losses of approximately $350.1 million and $308.0 million, respectively. The prior service credit and actuarial loss included in unrestricted net assets and expected to be recognized in net periodic pension cost during the year ending September 30, 2016 are approximately $2.0 million and $17.5 million, respectively.

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The following table sets forth the change in benefit obligations, change in the plans' assets, and the reconciliation of underfunded status of the System's defined benefit plans as of September 30, 2015 and 2014 (in thousands):

	Defined benefit pension plans		Postretirement benefits plan	
	2015	2014	2015	2014
Change in benefit obligation:				
Benefit obligation at prior measurement date	$ 908,910	804,718	78,136	67,904
Service cost	23,106	24,830	3,789	3,617
Interest cost	37,775	38,108	3,393	3,270
Plan amendments	—	—	—	(577)
Actuarial (gain) loss	(5,176)	79,636	(14,067)	5,413
Benefits paid	(42,326)	(38,382)	(1,670)	(1,491)
Benefit obligation at current measurement date	922,289	908,910	69,581	78,136
Change in plans' assets:				
Fair value of assets at prior measurement date	663,472	605,715	—	—
Actual return on plans' assets	(28,974)	45,364	—	—
Employer contributions	57,663	50,775	1,670	1,491
Benefits paid	(42,326)	(38,382)	(1,670)	(1,491)
Fair value of plans' assets at current measurement date	649,835	663,472	—	—
Accrued benefit cost	$ (272,454)	(245,438)	(69,581)	(78,136)

The actuarial loss in 2015 primarily relates to changes in the discount rate and mortality table used to measure the benefit obligation and the actuarial gain in 2014 primarily relates to changes in the discount rate.

(Continued)

The accrued benefit cost included in the consolidated balance sheets includes the following (in thousands):

	Accrued pension and postretirement obligations		Fair value of plans' assets	
	2015	2014	2015	2014
Y-NHH and Subsidiaries – accrued pension and postretirement obligations	$ (230,944)	(233,609)	340,669	347,238
Bridgeport Hospital – accrued pension and postretirement obligations	(68,304)	(58,281)	142,986	145,156
Greenwich Hospital – accrued pension and postretirement obligations	(42,787)	(31,684)	166,180	171,078
	$ (342,035)	(323,574)	649,835	663,472

Benefit Obligation and Assumptions

The projected benefit obligation, accumulated benefit obligation, and fair value of the plans' assets were as follows (in thousands):

	September 30	
	2015	2014
Projected benefit obligation	$ (922,289)	(908,910)
Accumulated benefit obligation	(919,111)	(829,877)
Fair value of plans' assets	649,835	663,472

As of September 30, 2015 and 2014, the underfunded status of the qualified defined benefit pension plans was approximately $222.2 million and $197.6 million, respectively, and that of the nonqualified defined benefit pension plan was approximately $50.2 million and $47.9 million, respectively. Additionally, there are assets limited as to use of approximately $78.8 million and $77.9 million, which are available to satisfy the obligations of the nonqualified defined benefit pension plan at September 30, 2015 and 2014, respectively.

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

The net periodic benefit cost for the years ended September 30, 2015 and 2014 is as follows (in thousands):

	Defined benefit pension plans		Postretirement benefits plan	
	2015	2014	2015	2014
Service cost	$ 23,106	24,830	3,789	3,617
Interest cost	37,775	38,108	3,392	3,270
Expected return on plan assets	(50,700)	(46,357)	—	—
Amortization of prior service cost	(1,951)	(2,029)	(37)	86
Recognized net actuarial loss	18,306	12,147	—	—
Net periodic benefit cost	$ 26,536	26,699	7,144	6,973

Weighted average assumptions used to determine benefit obligations at September 30, 2015 and 2014 are as follows:

	Defined benefit pension plans		Postretirement benefits plan	
	2015	2014	2015	2014
Discount rate for determining benefit obligations at year-end, qualified plan	4.3–4.4%	4.2–4.3%	4.5%	4.4%
Discount rate for determining benefit obligations at year-end, nonqualified plan	4.3%	4.4%	—	—
Rate of compensation increase	2.5–4.0%	2.5–5.0%	—	—

Weighted average assumptions used to determine net periodic benefit cost for the years ended September 30, 2015 and 2014 are as follows:

	Defined benefit pension plans		Postretirement benefits plan	
	2015	2014	2015	2014
Discount rate for determining net periodic benefit cost at year-end, qualified plan	4.2–4.3%	4.8–4.9%	4.4%	4.9%
Discount rate for determining net periodic benefit cost at year-end, nonqualified plan	4.3–4.4%	4.9%	—	—
Expected rate of return on plan assets	6.75–7.75	6.75–7.75	—	—
Rate of compensation increase	2.5–5.0%	3.5–5.0%	—	—

For measurement purposes relating to the postretirement benefits plan, a 4.0% and 5.0% annual rate of increase in the per capita cost of covered health care benefits was assumed for fiscal 2015 and fiscal 2014, respectively. Rates are assumed to decline to 4.5% through fiscal 2016.

(Continued)

Assumed health care cost trend rate assumptions have a significant effect on the amounts reported. A 1% change in the assumed health care cost trend rate would have the following effects (in thousands):

	1% increase	1% decrease
Effect on total of service and interest cost components	$ 50	(59)
Effect on postretirement benefit obligations	335	(381)

The asset allocation of the System's pension plans at September 30, 2015 and 2014, on a combined basis, was as follows:

Asset category	Target allocation 2016	Percentage of assets 2015	2014
Equity securities	42–46	46%	44%
Debt securities	17–21	22	22
All other assets	33–41	32	34
		100%	100%

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

Financial assets carried at fair value, as of September 30, 2015, are classified in the following tables (see note 15 for description) (in thousands):

		Investments measured at NAV	Investments classified in the fair value hierarchy Level 1	Total
Money market funds	$	—	30,477	30,477
U.S. equity securities		75,363	68,016	143,379
International equity securities		96,995	58,733	155,728
Fixed income:				
U.S. government		28,183	36,989	65,172
Corporate debt		—	15,921	15,921
International government		10,776	30,504	41,280
Commodities		10,645	—	10,645
Private equity		17,043	—	17,043
Hedge funds:				
Absolute return		29,438	—	29,438
Multi strategy/other		113,206	—	113,206
Long/short equity		10,453	—	10,453
Real estate		17,093	—	17,093
Total investments	$	409,195	240,640	649,835

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

Financial assets carried at fair value, as of September 30, 2014, are classified in the following tables (see note 15 for description) (in thousands):

		Investments measured at NAV	Investments classified in the fair value hierarchy Level 1	Total
Money market funds	$	—	21,854	21,854
U.S. equity securities		56,742	87,735	144,477
International equity securities		61,143	77,642	138,785
Fixed income:				
U.S. government		42,800	17,018	59,818
Corporate debt		—	50,530	50,530
International government		9,489	32,038	41,527
Commodities		27,993	—	27,993
Private equity		15,267	—	15,267
Hedge funds:				
Absolute return		30,083	—	30,083
Multi strategy/other		104,755	—	104,755
Long/short equity		5,450	—	5,450
Real estate		19,444	3,489	22,933
Total investments	$	373,166	290,306	663,472

There are no pension investments that are measured at fair value based on Level 2 and Level 3 inputs at September 30, 2015 or 2014.

The System's investment strategy for its pension assets balances the liquidity needs of the pension plans with the long-term return goals necessary to satisfy future pension obligations. The target asset allocation seeks to capture the equity premium granted by the capital markets over the long-term while ensuring security of principal to meet near term expenses and obligations through the fixed income allocation. The allocation of the investment pool to various sectors of the markets is designed to reduce volatility in the portfolio.

The System's pension portfolios return assumption of 7.75% is based on the targeted weighted- average return of comparative market indices for the asset classes represented in the portfolio and discounted for pension expenses.

(Continued)

The future cash flows of the System relative to retirement benefits are expected to be as follows (in thousands):

	Defined benefit pension plans	Postretirement benefit plan
Estimated benefit payments related to years ending September 30:		
2016	$ 43,852	2,131
2017	46,301	2,399
2018	49,597	2,606
2019	52,417	2,835
2020	56,199	3,073
2021 to 2025	319,889	20,305

The System expects to make contributions of approximately $51.7 million for pension benefits and approximately $2.1 million for postretirement benefits in fiscal 2016.

(10) Professional Liability Insurance

In 1978, Y-NHH and a number of other academic medical centers formed The Medical Centre Insurance Company Ltd. (the Captive) to insure for professional and comprehensive general liability risks. In 1997, the Captive formed MCIC Vermont, Inc. (MCIC) to write direct insurance for the professional and general liability risks of the shareholders. Since 1997, the Captive has acted as a reinsurer for varying levels of per claim limit exposure. MCIC has reinsurance coverage from outside reinsurers for amounts above the per claim limits. Premiums are based on claims made coverage, and are actuarially determined based on actual experience of the System, the Captive, and MCIC.

Y-NHH controls less than 20% of the Class A stock of MCIC; however, for accounting purposes the investment in the insurance companies is recorded on the equity method because of contractual agreements.

The System entities participate in the Y-NHH insurance program as additional insureds. All System entities initially pay premiums to Y-NHHSC. Y-NHHSC generally assumes the responsibility for ensuring that all the System members pay all premiums owed by them to MCIC. Y-NHHSC manages MCIC's operations for all other System members.

MCIC's policy is to establish retrospective-related premiums for its shareholders equivalent to estimated losses and general and administrative expenses, less estimated investment income, so that its results of operations are breakeven each year. The System accrues premiums as incurred.

The estimate for claims-made professional liabilities and the estimate for incidents that have been incurred but not reported aggregated approximately $180.4 million and $179.4 million at September 30, 2015 and 2014, respectively for the System. The undiscounted estimate for incidents that have been incurred but not reported aggregated approximately $69.1 million and $64.0 million for the System at September 30, 2015

(Continued)

and 2014, respectively, and is included in professional insurance liabilities in the accompanying consolidated balance sheets at the actuarially determined present value of approximately $63.0 million and $57.6 million, respectively, based on a discount rate of 2.0% and 2.50% for the years ended September 30, 2015 and 2014, respectively.

The System has recorded related insurance recoveries receivable of approximately $117.6 million and $121.9 million at September 30, 2015 and 2014, respectively, in consideration of the expected insurance recoveries for the total discounted claims-made insurance. The current portion of professional liabilities and the related insurance receivable represents an estimate of expected settlements and insurance recoveries over the next 12 months.

Lukan, the Y-NHH sponsored professional liability program, continues to manage all incidents and claims reported to Lukan prior to the acquisition of HSR, as well as extending professional liability coverage for post-acquisition risks to certain affiliated community clinicians.

Prior to the 2012 acquisition of HSR, Caritas provided excess professional liability and general liability insurance to HSR and their employed clinicians. Caritas continued to manage all incidents and claims reported prior to the acquisition of HSR and are included in the amounts above.

Caritas and Lukan have recorded the undiscounted estimate for claims-made professional liabilities, and the estimate for incidents that have been incurred but not reported aggregated approximately $29.6 million at September 30, 2014, respectively, and are included in professional liabilities in the accompanying consolidated statements of financial position.

In October 2014, Y-NHH disposed of its interest in Caritas and Lukan (the Captives) through a novation agreement with Medical Centre Insurance Company, Ltd (MCIC) for a total price of approximately $40.2 million. The novation agreement assigns and transfers all of the Captives' past, present and future rights, risks, liabilities and obligations, and transfers substantially all of the assets of the Captives to MCIC. Y-NHH dissolved the Captives in the fiscal year ended September 30, 2015.

The System's estimates for professional insurance liabilities are based upon complex actuarial calculations which utilize factors such as historical claims experience for the System and related industry factors, trending models, estimates for the payment patterns of future claims and present value discount factors. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Revisions to estimated amounts resulting from actual experience differing from projected expectations are recorded in the period the information becomes known or when changes are anticipated.

(Continued)

(11) Commitments and Contingencies

(a) Leases

The System leases various equipment and properties under several noncancelable operating leases that range in terms. The System is responsible for operating expenses, as defined, during the lease terms. Future minimum lease payments under these leases are as follows (in thousands):

2016	$	43,537
2017		37,894
2018		32,653
2019		30,510
2020		14,611
Thereafter		137,229
	$	296,434

The System incurred rent expense under these leases of approximately $51.3 million and $33.0 million for the years ended September 30, 2015 and 2014, respectively.

(b) Cancer Hospital

Y-NHH has a shared facilities and services agreement with the University in connection with the Cancer Hospital which is recorded as deferred revenue. Deferred revenue, from this agreement, at September 30, 2015 and 2014 was approximately $42.7 million and $44.0 million, respectively.

(c) Inpatient Rehabilitation Unit Agreement

During September 2014, Y-NHH entered into an agreement with another health care provider to provide a framework for implementing programs in a manner that is consistent with the charitable mission of each organization and the communities they serve. Under the terms of the agreement, Y-NHH will utilize beds at the health care provider's location under a lease arrangement to provide inpatient rehabilitation services to its patients. In addition, Y-NHH will furnish an $8.0 million term loan to the health care provider.

(d) Litigation

Various lawsuits and claims arising in the normal course of operations are pending, or are in progress against the System. Such lawsuits and claims are either specifically covered by insurance as explained in note 10, or are deemed immaterial. While the outcomes of the lawsuits and claims cannot be determined at this time, management believes that any loss which may arise from these actions will not have a material adverse effect on the consolidated financial position or changes in net assets of the System.

The System has received requests for information from certain governmental agencies relating to, among other things, patient billings. These requests cover several prior years relating to compliance with certain laws and regulations. Management is cooperating with those governmental agencies in their information requests and ongoing investigations. The ultimate results of those investigations, including the impact on the System, cannot be determined at this time.

(Continued)

(e) Affiliation Agreement

In July 2015, YNHHS entered into an affiliation agreement with Lawrence + Memorial Corporation and Subsidiaries (L+M) and its medical foundation. Under the affiliation agreement, L+M and Westerly Hospital would each continue to operate as separate Hospitals under YNHHS with YNHHS committing to make investments for various clinical specialties, primary care, and other strategic investments. During the regulatory approval process, the Connecticut Office of Health Care Access (OHCA), and the Office of the Attorney General, along with the State of Rhode Island and the Federal Trade Commission will review the proposed transaction. Upon completion of the regulatory review process, and upon receipt of the required regulatory approvals, the proposed transaction will be completed.

(12) Functional Expenses

The System provides general acute health care services to residents within its geographic areas. Net expenses related to providing these services are as follows (in thousands):

	Year ended September 30	
	2015	2014
Health care services	$ 2,589,819	2,374,449
General and administrative	852,805	850,125
	$ 3,442,624	3,224,574

(13) Other Revenue

Other revenue consisted of the following (in thousands):

	Year ended September 30	
	2015	2014
Cafeteria and vending	$ 14,673	13,676
Contributions	3,406	5,495
Parking income	9,241	7,902
Net assets released from restrictions for operations	21,196	13,178
Net assets released from restrictions for free care	596	613
Net assets released from restrictions for medical research and clinical programs	881	5,269
Grants	20,168	19,533
Rental income	3,304	3,896
Electronic health records incentive payment	3,973	9,231
Foundation distributed income	2,820	2,532
Other	29,337	25,669
	$ 109,595	106,994

(Continued)

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2012 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement, or upgrade certified EHR technology. In subsequent years, providers must demonstrate meaningful use of such technology to qualify for additional Medicaid incentive payments. Hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to payment penalties or downward adjustments to their Medicare payments beginning in federal fiscal year 2015.

The System uses a grant accounting model to recognize revenue for the Medicare and Medicaid EHR incentive payments. Under this accounting policy, EHR incentive payment revenue is recognized when the System is reasonably assured that the EHR meaningful use criteria for the required period of time were met and that the grant revenue will be received. Medicare EHR incentive payment revenue was approximately $4.0 million and $7.4 million for the years ended September 30, 2015 and 2014, respectively, and Medicaid EHR incentive payment revenue was approximately $1.8 million for the year ended September 30, 2014. EHR incentive payment revenue is included in other revenue in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment upon final settlement of the applicable cost report from which payments were calculated. Additionally, the System's attestation of compliance with the meaningful use criteria is subject to audit by the federal government.

(14) Non-operating Gains and Losses, Net

Nonoperating gains and losses consisted of the following (in thousands):

	Year ended September 30	
	2015	2014
Income from investments, donations and other, net	$ 5,099	3,103
Income attributable to noncontrolling interest	(5,522)	(5,992)
Change in unrealized gains and losses on investments	14,536	86,913
Change in fair value of swap, including counterparty payments	(29,678)	(17,204)
Loss on refunding of long-term debt	—	(32,631)
	$ (15,565)	34,189

(Continued)

Contributions received consisted of the following (in thousands):

	2015	2014
Unrestricted contributions	$ 4,360	3,966
Temporarily restricted contributions	28,157	24,185
Permanently restricted contributions	15,176	5,372
Total contributions	47,693	33,523
Less fundraising costs	(9,402)	(9,473)
	$ 38,291	24,050

During 2015, the Attorney General approved the transfer of certain philanthropic funds to Y-NHH from the Hospital of Saint Raphael and its Foundation related to Y-NHH's acquisition of the Hospital of Saint Raphael in FY 2012. The funds approved for transfer are included as contributions to temporarily restricted net assets and permanently restricted net assets totaling $8.8 million and $11.5 million, respectively, for the year ended September 30, 2015.

(15) Fair Values of Financial Instruments

In determining fair value, the System utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. The System also considers nonperformance risk in the overall assessment of fair value

ASC No. 820-10 establishes a three-tier valuation hierarchy for fair value disclosure purposes. This hierarchy is based on the transparency of the inputs utilized for the valuation. The three levels are defined as follows:

Level 1: Quoted prices in active markets that are accessible at the measurement date for identical assets or liabilities. This established hierarchy assigns the highest priority to Level 1 assets.

Level 2: Observable inputs that are based on data not quoted in active markets, but corroborated by market data.

Level 3: Unobservable inputs that are used when little or no market data is available. The inputs are assigned the lowest priority.

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

Financial assets carried at fair value as of September 30, 2015 are classified in the following table by level within the fair value hierarchy as described above (in thousands):

	September 30			
	Investments measured at NAV	Investments classified in the fair value hierarchy		
		Level 1	Level 2	Total
Cash and cash equivalents	$ —	194,946	—	194,946
Money market funds	—	130,047	—	130,047
Private equity	7,489	—	—	7,489
U.S. equity securities	31,174	73,618	—	104,792
International equity securities	47,463	58,013	—	105,476
Fixed income:				
U.S. government	288,508	129,327	—	417,835
Corporate bonds	—	4,945	—	4,945
International government	42,470	55,237	—	97,707
Hedge Funds:				
Absolute return	21,909	—	—	21,909
Long/short equity	6,936	—	—	6,936
Perpetual trusts	32,649	—	—	32,649
Commodities	1,595		—	1,595
Real estate	8,241	37	—	8,278
Interest in Yale University endowment pool	855,264	—	—	855,264
Total investments	$ 1,343,698	646,170	—	1,989,868
Liabilities:				
Interest rate swaps	$ —	—	(54,707)	(54,707)

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)
Notes to Consolidated Financial Statements
September 30, 2015 and 2014

Financial assets carried at fair value as of September 30, 2014 are classified in the following table by level within the fair value hierarchy as described above (in thousands):

	September 30			
	Investments measured at NAV	Investments classified in the fair value hierarchy		
		Level 1	Level 2	Total
Cash and cash equivalents	$ —	161,059	—	161,059
Money market funds	—	212,529	—	212,529
Private equiy	8,272	—	—	8,272
U.S. equity securities	31,816	65,919	—	97,735
International equity securities	44,107	72,528	—	116,635
Fixed income:				
U.S. government	153,973	147,701	—	301,674
Corporate bonds	—	27,097	—	27,097
Mortgage backed securities	—	24		24
International government	34,321	51,839	—	86,160
Hedge Funds:				
Absolute return	22,310	—	—	22,310
Long/short equity	2,460	—	—	2,460
Perpetual trusts	34,296	—	—	34,296
Commodities	2,640	76	—	2,716
Real estate	11,241	44	—	11,285
Interest in Yale University endowment pool	752,731	—	—	752,731
Total investments	$ 1,098,167	738,816	—	1,836,983
Liabilities:				
Interest rate swaps	$ —	—	(36,134)	(36,134)

The amounts reported in the tables as detailed above do not include assets invested in the System's defined benefit pension plan. The beneficial interest in remainder trust listed in the above tables are included in other assets. The interest rate swaps listed above are classified in the accompanying consolidated balance sheets as "other long-term liabilities" at September 30, 2015 and 2014. There are no assets or liabilities that are measured at fair value based on Level 3 inputs at September 30, 2015 or 2014.

(Continued)

The following is a summary of total investments as of September 30, 2015, with restrictions to redeem the investments at the measurement date, any unfunded capital commitments and investment strategies of the investees (in thousands):

Description of investment	Carrying value	Unfunded commitments	Redemption frequency	Notice period	Funds availability
Private equity	$ 7,489	$ 4,150	N/A	N/A	N/A
Global equity	33,887	N/A	30 days	2 years	N/A
Hedge funds:					
Absolute return	11,494	N/A	N/A	N/A	N/A
Long/short equity	6,936	N/A			
Real estate	6,781	2,295	N/A	N/A	N/A
Commodities	82	N/A	N/A	N/A	N/A
	$ 66,669				

The fair value of long-term debt was approximately $934.5 million and $934.3 million at September 30, 2015 and 2014, respectively. The fair value of the capital leases was approximately $112.5 million and $74.7 million at September 30, 2015 and 2014, respectively.

(16) Subsequent Events

Management has evaluated subsequent events through December 23, 2015, which is the date the consolidated financial statements were issued. No other events have occurred that require disclosure or adjustment to the consolidated financial statements.

SUPPLEMENTARY INFORMATION

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidating Balance Sheet

September 30, 2015

(In thousands)

Assets	Yale-New Haven Health Services Corporation	NEMG	Yale-New Haven Hospital and Subsidiaries	Bridgeport Hospital and Subsidiaries	Eliminations	Obligated Group	Greenwich Health Care Services, Inc. and Subsidiaries	Other Non-Obligated Entities	Eliminations	Total
Current assets:										
Cash and cash equivalents	$ 24,322	8,523	103,628	26,867	—	163,340	31,360	2,071	(1,825)	194,946
Short-term investments	10,116		980,087	97,808	—	1,088,011	72,659	—	—	1,160,670
Accounts receivable for services to patients, less allowance for uncollectible accounts	—	16,401	293,352	54,662	—	364,415	41,279	5,017	(5,017)	405,694
Professional liabilities insurance recoveries receivable – current portion	—	—	19,852	6,009	—	25,861	6,309	—	—	32,170
Other current assets	111,267	2,923	110,628	18,059	(147,426)	95,451	13,857	7,569	(25,337)	91,540
Amounts on deposit with trustee in debt service fund	—	—	4,786	679	—	5,465	—	—	—	5,465
Total current assets	145,705	27,847	1,512,333	204,084	(147,426)	1,742,543	165,464	14,657	(32,179)	1,890,485
Assets limited as to use			96,888	1,160		98,048	108,271	—	—	206,319
Long-term investments	11,201	—	289,434	55,382	—	356,017	64,783	—	—	420,800
Deferred financing costs, less accumulated amortization	9,608	—	8,909	1,196	(9,608)	10,105	389	—	—	10,494
Professional liabilities insurance recoveries receivable – noncurrent	—	—	57,025	18,161	—	75,186	10,208	—	—	85,394
Goodwill	52,050	267	44,774	17,217	—	114,308	—	—	—	114,308
Other assets	952,268	2,081	169,842	24,439	(943,369)	205,261	12,522	10,741	(17,369)	211,155
Property, plant, and equipment, net	133,699	5,230	865,507	142,041	—	1,146,477	242,270	6,372	(6,372)	1,388,747
Construction in progress	1,647	55	80,774	69,785	—	152,261	4,840	—	—	157,101
	135,346	5,285	946,281	211,826	—	1,298,738	247,110	6,372	(6,372)	1,545,848
Total assets	$ 1,306,178	35,480	3,125,486	533,465	(1,100,403)	3,900,206	608,747	31,770	(55,920)	4,484,803

See accompanying notes to consolidated financial statements.

Liabilities and Net Assets	Yale-New Haven Health Services Corporation	NEMG	Yale-New Haven Hospital and Subsidiaries	Bridgeport Hospital and Subsidiaries	Eliminations	Obligated Group	Greenwich Health Care Services, Inc. and Subsidiaries	Other Non-Obligated Entities	Eliminations	Total
Current liabilities:										
Accounts payable and accrued expenses	$ 77,718	28,093	352,360	68,978	(49,033)	478,116	33,068	4,252	(15,553)	499,883
Current portion of long-term debt	7,930	—	8,083	6,123	(7,930)	14,206	2,675	—	—	16,881
Current portion of capital lease obligation	—	—	2,003	47	—	2,050	—	—	—	2,050
Professional liabilities – current portion	—	—	19,852	6,009	—	25,861	6,309	—	—	32,170
Other current liabilities	—	3,256	59,087	15,856	—	78,199	14,667	157	(157)	92,866
Total current liabilities	85,648	31,349	441,385	97,013	(56,963)	598,432	56,719	4,409	(15,710)	643,850
Long-term debt, net of current portion	824,431	—	800,348	73,372	(824,431)	873,720	32,430	—	—	906,150
Long-term capital lease obligations, net of current portion	—	—	46,850	60,309	—	107,159	—	—	—	107,159
Accrued pension and postretirement benefit obligations	8,858	—	228,810	68,304	(8,858)	297,114	42,787	—	—	339,901
Professional liabilities - noncurrent	—	—	96,778	33,706	—	130,484	17,819	—	—	148,303
Other long-term liabilities	231,347	—	246,389	31,334	(210,151)	298,919	18,993	8,950	(22,061)	304,801
Deferred revenue	—	—	42,720	—	—	42,720	—	—	—	42,720
Total liabilities	1,150,284	31,349	1,903,280	364,038	(1,100,403)	2,348,548	168,748	13,359	(37,771)	2,492,884
Net assets:										
Unrestricted	155,894	4,131	1,104,379	111,706	—	1,376,110	374,623	18,411	(18,149)	1,750,995
Temporarily restricted	—	—	70,941	34,845	—	105,786	41,782	—	—	147,568
Permanently restricted	—	—	46,886	22,876	—	69,762	23,594	—	—	93,356
Total net assets	155,894	4,131	1,222,206	169,427	—	1,551,658	439,999	18,411	(18,149)	1,991,919
Total liabilities and net assets	$ 1,306,178	35,480	3,125,486	533,465	(1,100,403)	3,900,206	608,747	31,770	(55,920)	4,484,803

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidating Statement of Operations and Changes in Net Assets

Year ended September 30, 2015

(In thousands)

	Yale New Haven Health Services Corporation and Subsidiaries	NEMG	Yale New Haven Hospital and Subsidiaries	Bridgeport Hospital and Subsidiaries	Eliminations	Obligated Group	Greenwich Health Care Services, Inc. and Subsidiaries	Other Non-Obligated Entities	Eliminations	Total
Operating revenue:										
Net patient service revenue	$ —	179,723	2,540,863	481,491	—	3,202,077	372,136	21,049	(21,049)	3,574,213
Less provision for bad debts, net	—	(3,245)	(50,382)	(15,417)	—	(69,044)	(12,484)	(176)	176	(81,528)
Net patient service revenue, less provision for bad debts	—	176,478	2,490,481	466,074	—	3,133,033	359,652	20,873	(20,873)	3,492,685
Other revenue	437,230	105,528	64,677	35,110	(484,510)	158,035	13,726	6,370	(68,536)	109,595
Total operating revenue	437,230	282,006	2,555,158	501,184	(484,510)	3,291,068	373,378	27,243	(89,409)	3,602,280
Operating expenses:										
Salaries and benefits	235,621	185,498	1,070,626	207,206	5,766	1,704,717	153,755	7,135	(7,135)	1,858,472
Supplies and other expenses	108,957	140,109	1,214,194	198,316	(418,365)	1,243,211	165,581	11,513	(76,088)	1,344,217
Depreciation and amortization	52,877	3,145	120,235	31,204	(41,616)	165,845	25,119	882	(5,902)	185,944
Insurance	32,133	7,185	17,162	6,864	(30,295)	33,049	1,959	153	(5,358)	29,803
Interest	—	—	20,826	3,048	—	23,874	314	130	(130)	24,188
Total operating expenses	429,588	335,937	2,443,043	446,638	(484,510)	3,170,696	346,728	19,813	(94,613)	3,442,624
Income (loss) from operations	7,642	(53,931)	112,115	54,546	—	120,372	26,650	7,430	5,204	159,656
Nonoperating gains (losses), net:										
Income from investments, donations and other, net	11,913	—	21,949	944	—	34,806	(8,040)	(4,206)	(8,447)	14,113
Change in fair value of swap, including counter party payments	—	—	(28,248)	—	—	(28,248)	(1,430)	—	—	(29,678)
Excess (deficiency) of revenue over expenses	19,555	(53,931)	105,816	55,490	—	126,930	17,180	3,224	(3,243)	144,091
Unrestricted net assets:										
Other changes in net assets	—	—	(370)	(16)	—	(386)	4	196	(196)	(382)
Transfer to NEMG	(13,652)	53,931	(12,516)	(27,763)	—	—	—	—	—	—
Net assets released from restrictions for purchases of fixed assets	—	—	4,515	1,242	—	5,757	1,585	—	—	7,342
Pension related changes other than net periodic benefit cost	—	—	(12,372)	(18,998)	—	(31,370)	(12,742)	—	—	(44,112)
Increase (decrease) in unrestricted net assets	5,903	—	85,073	9,955	—	100,931	6,027	3,420	(3,439)	106,939

(Continued)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(d/b/a Yale New Haven Health System and Subsidiaries)

Consolidating Statement of Operations and Changes in Net Assets

Year ended September 30, 2015

(In thousands)

	Yale New Haven Health Services Corporation and Subsidiaries	NEMG	Yale New Haven Hospital and Subsidiaries	Bridgeport Hospital and Subsidiaries	Eliminations	Obligated Group	Greenwich Health Care Services, Inc. and Subsidiaries	Other Non-Obligated Entities	Eliminations	Total
Temporarily restricted net assets:										
Income from investments	—	—	298		—	298	1,936	—	—	2,234
Net realized and unrealized gains on investments	—	—	2,651	1,448	—	4,099	(2,764)	—	—	1,335
Bequests and contributions	—	—	17,989	7,377	—	25,366	4,970	—	—	30,336
Net assets released from restrictions for purchases of fixed assets	—	—	(3,123)	(1,242)	—	(4,365)	(1,585)	—	—	(5,950)
Net assets released from restrictions for operations	—	—	(9,854)	(6,559)	—	(16,413)	(4,783)	—	—	(21,196)
Net assets released from restrictions for clinical programs	—	—	(1,477)		—	(1,477)	—	—	—	(1,477)
Other changes in net assets	—	—	139	542	—	681	(107)	—	—	574
Increase (decrease) in temporarily restricted net assets	—	—	6,623	1,566	—	8,189	(2,333)	—	—	5,856
Permanently restricted net assets:										
Bequests and contributions	—	—	13,654	1,133	—	14,787	388	—	—	15,175
Net assets released from restrictions for purchases of fixed assets	—	—	(1,392)		—	(1,392)	—	—	—	(1,392)
Net realized and unrealized on investments	—	—	—		—	—	(1)	—	—	(1)
Changes in beneficial interest in perpetual trusts	—	—	(1,282)	—	—	(1,282)	—	—	—	(1,282)
Increase in permanently restricted net assets	—	—	10,980	1,133	—	12,113	387	—	—	12,500
Increase (decrease) in net assets	5,903	—	102,676	12,654	—	121,233	4,081	3,420	(3,439)	125,295
Net assets at beginning of year	149,991	4,131	1,119,530	156,773	—	1,430,425	435,918	14,991	(14,710)	1,866,624
Net assets at end of year	$ 155,894	4,131	1,222,206	169,427	—	1,551,658	439,999	18,411	(18,149)	1,991,919

See accompanying notes to consolidated financial statements.

ATTACHMENT VII

FINANCIAL WORKSHEETS REVISED TO INCLUDE FY 2015

NON-PROFIT

Applicant: Yale New Haven Health System

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
LINE	**Total Entity:**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Actual**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$11,767,479,000	$12,297,456,000	$13,374,327,000	$599,124,000	$13,973,451,000	$13,298,161,000	$1,254,311,000	$14,552,472,000	$13,330,316,000	$1,319,830,000	$14,650,146,000	$13,379,236,000	$1,386,537,000	$14,765,773,000
2	Less: Allowances	$8,157,566,000	$8,473,579,000	$9,395,854,000	$346,059,000	$9,741,913,000	$9,333,090,000	$741,688,000	$10,074,778,000	$9,331,729,000	$797,652,000	$10,129,381,000	$9,346,867,000	$858,637,000	$10,205,504,000
3	Less: Charity Care	$139,796,000	$127,264,000	$147,836,000	$3,768,000	$151,604,000	$148,923,000	$7,888,000	$156,811,000	$149,896,000	$8,300,000	$158,196,000	$150,878,000	$8,719,000	$159,597,000
4	Less: Other Deductions	$58,682,000	$122,400,000	$182,106,000	$9,101,000	$191,207,000	$182,106,000	$18,202,000	$200,308,000	$182,106,000	$18,202,000	$200,308,000	$182,106,000	$18,202,000	$200,308,000
	Net Patient Service Revenue	**$3,411,435,000**	**$3,574,213,000**	**$3,648,531,000**	**$240,196,000**	**$3,888,727,000**	**$3,634,042,000**	**$486,533,000**	**$4,120,575,000**	**$3,666,585,000**	**$495,676,000**	**$4,162,261,000**	**$3,699,385,000**	**$500,979,000**	**$4,200,364,000**
5	Medicare	$1,102,618,000	$1,156,905,000	$1,198,850,000	$86,990,000	$1,285,840,000	$1,183,306,000	$175,699,000	$1,359,005,000	$1,189,982,000	$178,902,000	$1,368,884,000	$1,195,809,000	$180,751,000	$1,376,560,000
6	Medicaid	$391,367,000	$410,636,000	$425,524,000	$25,955,000	$451,479,000	$420,006,000	$52,423,000	$472,429,000	$422,376,000	$53,378,000	$475,754,000	$424,444,000	$53,930,000	$478,374,000
7	CHAMPUS & TriCare	$10,732,000	$11,261,000	$11,669,000	$6,715,000	$18,384,000	$11,518,000	$13,563,000	$25,081,000	$11,583,000	$13,810,000	$25,393,000	$11,639,000	$13,953,000	$25,592,000
8	Other	($55,517,000)	($122,400,000)	($182,106,000)	($9,101,000)	($191,207,000)	($182,106,000)	($18,202,000)	($200,308,000)	($182,106,000)	($18,202,000)	($200,308,000)	($182,106,000)	($18,202,000)	($200,308,000)
	Total Government	**$1,449,200,000**	**$1,456,402,000**	**$1,453,937,000**	**$110,559,000**	**$1,564,496,000**	**$1,432,724,000**	**$223,483,000**	**$1,656,207,000**	**$1,441,835,000**	**$227,888,000**	**$1,669,723,000**	**$1,449,786,000**	**$230,432,000**	**$1,680,218,000**
9	Commercial Insurers	$1,840,390,000	$1,989,967,000	$2,062,116,000	$116,568,000	$2,178,684,000	$2,070,557,000	$235,268,000	$2,305,825,000	$2,093,250,000	$239,550,000	$2,332,800,000	$2,117,455,000	$242,023,000	$2,359,478,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$97,042,000	$101,820,000	$105,512,000	$5,371,000	$110,883,000	$104,144,000	$10,848,000	$114,992,000	$104,731,000	$11,046,000	$115,777,000	$105,244,000	$11,160,000	$116,404,000
12	Workers Compensation	$24,803,000	$26,024,000	$26,968,000	$4,635,000	$31,603,000	$26,618,000	$9,362,000	$35,980,000	$26,768,000	$9,533,000	$36,301,000	$26,899,000	$9,631,000	$36,530,000
13	Other	$0	$0	$0	$3,064,000	$3,064,000	$0	$7,573,000	$7,573,000	$0	$7,659,000	$7,659,000	$0	$7,733,667	$7,733,667
	Total Non-Government	**$1,962,235,000**	**$2,117,811,000**	**$2,194,596,000**	**$129,638,000**	**$2,324,234,000**	**$2,201,319,000**	**$263,051,000**	**$2,464,370,000**	**$2,224,749,000**	**$267,788,000**	**$2,492,537,000**	**$2,249,598,000**	**$270,547,667**	**$2,520,145,667**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$3,411,435,000**	**$3,574,213,000**	**$3,648,533,000**	**$240,197,000**	**$3,888,730,000**	**$3,634,043,000**	**$486,534,000**	**$4,120,577,000**	**$3,666,584,000**	**$3,666,584,000**	**$7,333,168,000**	**$3,699,384,000**	**$500,979,667**	**$4,200,363,667**
14	Less: Provision for Bad Debts	$123,743,000	$81,528,000	$105,127,000	$8,820,000	**$113,947,000**	$105,887,000	$17,537,000	**$123,424,000**	$106,583,000	$17,654,000	**$124,237,000**	$107,286,000	$17,664,000	**$124,950,000**
	Net Patient Service Revenue less provision for bad debts	**$3,287,692,000**	**$3,492,685,000**	**$3,543,404,000**	**$231,376,000**	**$3,774,780,000**	**$3,528,155,000**	**$468,996,000**	**$3,997,151,000**	**$3,560,002,000**	**$478,022,000**	**$4,038,024,000**	**$3,592,099,000**	**$483,315,000**	**$4,075,414,000**
15	Other Operating Revenue	$87,934,000	$88,397,523	$112,600,000	$9,313,000	**$121,913,000**	$115,978,000	$18,625,000	**$134,603,000**	$119,457,000	$18,625,000	**$138,082,000**	$123,040,000	$18,625,000	**$141,665,000**
17	Net Assets Released from Restrictions	$19,060,000	$21,197,477	$0		**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	TOTAL OPERATING REVENUE	**$3,394,686,000**	**$3,602,280,000**	**$3,656,004,000**	**$240,689,000**	**$3,896,693,000**	**$3,644,133,000**	**$487,621,000**	**$4,131,754,000**	**$3,679,459,000**	**$496,647,000**	**$4,176,106,000**	**$3,715,139,000**	**$501,940,000**	**$4,217,079,000**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$1,366,381,000	$1,434,450,000	$1,471,076,000	$111,777,000	$1,582,853,000	$1,464,693,000	$220,020,000	$1,684,713,000	$1,494,063,000	$222,920,000	$1,716,983,000	$1,525,348,000	$225,493,000	$1,750,841,000
2	Fringe Benefits	$377,757,000	$424,022,000	$434,848,000	$31,756,000	$466,604,000	$429,113,000	$61,230,000	$490,343,000	$436,279,000	$61,774,000	$498,053,000	$445,533,000	$62,181,000	$507,714,000
3	Physicians Fees	$548,304,000	$565,197,000	$589,037,000	$22,261,000	$611,298,000	$597,313,000	$33,966,000	$631,279,000	$618,512,000	$34,176,000	$652,688,000	$640,614,000	$34,535,000	$675,149,000
4	Supplies and Drugs	$474,136,000	$481,650,000	$493,629,000	$38,648,000	$532,277,000	$496,851,000	$78,195,000	$575,046,000	$510,533,000	$80,226,000	$590,759,000	$525,236,000	$81,646,000	$606,882,000
5	Depreciation and Amortization	$192,072,000	$185,944,000	$197,286,000	$14,369,000	$211,655,000	$199,607,000	$30,394,000	$230,001,000	$193,522,000	$30,785,000	$224,307,000	$193,657,000	$31,804,000	$225,461,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$26,917,000	$24,188,000	$44,341,000	$1,684,000	$46,025,000	$45,505,000	$3,168,000	$48,673,000	$49,426,000	$3,001,000	$52,427,000	$48,812,000	$2,755,000	$51,567,000
8	Malpractice Insurance Cost	$9,731,000	$29,803,000	$38,435,000	$8,417,000	$46,852,000	$39,448,000	$16,833,000	$56,281,000	$41,316,000	$16,863,000	$58,179,000	$43,232,000	$16,840,000	$60,072,000
9	Lease Expense	$30,893,000	$31,740,000	$33,079,000	$3,982,000	$37,061,000	$32,940,000	$7,964,000	$40,904,000	$33,531,000	$7,985,000	$41,516,000	$34,163,000	$7,969,000	$42,132,000
10	Other Operating Expenses	$198,384,000	$265,629,000	$285,171,000	$8,494,000	$293,665,000	$230,956,000	$21,282,000	$252,238,000	$195,238,000	$21,858,000	$217,096,000	$150,242,000	$22,319,000	$172,561,000
	TOTAL OPERATING EXPENSES	**$3,224,575,000**	**$3,442,624,000**	**$3,586,902,000**	**$241,388,000**	**$3,828,290,000**	**$3,536,426,000**	**$473,052,000**	**$4,009,478,000**	**$3,572,420,000**	**$479,588,000**	**$4,052,008,000**	**$3,606,837,000**	**$485,542,000**	**$4,092,379,000**
	INCOME/(LOSS) FROM OPERATIONS	**$170,111,000**	**$159,656,000**	**$69,102,000**	**($699,000)**	**$68,403,000**	**$107,707,000**	**$14,569,000**	**$122,276,000**	**$107,039,000**	**$17,059,000**	**$124,098,000**	**$108,302,000**	**$16,398,000**	**$124,700,000**
	NON-OPERATING REVENUE	$34,189,000	($29,663,887)	$34,997,000	$4,429,000	**$39,426,000**	$49,298,000	$8,859,000	**$58,157,000**	$49,420,000	$8,859,000	**$58,279,000**	$49,533,000	$8,859,000	**$58,392,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$204,300,000**	**$129,992,113**	**$104,099,000**	**$3,730,000**	**$107,829,000**	**$157,005,000**	**$23,428,000**	**$180,433,000**	**$156,459,000**	**$25,918,000**	**$182,377,000**	**$157,835,000**	**$25,257,000**	**$183,092,000**
	Principal Payments	$8,008,000	$16,472,000	$19,196,000	$2,755,000	**$21,951,000**	$20,027,000	$5,726,000	**$25,753,000**	$19,942,000	$5,911,000	**$25,853,000**	$21,957,000	$6,137,000	**$28,094,000**
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**5.0%**	**4.5%**	**1.9%**	**-0.3%**	**1.8%**	**3.0%**	**3.0%**	**3.0%**	**3.0%**	**3.4%**	**3.0%**	**3.0%**	**3.3%**	**3.0%**
2	Hospital Non Operating Margin	**1.0%**	**-0.8%**	**1.0%**	**1.8%**	**1.0%**	**1.4%**	**1.8%**	**1.4%**	**1.3%**	**1.8%**	**1.4%**	**1.3%**	**1.8%**	**1.4%**
3	Hospital Total Margin	**6.0%**	**3.6%**	**2.8%**	**1.5%**	**2.8%**	**4.3%**	**4.8%**	**4.4%**	**4.3%**	**5.2%**	**4.4%**	**4.2%**	**5.0%**	**4.3%**
D.	**FTEs**	**16,037**	**16,230**	**16,322**	**1,411**	**17,733**	**16,382**	**2,712**	**19,094**	**16,418**	**2,704**	**19,122**	**16,454**	**2,704**	**19,158**
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	**109,275**	**111,563**	**115,101**	**8,833**	**123,934**	**116,139**	**17,474**	**133,613**	**116,960**	**17,474**	**134,434**	**117,790**	**17,508**	**135,298**
2	Outpatient Visits	**1,754,308**	**1,857,501**	**1,828,007**	**313,826**	**2,141,833**	**1,843,660**	**632,244**	**2,475,904**	**1,859,472**	**637,543**	**2,497,015**	**1,875,446**	**640,471**	**2,515,917**
	TOTAL VOLUME	**1,863,583**	**1,969,064**	**1,943,108**	**322,658**	**2,265,766**	**1,959,799**	**649,718**	**2,609,517**	**1,976,432**	**655,017**	**2,631,449**	**1,993,236**	**657,979**	**2,651,215**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

LINE	Total Entity:L+M Hospital	FY 2014 Actual	FY 2015 Actual	FY 2016 Projected	FY 2016 Projected	FY 2016 Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$795,287,303	$843,024,228	$860,182,747	$14,094,145	$874,276,892	$894,590,057	$37,459,572	$932,049,629	$930,373,659	$53,320,158	$983,693,817	$967,588,605	$68,907,570	$1,036,496,176
2	Less: Allowances	$450,251,022	$485,513,042	$487,243,916	$8,281,757	$495,525,673	$521,291,544	$22,590,447	$543,881,991	$553,773,091	$32,780,153	$586,553,244	$590,539,350	$43,351,970	$633,891,321
3	Less: Charity Care	$5,449,069	$5,427,817	$5,893,713	$96,569	$5,990,282	$6,374,640	$266,928	$6,641,568	$6,894,811	$395,145	$7,289,956	$7,457,427	$531,086	$7,988,514
4	Less: Other Deductions	$2,458,020	$12,801,007	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787
	Net Patient Service Revenue	**$337,129,192**	**$339,282,362**	**$348,843,331**	**$5,715,818**	**$354,559,149**	**$348,722,086**	**$14,602,197**	**$363,324,283**	**$351,503,970**	**$20,144,860**	**$371,648,830**	**$351,390,041**	**$25,024,513**	**$376,414,554**
5	Medicare	$116,154,499	$120,428,761	$123,580,930	$1,924,467	$125,505,397	$123,539,459	$4,916,434	$128,455,893	$124,490,992	$6,782,601	$131,273,593	$124,452,023	$8,425,538	$132,877,561
6	Medicaid	$36,747,588	$38,099,829	$39,097,075	$608,840	$39,705,915	$39,083,955	$1,555,403	$40,639,358	$39,384,989	$2,145,799	$41,530,788	$39,372,661	$2,665,572	$42,038,233
7	CHAMPUS & TriCare	$10,981,081	$11,385,164	$11,683,166	$181,936	$11,865,102	$11,679,245	$464,793	$12,144,038	$11,769,202	$641,217	$12,410,419	$11,765,518	$796,538	$12,562,056
8	Other	($2,458,020)	($12,801,007)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)
	Total Government	**$161,425,149**	**$157,112,747**	**$156,159,384**	**$2,715,243**	**$158,874,627**	**$156,100,872**	**$6,936,630**	**$163,037,502**	**$157,443,396**	**$9,569,618**	**$167,013,013**	**$157,388,414**	**$11,887,649**	**$169,276,063**
9	Commercial Insurers	$163,214,231	$169,220,201	$173,649,464	$2,704,160	$176,353,624	$173,591,191	$6,908,316	$180,499,507	$174,928,235	$9,530,556	$184,458,791	$174,873,478	$11,839,126	$186,712,603
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,131,510	$5,320,340	$5,459,598	$85,020	$5,544,617	$5,457,766	$217,200	$5,674,965	$5,499,803	$299,644	$5,799,447	$5,498,081	$372,226	$5,870,307
12	Workers Compensation	$7,358,302	$7,629,074	$7,828,761	$121,914	$7,950,675	$7,826,134	$311,452	$8,137,586	$7,886,413	$429,673	$8,316,086	$7,883,944	$533,752	$8,417,696
13	Other	$0	$0	$5,746,124	$89,482	$5,835,606	$5,746,124	$228,599	$5,974,723	$5,746,124	$315,370	$6,061,494	$5,746,124	$391,761	$6,137,885
	Total Non-Government	**$175,704,043**	**$182,169,615**	**$192,683,947**	**$3,000,575**	**$195,684,522**	**$192,621,214**	**$7,665,567**	**$200,286,781**	**$194,060,574**	**$10,575,243**	**$204,635,817**	**$194,001,627**	**$13,136,865**	**$207,138,492**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$337,129,192**	**$339,282,362**	**$348,843,331**	**$5,715,818**	**$354,559,149**	**$348,722,086**	**$14,602,197**	**$363,324,283**	**$351,503,970**	**$20,144,860**	**$371,648,830**	**$351,390,041**	**$25,024,513**	**$376,414,554**
14	Less: Provision for Bad Debts	$14,930,302	$12,821,337	$13,803,283	$210,310	$14,013,593	$13,798,485	$537,280	$14,335,765	$13,908,561	$741,219	$14,649,780	$13,904,053	$920,763	$14,824,816
	Net Patient Service Revenue less provision for bad debts	**$322,198,890**	**$326,461,025**	**$335,040,048**	**$5,505,508**	**$340,545,556**	**$334,923,601**	**$14,064,917**	**$348,988,518**	**$337,595,409**	**$19,403,641**	**$356,999,050**	**$337,485,988**	**$24,103,750**	**$361,589,738**
15	Other Operating Revenue	$28,151,061	$30,874,305	31,185,817		$31,185,817	31,185,817		$31,185,817	31,185,817		$31,185,817	31,185,817		$31,185,817
17	Net Assets Released from Restric	$671,797	$577,092	$0		$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$351,021,748**	**$357,912,422**	**$366,225,866**	**$5,505,508**	**$371,731,374**	**$366,109,418**	**$14,064,917**	**$380,174,335**	**$368,781,227**	**$19,403,641**	**$388,184,868**	**$368,671,806**	**$24,103,750**	**$392,775,556**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$143,838,674	$140,605,613	$ 143,576,703	$603,987	$144,180,691	$140,019,192	$760,868	$140,780,059	$141,973,430	$754,514	$142,727,944	$143,983,025	$1,270,138	$145,253,163
2	Fringe Benefits	$51,044,718	$51,698,355	$ 54,026,420	$847,885	$54,874,305	$52,456,564	$1,228,742	$53,685,306	$52,771,303	$1,254,900	$54,026,203	$53,087,931	$1,407,884	$54,495,815
3	Physicians Fees	$38,647,767	$29,998,356	$ 30,254,332	$2,845,324	$33,099,655	$22,993,292	$4,677,729	$27,671,021	$22,533,426	$4,788,754	$27,322,180	$22,848,894	$4,921,640	$27,770,534
4	Supplies and Drugs	$59,538,141	$63,622,692	$64,288,904	$55,178	$64,344,082	$64,610,349	$345,629	$64,955,978	$65,540,738	$651,937	$66,192,675	$66,471,416	$917,694	$67,389,110
5	Depreciation and Amortization	$22,728,484	$23,639,711	$26,054,143	$77,061	$26,131,204	$27,572,414	$154,122	$27,726,536	$27,826,240	$154,122	$27,980,362	$28,839,752	$154,122	$28,993,874
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$3,542,721	$3,553,690	$3,368,376	$0	$3,368,376	$3,167,699	$0	$3,167,699	$2,973,808	$0	$2,973,808	$2,749,451	$0	$2,749,451
8	Malpractice Insurance Cost	$4,538,822	$4,818,820	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632
9	Lease Expense	$4,618,504	$4,647,875	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308
10	Other Operating Expenses	$25,332,830	$30,741,467	$ 30,490,536	$0	$30,490,536	$30,490,536	$0	$30,490,536	$30,795,441	$0	$30,795,441	*$29,255,669*	$0	$29,255,669
	TOTAL OPERATING EXPENSES	**$353,830,661**	**$353,326,579**	**$361,724,355**	**$4,429,435**	**$366,153,790**	**$350,974,986**	**$7,167,089**	**$358,142,075**	**$354,079,327**	**$7,604,227**	**$361,683,554**	**$356,901,079**	**$8,671,477**	**$365,572,556**
	INCOME/(LOSS) FROM OPERA	**($2,808,913)**	**$4,585,843**	**$4,501,511**	**$1,076,073**	**$5,577,584**	**$15,134,432**	**$6,897,828**	**$22,032,260**	**$14,701,900**	**$11,799,414**	**$26,501,313**	**$11,770,727**	**$15,432,273**	**$27,202,999**
	NON-OPERATING REVENUE	**$8,788,601**	**$9,936,909**	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**		$8,262,701
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$5,979,688**	**$14,522,752**	**$12,764,212**	**$1,076,073**	**$13,840,285**	**$23,397,133**	**$6,897,828**	**$30,294,961**	**$22,964,601**	**$11,799,414**	**$34,764,014**	**$20,033,428**	**$15,432,273**	**$35,465,700**
	Principal Payments	**$5,152,609**	**$5,316,471**	$5,510,844	$0	$5,510,844	$5,725,738	$0	$5,725,738	$5,911,163	$0	$5,911,163	$6,137,126		$6,137,126
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**-0.8%**	**1.3%**	**1.2%**	**19.5%**	**1.5%**	**4.1%**	**49.0%**	**5.8%**	**4.0%**	**60.8%**	**6.8%**	**3.2%**	**64.0%**	**6.9%**
2	Hospital Non Operating Margin	**2.3%**	**2.6%**	**2.3%**	**0.0%**	**2.2%**	**2.3%**	**0.0%**	**2.2%**	**2.2%**	**0.0%**	**2.1%**	**2.2%**	**0.0%**	**2.1%**
3	Hospital Total Margin	**1.7%**	**4.1%**	**3.5%**	**19.5%**	**3.7%**	**6.4%**	**49.0%**	**8.0%**	**6.2%**	**60.8%**	**9.0%**	**5.4%**	**64.0%**	**9.0%**
D.	**FTEs**	**1,849**	**1,835**	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	14,153	14,076	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	449,789	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	TOTAL VOLUME	**472,263**	**463,865**	**469,289**	**3,641**	**472,930**	**469,160**	**11,259**	**480,419**	**469,017**	**14,967**	**483,984**	**468,900**	**18,035**	**486,935**

LINE	Total Entity: LMC w/o LMPA	FY 2014 Actual Results	FY 2015 Actual Results	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected W/ CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected W/ CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected W/ CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected W/ CON	FY 2016 Projected Incremental	FY 2016 Projected Incremental	Total WO LMPA	FY 2017 Projected Incremental	FY 2017 Projected Incremental	Total WO LMPA	FY 2018 Projected Incremental	FY 2018 Projected Incremental	Total WO LMPA	FY 2019 Projected Incremental	FY 2019 Projected Incremental	Total WO LMPA
A.	**OPERATING REVENUE**																										
1	Total Gross Patient Revenue	$1,078,626,933	$1,138,758,476	$1,166,642,891	($15,527,210)	$1,151,115,681	$1,213,308,606	($24,164,292)	$1,189,144,314	$1,261,840,951	($9,784,371)	$1,252,056,580	$1,312,314,589	$3,738,813	$1,316,053,401	$15,802,747	($31,329,957)	($15,527,210)	$41,002,017	($65,166,310)	($24,164,292)	$57,988,591	($67,772,962)	($9,784,371)	$74,222,693	($70,483,882)	$3,738,813
2	Less: Allowances	$615,856,880	$664,069,131	$673,832,103	($6,485,677)	$667,346,426	$717,135,552	($8,304,750)	$708,830,803	$762,088,601	$104,770	$762,193,372	$811,978,164	$8,494,495	$820,472,659	$9,142,613	($15,628,290)	($6,485,677)	$24,552,405	($32,857,155)	($8,304,750)	$35,563,460	($35,458,689)	$104,770	$46,658,780	($38,164,285)	$8,494,495
3	Less: Charity Care	$6,782,933	$6,124,509	$7,336,420	$37,861	$7,374,281	$7,629,877	$129,891	$7,759,768	$7,935,072	$231,593	$8,166,665	$8,252,475	$328,358	$8,580,833	$99,375	($61,514)	$37,861	$257,841	($127,950)	$129,891	$364,661	($133,068)	$231,593	$466,749	($138,391)	$328,358
4	Less: Other Deductions	$2,458,020	$12,801,007	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Patient Service Revenue	**$453,529,100**	**$455,763,829**	**$467,272,580**	**($9,079,394)**	**$458,193,186**	**$470,341,390**	**($15,989,434)**	**$454,351,956**	**$473,615,490**	**($10,120,734)**	**$463,494,756**	**$473,882,163**	**($5,084,040)**	**$468,798,123**	**$6,560,759**	**($15,640,153)**	**($9,079,394)**	**$16,191,771**	**($32,181,205)**	**($15,989,434)**	**$22,060,471**	**($32,181,205)**	**($10,120,734)**	**$27,097,165**	**($32,181,205)**	**($5,084,040)**
5	Medicare	$161,243,669	$165,691,332	$169,559,164	($2,853,646)	$166,705,519	$170,162,485	($4,893,784)	$165,268,700	$171,320,254	($2,848,199)	$168,472,056	$171,414,554	($1,093,576)	$170,320,977	$2,210,650	($5,064,295)	($2,853,646)	$5,536,152	($10,429,936)	($4,893,784)	$7,581,738	($10,429,936)	($2,848,199)	$9,336,360	($10,429,936)	($1,093,576)
6	Medicaid	$48,109,726	$49,436,760	$50,590,792	($1,354,632)	$49,236,160	$50,770,802	($2,496,483)	$48,274,320	$51,116,242	($1,886,148)	$49,230,094	$51,144,378	($1,362,627)	$49,781,751	$659,584	($2,014,216)	($1,354,632)	$1,651,803	($4,148,286)	($2,496,483)	$2,262,137	($4,148,286)	($1,886,148)	$2,785,658	($4,148,286)	($1,362,627)
7	CHAMPUS & TriCare	$12,447,146	$12,790,482	$13,089,058	($276,461)	$12,812,597	$13,135,631	($493,466)	$12,642,165	$13,225,005	($335,557)	$12,889,447	$13,232,284	($200,110)	$13,032,174	$170,650	($447,111)	($276,461)	$427,361	($920,827)	($493,466)	$585,270	($920,827)	($335,557)	$720,717	($920,827)	($200,110)
8	Other	($2,458,020)	($12,801,007)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Government	**$219,342,521**	**$215,117,567**	**$215,037,227**	**($4,484,738)**	**$210,552,489**	**$215,867,131**	**($7,883,733)**	**$207,983,399**	**$217,459,714**	**($5,069,904)**	**$212,389,810**	**$217,589,429**	**($2,656,314)**	**$214,933,115**	**$3,040,884**	**($7,525,622)**	**($4,484,738)**	**$7,615,316**	**($15,499,049)**	**($7,883,733)**	**$10,429,145**	**($15,499,049)**	**($5,069,904)**	**$12,842,735**	**($15,499,049)**	**($2,656,314)**
9	Commercial Insurers	$215,639,465	$221,587,554	$226,760,205	($4,072,006)	$222,688,199	$227,567,057	($7,250,433)	$220,316,624	$229,115,401	($4,516,815)	$224,598,587	$229,241,513	($2,170,433)	$227,071,080	$3,187,739	($7,259,746)	($4,072,006)	$7,701,043	($14,951,476)	($7,250,433)	$10,434,661	($14,951,476)	($4,516,815)	$12,781,042	($14,951,476)	($2,170,433)
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$9,955,354	$10,229,957	$10,468,761	$23,625	$10,492,386	$10,506,011	$109,366	$10,615,377	$10,577,493	$235,662	$10,813,155	$10,583,315	$343,995	$10,927,309	$136,488	($112,863)	$23,625	$341,808	($232,442)	$109,366	$468,104	($232,442)	$235,662	$576,437	($232,442)	$343,995
12	Workers Compensation	$8,591,760	$8,828,750	$9,034,845	($124,129)	$8,910,717	$9,066,993	($203,248)	$8,863,745	$9,128,684	($94,251)	$9,034,433	$9,133,708	($757)	$9,132,952	$117,793	($241,922)	($124,129)	$294,990	($498,238)	($203,248)	$403,988	($498,238)	($94,251)	$497,482	($498,238)	($757)
13	Other	$0	$0	$5,971,541	($422,145)	$5,549,396	$7,334,198	($761,386)	$6,572,812	$7,334,198	($675,427)	$6,658,771	$7,334,198	$1,232,319	$8,566,517	$77,855	($500,000)	($422,145)	$238,614	($1,000,000)	($761,386)	$324,573	($1,000,000)	($675,427)	$399,469	$832,850	$1,232,319
	Total Non-Government	**$234,186,579**	**$240,646,262**	**$252,235,353**	**($4,594,655)**	**$247,640,697**	**$254,474,259**	**($8,105,701)**	**$246,368,558**	**$256,155,776**	**($5,050,830)**	**$251,104,946**	**$256,292,734**	**($594,877)**	**$255,697,857**	**$3,519,875**	**($8,114,530)**	**($4,594,655)**	**$8,576,455**	**($16,682,156)**	**($8,105,701)**	**$11,631,326**	**($16,682,156)**	**($5,050,830)**	**$14,254,429**	**($14,849,306)**	**($594,877)**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$453,529,100**	**$455,763,829**	**$467,272,580**	**($9,079,394)**	**$458,193,186**	**$470,341,390**	**($15,989,434)**	**$454,351,956**	**$473,615,490**	**($10,120,734)**	**$463,494,756**	**$473,882,163**	**($3,251,190)**	**$470,630,973**	**$6,560,759**	**($15,640,153)**	**($9,079,394)**	**$16,191,771**	**($32,181,205)**	**($15,989,434)**	**$22,060,471**	**($32,181,205)**	**($10,120,734)**	**$27,097,165**	**($30,348,355)**	**($3,251,190)**
14	Less: Provision for Bad Debts	$20,298,386	$16,683,423	$17,177,163	($53,652)	$17,123,511	$17,239,519	($289,105)	$16,950,414	$17,359,178	($291,154)	$17,068,024	$17,368,924	($291,320)	$17,077,604	$231,324	($284,976)	($53,652)	$297,261	($586,366)	($289,105)	$295,212	($586,366)	($291,154)	$295,047	($586,366)	($291,320)
	Net Patient Service Revenue less provision for bad debts	**$433,230,714**	**$439,080,406**	**$450,095,417**	**($9,025,742)**	**$441,069,675**	**$453,101,871**	**($15,700,329)**	**$437,401,542**	**$456,256,312**	**($9,829,580)**	**$446,426,732**	**$456,513,239**	**($4,792,721)**	**$451,720,518**	**$6,329,435**	**($15,355,177)**	**($9,025,742)**	**$15,894,510**	**($31,594,839)**	**($15,700,329)**	**$21,765,259**	**($31,594,839)**	**($9,829,580)**	**$26,802,118**	**($31,594,839)**	**($4,792,721)**
15	Other Operating Revenue	$20,795,287	$20,376,803	$18,625,441	($4,621,670)	$14,003,771	$18,625,441	($9,243,341)	$9,382,100	$18,625,441	($9,243,341)	$9,382,100	$18,625,441	($9,243,341)	$9,382,100	$0	($4,621,670)	($4,621,670)	$0	($9,243,341)	($9,243,341)	$0	($9,243,341)	($9,243,341)	$0	($9,243,341)	($9,243,341)
17	Net Assets Released from Restrictions	$876,203	$830,659	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	**$454,902,204**	**$460,287,868**	**$468,720,858**	**($13,647,412)**	**$455,073,446**	**$471,727,312**	**($24,943,670)**	**$446,783,642**	**$474,881,753**	**($19,072,921)**	**$455,808,832**	**$475,138,680**	**($14,036,062)**	**$461,102,618**	**$6,329,435**	**($19,976,847)**	**($13,647,412)**	**$15,894,510**	**($40,838,180)**	**($24,943,670)**	**$21,765,259**	**($40,838,180)**	**($19,072,921)**	**$26,802,118**	**($40,838,180)**	**($14,036,062)**
B.	**OPERATING EXPENSES**																										
1	Salaries and Wages	$213,467,507	$212,124,691	$221,742,774	($16,503,691)	$205,239,083	$218,731,892	($32,626,276)	$186,105,616	$220,764,261	($33,138,558)	$187,625,703	$223,223,873	($32,878,788)	$190,345,085	$905,945	($17,409,636)	($16,503,691)	$1,288,033	($33,914,309)	($32,626,276)	$1,284,466	($34,423,024)	($33,138,558)	$2,060,581	($34,939,369)	($32,878,788)
2	Fringe Benefits	$59,185,837	$59,040,657	$61,335,944	($2,486,287)	$58,849,657	$59,361,624	($4,867,704)	$54,493,920	$59,610,824	($4,866,259)	$54,744,565	$59,979,697	($4,677,288)	$55,302,409	$1,088,338	($3,574,625)	($2,486,287)	$1,868,477	($6,736,181)	($4,867,704)	$1,910,340	($6,776,599)	($4,866,259)	$2,139,970	($6,817,258)	($4,677,288)
3	Physicians Fees	$54,475,011	$39,688,243	$36,262,759	$11,192,773	$47,455,533	$29,552,481	$16,362,803	$45,915,284	$29,230,792	$17,197,407	$46,428,199	$29,614,758	$18,070,023	$47,684,781	$4,130,042	$7,062,732	$11,192,773	$4,413,823	$11,948,980	$16,362,803	$4,614,665	$12,582,742	$17,197,407	$4,840,506	$13,229,517	$18,070,023
4	Supplies and Drugs	$71,998,110	$76,774,253	$77,727,905	($1,407,896)	$76,320,009	$78,132,953	($2,332,868)	$75,800,085	$79,257,684	($1,760,116)	$77,497,568	$80,382,942	($1,273,097)	$79,109,845	($216,413)	($1,191,483)	($1,407,896)	$62,014	($2,394,882)	($2,332,868)	$669,252	($2,429,368)	($1,760,116)	$1,190,768	($2,463,865)	($1,273,097)
5	Depreciation and Amortization	$27,479,122	$28,953,704	$28,415,203	$40,565	$28,455,768	$30,071,062	$67,013	$30,138,075	$30,347,890	$64,653	$30,412,543	$31,453,247	$55,229	$31,508,476	$161,689	($121,124)	$40,565	$323,378	($256,365)	$67,013	$323,378	($258,725)	$64,653	$323,378	($268,149)	$55,229
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,554,919	$3,553,690	$3,368,376	$0	$3,368,376	$3,167,699	$0	$3,167,699	$2,973,808	$0	$2,973,808	$2,749,451	$0	$2,749,451	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
8	Malpractice Insurance Cost	$14,513,454	$17,152,933	$16,833,046	($1,285,561)	$15,547,485	$16,833,046	($2,571,122)	$14,261,924	$16,833,046	($2,571,122)	$14,261,924	$16,833,046	($2,571,122)	$14,261,924	$0	($1,285,561)	($1,285,561)	$0	($2,571,122)	($2,571,122)	$0	($2,571,122)	($2,571,122)	$0	($2,571,122)	($2,571,122)
9	Lease Expense	$6,969,829	$7,693,864	$7,964,369	($1,067,938)	$6,896,432	$7,964,369	($2,135,875)	$5,828,494	$7,964,369	($2,135,875)	$5,828,494	$7,964,369	($2,135,875)	$5,828,494	$0	($1,067,938)	($1,067,938)	$0	($2,135,875)	($2,135,875)	$0	($2,135,875)	($2,135,875)	$0	($2,135,875)	($2,135,875)
10	Other Operating Expenses	$21,943,887	$25,385,377	$23,767,337	($2,057,025)	$21,710,311	$20,618,407	($4,115,241)	$16,503,166	$21,103,061	($4,127,570)	$16,975,491	$21,576,050	($4,137,325)	$17,438,725	$332,187	($2,389,212)	($2,057,025)	$663,184	($4,778,425)	($4,115,241)	$698,639	($4,826,209)	($4,127,570)	$734,733	($4,872,058)	($4,137,325)
	TOTAL OPERATING EXPENSES	**$473,587,676**	**$470,367,412**	**$477,417,713**	**($13,575,060)**	**$463,842,653**	**$464,433,533**	**($32,219,270)**	**$432,214,263**	**$468,085,735**	**($31,337,441)**	**$436,748,294**	**$473,777,432**	**($29,548,243)**	**$444,229,190**	**$6,401,788**	**($19,976,848)**	**($13,575,060)**	**$8,618,909**	**($40,838,179)**	**($32,219,270)**	**$9,500,739**	**($40,838,180)**	**($31,337,441)**	**$11,289,936**	**($40,838,179)**	**($29,548,243)**
	INCOME/(LOSS) FROM OPERATIONS	**($18,685,472)**	**($10,079,544)**	**($8,696,855)**	**($72,353)**	**($8,769,207)**	**$7,293,779**	**$7,275,601**	**$14,569,379**	**$6,796,018**	**$12,264,521**	**$19,060,538**	**$1,361,248**	**$15,512,181**	**$16,873,429**	**($72,353)**	**$1**	**($72,353)**	**$7,275,601**	**($1)**	**$7,275,601**	**$12,264,520**	**$1**	**$12,264,521**	**$15,512,182**	**($0)**	**$15,512,181**
	NON-OPERATING REVENUE	**$15,297,404**	**$11,832,973**	**$8,858,736**	**$0**	$8,858,736	**$8,858,736**	**$0**	$8,858,736	**$8,858,736**	**$0**	$8,858,736	**$8,858,736**	**$0**	$8,858,736	**$0**	**$0**	$0	**$0**	**$0**	$0	**$0**	**$0**	$0	**$0**	**$0**	$0
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**($3,388,068)**	**$1,753,429**	**$161,881**	**($72,353)**	**$89,529**	**$16,152,515**	**$7,275,601**	**$23,428,115**	**$15,654,754**	**$12,264,521**	**$27,919,274**	**$10,219,984**	**$15,512,181**	**$25,732,165**	**($72,353)**	**$1**	**($72,353)**	**$7,275,601**	**($1)**	**$7,275,601**	**$12,264,520**	**$1**	**$12,264,521**	**$15,512,182**	**($0)**	**$15,512,181**
	Principal Payments	**$5,152,609**	**$5,316,471**	$5,510,844		$5,510,844	$5,725,738		$5,725,738	$5,911,163		$5,911,163	$6,137,126		$6,137,126			$0			$0			$0			$0
C.	**PROFITABILITY SUMMARY**																										
1	Hospital Operating Margin	**-4.1%**	**-2.2%**	**-1.9%**	**0.5%**	**-1.9%**	**1.5%**	**-29.2%**	**3.3%**	**1.4%**	**-64.3%**	**4.2%**	**0.3%**	**-110.5%**	**3.7%**	**-1.1%**	**-45.9%**	**0.5%**	**45.8%**	**-43.7%**	**-29.2%**	**56.3%**	**-45.0%**	**-64.3%**	**57.9%**	**-46.8%**	**-110.5%**
2	Hospital Non Operating Margin	**3.4%**	**2.6%**	**1.9%**	**0.0%**	**1.9%**	**1.9%**	**0.0%**	**2.0%**	**1.9%**	**0.0%**	**1.9%**	**1.9%**	**0.0%**	**1.9%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
3	Hospital Total Margin	**-0.7%**	**0.4%**	**0.0%**	**0.5%**	**0.0%**	**3.4%**	**-29.2%**	**5.2%**	**3.3%**	**-64.3%**	**6.1%**	**2.2%**	**-110.5%**	**5.6%**	**-1.1%**	**-45.9%**	**0.5%**	**45.8%**	**-43.7%**	**-29.2%**	**56.3%**	**-45.0%**	**-64.3%**	**57.9%**	**-46.8%**	**-110.5%**
D.	**FTEs**	**2,849**	**2,822**	2,821	(181)	2,641	2,711	(325)	2,386	2,701	(323)	2,378	2,691	(313)	2,378	0	($181)	(181)	1	($326)	(325)	3	($326)	(323)	13	($326)	(313)
	FTE reduction is a transfer to NEMG see separate CON																										
E.	**VOLUME STATISTICS[c]**																										
1	Inpatient Discharges	17,288	17,000	17,243	211	17,454	17,081	393	17,474	16,900	574	17,474	16,753	755	17,508	211	0	211	393	0	393	574	0	574	755	0	755
2	Outpatient Visits	585,965	568,902	618,543	4,554	623,097	620,364	11,880	632,244	621,913	15,630	637,543	621,913	18,558	640,471	4,554	0	4,554	11,880	0	11,880	15,630	0	15,630	18,558	0	18,558
	TOTAL VOLUME	**603,253**	**585,902**	**635,786**	**4,765**	**640,551**	**637,445**	**12,273**	**649,718**	**638,813**	**16,204**	**655,017**	**638,666**	**19,313**	**657,979**	**4,765**	**0**	**4,765**	**12,273**	**0**	**12,273**	**16,204**	**0**	**16,204**	**19,313**	**0**	**19,313**

ATTACHMENT VIII

FINANCIAL WORKSHEET A FOR L+M WITHOUT ASSOCIATED SPECIALISTS OF CT

LINE	Total Entity:L+M Hospital w/o ASOC	FY 2014	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$788,136,573	$839,272,512	$852,448,517	$14,023,919	$866,472,437	$886,546,458	$37,272,979	$923,819,437	$922,008,316	$53,052,862	$975,061,178	$958,888,649	$68,562,223	$1,027,450,872
2	Less: Allowances	$446,502,255	$483,244,808	$480,941,850	$8,211,581	$489,153,431	$514,682,289	$22,403,989	$537,086,278	$546,844,451	$32,513,069	$579,357,519	$583,278,646	$43,006,907	$626,285,554
3	Less: Charity Care	$5,424,367	$5,405,542	$5,866,995	$96,520	$5,963,515	$6,345,742	$266,793	$6,612,536	$6,863,555	$394,933	$7,258,487	$7,423,621	$530,802	$7,954,423
4	Less: Other Deductions	$2,458,020	$12,801,007	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787
	Net Patient Service Revenue	**$333,751,931**	**$337,821,155**	**$347,437,885**	**$5,715,818**	**$353,153,703**	**$347,316,640**	**$14,602,197**	**$361,918,837**	**$350,098,524**	**$20,144,860**	**$370,243,384**	**$349,984,595**	**$25,024,513**	**$375,009,108**
5	Medicare	$114,777,095	$119,697,210	$122,862,324	$1,920,631	$124,782,955	$122,820,933	$4,906,633	$127,727,566	$123,770,627	$6,769,080	$130,539,707	$123,731,733	$8,408,743	$132,140,476
6	Medicaid	$36,357,088	$37,915,596	$38,918,186	$608,384	$39,526,570	$38,905,075	$1,554,238	$40,459,313	$39,205,902	$2,144,191	$41,350,094	$39,193,582	$2,663,575	$41,857,157
7	CHAMPUS & TriCare	$10,871,028	$11,337,033	$11,636,815	$181,911	$11,818,726	$11,632,894	$464,728	$12,097,622	$11,722,844	$641,128	$12,363,972	$11,719,160	$796,428	$12,515,588
8	Other	($2,458,020)	($12,801,007)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)
	Total Government	**$159,547,191**	**$156,148,833**	**$155,215,538**	**$2,710,926**	**$157,926,463**	**$155,157,115**	**$6,925,599**	**$162,082,714**	**$156,497,586**	**$9,554,400**	**$166,051,986**	**$156,442,688**	**$11,868,745**	**$168,311,434**
9	Commercial Insurers	$161,745,469	$168,678,963	$173,139,286	$2,706,579	$175,845,865	$173,080,956	$6,914,496	$179,995,452	$174,419,278	$9,539,082	$183,958,360	$174,364,469	$11,849,716	$186,214,185
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,109,407	$5,328,430	$5,469,328	$85,499	$5,554,827	$5,467,486	$218,423	$5,685,909	$5,509,762	$301,332	$5,811,094	$5,508,031	$374,323	$5,882,354
12	Workers Compensation	$7,349,864	$7,664,928	$7,867,610	$122,989	$7,990,599	$7,864,959	$314,201	$8,179,160	$7,925,774	$433,465	$8,359,238	$7,923,283	$538,462	$8,461,745
13	Other	$0	$0	$5,746,124	$89,826	$5,835,950	$5,746,124	$229,477	$5,975,601	$5,746,124	$316,582	$6,062,706	$5,746,124	$393,267	$6,139,391
	Total Non-Government	**$174,204,740**	**$181,672,322**	**$192,222,347**	**$3,004,893**	**$195,227,240**	**$192,159,525**	**$7,676,597**	**$199,836,123**	**$193,600,938**	**$10,590,460**	**$204,191,398**	**$193,541,907**	**$13,155,768**	**$206,697,675**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$333,751,931**	**$337,821,155**	**$347,437,885**	**$5,715,818**	**$353,153,703**	**$347,316,640**	**$14,602,197**	**$361,918,837**	**$350,098,524**	**$20,144,860**	**$370,243,384**	**$349,984,595**	**$25,024,513**	**$375,009,108**
14	Less: Provision for Bad Debts	$14,966,698	$12,798,310	$13,779,946	$210,310	$13,990,256	$13,775,137	$537,280	$14,312,417	$13,885,471	$741,219	$14,626,690	$13,880,952	$920,763	$14,801,715
	Net Patient Service Revenue less provision for bad debts	**$318,785,233**	**$325,022,845**	**$333,657,939**	**$5,505,508**	**$339,163,447**	**$333,541,503**	**$14,064,917**	**$347,606,420**	**$336,213,053**	**$19,403,641**	**$355,616,694**	**$336,103,643**	**$24,103,750**	**$360,207,393**
15	Other Operating Revenue	$29,607,174	$30,854,159	31,179,479		$31,179,479	31,179,479		$31,179,479	31,179,479		$31,179,479	31,179,479		$31,179,479
17	Net Assets Released from Restrictions	$671,797	$577,092	$0		$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$349,064,204**	**$356,454,096**	**$364,837,419**	**$5,505,508**	**$370,342,927**	**$364,720,983**	**$14,064,917**	**$378,785,900**	**$367,392,533**	**$19,403,641**	**$386,796,174**	**$367,283,122**	**$24,103,750**	**$391,386,872**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$142,343,619	$140,640,103	$ 143,576,703	$603,987	$144,180,691	$140,019,192	$760,868	$140,780,059	$141,973,430	$754,514	$142,727,944	$143,983,025	$1,270,138	$145,253,163
2	Fringe Benefits	$50,942,363	$51,694,855	$ 54,026,420	$847,885	$54,874,305	$52,456,564	$1,228,742	$53,685,306	$52,771,303	$1,254,900	$54,026,203	$53,087,931	$1,407,884	$54,495,815
3	Physicians Fees	$37,964,369	$29,627,730	$ 29,986,525	$2,845,324	$32,831,849	$22,789,759	$4,677,729	$27,467,488	$22,333,964	$4,788,754	$27,122,718	$22,646,640	$4,921,640	$27,568,280
4	Supplies and Drugs	$59,512,480	$63,622,692	$64,288,904	$55,178	$64,344,082	$64,610,349	$345,629	$64,955,978	$65,540,738	$651,937	$66,192,675	$66,471,416	$917,694	$67,389,110
5	Depreciation and Amortization	$22,728,484	$23,639,711	$26,054,143	$77,061	$26,131,204	$27,572,414	$154,122	$27,726,536	$27,826,240	$154,122	$27,980,362	$28,839,752	$154,122	$28,993,874
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$3,542,721	$3,553,690	$3,368,376	$0	$3,368,376	$3,167,699	$0	$3,167,699	$2,973,808	$0	$2,973,808	$2,749,451	$0	$2,749,451
8	Malpractice Insurance Cost	$4,538,822	$4,818,820	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632
9	Lease Expense	$4,618,504	$4,647,875	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308
10	Other Operating Expenses	$22,334,118	$27,882,477	$ 27,596,503	$0	$27,596,503	$27,596,503	$0	$27,596,503	$27,872,468	$0	$27,872,468	*$26,478,844*	$0	$26,478,844
	TOTAL OPERATING EXPENSES	**$348,525,480**	**$350,127,953**	**$358,562,515**	**$4,429,435**	**$362,991,950**	**$347,877,420**	**$7,167,089**	**$355,044,509**	**$350,956,891**	**$7,604,227**	**$358,561,119**	**$353,921,999**	**$8,671,477**	**$362,593,477**
	INCOME/(LOSS) FROM OPERATIONS	**$538,724**	**$6,326,143**	**$6,274,904**	**$1,076,073**	**$7,350,977**	**$16,843,563**	**$6,897,828**	**$23,741,391**	**$16,435,641**	**$11,799,414**	**$28,235,055**	**$13,361,123**	**$15,432,273**	**$28,793,396**
	NON-OPERATING REVENUE	**$8,788,601**	**$9,936,909**	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**		$8,262,701
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$9,327,325**	**$16,263,052**	**$14,537,605**	**$1,076,073**	**$15,613,678**	**$25,106,264**	**$6,897,828**	**$32,004,092**	**$24,698,342**	**$11,799,414**	**$36,497,756**	**$21,623,824**	**$15,432,273**	**$37,056,097**
	Principal Payments	**$5,152,609**	**$5,316,471**	$5,510,844	$0	$5,510,844	$5,725,738	$0	$5,725,738	$5,911,163	$0	$5,911,163	$6,137,126		$6,137,126
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**0.2%**	**1.8%**	**1.7%**	**19.5%**	**2.0%**	**4.6%**	**49.0%**	**6.3%**	**4.5%**	**60.8%**	**7.3%**	**3.6%**	**64.0%**	**7.4%**
2	Hospital Non Operating Margin	**2.3%**	**2.6%**	**2.3%**	**0.0%**	**2.2%**	**2.3%**	**0.0%**	**2.2%**	**2.2%**	**0.0%**	**2.1%**	**2.2%**	**0.0%**	**2.1%**
3	Hospital Total Margin	**2.7%**	**4.6%**	**4.0%**	**19.5%**	**4.2%**	**6.9%**	**49.0%**	**8.4%**	**6.7%**	**60.8%**	**9.4%**	**5.9%**	**64.0%**	**9.5%**
D.	**FTEs**	**1,849**	**1,835**	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	14,153	14,076	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	449,789	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	TOTAL VOLUME	**472,263**	**463,865**	**469,289**	**3,641**	**472,930**	**469,160**	**11,259**	**480,419**	**469,017**	**14,967**	**483,984**	**468,900**	**18,035**	**486,935**

ATTACHMENT IX

FINANCIAL ASSUMPTIONS FOR L+MH

Lawrence + Memorial Hospital Affliation with Yale New Haven Health System
Assumptions

	Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1)	Government	0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2)	Non-Government	0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3)	Inpatient Volume	0.8%	0.1%	0.0%	0.2%
4)	Outpatient Volume	0.8%	1.6%	0.8%	0.6%

		FY 2016	FY 2017	FY 2018	FY 2019
	EXPENSES				
A.	**Salaries and Fringe Benefits**	1.5%	1.5%	1.5%	1.5%
B.	**Non-Salary**				
1)	Supplies and Drugs	2.0%	1.5%	1.5%	1.5%
2)	Professional and Contracted Services	2.0%	1.5%	1.5%	1.5%
3)	Malpractice Insurance and Lease Expen	0.0%	0.0%	0.0%	0.0%
4)	All Other Expenses	1.0%	1.0%	1.0%	1.0%
5)	All Other Expenses				

	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	1,829	1,758	1,752	1,753

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

ATTACHMENT X

REVISED MONTHLY FINANCIAL REPORT

L+M

38a. Provide monthly financial reports that include statistics for the current month, and year to date and comparable month from the previous year for the following:

	L&M Hospital				L+M Corporation (Consolidated)			
	Sep-15 YTD	Sep-14 YTD	Sep-15 MTD	Sep-14 MTD	Sep-15 YTD	Sep-14 YTD	Sep-15 MTD	Sep-14 MTD
Monthly Financial Measurement/Indicators								
A. Operating Performance:								
Operating Margin	1.29%	-0.79%	-5.37%	3.17%	-2.33%	-4.25%	-7.77%	-5.51%
Non operating Margin	NA	NA	NA	NA	NA	NA	NA	NA
Total Margin	4.07%	1.70%	-1.64%	30.11%	0.23%	-2.03%	-5.34%	13.64%
Bad Debt as % of Net Revenue	6.14%	7.69%	1.64%	4.91%	5.71%	6.69%	2.78%	3.18%
B. Liquidity:								
Current Ratio	3.0	3.6	3.0	3.6	3.5	3.6	3.5	3.6
Days Cash on Hand	133.9	148.7	133.9	148.7	137.7	149.9	137.7	149.9
Days in Net Accounts Receivable	38.2	38.0	38.2	38.0	38.2	36.8	38.2	36.8
Average Payment Period	61.4	55.4	61.4	55.4	59.6	59.9	59.6	59.9
C. Leverage and Capital Structure:								
Long-term Debt to Equity	82.7%	66.4%	82.7%	66.4%	40.7%	37.4%	40.7%	37.4%
Long-term Debt to Capitalization	44.0%	38.7%	44.0%	38.7%	27.9%	26.2%	27.9%	26.2%
Unrestricted Cash to Debt	113.9%	121.5%	113.9%	121.5%	157.3%	164.5%	157.3%	164.5%
Times Interest Earned Ratio	5.1	2.7	-0.6	31.5	1.3	-1.6	-5.5	19.1
Debt Service Coverage Ratio	4.8	3.7	4.8	3.7	3.9	2.5	3.9	2.5
Equity Financing Ratio	0.38	0.45	0.38	0.45	0.51	0.55	0.51	0.55
D. Additional Statistics:								
Income from Operation	4,609,596	(2,786,298)	(1,494,589)	1,033,571	(10,704,990)	(19,302,774)	(3,038,473)	(2,427,560)
Revenue Over/(Under) Expense	14,546,505	6,002,303	(455,215)	9,822,172	1,058,968	(9,235,413)	(2,089,932)	6,012,338
EBITA	31,802,997	23,484,907	1,024,700	3,758,593	21,802,402	11,727,569	75,610	562,917
Patient Cash Collected	NA	NA	NA	NA	NA	NA	NA	NA
Cash and Cash Equivalents	13,362,306	6,864,347	13,362,306	6,864,347	23,832,707	16,488,990	23,832,707	16,488,990
Net Working Cash	112,468,945	132,685,733	112,468,945	132,685,733	177,844,476	191,945,631	177,844,476	191,945,631
Unrestricted Assets	103,203,167	138,173,768	103,203,167	138,173,768	225,148,826	257,831,382	225,148,826	257,831,382
Credit Ratings (S&P, Fitch, Moody's)								
Fitch A with Stable								
S&P A- with Negative								

ATTACHMENT XI

MONTHLY FINANCIAL REPORT

YNHHSC

38c. Provide monthly financial reports that include statistics for the current month, and year to date and comparable month from the previous year for the following:

Yale New Haven Health System

	Sep-15 YTD	Sep-14 YTD	Sep-15 MTD	Sep-14 MTD
Monthly Financial Measurement/Indicators				
A. Operating Performance:				
Operating Margin	4.43%	5.01%	6.81%	6.41%
Non operating Margin	NA	NA	NA	NA
Total Margin	4.00%	6.02%	2.41%	3.26%
Bad Debt as % of Net Revenue	2.28%	3.63%	1.71%	3.70%
B. Liquidity:				
Current Ratio	2.9	3.0	2.9	3.0
Days Cash on Hand	195.2	193.5	195.2	193.5
Days in Net Accounts Receivable	41.4	39.4	41.4	39.4
Average Payment Period	72.2	68.3	72.2	68.3
C. Leverage and Capital Structure:				
Long-term Debt to Equity	46.3%	50.2%	46.3%	50.2%
Long-term Debt to Capitalization	31.3%	32.9%	31.3%	32.9%
Unrestricted Cash to Debt	146.9%	128.3%	146.9%	128.3%
Times Interest Earned Ratio	7.0	8.6	4.5	4.2
Debt Service Coverage Ratio	4.6	5.6	4.6	5.6
Equity Financing Ratio	0.44	0.44	0.44	0.44
D. Additional Statistics:				
Income from Operations	159,656,000	170,112,000	20,453,000	19,256,000
Revenue Over/(Under) Expense	144,091,000	204,301,000	7,239,000	9,781,000
EBITA	369,788,000	389,101,000	38,285,000	44,845,000
Patient Cash Collected	NA	NA	NA	NA
Cash and Cash Equivalents	194,946,000	161,059,000	194,946,000	161,059,000
Net Working Cash	1,246,635,000	1,115,450,000	1,246,635,000	1,115,450,000
Unrestricted Assets	1,750,995,000	1,644,056,000	1,750,995,000	1,644,056,000
Credit Ratings (S&P, Fitch, Moody's)				
Fitch	AA- with Stable			
S&P	A+ with Positive			
Moody's	Aa3 with Stable			

State of Connecticut
GENERAL ASSEMBLY

PUBLIC HEALTH COMMITTEE
LEGISLATIVE OFFICE BUILDING, ROOM 3000
HARTFORD, CONNECTICUT 06106-1591

December 21, 2015

Dr. Raul Pino, Acting Commissioner
Department of Public Health
410 Capitol Avenue
Hartford, CT 06106

Kimberly Martone, Director of Operations
Office of Health Care Access
410 Capitol Avenue
Hartford, CT 06106

Dear Commissioner Pino and Director Martone,

In reviewing the application of the Yale-New Haven Health Services to acquire Lawrence + Memorial Hospital, a major obstacle has emerged: none of the records which would cast light on the past actions of Yale-New Haven Health System (in acquiring Bridgeport and Greenwich Hospitals) are available. These records were not maintained beyond the seven year retention period and, as a consequence, are unavailable to both the public and to your Office and staff.

We respectfully request that, prior to any determination of "completeness" of this application (or the companion application of Yale-New Haven Health Services Corporation's Northeast Medical Group, Inc. to acquire Lawrence + Memorial Physician Association, Inc.) this gap be remedied. Specifically, in your final orders (dated June 13, 1996 for Bridgeport Hospital, December 17, 1997 for Greenwich Hospital), you requested the applicant (Yale-New Haven Health System) to fill in "Attachment 11" as evidence of compliance with your Order. Our suggestion is that the original application and the attachments to your Orders *be produced by the applicants* (since OHCA and its predecessor agencies will otherwise be unable to evaluate the current applications).

Our most accurate guide to the future (whether applicants before your agency will live up to their promises) is the past (whether they have in the past). We do not see how you could responsibly review the application before you, especially given its significant potential consequence to the consumer of health services in Connecticut, without having this evidence available. Moreover, we do not believe that the public could adequately evaluate these applications without your Office making this information

available: "What was the position of Greenwich and Bridgeport Hospitals prior to their acquisition by YNHHS, what was proposed in the applications for those acquisitions/affiliations, and what has been the result since approval of those applications?"

Very truly yours,

Terry Gerratana
Senate District #6
Co-Chair

Matthew Ritter
House District #1
Co-Chair

CC: George Jepsen, Attorney General
Office of Attorney General
55 Elm Street
Hartford, CT 06106

State of Connecticut

SENATOR LEONARD A. FASANO
SENATE MINORITY LEADER
34TH DISTRICT

SUITE 3400
LEGISLATIVE OFFICE BUILDING
HARTFORD, CONNECTICUT 06106-1591
www.SenatorFasano.com

HARTFORD: (860) 240-8800
TOLL FREE: (800) 842-1421
FAX: (860) 240-8306
Len.Fasano@cga.ct.gov

January 5, 2016

The Honorable Dr. Raul Pino
Acting Commissioner of Public Health
410 Capitol Ave., P.O. Box 340308
Hartford, CT 06134

Dear Commissioner Pino:

I am writing to join a number of my colleagues in the legislature in urging your agency to analyze fully the potential impact of Yale-New Haven Health Services' proposed acquisition of Lawrence and Memorial Health's operations on health care costs, prices, access and provider diversity. This transaction will lead to a further consolidation of Connecticut's hospital and health care market. Proceeding without a full understanding of the impact this consolidation will have on health care prices in the region and access to affordable care could result in irreversible harm to patients and payers.

A report released by a coalition of consumer, health care advocacy and labor organizations supports my concern. The report, entitled *Hospital Consolidation in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, describes patterns in hospital acute care inpatient discharge data that suggest that Connecticut's hospital markets are already highly concentrated and that the purchase of L+M by the Yale New Haven Health System will deepen that market concentration along the shoreline, where Yale-New Haven Health System is already a dominant actor.

The concerns raised in this report were recently validated, when the National Bureau of Economic Research released the largest study of hospital pricing for privately insured patients in history. Based on 88 million individual records, the study shows definitively that "hospital prices are positively associated with indicators of hospital market power. Even after conditioning on many demand and cost factors, hospital prices in monopoly markets are 15.3% higher than those in markets with four or more hospitals."

As co-author of Public Acts 14-168 and 15-146, let me state clearly that OHCA has both the legal authority and the obligation to request and analyze relevant cost, pricing and market data. Indeed, such

an analysis is necessary in order meet OHCA's existing statutory duty to ensure that the proposed transaction *"will improve quality, accessibility and cost effectiveness of health care delivery in the region" and* will not *"negatively impact the diversity of health care providers and patient choice in the geographic region"* or result in market consolidation that *"adversely affects health care costs or accessibility to health care."* Thus, while the more detailed legal requirements of the formal "Cost and Market Impact Review" contained in P.A. 15-146 do not apply to this transaction, OHCA nevertheless has the power and duty to conduct a thorough review of the cost, pricing, access and provider diversity implications of the transaction in order to fulfill its obligation to preserve access to affordable, quality health care.

To fulfill this duty, in addition to any other relevant data, I urge you to request and analyze data from the applicants on prices charged by the Hospital of St. Raphael before and after its acquisition by Yale-New Haven Hospital, and similar comparative data between current risk-adjusted prices at L+M and the Yale-New Haven Health System hospitals in Bridgeport, Greenwich and New Haven. This information is necessary in order to understand the likely impact this transaction will have on regional health care costs and the prices charged at L+M post transaction. Patients and payers in southeast Connecticut, who rely on L+M services, have a right to know what impact the proposed consolidation will have on their health care costs and access to affordable, quality services.

While the Attorney General has the authority and responsibility to enforce the Connecticut Anti Trust Act in the hospital and health care market, it is increasingly clear that Anti Trust laws alone cannot protect patients and consumers from the negative impacts of health care consolidation. Health care is a unique commodity. Access to affordable, quality care close to home is a necessity. Patients often have little choice in where they are sent for care, no understanding of the true cost of care, no negotiating power and little ability to comparison shop. These are the very factors that give large integrated health systems disproportionate power to control where care is provided and the price charged for that care. This is exactly why the legislature charged OHCA with the power and duty to conduct a policy based analysis of large health care transactions to ensure that consolidation does not lead to higher costs, less consumer choice and provider diversity, and reduced access to care.

Thank you for your time and attention. I appreciate your agency's diligence in this matter.

Sincerely,

Len Fasano
Senate Minority Leader

CC: Attorney General George Jepsen

Greer, Leslie

From: Martone, Kim
Sent: Friday, January 08, 2016 1:20 PM
To: Ciesones, Ron
Cc: Greer, Leslie; Lazarus, Steven; Roberts, Karen
Subject: FW: year end financials for L+M and L+MH (DN:15-32033-CON)
Attachments: FY2015 Lawrence and Memorial Corporation and Subsidiaries Audit Report.pdf; FY2015 Lawrence and Memorial Hospital Audit Report.pdf

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From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Friday, January 08, 2016 1:15 PM
To: Lazarus, Steven
Cc: Martone, Kim
Subject: FW: year end financials for L+M and L+MH (DN:15-32033-CON)

Hello Steve-
As noted in the recent completeness question responses for the above referenced dockets, I am forwarding the final audited financials for 2015. Please let me know if you have any questions. Thanks, Karen

kmb consulting llc

Karen M. Banoff, DNP, RN
Principal
203- 459-1601 (office)
203-209-0681 (mobile)

Lawrence + Memorial Hospital

Consolidated Financial Statements and Supplemental Information
September 30, 2015 and 2014

Lawrence + Memorial Hospital
Index
September 30, 2015 and 2014

Independent Auditor's Report

To the Board of Trustees of
Lawrence + Memorial Hospital

We have audited the accompanying consolidated financial statements of Lawrence + Memorial Hospital and its subsidiary (a subsidiary of Lawrence + Memorial Corporation, the "Hospital"), which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Hospital at September 30, 2015 and September 30, 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual organizations and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations and cash flows of the individual organizations.

PricewaterhouseCoopers LLP

January 5, 2016

Lawrence + Memorial Hospital
Consolidated Balance Sheets
September 30, 2015 and 2014

	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 13,362,306	$ 6,917,676
Investments	107,365,636	128,450,331
Patient accounts receivable, net of allowance for doubtful accounts of $9,766,654 and $6,293,473, respectively	37,976,959	36,373,069
Other receivables	4,131,254	4,156,260
Inventories	6,194,355	6,580,753
Due from affiliates	1,958,442	1,954,838
Prepaid expenses and other current assets	3,125,348	2,689,506
Debt service fund	1,304,613	1,304,562
Total current assets	175,418,913	188,426,995
Assets limited as to use		
Cash	183,677	182,862
Construction fund	-	561,676
Investments held in trust	926,080	925,227
Endowment investments	17,802,689	18,987,367
Funds held in trust by others	3,584,118	6,985,614
Contributions receivable	20,366	20,366
Total assets limited as to use	22,516,930	27,663,112
Deferred financing costs and other assets, net	2,187,006	2,315,752
Other receivables	19,596,372	16,536,719
Property, plant and equipment, net	150,976,973	160,857,796
	$ 370,696,194	$ 395,800,374
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 33,209,795	$ 25,786,034
Accrued vacation and sick pay	10,112,002	11,281,701
Salaries, wages, payroll taxes and amounts withheld from employees	4,908,525	5,950,567
Due to affiliates	2,512,703	2,215,430
Due to third party payors	6,711,203	5,165,225
Current portion of long-term debt	5,495,740	5,342,305
Total current liabilities	62,949,968	55,741,262
Accrued pension and other postretirement benefits	52,989,394	43,216,010
Other liabilities	23,691,278	20,601,530
Long-term debt, less current portion	102,938,747	108,587,802
Total liabilities	242,569,387	228,146,604
Net assets		
Unrestricted	103,203,168	138,173,767
Temporarily restricted	18,960,042	23,432,028
Permanently restricted	5,963,597	6,047,975
Total net assets	128,126,807	167,653,770
	$ 370,696,194	$ 395,800,374

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Consolidated Statements of Operations
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted revenues, gains and other support		
Net revenues from services to patients	$ 339,282,362	$ 337,129,192
Provision for bad debt	(12,821,337)	(14,930,302)
Net revenue less provision for bad debt	326,461,025	322,198,890
Other operating revenues	30,874,305	28,151,061
Net assets released from restriction used for operations	577,092	671,797
Total unrestricted revenues, gains and other support	357,912,422	351,021,748
Expenses		
Salaries and wages	140,605,613	143,838,674
Employee benefits	51,698,355	51,044,718
Supplies	63,622,692	59,538,141
Purchased services	29,998,356	38,647,767
Other	40,208,162	34,490,156
Interest	3,553,690	3,542,721
Depreciation and amortization	23,639,711	22,728,484
Total expenses	353,326,579	353,830,661
Income (loss) from operations	4,585,843	(2,808,913)
Nonoperating gains		
Unrestricted investment income	228,240	180,488
Income from investments and realized gains	9,708,669	8,608,113
Total nonoperating gains	9,936,909	8,788,601
Excess of revenues over expenses	14,522,752	5,979,688
Transfers to affiliated entities	(19,764,884)	(33,861,262)
Net unrealized (losses) gains on investments	(16,107,490)	31,059
Net assets released from restriction used for purchase of property, plant and equipment	140,748	139,360
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	$ (34,970,599)	$ (31,986,321)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted net assets		
Excess of revenues over expenses	$ 14,522,752	$ 5,979,688
Transfer to affiliated entities	(19,764,884)	(33,861,262)
Net unrealized gains on investment	(16,107,490)	31,059
Net assets released from restriction used for purchase of property, plant and equipment	140,748	139,360
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	(34,970,599)	(31,986,321)
Unrestricted net assets		
Beginning of year	138,173,767	170,160,088
End of year	$ 103,203,168	$ 138,173,767
Temporarily restricted net assets		
Income from investments	$ 538,194	$ 614,481
Net assets released from restriction	(4,718,825)	(811,157)
Contributions received	262,546	222,134
Change in value of irrevocable trust	683,868	111,315
Net realized and unrealized (losses) gains on investments	(1,237,769)	1,097,007
(Decrease) increase in temporarily restricted net assets	(4,471,986)	1,233,780
Temporarily restricted net assets		
Beginning of year	23,432,028	22,198,248
End of year	$ 18,960,042	$ 23,432,028
Permanently restricted net assets		
Change in value of funds held in trust by others	$ (84,378)	$ 100,721
(Decrease) increase in permanently restricted net assets	(84,378)	100,721
Permanently restricted net assets		
Beginning of year	6,047,975	5,947,254
End of year	$ 5,963,597	$ 6,047,975
Decrease in net assets	$ (39,526,963)	$ (30,651,820)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Hospital
Consolidated Statements of Cash Flows
Years Ended September 30, 2015 and 2014

	2015	2014
Cash flows from operating activities		
Change in net assets	$ (39,526,963)	$ (30,651,820)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	23,639,711	22,728,484
Restricted contributions	(493,535)	(725,796)
Net unrealized losses (gains) on investments	18,243,554	(755,794)
Provision for bad debts	12,821,337	14,930,302
Decrease (increase) in funds held in trust by others	3,401,496	(212,036)
Changes in other operating accounts		
Patient accounts receivable, net	(14,425,227)	(17,399,463)
Other receivables, net	(3,034,647)	(3,021,526)
Inventories	386,398	(735,283)
Due from affiliates	(3,604)	(638,063)
Prepaid expenses and other current assets	(435,842)	(433,409)
Deferred financing costs and other assets	128,746	(539,576)
Accounts payable	6,665,372	1,274,289
Accrued vacation and sick pay	(1,169,699)	(241,571)
Salaries, wages, payroll taxes and amounts withheld from employees	(1,042,042)	1,455,110
Due to affiliates	297,273	347,698
Due to third party payors	1,545,978	1,339,131
Pension, postretirement and other liabilities	12,863,132	3,733,372
Net cash provided by (used in) operating activities	19,861,438	(9,545,951)
Cash flows from investing activities		
Purchase of property, plant and equipment, net	(13,000,499)	(21,164,013)
Purchase of investments	(28,398,638)	(58,786,901)
Sales of investments	32,984,465	70,017,432
(Increase) decrease in debt service fund	(51)	1,693
Decrease in funds held in escrow	-	2,247,255
Net cash used in investing activities	(8,414,723)	(7,684,534)
Cash flows from financing activities		
Restricted contributions	493,535	725,796
Principal payments of long term debt	(5,495,620)	(27,739,349)
Proceeds of long term debt	-	50,742,745
Net cash (used in) provided by financing activities	(5,002,085)	23,729,192
Net increase in cash and cash equivalents	6,444,630	6,498,707
Cash and cash equivalents		
Beginning of year	6,917,675	418,968
End of year	$ 13,362,305	$ 6,917,675
Supplemental disclosure of noncash activities		
Construction in process included in accounts payable	$ 914,729	$ 1,673,118
Contributed securities	493,535	725,796

The accompanying notes are an integral part of these consolidated financial statements.

1. Significant Accounting Policies and Organization

Organization
Lawrence + Memorial Hospital (the "Hospital"), a non-profit organization incorporated under the General Statutes of the State of Connecticut, is a wholly owned subsidiary of Lawrence + Memorial Corporation (the "Corporation"). The Board of the Corporation elects a Board of Directors who manages the property and affairs of the Hospital.

Principles of Consolidation
The consolidated financial statements include the accounts of the Hospital and its wholly owned subsidiary, Associated Specialists of Southeastern Connecticut, Inc. ("Associated Specialists"). All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates
The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying footnotes. Actual results could differ from those estimates and there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Hospital's significant estimates include the collectability of patient accounts receivable, useful lives of fixed assets, estimated settlements due to third party payors, valuation of certain investments, estimated reserves for self-insurance liabilities, and benefit plan assumptions.

Regulatory Matters
The Hospital is required to file annual operating information with the State of Connecticut Office of Health Care Access ("OHCA").

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital and its subsidiary in perpetuity or in funds held in trust by others whose purpose is for the funds to be maintained in perpetuity.

Donor Restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions in the accompanying consolidated statements of operations.

Cash and Cash Equivalents
The Hospital and its subsidiary consider all highly liquid investments with original maturities of three months or less at the date of purchase to be cash equivalents.

Investments
Investments in equity and debt securities are recorded at fair value in the balance sheet. Fair value is generally determined based on quoted market prices where available or net asset values provided by investment managers. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the change in net assets.

Realized and unrealized gains and losses on donor restricted endowment funds are included in temporarily restricted net assets under State law which allows the Board to appropriate as much of the net appreciation of investments as is prudent considering the Hospital's long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends and general economic conditions.

Investments in limited liability companies are accounted for using the equity method in instances where the limited partner's interest is more than minor (3-5%).

Fair Value Measurements
Fair value guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Hospital for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

- Level 1 – Quoted prices in active markets for identical assets.

- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets in active markets, quoted prices in markets that are not active, or can be corroborated by observable market data for substantially the same term of the assets.

- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

Assets Held in Trust by Others
The Hospital has been named sole or participating beneficiary in several perpetual and charitable remainder trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity from the perpetual trusts and to receive the remainder of the trust assets for the charitable remainder trusts. For perpetual trusts, the estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. The charitable remainder trusts are recorded at the present value of the estimated future distributions expected to be received over the expected term of the trust agreement. The Hospital uses appropriate credit adjusted rates. In 2015 a significant remainder trust payment of $4 million was received from the estate of a donor in accordance with the terms of

the trust document. At the time of the trust termination, the trust was recorded at $3.2 million and based on the value of the trust received; $.8 million was recorded as a change in value of irrevocable trusts in the Hospital's change in temporarily restricted net assets. The release from restriction of the $4 million for use on operations was recorded on the Corporation's Statement of Operations as all gifts and development activity is recorded at the Corporation.

Assets Limited as to Use
Assets limited as to use include assets set aside by the Board of Directors and contribution receivables for the established purpose of providing for future improvement, expansion and replacement of plant and equipment. In addition, the Hospital's interest in externally managed trusts, and unexpended bond proceeds for construction purposes are also included therein.

Property, Plant and Equipment
Property, plant and equipment are recorded at cost, or, if received as a donation, at the fair value on the date received. The Hospital provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their useful lives. American Hospital Association lives are generally used and provide for a 2-25 year life for land improvements, 5-50 year life for buildings and 2-25 year life for equipment. Lease improvements are amortized over the life of the lease.

Nonoperating Gains and Losses
Activities other than in connection with providing health care services are considered to be nonoperating.

Excess of Revenues Over Expenses
The consolidated statement of operations includes excess of revenues over expenses. Changes in unrestricted net assets which are excluded from the excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension-related charges other than periodic pension costs and other postretirement benefits liabilities.

Fair Value of Financial Instruments
Certain investments and other assets and liabilities are carried at amounts that approximate fair value based on current market conditions. The fair value of long-term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to the Hospital for debt of the same remaining maturities.

Medical Malpractice Self-Insurance
The Hospital purchases claims made-based professional and general liability insurance to cover medical malpractice claims from L + M Indemnity, Ltd., a wholly owned subsidiary of the Hospital's parent. The Hospital has adopted the policy of self-insuring the tail coverage portion of its malpractice insurance coverage. Management has accrued the estimate of losses anticipated to be incurred.

Income Taxes
The Hospital and its wholly owned subsidiary, Associated Specialists, are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c) (3) of the Internal Revenue Code.

Inventories
Inventory consists of supplies, both medical and general, pharmaceuticals and food products needed to sustain daily operation of patient care. Inventories are carried at the lower of cost or market under the first-in-first-out (FIFO) method.

Impairment of Long-Lived Assets
Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to dispose.

Accrued Vacation and Sick Pay
Accrued vacation is recorded as a liability as time is earned. As the time is used, the time is relieved from the liability. Accrued sick time is recorded as a percent for employees who have a balance greater than or equal to 800 hours. This payout is only upon termination of employment.

Labor action update
The Hospital's negotiations with two of its three unions, AFT Healthcare, AFT-CT, AFT, AFL-CIO, Local 5049 (registered nurses) and AFT Healthcare, AFT-CT, AFLCIO, Local 5051 (licensed practical nurses and technicians) for a new contract resulted in a 4-day strike that commenced on November 27, 2013. The Hospital brought in temporary replacement workers, and, in order to provide ongoing patient care given the threat of additional, intermittent strikes, had a lockout of employees through December 18, 2013. The lockout was lifted and employees returned to work without a contract being reached. A contract was reached and ratified and the workforce had a three year contract that was signed in February 2014. The Hospital monitored the negative impact of the strike and lockout on both revenues and expenses. This impact consisted of a reduction in net revenue of approximately $1,900,000 (unaudited) and $12,300,000 (unaudited) of replacement workers, security and reduced salary costs during 2014.

Subsequent Events
The Hospital has performed an evaluation of subsequent events through January 5, 2016, which is the date the financial statements were issued.

2. Revenues from Services to Patients and Charity Care

The following summarizes net revenues from services to patients:

	2015	2014
Gross charges from services to patients	$ 843,024,228	$ 795,287,303
Less: Charity care	5,427,817	5,449,069
Charges from services to patients, net of charity care	837,596,411	789,838,234
Deductions		
Allowances	485,513,042	450,251,022
State of Connecticut uncompensated care system	12,801,007	2,458,020
Total deductions	498,314,049	452,709,042
Net revenues from services to patients	$ 339,282,362	$ 337,129,192

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payors are different from established billing rates of the Hospital, and these differences are accounted for as allowances. The State of Connecticut has reduced Uncompensated Care Payments to all hospitals beginning July 2013 for a three year period. In 2014 and 2015, the Corporation paid cash into the State of Connecticut Uncompensated Care Pool that exceeded the amount was received from the State.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Adjustments related to prior year settlements increased the Hospital's revenues by approximately $4,119,679 in 2015 and decreased the Hospital's revenues by approximately $1,584,575 in 2014.

During 2015 and 2014, approximately 36% and 35%, respectively, of net patient service revenue was received under the Medicare program, and 12% and 11%, respectively, under the state Medicaid program. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation. Noncompliance could result in significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and reductions of funding levels could have an adverse impact on the Hospital.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines.

3. Investments

Investments at September 30 consist of:

	2015	2014
Investments		
Cash and cash equivalents	$ 2,475,788	$ 2,582,141
Bonds	14,797,119	20,187,600
Mutual funds	26,419,933	54,002,586
Hedge funds	57,529,962	47,442,075
Private equities	6,142,834	4,235,929
Total other investments	107,365,636	128,450,331
Funds held in trust by others		
Investments held in trust by others	3,584,118	6,985,614
Total investments held in trust by others	3,584,118	6,985,614
Endowment investments		
Cash and cash equivalents	201,141	255,829
Bonds	2,447,475	2,481,439
Mutual funds	8,553,873	10,596,174
Hedge funds	6,053,615	4,977,463
Private equities	231,641	168,351
Marketable equities	314,944	508,111
Total endowment investments	17,802,689	18,987,367
Total Investments at fair value	$ 128,752,443	$ 154,423,312

The Hospital's financial instrument categorization is based upon the lowest level of input that is significant to the fair value measurement within the valuation hierarchy. The following table presents the financial instruments carried at fair value using the valuation hierarchy:

	2015			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 2,475,788	$ -	$ -	$ 2,475,788
Bonds	9,306,863	5,490,256	-	14,797,119
Mutual funds	26,419,933	-	-	26,419,933
Hedge funds	-	-	57,529,962	57,529,962
Private equities	-	-	6,142,834	6,142,834
Total other investments	38,202,584	5,490,256	63,672,796	107,365,636
Funds held in trust by others				
Investments held in trust by others	-	-	3,584,118	3,584,118
Total held in trust by others	-	-	3,584,118	3,584,118
Endowment investments				
Cash and cash equivalents	201,141	-	-	201,141
Bonds	1,582,765	564,931	299,779	2,447,475
Mutual funds	7,225,792	-	1,328,081	8,553,873
Hedge funds	-	-	6,053,615	6,053,615
Private equities	-	-	231,641	231,641
Marketable equities	314,944	-	-	314,944
Total endowment investments	9,324,642	564,931	7,913,116	17,802,689
	$ 47,527,226	$ 6,055,187	$ 75,170,030	$ 128,752,443

	2014			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 2,582,141	$ -	$ -	$ 2,582,141
Bonds	14,261,701	5,925,899	-	20,187,600
Mutual funds	54,002,586	-	-	54,002,586
Hedge funds	-	-	47,442,075	47,442,075
Private equities	-	-	4,235,929	4,235,929
Total other investments	70,846,428	5,925,899	51,678,004	128,450,331
Funds held in trust by others				
Investments held in trust by others	-	-	6,985,614	6,985,614
Total held in trust by others	-	-	6,985,614	6,985,614
Endowment investments				
Cash and cash equivalents	255,829	-	-	255,829
Bonds	1,560,348	608,664	312,427	2,481,439
Mutual funds	9,018,452	-	1,577,722	10,596,174
Hedge funds	-	-	4,977,463	4,977,463
Private equities	-	-	168,351	168,351
Marketable equities	508,111	-	-	508,111
Total endowment investments	11,342,740	608,664	7,035,963	18,987,367
	$ 82,189,168	$ 6,534,563	$ 65,699,581	$ 154,423,312

Fair value for Level 1 is based upon quoted prices in active markets that the Hospital has the ability to access at the measurement date. Market price data is generally obtained from exchange or dealer markets. The Hospital does not adjust the quoted price for such assets.

Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers.

Fair value for Level 3 is based on valuation techniques that use significant inputs that are unobservable as they trade infrequently or not at all and reflect assumptions based on the best information available in the circumstances.

Investments included in Level 3 primarily consist of the Hospital's ownership in alternative investments (principally limited partnership interests in hedge funds). The value of these alternative investments represents the ownership interest in the net asset value ("NAV") of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner and are based on appraisals, or other estimates that require varying degrees of judgment. If no public market exists for the investment securities, the fair value is determined by the general partner taking into consideration, among other things, the cost of the securities, prices of recent significant placements of securities of the same issuer, and subsequent developments concerning the companies to which the securities relate. Also included in Level 3 investments are charitable remainder trusts held by third parties which are recorded at the present value of the future distributions expected to be received over the term of the agreement.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The following table is a roll forward of the amounts by investment type for financial instruments classified by the Hospital within Level 3 of the fair value hierarchy defined above:

	Beginning October 1, 2014	Investment Income	Realized Gains	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2015
Investment pool								
Hedge funds	$ 54,309,686	$ 386,194	$ 822,070	$ (5,276,131)	$ (238,953)	$ 15,395,580	$ (187,009)	$ 65,211,437
Private equities	4,404,281	667	319,946	463,808	(108,941)	1,799,667	(504,953)	6,374,475
Funds held in trust	6,985,614	-	-	599,490	-	-	(4,000,986)	3,584,118
	$ 65,699,581	$ 386,861	$ 1,142,016	$ (4,212,833)	$ (347,894)	$ 17,195,247	$ (4,692,948)	$ 75,170,030

	Beginning October 1, 2013	Investment Income	Realized Gains	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2014
Investment pool								
Hedge funds	$ 51,695,126	$ 526,509	$ 242,582	$ 1,907,402	$ (133,494)	$ 339,590	$ (268,029)	$ 54,309,686
Private equities	1,862,538	-	386,731	262,436	(78,224)	2,047,216	(76,416)	4,404,281
Funds held in trust	6,773,578	-	-	212,036	-	-	-	6,985,614
	$ 60,331,242	$ 526,509	$ 629,313	$ 2,381,874	$ (211,718)	$ 2,386,806	$ (344,445)	$ 65,699,581

There were no significant transfers between levels of assets for the fiscal year ended September 30, 2015.

A summary of the investment return is presented below:

	2015	2014
Investment income	$ 1,862,864	$ 1,936,104
Realized and unrealized (losses) gains	(9,218,819)	8,085,342
Management fees and other costs	(439,538)	(680,378)
Total return on endowment investments	$ (7,795,493)	$ 9,341,068

Following is additional information related to funds whose fair value is not readily determinable as of September 30, 2015.

	Strategy	Fair Value	# of Investments	Timing to Draw Down Commitments	Redemption Terms	Redemption Restrictions
Equity securities	Global developed and emerging market equity	$ 25,921,894	2	No remaining commitments	Monthly with 10 day's notice	None
Absolute return	Long/short and long-biased equity and credit hedge funds	15,477,269	7	No remaining commitments	Annual with 90 day's notice	lock up provision of 12 months from the purchase date
Directional hedge	Long/short and long-biased equity and credit hedge funds	20,779,531	1	No remaining commitments	Quarterly with 60 day's notice	lock up provision of 25 months from the purchase date
Commodities	Commodity index	3,032,743	1	No remaining commitments	Monthly with 5 day's notice	None
Private equity	Private equity	6,374,475	9	Long term 5 years	Illiquid	Long Term 5-10 years
		$ 71,585,912				

None of the funds invested in are finite lived. Unfunded commitments at September 30, 2015 total approximately $5.4 million and relate to private equity funds. There are no liquidity restrictions in place at September 30, 2015.

4. Endowment

The Hospital's endowment consists of donor restricted endowment funds for a variety of purposes. The net assets associated with endowment funds including funds designated by the Board of Directors to function as endowments are classified and reported based on the existence or absence of donor imposed restrictions.

The Hospital understands net asset classification guidance requires that donor restricted endowment gifts be maintained in perpetuity. Consistent with net asset classification guidance, the Hospital classified as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure. The Hospital considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund.
- The purposes of the Hospital and donor-restricted endowment fund.
- General economic conditions.
- The possible effect of inflation and deflation.
- The expected total return from income and the appreciation of investments.
- Other resources of the Hospital.
- The investment policies of the Hospital.

Changes in endowment net assets for year ended September 30:

	2015			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 16,369,375	$ 2,839,683	$ 19,209,058
Investment return				
Investment income		45,381		45,381
Net realized and unrealized gains		(1,237,769)		(1,237,769)
Total investment return	-	(1,192,388)	-	(1,192,388)
Income distribution		(140,748)		(140,748)
Endowment net assets at end of year	$ -	$ 15,036,239	$ 2,839,683	$ 17,875,922

	2014			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ -	$ 15,304,434	$ 2,839,683	$ 18,144,117
Investment return				
Investment income	-	107,295	-	107,295
Net realized and unrealized gains	-	1,097,006	-	1,097,006
Total investment return	-	1,204,301	-	1,204,301
Income distribution	-	(139,360)	-	(139,360)
Endowment net assets at end of year	$ -	$ 16,369,375	$ 2,839,683	$ 19,209,058

The portion of the endowment retained either by explicit donor stipulation or by net asset classification guidance is summarized as follows:

	2015	2014
Temporarily restricted net assets		
Unspent income and appreciation on permanently restricted endowments for purchase of equipment and healthcare services	$ 15,036,239	$ 16,369,376
Total endowment funds classified as temporarily restricted net assets	$ 15,036,239	$ 16,369,376
Permanently restricted net assets		
Corpus of permanently restricted contributions for which income is to be used for purchase of equipment and healthcare services	$ 2,839,683	$ 2,839,683
Total endowment funds classified as permanently restricted net assets	$ 2,839,683	$ 2,839,683

Endowment Funds With Deficits
From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist they are classified as a reduction of unrestricted net assets.

Endowment Investment Return Objectives and Risk Parameters
The Hospital has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by the endowment while seeking to maintain the permanent nature of endowment funds. Under this policy, the return objective for the endowment assets measured over a full market cycle shall be to maximize the return against a blended index, based on the endowment's target asset allocation applied to the appropriate individual benchmarks.

Strategies Employed for Achieving Endowment Investment Objectives
To achieve its long-term rate of return objectives, the Hospital relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Hospital targets a diversified asset allocation to achieve its long-term objectives within prudent Hospital risk constraints.

Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives
Spending is guided by several factors most important is the value of the portfolio. Generally, the Board will approve a spending policy limiting annual expenditures for grants and operating expenses up to 4.5% of the value of the Funds' assets based on a 12 quarter rolling average for the endowment and operating funds.

Investment managers are given ample notice of the required withdrawal schedule. Appropriate liquidity is maintained to fund these withdrawals without impairing the investment process.

5. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30, 2015 and 2014:

	2015	2014
Funds held in trust by others	$ 482,010	$ 3,799,127
Contributions receivable	20,366	20,366
Free beds and plant replacement and expansion	15,036,239	16,369,376
Specific purpose reserves	3,421,427	3,243,159
	$ 18,960,042	$ 23,432,028

Permanently restricted net assets at September 30 are restricted to:

	2015	2014
Funds held in trust by others	$ 3,123,914	$ 3,208,292
Donor restricted endowment funds	2,839,683	2,839,683
	$ 5,963,597	$ 6,047,975

6. Property, Plant and Equipment

Property, plant and equipment consist of the following:

	2015	2014
Land and land improvements	$ 8,904,363	$ 8,846,232
Buildings	152,295,547	150,910,346
Equipment	270,848,642	265,024,485
	432,048,552	424,781,063
Less: Accumulated depreciation	(283,857,352)	(265,615,130)
	148,191,200	159,165,933
Construction in progress	2,785,773	1,691,863
	$ 150,976,973	$ 160,857,796

7. Long-Term Debt

	2015	2014
CHEFA Series F Revenue Bonds		
Various rate bonds, due 2016 to 2026	$ 28,065,000	$ 30,900,000
5.0% Term Bonds, due 2027 to 2031	8,705,000	8,705,000
5.0% Term Bonds, due 2032 to 2036	11,100,000	11,100,000
CHEFA Series G revenue bonds		
3.2% Term Bonds, due 2016 to 2023, option to extend with a maturity date of 2038	28,375,000	29,200,000
CHEFA H revenue bonds		
Variable rate bonds, due 2023 to 2034	21,405,000	21,405,000
Tax exempt lease	8,302,654	9,963,984
Capital lease obligation	53,360	112,009
Total debt outstanding	106,006,014	111,385,993
Less: Amounts classified as current	5,495,740	5,342,305
Add: Bond premium	2,428,473	2,544,115
Total long-term portion of long-term debt	$ 102,938,747	$ 108,587,803

On September 15, 2011 the Connecticut Health and Education Facilities Authority ("CHEFA") issued $58,940,000 of Series F Bonds (the "Series F Bonds") on behalf of the Hospital and Lawrence + Memorial Corporation (collectively referred to as the "Obligated Group" under the Series F Bond agreements). The Series F Bonds are structured with a term bonds due at various dates through July 1, 2036, with annual sinking fund payments due each July 1st. Interest on the Series F Bonds is payable semiannually on the first business day of January 1 and July 1 which began on January 1, 2012.

The tax exempt lease was obtained on June 27, 2013 in the principal amount of $12,000,000. This is a seven year equipment lease on specific capital purchases that is administered through CHEFA and Bank of America-Merrill Lynch. This lease obligations will be amortized monthly through June 27, 2020 at a nominal annual interest rate of 1.759%.

On October 10, 2013 Series G was issued in a private placement offering with Bank of America-Merrill Lynch and CHEFA in the amount of $29,200,000 with an interest rate of 3.20% until October 1, 2023 with an option to extend at a negotiated rate with a maturity date of July 1, 2038.

On November 5, 2013, Series H was issued by CHEFA to refinance Series E. Series H was issued in the amount of $21,405,000 with a variable rate and a maturity date of July 1, 2034. This bond has a letter of credit guaranteed by T.D. Bank. Interest on the Series H Bonds accrues at the weekly rate and is payable on the first business day of each month commencing January 1, 2014.

Under the terms of the trust indenture for the Series F, G and H Bonds, the Obligated Group is required to meet certain financial covenants including a debt service coverage ratio and days cash on hand ratio. Members of the Obligated Group are jointly and severally obligated to provide amounts sufficient to enable the Authority to pay principal and interest on the Series F, G and H Bonds. The Bonds and bond proceeds have been allocated to the Hospital and as such, the Hospital will make future debt service payments as required under the terms of the bonds.

The bonds may be retired at an earlier date pursuant to terms of the master indenture. Payment of the bonds is collateralized by a pledge of the gross receipts, as defined and certain real property of the Hospital.

The Series H Bonds are considered variable rate demand bonds and are remarketed on a weekly basis. The Hospital maintains a letter of credit in the amount of $21,405,000 which expires on November 5, 2016. If the bonds are unable to be remarketed, the letter of credit could be utilized to purchase the bonds. The Obligated Group would then be subject to the payment terms of the letter of credit, which are monthly installments. The Series H Bonds have been successfully remarketed in the past and there have been no draws on the letter of credit.

The fair value of the outstanding bonds is $101,550,368 and $106,215,296 at September 30, 2015 and, 2014, respectively.

Principal repayments on the outstanding long term debt are as follows:

Years	Annual Principal Repayment
2016	$ 5,495,740
2017	5,730,772
2018	5,916,285
2019	6,142,340
2020 and thereafter	82,720,877
	$ 106,006,014

The Hospital made cash interest payments of $3,495,549 and $3,566,051 in fiscal year 2015 and 2014, respectively. No interest was capitalized during 2015 or 2014.

8. Pension and Other Postretirement Benefits

The Hospital has a defined benefit plan covering all employees who elected to stay in the plan. The plan is frozen to new participants as of June 30, 1999. The benefits are based on years of service and the employee's compensation during the last five years of employment.

The Hospital provides health care and life insurance benefits to its retired employees who meet certain eligibility requirements. The Hospital's policy is to fund the cost of postretirement benefits other than pension as incurred. This plan was frozen to include only those employees who retired prior to May 1, 1994.

The following table sets forth the Plans' funded status and amounts recognized in the consolidated balance sheet at September 30, 2015 and 2014 (measurement date of September 30):

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Change in benefit obligation				
Benefit obligation at beginning of year	$ 156,674,809	$ 145,789,789	$ 837,437	$ 1,000,744
Service cost	2,141,301	2,402,724	-	-
Interest cost	6,195,482	6,417,121	24,077	29,884
Employee contributions	41,451	69,839	-	-
Benefits paid	(7,608,334)	(7,015,362)	(91,218)	(95,403)
Actuarial loss (gain)	4,414,165	9,010,698	(15,972)	(97,788)
Benefit obligation at end of year	161,858,874	156,674,809	754,324	837,437
Change in plan assets				
Fair value of plan assets at beginning of year	115,176,724	105,860,348	-	-
Actual return on plan assets	(4,147,965)	9,861,899	-	-
Employee contributions	41,451	69,839		-
Employer contributions	7,400,000	6,400,000	95,403	95,403
Benefits paid	(7,608,334)	(7,015,362)	(95,403)	(95,403)
Fair value of plan assets at end of year	110,861,876	115,176,724	-	-
Funded status of the plan	(50,996,998)	(41,498,085)	(754,324)	(837,437)
Unrecognized net loss (gain) from past experience different from that assumed and effects of changes in assumptions	55,236,126	41,399,294	(443,280)	(488,085)
	4,050	79,157		-
Accrued benefit costs recognized in the consolidated balance sheet	$ 4,243,178	$ (19,634)	$ (1,197,604)	$ (1,325,522)
Components of net periodic benefit costs				
Service cost	$ 2,141,301	$ 2,402,724	$ -	$ -
Interest cost	6,195,482	6,417,121	24,077	29,884
Expected return on plan assets	(8,603,526)	(7,920,200)	-	-
Amortization of net loss (gain)	3,328,824	2,676,330	(60,777)	(66,454)
Net amortization and deferral	75,107	111,153	-	-
Benefit cost	$ 3,137,188	$ 3,687,128	$ (36,700)	$ (36,570)

The net actuarial loss of approximately $4.4 million is due to a loss of approximately $7.5 million due to a change in mortality table offset by gains due to decrease in discount rate and other changes in assumptions.

The weighted average assumptions used to determine the net benefit cost at the beginning of the year are as follows:

	2015	2014
Discount rate	4.05 %	4.51 %
Average rate of compensation increases	2.50 %	2.50 %
Expected return on assets	7.50 %	7.50 %

The weighted average assumptions used to determine the benefit obligation at the end of the year are as follows:

	2015	2014
Discount rate	4.10 %	4.05 %
Average rate of compensation increases	2.50 %	2.50 %

The Plan's asset allocations as of September 30 are as follows:

Asset Category	2015	2014
Cash	2 %	2 %
Bonds	32	24
Mutual funds	26	45
Hedge funds	40	29
	100 %	100 %

The expected rate of return on assets is calculated based on past experience.

Expected benefits to be paid under the plans are as follows:

Fiscal Years Beginning October 1,	Expected Benefits
2015	$ 7,940,500
2016	8,280,197
2017	8,395,891
2018	8,784,310
2019	9,069,440
Expected aggregate for 5 fiscal years beginning 2020	49,712,011

Annual employer contributions are determined by the Hospital based upon calculations prepared by the plan's actuary. Expected contributions to the plans for 2016 are approximately (unaudited):

Pension	$ 7,940,000
Retiree health	89,642

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) for participants is assumed to be 8% in 2015 reducing to 5.0% by the year 2020 and remaining at that level thereafter. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a one percentage point increase in the assumed health care cost trend rate would increase the accumulated post-retirement benefit obligation and service cost plus interest cost by approximately $49,000 and $56,000, respectively, at September 30, 2015 and 2014. A one percentage point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $45,000 and $51,000, respectively, at September 30, 2015 and 2014.

Plan Assets

The defined benefit plan assets are valued utilizing the same fair value hierarchy as the Hospital's investments as described in Note 1.

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2015:

	Level 1	Level 2	Level 3	2015
Investments, at fair value				
Cash	$ 2,345,782	$ -	$ -	$ 2,345,782
Bonds	35,027,573	-	-	35,027,573
Mutual funds	24,119,636	4,946,910	-	29,066,546
Hedge funds	-	-	44,421,975	44,421,975
Total investments, at fair value	$ 61,492,991	$ 4,946,910	$ 44,421,975	$ 110,861,876

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2014:

	Level 1	Level 2	Level 3	2014
Investments, at fair value				
Cash	$ 2,417,830	$ -	$ -	$ 2,417,830
Bonds	27,571,791	-	-	27,571,791
Mutual funds	46,557,396	5,171,869	-	51,729,265
Hedge funds	-	-	33,457,838	33,457,838
Total investments, at fair value	$ 76,547,017	$ 5,171,869	$ 33,457,838	$ 115,176,724

There were transfers between levels during 2015 and no transfers during 2014.

The table below represents the change in fair value measurements for Level 3 investments held by the plan for the years ended September 30:

	2015	2014
Beginning balances	$ 33,457,838	$ 31,893,958
Realized gains	554,617	4,588,368
Fees	(204,757)	(79,614)
Unrealized losses	(3,485,723)	(2,944,874)
Purchases	14,100,000	-
Sales	-	-
Ending balances	$ 44,421,975	$ 33,457,838

The investment objective for the pension and post retirement plans seeks a positive long-term total return after inflation to meet the Hospital's current and future plan obligations.

Asset allocations combine tested theory and informed market judgment to balance investment risks with the need for high returns.

The Hospital's 401(k) plan covers eligible employees who elect to participate. Eligible employees may contribute a percentage of their salary. The Hospital matches 100% of the first 4% of gross pay deferred by employees for those employees who do not participate in the defined benefit plan. Contributions charged to operations were approximately $3,416,963 and $3,296,282 for 2015 and 2014, respectively.

9. Functional Expenses

The Hospital provides general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses by function are as follows:

	2015	2014
Health care services	$ 249,259,940	$ 258,736,071
General and administrative	104,066,639	95,094,590
	$ 353,326,579	$ 353,830,661

10. Contingencies

The Hospital is a party to various lawsuits incidental to its business. Management believes that the lawsuits will not have a material adverse effect on the Hospital's financial position, results of operations, changes in net assets or cash flows.

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Assets				
Current assets				
Cash and cash equivalents	$ 13,348,901	$ 13,405	$ -	$ 13,362,306
Investments	107,365,636	-	-	107,365,636
Patient accounts receivable, net	37,925,784	51,175	-	37,976,959
Other receivables	4,131,254	-	-	4,131,254
Inventories	6,194,355	-	-	6,194,355
Due from affiliates	2,065,142	-	(106,700)	1,958,442
Prepaid expenses and other current assets	3,125,348	-	-	3,125,348
Debt service fund	1,304,613	-	-	1,304,613
Total current assets	175,461,033	64,580	(106,700)	175,418,913
Assets limited as to use				
Cash	183,677	-	-	183,677
Construction funds	-	-	-	-
Investments held in trust	926,080	-	-	926,080
Endowment investments	17,802,689	-	-	17,802,689
Funds held in trust by others	3,584,118	-	-	3,584,118
Contributions receivable	20,366	-	-	20,366
Total assets limited as to use	22,516,930	-	-	22,516,930
Other assets				
Deferred financing costs	2,187,006	-	-	2,187,006
Other receivables	19,596,372	-	-	19,596,372
Property, plant and equipment	150,976,973	-	-	150,976,973
Total assets	$ 370,738,314	$ 64,580	$ (106,700)	$ 370,696,194

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Liabilities				
Current liabilities				
Accounts payable	$ 32,897,000	$ 312,795	$ -	$ 33,209,795
Accrued vacation and sick pay	10,112,002	-	-	10,112,002
Salaries, wages, payroll taxes and amounts withheld from employees	4,908,525	-	-	4,908,525
Due to affiliates	2,512,703	106,700	(106,700)	2,512,703
Due to third party payors	6,711,203	-	-	6,711,203
Current portion of long-term debt	5,495,740	-	-	5,495,740
Total current liabilities	62,637,173	419,495	(106,700)	62,949,968
Accrued pension and other postretirement benefits	52,989,394	-	-	52,989,394
Other liabilities	23,691,278	-	-	23,691,278
Long-term debt, less current portion	102,938,747	-	-	102,938,747
Total liabilities	242,256,592	419,495	(106,700)	242,569,387
Net assets				
Unrestricted	103,558,083	(354,915)	-	103,203,168
Temporarily restricted	18,960,042	-	-	18,960,042
Permanently restricted	5,963,597	-	-	5,963,597
Total net assets	128,481,722	(354,915)	-	128,126,807
	$ 370,738,314	$ 64,580	$ (106,700)	$ 370,696,194

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Assets				
Current assets				
Cash and cash equivalents	$ 6,917,676	$ -	$ -	$ 6,917,676
Investments	128,450,331	-	-	128,450,331
Patient accounts receivable, net	36,289,187	83,882	-	36,373,069
Other receivables	4,156,260	-	-	4,156,260
Inventories	6,580,753	-	-	6,580,753
Due from affiliates	2,064,619	-	(109,781)	1,954,838
Prepaid expenses and other current assets	2,689,506	-	-	2,689,506
Debt service fund	1,304,562	-	-	1,304,562
Total current assets	188,452,894	83,882	(109,781)	188,426,995
Assets limited as to use				
Cash	182,862	-	-	182,862
Construction funds	561,676	-	-	561,676
Investments held in trust	925,227	-	-	925,227
Endowment investments	18,987,367	-	-	18,987,367
Funds held in trust by others	6,985,614	-	-	6,985,614
Contributions receivable	20,366	-	-	20,366
Funds held in escrow by agreement with State of Connecticut Health and Educational Facilities Authority and trustees	-	-	-	-
Total assets limited as to use	27,663,112	-	-	27,663,112
Other assets				
Deferred financing costs	2,315,752	-	-	2,315,752
Other receivables	16,536,719	-	-	16,536,719
Property, plant and equipment	160,857,796	-	-	160,857,796
Total assets	$ 395,826,273	$ 83,882	$ (109,781)	$ 395,800,374

Lawrence + Memorial Hospital
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Liabilities				
Current liabilities				
Accounts payable	$ 25,518,874	$ 267,160	$ -	$ 25,786,034
Accrued vacation and sick pay	11,241,300	40,401	-	11,281,701
Salaries, wages, payroll taxes and amounts withheld from employees	5,728,350	222,217	-	5,950,567
Due to affiliates	2,215,430	109,781	(109,781)	2,215,430
Due to third party payors	5,165,225	-	-	5,165,225
Current portion of long-term debt	5,342,305	-	-	5,342,305
Total current liabilities	55,211,484	639,559	(109,781)	55,741,262
Accrued pension and other postretirement benefits	43,216,010	-	-	43,216,010
Other liabilities	20,601,530	-	-	20,601,530
Long-term debt, less current portion	108,587,802	-	-	108,587,802
Total liabilities	227,616,826	639,559	(109,781)	228,146,604
Net assets				
Unrestricted	138,729,444	(555,677)	-	138,173,767
Temporarily restricted	23,432,028	-	-	23,432,028
Permanently restricted	6,047,975	-	-	6,047,975
Total net assets	168,209,447	(555,677)	-	167,653,770
	$ 395,826,273	$ 83,882	$ (109,781)	$ 395,800,374

Lawrence + Memorial Hospital
Consolidating Statement of Operations
Year Ended September 30, 2015

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Net revenues from services to patients	$ 337,821,155	$ 1,461,207	$ -	$ 339,282,362
Provision for bad debt	(12,798,310)	(23,027)	-	(12,821,337)
Net revenue less provision for bad debt	325,022,845	1,438,180	-	326,461,025
Other operating revenues	30,854,159	57,404	(37,258)	30,874,305
Net assets released from restriction used for operation	577,092	-	-	577,092
	356,454,096	1,495,584	(37,258)	357,912,422
Operating expenses				
Salaries and wages	140,640,103	(34,490)	-	140,605,613
Employee benefits	51,694,855	15,075	(11,575)	51,698,355
Supplies	63,622,692	-	-	63,622,692
Purchased services	29,627,730	370,626	-	29,998,356
Other	37,349,172	2,884,673	(25,683)	40,208,162
Interest	3,553,690	-	-	3,553,690
Depreciation and amortization	23,639,711	-	-	23,639,711
Total expenses	350,127,953	3,235,884	(37,258)	353,326,579
Income (loss) from operations	6,326,143	(1,740,300)	-	4,585,843
Nonoperating gains				
Unrestricted investment income	228,240	-		228,240
Income from investments and realized gains	9,708,669	-		9,708,669
	9,936,909	-	-	9,936,909
Excess (deficit) of revenues over expenses	16,263,052	(1,740,300)	-	14,522,752
Transfers to affiliate entities	(21,705,946)	1,941,062	-	(19,764,884)
Net unrealized losses on investments	(16,107,490)	-	-	(16,107,490)
Net assets released from restriction used for purchase of property, plant and equipment	140,748	-	-	140,748
Pension related changes other than periodic pension costs	(13,761,725)	-	-	(13,761,725)
(Decrease) increase in unrestricted net assets	$ (35,171,361)	$ 200,762	$ -	$ (34,970,599)

Lawrence + Memorial Hospital
Consolidating Statement of Operations
Year Ended September 30, 2014

	Lawrence & Memorial Hospital	Associated Specialists of Connecticut	Eliminating Entities	Consolidated
Net revenues	$ 333,751,931	$ 3,377,261	$ -	$ 337,129,192
Provision for bad debt	(14,966,698)	36,396	-	(14,930,302)
Net revenue less provision for bad debt	318,785,233	3,413,657	-	322,198,890
Other operating revenues	29,607,174	319,074	(1,775,187)	28,151,061
Net assets released from restriction	671,797	-	-	671,797
	349,064,204	3,732,731	(1,775,187)	351,021,748
Operating expenses				
Salaries and wages	142,343,619	1,610,637	(115,582)	143,838,674
Employee benefits	50,942,363	361,785	(259,430)	51,044,718
Supplies	59,512,480	25,661	-	59,538,141
Purchased services	37,964,369	1,604,552	(921,154)	38,647,767
Other	31,491,444	3,477,733	(479,021)	34,490,156
Interest	3,542,721	-	-	3,542,721
Depreciation and amortization	22,728,484	-	-	22,728,484
	348,525,480	7,080,368	(1,775,187)	353,830,661
Income (loss) from operations	538,724	(3,347,637)	-	(2,808,913)
Nonoperating gains				
Unrestricted income	180,488	-	-	180,488
Income from investments	8,608,113	-	-	8,608,113
	8,788,601	-	-	8,788,601
Excess of revenues over expenses	9,327,325	(3,347,637)	-	5,979,688
Transfers from affiliate	(37,512,132)	3,650,870	-	(33,861,262)
Net unrealized gains on investments	31,059	-	-	31,059
Net assets released from restriction used for purchase of property, plant and equipment	139,360	-	-	139,360
Donated equipment	6,350	-	-	6,350
Pension related changes other than periodic pension costs	(4,281,516)	-	-	(4,281,516)
(Decrease) increase in unrestricted net assets	$ (32,289,554)	$ 303,233	$ -	$ (31,986,321)

Lawrence + Memorial Corporation and Subsidiaries

Consolidated Financial Statements and Supplemental Information
September 30, 2015 and 2014

Lawrence + Memorial Corporation and Subsidiaries
Index
September 30, 2015 and 2014

Independent Auditor's Report

To the Board of Trustees of
Lawrence + Memorial Corporation

We have audited the accompanying consolidated financial statements of Lawrence + Memorial Corporation (the "Corporation") and its subsidiaries, which comprise the consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the financial statements of Visiting Nurse Association of Southeastern Connecticut, Inc., a wholly owned subsidiary, which statements reflect total assets of $22,024,179 and $20,659,633 as of September 30, 2015 and September 30, 2014, respectively, and total revenues of $16,957,535 and $16,156,841 for the years then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Visiting Nurse Association of Southeastern Connecticut, Inc., is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Corporation's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Lawrence + Memorial Corporation (the "Corporation") and its subsidiaries at September 30, 2015 and September 30, 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and cash flows of the individual organizations and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, and changes in net assets of the individual organizations.

PricewaterhouseCoopers LLP

January 5, 2016

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Balance Sheets
September 30, 2015 and 2014

	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 24,264,612	$ 16,480,529
Investments	162,278,643	184,426,039
Patient accounts receivable, net of allowance for doubtful accounts of $14,427,346 and $10,334,227, respectively	50,471,594	47,482,954
Other receivables	6,075,280	5,792,415
Inventories	8,154,843	8,393,007
Prepaid expenses and other current assets	3,810,426	3,748,725
Debt service fund	1,304,613	1,304,562
Total current assets	256,360,011	267,628,231
Assets limited as to use		
Cash	183,677	182,862
Construction fund	-	561,676
Investments held in trust	926,080	925,227
Endowment investments	35,458,701	36,641,428
Funds held in trust by others	7,633,141	11,348,610
Contributions receivable	2,916,786	3,520,787
Total assets limited as to use	47,118,385	53,180,590
Intangible assets, net	2,604,375	2,978,625
Other receivables	2,818,554	2,580,786
Deferred financing costs and other assets, net	2,187,006	2,315,752
Property, plant and equipment, net	196,288,742	206,850,299
	$ 507,377,073	$ 535,534,283
Liabilities and Net Assets		
Current liabilities		
Accounts payable	$ 37,172,933	$ 36,357,188
Accrued vacation and sick pay	13,689,948	14,223,728
Salaries, wages, payroll taxes and amounts withheld from employees	9,618,789	10,671,516
Due to third party payors	8,175,846	7,257,949
Other current liabilities	655,581	582,553
Current portion of long-term debt	5,495,740	5,476,980
Total current liabilities	74,808,837	74,569,914
Accrued pension and other postretirement benefits	53,468,405	43,588,661
Other liabilities	31,629,767	26,410,901
Long-term debt less current portion	102,938,747	108,587,802
Total liabilities	262,845,756	253,157,278
Net assets		
Unrestricted	208,910,764	241,902,500
Temporarily restricted	20,286,597	24,770,687
Permanently restricted	15,333,956	15,703,818
Total net assets	244,531,317	282,377,005
	$ 507,377,073	$ 535,534,283

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Statements of Operations
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted revenues, gains and other support		
Net revenues from services to patients	$ 455,465,769	$ 453,529,100
Provision for bad debt	(16,683,423)	(20,298,386)
Net revenue less provision for bad debt	438,782,346	433,230,714
Other operating revenues	16,375,817	20,795,287
Net assets released from restriction used for operations	4,831,645	876,203
Total unrestricted revenues, gains and other support	459,989,808	454,902,204
Operating expenses		
Salaries and wages	212,124,691	213,467,507
Employee benefits	59,040,657	59,185,837
Supplies	76,774,253	71,998,110
Purchased services	39,607,243	54,475,011
Other	50,232,174	43,427,170
Interest	3,553,690	3,554,919
Depreciation and amortization	28,953,704	27,479,122
Total expenses	470,286,412	473,587,676
Loss from operations	(10,296,604)	(18,685,472)
Nonoperating gains		
Unrestricted investment income	228,240	180,488
Nonoperating expenses	(1,527,184)	-
Income from investments and realized gains	13,131,917	9,832,164
Inherent contribution received from purchase of Westerly Hospital	-	5,284,752
Total nonoperating gains	11,832,973	15,297,404
Excess (deficit) of revenues over expenses	1,536,369	(3,388,068)
Net unrealized (losses) gains on investments	(20,907,128)	2,028,088
Net assets released from restrictions used for purchase of property, plant and equipment	140,748	1,006,500
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	$ (32,991,736)	$ (4,628,646)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Statements of Changes in Net Assets
Years Ended September 30, 2015 and 2014

	2015	2014
Unrestricted net assets		
Excess (deficit) of revenues over expenses	$ 1,536,369	$ (3,388,068)
Net unrealized (losses) gains on investments	(20,907,128)	2,028,088
Net assets released from restrictions used for purchase of property, plant and equipment	140,748	1,006,500
Donated equipment	-	6,350
Pension related changes other than periodic pension costs	(13,761,725)	(4,281,516)
Decrease in unrestricted net assets	(32,991,736)	(4,628,646)
Beginning of year unrestricted net assets	241,902,500	246,531,146
End of year unrestricted net assets	$ 208,910,764	$ 241,902,500
Temporarily restricted net assets		
Income from investments	$ 549,250	$ 677,343
Net assets released from restrictions	(4,972,392)	(1,882,704)
Contributions received	474,954	421,640
Change in value of funds held in trust by others	683,868	111,315
Net realized and unrealized (losses) gains on investments	(1,219,770)	1,288,111
(Decrease) increase in temporarily restricted net assets	(4,484,090)	615,705
Temporarily restricted net assets		
Beginning of year	24,770,687	24,154,982
End of year	$ 20,286,597	$ 24,770,687
Permanently restricted net assets		
Income from investments	$ 17,103	$ 20,569
Contributions received	77,827	80,074
Change in value of funds held in trust by others	(398,351)	280,866
Net realized and unrealized (losses) gains on investments	(66,441)	32,831
(Decrease) increase in permanently restricted net assets	(369,862)	414,340
Permanently restricted net assets		
Beginning of year	15,703,818	15,289,478
End of year	15,333,956	15,703,818
Decrease in net assets	$ (37,845,688)	$ (3,598,601)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended September 30, 2015 and 2014

	2015	2014
Cash flows from operating activities		
Change in net assets	$ (37,845,688)	$ (3,598,601)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	28,953,704	27,479,122
Net unrealized and realized losses (gains) on investments	23,070,838	(2,963,155)
Inherent contribution received from purchase of Westerly Hospital	-	(4,940,302)
Provision for bad debts	16,683,423	20,298,386
Decrease (increase) in funds held in trust by others	3,715,469	(392,181)
Decrease in contributions receivable	604,001	(817,794)
Restricted contributions	(1,024,204)	(1,164,969)
Changes in other operating accounts		
Patient accounts receivable, net	(19,672,063)	(20,461,592)
Other receivables, net	(520,633)	(504,322)
Inventories	238,164	(891,853)
Prepaid expenses and other current assets	(61,701)	(191,218)
Deferred financing costs and other assets	128,746	(539,576)
Accounts payable	57,356	(3,713,678)
Accrued vacation and sick pay	(533,780)	1,643,021
Salaries, wages, payroll taxes and amounts withheld from employees	(1,052,727)	569,862
Due to third party payors	917,897	1,386,968
Amortization on Intangibles	374,250	-
Pension, postretirement and other liabilities	15,171,638	5,674,664
Net cash provided by operating activities	29,204,690	16,872,782
Cash flows from investing activities		
Purchase of property, plant and equipment, net	(17,633,758)	(25,715,324)
Purchases of investments	(61,391,317)	(70,459,536)
Sales of investments	62,210,610	77,121,334
Decrease in debt service fund	(51)	1,693
Decrease in funds held in escrow	-	2,247,255
Net cash used in investing activities	(16,814,516)	(16,804,578)
Cash flows from financing activities		
Restricted contributions	1,024,204	1,164,969
Principal payments of long term debt	(5,630,295)	(28,364,994)
Proceeds of long term debt	-	32,080,103
Net cash (used in) provided by financing activities	(4,606,091)	4,880,078
Net increase in cash and cash equivalents	7,784,083	4,948,282
Cash and cash equivalents		
Beginning of year	16,480,529	11,532,247
End of year	$ 24,264,612	$ 16,480,529
Supplemental disclosure of noncash activities		
Construction in process included in accounts payable	$ 914,729	$ 1,673,118
Contributed securities	1,024,204	1,164,969

The accompanying notes are an integral part of these consolidated financial statements.

1. Significant Accounting Policies and Organization

Organization

Lawrence + Memorial Corporation (the "Corporation") is a not-for-profit organization incorporated under the Nonstock Corporation Act of the State of Connecticut. The Corporation is organized exclusively for public welfare, charitable, scientific, literary and education purposes, including the furtherance of the welfare, programs and activities of Lawrence + Memorial Hospital (the "Hospital"), a nonprofit organization incorporated under the General Statutes of the State of Connecticut.

Yale New Haven Health System Affiliation

On July 17, 2015, the Corporation and Yale New Haven Health System ("YNHHS") announced they have approved a definitive agreement to affiliate, pending regulatory approvals. The definitive agreement, approved by both Boards of Directors, is based on the mutual belief that an affiliation would enhance healthcare quality, access and efficiency. Under the agreement, the Corporation will become a corporate member of YNHHS, joining Bridgeport, Greenwich and Yale-New Haven Hospitals as a full member of YNHHS. The affiliation will require review and approval by Connecticut and Rhode Island state agencies. The process is expected to be completed by Summer 2016. The Corporation incurred approximately $1.5 million in legal and other professional expenses in connection with due diligence as a result of this agreement which has been recorded as nonoperating expenses within the Consolidated Statement of Operations.

The following entities are subsidiaries of the Corporation: Lawrence + Memorial Hospital ("L+M"), L& M Physician Association Inc., L&M Systems, Inc., VNA of Southeastern Connecticut, L&M Healthcare, L&M Indemnity Ltd, VNA of Southeastern Connecticut Inc. and LMW Healthcare Inc. (Westerly Hospital).

Acquisition of Westerly Hospital

On June 1, 2013, the Corporation and its subsidiary, LMW Healthcare, Inc. ("LMW") completed the acquisition of certain assets and liabilities of Westerly Hospital, a 125-bed general acute care hospital located in Westerly, Rhode Island on a 10.6 acre campus. The acquisition was the culmination of a process that included the appointment of W. Mark Russo, Esq. as the special master (the "Special Master") for Westerly Hospital and its affiliates by the Rhode Island Superior Court for the County of Washington (the "RI Court") in December 2011, due to the deteriorating financial condition of Westerly Hospital. The Special Master was granted authority by the RI Court to negotiate the sale of the assets of Westerly Hospital and its affiliates.

The Corporation formed LMW as a Rhode Island nonprofit corporation, and in June 2012, LMW entered into an Asset Purchase Agreement (the "Purchase Agreement") with the Special Master for Westerly Hospital and its affiliates, which was approved by the RI Court in September 2012. The Corporation guaranteed LMW's commitments under the Purchase Agreement. Pursuant to the Purchase Agreement and upon the successful completion of regulatory review by various Rhode Island agencies, the Corporation acquired certain assets and liabilities of Westerly Hospital and its affiliates, in order to expand its care and operations to the Westerly, Rhode Island community. The acquisition of the Westerly Hospital furthers the Corporation and Lawrence + Memorial Hospital's strategy of improving the depth and breadth of services available to all residents in the eastern Connecticut and western Rhode Island regions, without regard to ability to pay. Lawrence + Memorial Hospital expects to reduce unnecessary duplication of effort and costs with Westerly Hospital, while maintaining community access to essential services in the Westerly service area.

The purchase price of $16,098,758 was paid in cash. The transaction resulted in an inherent contribution of $12,011,469 which has been appropriately allocated to the three net asset classes within the statement of changes in net assets in 2013. The inherent contribution is a result of the value of net assets being acquired exceeding the purchase price. The purchase price allocation was preliminary and has been adjusted as additional information was obtained in 2014. An additional $5.3 million in inherent contribution was recorded in 2014, principally due to $3.1 million better experience on accounts receivable collections and $1.8 million in favorable final settlement of assumed accounts payable liabilities.

L&M Healthcare has an affiliation agreement effective January 31, 1999 (the "Agreement") with the Hospice of Southeastern Connecticut, Inc. (the "Hospice"). The Agreement gives L&M Healthcare a membership of the Hospice with one other not-for-profit healthcare organization. L&M Healthcare does not have an equity investment in the Hospice because the affiliation agreement does not require L&M Healthcare to provide capital to the Hospice and L&M Healthcare is not entitled to any of the net assets of the Hospice should the relationship terminate or the Hospice dissolve. The Corporation and its subsidiaries have never given capital to the Hospice and the Hospice has never made capital distributions to the Corporation or its subsidiaries.

L & M Physician Association, Inc. ("LMPA") was formed exclusively for the charitable purpose of benefiting, supporting, and furthering the charitable activities of Lawrence + Memorial Hospital by engaging physicians to provide physician services to the Hospital, organizations affiliated with the Hospital and communities they serve for purpose of practicing medicine and health care services.

Principles of Consolidation
The consolidated financial statements include the accounts of the Corporation and its wholly owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying footnotes. Actual results could differ from those estimates and there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The Corporation's significant estimates include the collectability of patient accounts receivable, useful lives of fixed assets, settlements due to third party payors, estimated reserves for self-insurance liabilities, and benefit plan assumptions.

Temporarily and Permanently Restricted Net Assets
Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time frame or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation and its subsidiaries in perpetuity or in funds held in trust by others whose purpose is for the funds to be maintained in perpetuity.

Donor Restricted Gifts
Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of operations as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are recorded as unrestricted contributions in the accompanying consolidated statements of operations.

Cash and Cash Equivalents
The Corporation and its subsidiaries consider all highly liquid investments with original maturities of three months or less at the date of purchase to be cash equivalents.

Investments
Investments in equity and debt securities are recorded at fair value in the balance sheet. Fair value is generally determined based on quoted market prices where available or net asset values provided by investment managers. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are included in the change in net assets. Under accounting principles generally accepted in the United States of America, an “other than temporary impairment” is recognized if the Corporation does not expect the fair value of a security to recover above cost or amortized cost. Once an “other than temporary impairment” charge has been recorded, a new cost basis is established.

The Corporation continues to review its securities for appropriate valuation on an ongoing basis. The Corporation determined that none of their investments were impaired as of September 30, 2015 or 2014.

Realized and unrealized gains and losses on donor restricted endowment funds are included in temporarily restricted net assets under State law which allows the Board to appropriate as much of the net appreciation of investments as is prudent considering the Corporation’s long and short-term needs, present and anticipated financial requirements, expected total return on its investments, price level trends, and general economic conditions.

Investments in limited liability companies are accounted for using the equity method in instances where the limited partner’s interest is more than minor (3-5%).

Fair Value Measurements
Fair value guidance establishes a hierarchy of valuation inputs based on the extent to which the inputs are observable in the marketplace. Observable inputs reflect market data obtained from sources independent of the reporting entity and unobservable inputs reflect the entities own assumptions about how market participants would value an asset or liability based on the best information available. Valuation techniques used to measure fair value must maximize the use of observable inputs and minimize the use of unobservable inputs. The guidance describes a fair value hierarchy based on three levels of inputs, of which the first two are considered observable and the last unobservable, that may be used to measure fair value.

The following describes the hierarchy of inputs used to measure fair value and the primary valuation methodologies used by the Corporation for financial instruments measured at fair value on a recurring basis. The three levels of inputs are as follows:

Level 1 Quoted prices in active markets for identical assets.

Level 2 Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets in active markets, quoted prices in markets that are not active, or can be corroborated by observable market data for substantially the same term of the assets.

Level 3 Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets.

Assets Held in Trust by Others
The Hospital has been named sole or participating beneficiary in several perpetual and charitable remainder trusts. Under the terms of these trusts, the Hospital has the irrevocable right to receive the income earned on the trust assets in perpetuity from the perpetual trusts and to receive the remainder of the trust assets for the charitable remainder trusts. For perpetual trusts, the estimated present value of the future payments to the Hospital is recorded at the fair value of the assets held in the trust. The charitable remainder trusts are recorded at the present value of the estimated future distributions expected to be received over the expected term of the trust agreement. The Hospital uses appropriate credit adjusted rates to discount amounts. In 2015 a significant remainder trust payment of $4 million was received from the estate of a donor in accordance with the terms of the trust documents. At the time of the trust termination, the trust was recorded at $3.2 million and based on the value of the trust received; $.8 million was recorded as a change in value of irrevocable trusts on the Hospital's change in temporarily restricted net assets. The release from restriction of the $4 million for use on operations was recorded on the Corporation's Statement of Operations as all gifts and development activity is recorded at the Corporation.

Assets Limited as to Use
Assets limited as to use include assets set aside by the Board of Directors, contribution receivables and for the established purpose of providing for future improvement, expansion and replacement of plant and equipment. In addition, the Corporation's interest in externally managed trusts, unexpended bond proceeds for construction purposes, and assets held by trustees are also included therein.

Property, Plant and Equipment
Property, plant and equipment are recorded at cost, or if received as a donation, at the fair value on the date received. The Corporation provides for depreciation of property, plant and equipment using the straight-line method in amounts sufficient to amortize the cost of its assets over their estimated useful lives. American Hospital Association lives are generally used and provide for a 2-25 year life for land improvements, 5-50 year life for buildings and a 2-25 year life for equipment. Lease improvements are amortized over the life of the lease.

Nonoperating Gains and Losses
Activities other than in connection with providing health care services are considered to be nonoperating.

Excess of Revenues Over Expenses
The consolidated statements of operations include nonoperating expenses in connection with the affiliation with Yale New Haven Health Systems in excess of revenues over expenses. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension-related charges other than periodic pension costs and other postretirement benefits liabilities.

Fair Value of Financial Instruments
Investments and other assets and liabilities are carried at amounts that approximate fair value based on current market conditions. The fair value of long term debt is estimated based on the quoted market prices for the same or similar issues or on current rates offered to the Corporation and its Subsidiaries for debt of the same remaining maturities.

Medical Malpractice Self-Insurance
The Corporation purchases claims made professional and general liability insurance to cover medical malpractice claims from L&M Indemnity Ltd, a wholly owned subsidiary of the Corporation. The Hospitals, LMPA and VNA have adopted the policy of self-insuring the tail portion of its malpractice insurance coverage. Management accrues its best estimate of losses as incidents which give rise to potential losses occur.

Income Taxes
The Corporation and its subsidiaries are not-for-profit organizations and are exempt from federal income taxes on related income under Section 501(c)(3) of the Internal Revenue Code, except for L&M Systems. L&M Systems provides for taxes based on current taxable income and the future tax consequences of temporary differences between financial and income tax reporting. Such amounts are not material to the consolidated financial statements.

Inventories
Inventory consists of supplies, both medical and general, pharmaceuticals and food products needed to sustain daily operation of patient care. Inventories are carried at the lower of cost or market under the first-in-first-out (FIFO) method.

Impairment of Long-Lived Assets
Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value less cost to dispose.

Accrued Vacation and Sick Pay
Accrued vacation is recorded as a liability as time is earned. As the time is used, the time is relieved from the liability. Accrued sick time is recorded as a percent for employees who have a balance greater than or equal to 800 hours. The payout is only upon termination of employment.

Labor Action Update

The Hospital's negotiations with two of its three unions, AFT Healthcare, AFT-CT, AFT, AFL-CIO, Local 5049 (registered nurses) and AFT Healthcare, AFT-CT, AFLCIO, Local 5051 (licensed practical nurses and technicians) for a new contract resulted in a 4-day strike that commenced on November 27, 2013. The Hospital brought in temporary replacement workers, and, in order to provide ongoing patient care given the threat of additional, intermittent strikes, had a lockout of employees through December 18, 2013. The lockout was lifted and employees returned to work without a contract being reached. A contract was reached and ratified and the workforce had a three year contract that was signed in February 2014. The Hospital monitored the negative impact of the strike and lockout on both revenues and expenses. This impact consisted of a reduction in net revenue of approximately $1,900,000 (unaudited) and $12,300,000 (unaudited) of replacement workers, security and reduced salary costs during 2014.

Subsequent Events

The Corporation has performed an evaluation of subsequent events through January 5, 2016, which is the date the financial statements were issued.

2. Revenues From Services to Patients and Charity Care

The following summarizes net revenues from services to patients:

	2015	2014
Gross charges from services to patients	$ 1,138,320,863	$ 1,078,626,933
Less: Charity care	6,124,509	6,782,933
Charges from services to patients, net of charity care	1,132,196,354	1,071,844,000
Deductions		
Allowances	663,929,578	615,856,880
State of Connecticut uncompensated care system	12,801,007	2,458,020
Total deductions	676,730,585	618,314,900
Net revenues from services to patients	$ 455,465,769	$ 453,529,100

Patient accounts receivable and revenues are recorded when patient services are performed. Amounts received from most payors are different from established billing rates of the Corporation, and these differences are accounted for as allowances. The State of Connecticut has reduced Uncompensated Care Payments to all hospitals beginning July 2013 for a three year period. In 2014 and 2015, the Corporation paid cash into the State of Connecticut Uncompensated Care Pool that exceeded the amount was received from the State.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Adjustments related to prior year settlements increased the Hospital's revenues by approximately $4,119,679 in 2015 and decreased the Hospital's revenue by approximately$1,584,575 in 2014.

During 2015 and 2014, approximately 36% and 35%, respectively, of net patient service revenue was received under the Medicare program, and 12% and 11%, respectively, under the state Medicaid program. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation. Non compliance could result in significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs. Changes in the Medicare and Medicaid programs and reductions of funding levels could have an adverse impact on the Hospital.

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to the established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's inability to pay, the Hospital utilizes the generally recognized federal poverty income guidelines.

3. Investments

Investments included in current assets consist of the following:

	2015	2014
Investments		
Cash and cash equivalents	$ 4,347,663	$ 6,293,794
Bonds	37,080,980	40,097,819
Mutual funds	39,711,437	72,596,528
Hedge funds	70,852,615	57,360,354
Private equities	6,682,428	4,535,516
Marketable equities	3,603,520	3,542,028
Total investments	162,278,643	184,426,039
Funds held in trust by others		
Investments held in trust by others	7,633,141	11,348,610
Total funds held in trust by others	7,633,141	11,348,610
Endowment investments		
Cash and cash equivalents	4,410,185	4,307,512
Bonds	5,312,210	5,061,901
Mutual funds	11,438,208	14,191,010
Hedge funds	7,603,385	6,263,387
Private equities	288,434	209,627
Marketable equities	6,406,279	6,607,991
Total endowment investments	35,458,701	36,641,428
Total investments at fair value	$ 205,370,485	$ 232,416,077

The Corporation's financial instrument categorization is based upon the lowest level of input that is significant to the fair value measurement within the valuation hierarchy. The following table presents the financial instruments carried at fair value using the by the fair value guidance valuation hierarchy defined above:

	2015			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 4,347,663	$ -	$ -	$ 4,347,663
Bonds	30,675,681	6,405,299	-	37,080,980
Mutual funds	39,711,437	-	-	39,711,437
Hedge funds	-	-	70,852,615	70,852,615
Private equities	-	-	6,682,428	6,682,428
Marketable equities	3,603,520	-	-	3,603,520
Total investments	78,338,301	6,405,299	77,535,043	162,278,643
Funds held in trust by others				
Investments held in trust by others	-	-	7,633,141	7,633,141
Total held in trust by others	-	-	7,633,141	7,633,141
Endowment investments				
Cash and cash equivalents	4,410,185	-	-	4,410,185
Bonds	3,435,383	1,577,048	299,779	5,312,210
Mutual funds	10,110,127	-	1,328,081	11,438,208
Hedge funds	-	-	7,603,385	7,603,385
Private equities	-	-	288,434	288,434
Marketable equities	6,406,279	-	-	6,406,279
Total endowment investments	24,361,974	1,577,048	9,519,679	35,458,701
Total Investments at fair value	$ 102,700,275	$ 7,982,347	$ 94,687,863	$ 205,370,485

	2014			
	Level 1	Level 2	Level 3	Total Fair Value
Investments				
Cash and cash equivalents	$ 6,293,794	$ -	$ -	$ 6,293,794
Bonds	33,184,269	6,913,550	-	40,097,819
Mutual funds	72,596,528	-	-	72,596,528
Hedge funds	-	-	57,360,354	57,360,354
Private equities	-	-	4,535,516	4,535,516
Marketable equities	3,542,028	-	-	3,542,028
Total investments	115,616,619	6,913,550	61,895,870	184,426,039
Funds held in trust by others				
Investments held in trust by others	-	-	11,348,610	11,348,610
Total held in trust by others	-	-	11,348,610	11,348,610
Endowment investments				
Cash and cash equivalents	4,307,512	-	-	4,307,512
Bonds	3,300,408	1,449,067	312,427	5,061,902
Mutual funds	12,613,287	-	1,577,722	14,191,009
Hedge funds	-	-	6,263,387	6,263,387
Private equities	-	-	209,627	209,627
Marketable equities	6,607,991	-	-	6,607,991
Total endowment investments	26,829,198	1,449,067	8,363,163	36,641,428
Total Investments at fair value	$ 142,445,817	$ 8,362,617	$ 81,607,643	$ 232,416,077

Fair value for Level 1 is based upon quoted prices in active markets that the Corporation has the ability to access at the measurement date. Market price data is generally obtained from exchange or dealer markets. The Corporation does not adjust the quoted price for such assets.

Fair value for Level 2 is based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets. Inputs are obtained from various sources including market participants, dealers and brokers.

Fair value for Level 3 is based on valuation techniques that use significant inputs that are unobservable as they trade infrequently or not at all and reflect assumptions based on the best information available in the circumstances.

Investments included in Level 3 primarily consist of the Corporations ownership in alternative investments (principally limited partnership interests in hedge funds). The value of these alternative investments represents the ownership interest in the net asset value ("NAV") of the respective partnership. The fair values of the securities held by limited partnerships that do not have readily determinable fair values are determined by the general partner and are based on appraisals, or other estimates that require varying degrees of judgment. If no public market exists for the investment securities, the fair value is determined by the general partner taking into consideration, among other things, the cost of the securities, prices of recent significant placements of securities of the same issuer, and subsequent developments concerning the companies to which the securities relate. Also included in Level 3 investments are charitable remainder trusts held by third parties which are recorded at the present value of the future distributions expected to be received over the term of the agreement and investments in for-profit companies.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Corporation believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The following table is a roll forward of the amounts by investment type for financial instruments classified by the Corporation within Level 3 of the fair value hierarchy defined above:

	Beginning October 1, 2014	Investment Income	Realized Gains	Unrealized (Losses) Gains	Investment Fees	Purchases	Sales	Ending September 30, 2015
Investment pool								
Hedge funds	$ 65,555,889	$ 458,045	$ 966,260	$ (6,421,508)	$ (295,818)	$ 20,216,000	$ (187,009)	$ 80,291,859
Private equities	4,703,144	667	330,143	534,090	(116,790)	1,821,362	(509,753)	6,762,863
Funds held in trust	11,348,610	102,675	393,314	(22,441)	(51,916)	41,181	(4,178,282)	7,633,141
	$ 81,607,643	$ 561,387	$ 1,689,717	$ (5,909,859)	$ (464,524)	$ 22,078,543	$ (4,875,044)	$ 94,687,863

	Beginning October 1, 2013	Investment Income	Realized Gains (Losses)	Unrealized Gains	Investment Fees	Purchases	Sales	Ending September 30, 2014
Investment pool								
Hedge funds	$ 62,386,880	$ 624,650	$ 270,868	$ 2,318,323	$ (158,389)	$ 381,586	$ (268,029)	$ 65,555,889
Private equities	1,996,835	-	387,382	311,627	(86,266)	2,169,982	(76,416)	4,703,144
Funds held in trust	10,956,429	141,409	(38,835)	344,380	(51,515)	-	(3,258)	11,348,610
	$ 75,340,144	$ 766,059	$ 619,415	$ 2,974,330	$ (296,170)	$ 2,551,568	$ (347,703)	$ 81,607,643

There were no significant transfers of assets between levels for the year ended September 30, 2015.

A summary of the investment return is presented below:

	2015	2014
Investment income	$ 3,232,345	$ 3,138,334
Realized and unrealized (losses) gains	(12,237,230)	10,268,410
Management fees and other costs	(671,327)	(754,021)
Total return on investments	$ (9,676,212)	$ 12,652,723

Following is additional information related to funds whose fair value is not readily determinable as of September 30, 2015.

	Strategy	Fair Value	Number of Investments	Timing to Draw Down Commitments	Redemption Terms	Redemption Restrictions
Equity securities	Global developed and emerging market equity	$ 32,433,821	2	No remaining commitments	Monthly with 10 day's notice	None
Absolute return	Long/short and long-biased equity and credit hedge funds	18,245,530	2	No remaining commitments	Annual with 90 day's notice	lock up provision of 12 months from the purchase date
Directional hedge	Long/short and long-biased equity and credit hedge funds	25,691,083	1	No remaining commitments	Quarterly with 60 day's notice	lock up provision of 25 months from the purchase date
Commodities	Commodity index	3,713,426	1	No remaining commitments	Monthly with 5 day's notice	None
Private equity	Private equity	6,970,862	9	Long term 5 years	Illiquid	Long Term 5-10 years
		$ 87,054,722				

None of the funds invested in are finite lived. Unfunded commitments at September 30, 2015 total approximately $5.5 million and relate to private equity funds. There are no liquidity restrictions in place at September 30, 2015.

4. Endowments

The Corporation's endowments consist of donor restricted endowment funds for a variety of purposes. The net assets associated with endowment funds including funds designated by the Board of Directors to function as endowments are classified and reported based on the existence or absence of donor imposed restrictions.

The Corporation understands net asset classification guidance to require that donor restricted endowment gifts be maintained in perpetuity. Consistent with net asset classification guidance, the Corporation classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure. The Corporation considers the following factors in making a determination to appropriate or accumulate endowment funds:

- The duration and preservation of the fund.
- The purposes of the Corporation and donor-restricted endowment fund.
- General economic conditions.
- The possible effect of inflation and deflation.
- The expected total return from income and the appreciation of investments.
- Other resources of the Corporation.
- The investment policies of the Corporation.

Changes in endowment net assets for the year ended September 30:

	2015			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 10,480,208	$ 17,497,079	$ 7,382,529	$ 35,359,816
Investment return				
Investment income	382,283	105,090	17,103	504,476
Net realized and unrealized gains (losses)	151,631	(1,268,480)	(66,441)	(1,183,290)
Contributions	87,352	-	77,827	165,179
Total investment return	621,266	(1,163,390)	28,489	(513,635)
Income distribution	-	(140,748)	-	(140,748)
Endowment net assets at end of year	$ 11,101,474	$ 16,192,941	$ 7,411,018	$ 34,705,433

	2014			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets at beginning of year	$ 9,257,584	$ 16,178,222	$ 7,249,055	$ 32,684,861
Addition of Westerly Hospital Endowment Net Assets	18,975	-	-	18,975
Investment return				
Investment income	304,778	170,106	20,569	495,453
Net realized and unrealized gains	715,724	1,288,111	32,832	2,036,667
Contributions	183,147	-	80,073	263,220
Total investment return	1,203,649	1,458,217	133,474	2,795,340
Income distribution	-	(139,360)	-	(139,360)
Endowment net assets at end of year	$ 10,480,208	$ 17,497,079	$ 7,382,529	$ 35,359,816

Endowment funds classified as permanently and temporarily restricted net assets:

The portion of the endowment retained either by explicit donor stipulation or by net asset classification guidance is summarized as follows:

	2015	2014
Temporarily restricted net assets		
Unspent income and appreciation on permanently restricted endowments for purchase of equipment and healthcare services	$ 16,192,941	$ 17,497,079
Total endowment funds classified as temporarily restricted net assets	$ 16,192,941	$ 17,497,079
Permanently restricted net assets		
Corpus of permanently restricted contributions for which income is to be used for purchase of equipment and healthcare services	$ 7,411,018	$ 7,382,529
Total endowment funds classified as permanently restricted net assets	$ 7,411,018	$ 7,382,529

Endowment Funds With Deficits

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist they are classified as a reduction of unrestricted net assets. The Corporation analyzed the endowments and notes there are no deficits as of September 30, 2015 and 2014.

Endowment Investment Return Objectives and Risk Parameters

The Corporation has adopted endowment investment and spending policies that attempt to provide predictable stream of funding to programs supported by the endowment while seeking to maintain the permanent nature of endowment funds. Under this policy, the return objective for the endowment assets measured over a full market cycle shall be to maximize the return against a blended index, based on the endowment's target asset allocation applied to the appropriate individual benchmarks.

Strategies Employed for Achieving Endowment Investment Objectives
To achieve its long-term rate of return objectives, the Corporation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). The Corporation targets a diversified asset allocation to achieve its long-term objectives within prudent Corporation risk constraints.

Endowment Spending Allocation and Relationship of Spending Policy to Investment Objectives
Spending is guided by several factors most important is the value of the portfolio. Generally, the Board will approve a spending policy limiting annual expenditures for grants and operating expenses up to 4.5% of the value of the Funds' assets based on a 12 quarter rolling average for the endowment, and operating funds.

Investment managers are given ample notice of the required withdrawal schedule. Appropriate liquidity is maintained to fund these withdrawals without impairing the investment process.

5. Temporary and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at September 30, 2015 and 2014:

	2015	2014
Temporarily restricted net assets		
Funds held in trust by others	$ 482,010	$ 3,799,127
Contributions receivable	20,366	20,366
Free beds and plant replacement and expansion	15,036,239	16,369,376
Specific purpose reserves	4,747,982	4,581,818
	$ 20,286,597	$ 24,770,687

Permanently restricted net assets at September 30, 2015 and 2014 are restricted to:

	2015	2014
Permanently restricted net assets		
Funds held in trust by others	$ 7,172,936	$ 7,571,288
Donor restricted endowment funds	8,161,020	8,132,530
	$ 15,333,956	$ 15,703,818

6. Property, Plant and Equipment

Property, plant and equipment consists of the following:

	2015	2014
Land and land improvements	$ 23,444,067	$ 23,323,273
Buildings	173,682,838	171,045,151
Equipment	293,448,847	284,414,885
	490,575,752	478,783,309
Less: Accumulated depreciation	(297,167,005)	(274,060,791)
	193,408,747	204,722,518
Construction in progress	2,879,995	2,127,781
	$ 196,288,742	$ 206,850,299

7. Long-Term Debt

	2015	2014
CHEFA Series F Revenue Bonds		
Various rate bonds, due 2016 to 2026	$ 28,065,000	$ 30,900,000
5.0% Term Bonds, due 2027 to 2031	8,705,000	8,705,000
5.0% Term Bonds, due 2032 to 2036	11,100,000	11,100,000
CHEFA Series G revenue bonds		
3.2% Term Bonds, due 2016 to 2023, option to extend 2038	28,375,000	29,200,000
CHEFA Series H revenue bonds		
Variable rate bonds, due 2023-2034	21,405,000	21,405,000
Tax exempt lease	8,302,654	9,963,984
Capital lease obligation	53,360	246,684
Total debt outstanding	106,006,014	111,520,668
Less: Amounts classified as current	5,495,740	5,476,980
Add: Bond premium	2,428,473	2,544,114
Total long-term portion of long-term debt	$ 102,938,747	$ 108,587,802

On September 15, 2011 the Connecticut Health and Education Facilities Authority ("CHEFA") issued $58,940,000 of Series F Bonds (the "Series F Bonds") on behalf of the Hospital and Lawrence + Memorial Corporation (collectively referred to as the "Obligated Group" under the Series F Bond agreements). The Series F Bonds are structured with a term bonds due at various dates through July 1, 2036, with annual sinking fund payments due each July 1st. Interest on the Series F Bonds is payable semiannually on the first business day of January 1 and July 1 which began on January 1, 2012.

The tax exempt lease was obtained on June 27, 2013 in the principal amount of $12,000,000. This is a seven year equipment lease on specific capital purchases that is administered through CHEFA and Bank of America-Merrill Lynch. This lease obligation will be amortized monthly through June 27, 2020 at a nominal annual interest rate of 1.759%.

On October 10, 2013 Series G was issued in a private placement offering with Bank of America-Merrill Lynch and CHEFA in the amount of $29,200,000 with an interest rate of 3.20% until October 1, 2023 with an option to extend at a negotiated rate with a maturity date of July 1, 2038.

On November 5, 2013, Series H was issued by CHEFA to refinance Series E. Series H was issued in the amount of $21,405,000 with a variable rate and a maturity date of July 1, 2034. This bond has a letter of credit guaranteed by T.D. Bank. Interest on the Series H Bonds accrues at the weekly rate and is payable on the first business day of each month commencing January 1, 2014.

Under the terms of the trust indenture for the Series F, G and H Bonds, the Obligated Group is required to meet certain financial covenants including a debt service coverage ratio and days cash on hand ratio. Members of the Obligated Group are jointly and severally obligated to provide amounts sufficient to enable the Authority to pay principal and interest on the Series F, G and H Bonds. The Bonds and bond proceeds have been allocated to the Hospital and as such, the Hospital will make future debt service payments as required under the terms of the bonds.

The bonds may be retired at an earlier date pursuant to terms of the master indenture. Payment of the bonds is collateralized by a pledge of the gross receipts, as defined and certain real property of the Hospital.

The Series H Bonds are considered variable rate demand bonds and are remarketed on a weekly basis. The Hospital maintains a letter of credit in the amount of $21,405,000 which expires on November 5, 2016. If the bonds are unable to be remarketed, the letter of credit could be utilized to purchase the bonds. The Obligated Group would then be subject to the payment terms of the letter of credit, which are monthly installments. The Series H Bonds have been successfully remarketed in the past and there have been no draws on the letter of credit.

The Corporation had a line of credit with Bank of America-Merrill Lynch for $13,802,758. This was taken as a bridge loan prior to issuance of Series G private Placement. The proceeds of Series G were used to pay off this line of credit on October 10, 2013. LMW Healthcare had a line of credit with Washington Trust for $4,860,642. This line was reissued at time of closing but was paid off in November 2013.

The fair value of the outstanding bonds is $101,550,368 and $106,215,296 at September 30, 2015 and September 30, 2014, respectively.

Principal repayments on the outstanding long term debt are as follows:

Years	Annual Principal Repayment
2016	$ 5,495,740
2017	5,730,772
2018	5,916,285
2019	6,142,340
2020 and thereafter	82,720,877
	$ 106,006,014

Cash interest payments of $3,495,549 and $3,566,051 were made in fiscal year 2015 and 2014, respectively. No interest was capitalized during 2015 and 2014.

8. Pension and Other Postretirement Benefits

The Hospital has a defined benefit plan covering all employees who elected to stay in the Plan. The Plan is frozen to new participants as of June 30, 1999. The benefits are based on years of service and the employee's compensation during the last five years of employment.

The Hospital provides health care and life insurance benefits to its retired employees who meet certain eligibility requirements. The Hospital's policy is to fund the cost of postretirement benefits other than pensions as incurred. This plan was frozen to include only those employees who retired prior to May 1, 1994.

The following table sets forth the Hospital's plans' funded status and amounts recognized in the consolidated balance sheet at September 30, 2015 and 2014 (measurement date of September 30):

	Pension Benefits		Other Postretirement Benefits	
	2015	2014	2015	2014
Change in benefit obligation				
Benefit obligation at beginning of year	$ 156,674,809	$ 145,789,789	$ 837,437	$ 1,000,744
Service cost	2,141,301	2,402,724	-	-
Interest cost	6,195,482	6,417,121	24,077	29,884
Employee contributions	41,451	69,839	-	-
Benefits paid	(7,608,334)	(7,015,362)	(91,218)	(95,403)
Actuarial (gain) loss	4,414,165	9,010,698	(15,972)	(97,788)
Benefit obligation at end of year	161,858,874	156,674,809	754,324	837,437
Change in plan assets				
Fair value of plan assets at beginning of year	115,176,724	105,860,348	-	-
Actual return on plan assets	(4,147,965)	9,861,899	-	-
Employee contributions	41,451	69,839	-	-
Employer contributions	7,400,000	6,400,000	91,218	95,403
Benefits paid	(7,608,334)	(7,015,362)	(91,218)	(95,403)
Fair value of plan assets at end of year	110,861,876	115,176,724	-	-
Funded status of the plan	(50,996,998)	(41,498,085)	(754,324)	(837,437)
Unrecognized net loss (gain) from past experience different from that assumed and effects of changes in assumptions	55,236,126	41,399,294	(443,280)	(488,085)
Unrecognized prior service cost	4,050	79,157	-	-
Accrued benefit costs recognized in the statements of operations	$ 4,243,178	$ (19,634)	$ (1,197,604)	$ (1,325,522)
Components of net periodic benefit costs				
Service cost	$ 2,141,301	$ 2,402,724	$ -	$ -
Interest cost	6,195,482	6,417,121	24,077	29,884
Expected return on plan assets	(8,603,526)	(7,920,200)	-	-
Amortization of net loss (gain)	3,328,824	2,676,330	(60,777)	(66,454)
Net amortization and deferral	75,107	111,153	-	-
Benefit cost	$ 3,137,188	$ 3,687,128	$ (36,700)	$ (36,570)

The net actuarial loss of approximately $4.4 million is due to a loss of approximately $7.5 million due to a change in mortality table offset by gains due to decrease in discount rate and other changes in assumptions.

The weighted average assumptions used to determine the net benefit cost at the beginning of the year are as follows:

	2015	2014
Discount rate	4.05 %	4.51 %
Average rate of compensation increases	2.50 %	2.50 %
Expected return on assets	7.50 %	7.50 %

The weighted average assumptions used to determine the benefit obligation at the end of the year are as follows:

	2015	2014
Discount rate	4.10 %	4.05 %
Average rate of compensation increases	2.50 %	2.50 %

The Plan's asset allocations as of September 30 are as follows:

Asset Category	2015	2014
Cash	2 %	2 %
Bonds	32	24
Mutual funds	26	45
Hedge funds	40	29
	100 %	100 %

The expected rate of return on plan assets is calculated based on past experience.

Expected benefits to be paid under the Hospital's plans are as follows:

Fiscal Years Beginning October 1,	Expected Benefits
2015	$ 7,940,500
2016	8,280,197
2017	8,395,891
2018	8,784,310
2019	9,069,440
Expected aggregate for 5 fiscal years beginning 2020	49,712,011

Annual employer contributions are determined by the Hospital based upon calculations prepared by the plan's actuary. Expected contributions to the plans for 2016 are approximately (unaudited):

Pension	$ 7,940,000
Retiree health	89,642

The weighted-average annual assumed rate of increase in the per capita cost of covered benefits (i.e., health care cost trend rate) for participants is assumed to be 8.0% in 2015 reducing to 5.0% by the year 2020 and remaining at that level thereafter. This health care cost trend rate assumption has a significant effect on the amounts reported. To illustrate, a one percentage point increase in the assumed health care cost trend rate would increase the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $49,000 and $56,000, respectively, at September 30, 2015 and 2014. A one percentage point decrease in the assumed health care cost trend rate would decrease the accumulated postretirement benefit obligation and service cost plus interest cost by approximately $45,000 and $51,000, respectively, at September 30, 2015 and 2014.

Plan Assets

The defined benefit plan assets are valued utilizing the same fair value hierarchy as the Hospital's investments as described in Note 1.

The following table summarizes the fair values of investments by major type held by the pension plan at September 30, 2015:

	Level 1	Level 2	Level 3	2015
Investments, at fair value				
Cash	$ 2,345,782	$ -	$ -	$ 2,345,782
Bonds	35,027,573	-	-	35,027,573
Mutual funds	24,119,636	4,946,910	-	29,066,546
Hedge funds	-	-	44,421,975	44,421,975
Total investments, at fair value	$ 61,492,991	$ 4,946,910	$ 44,421,975	$ 110,861,876

The following table summarizes the fair values of investments by major type held by the staff pension health plan at September 30, 2014:

	Level 1	Level 2	Level 3	2014
Investments, at fair value				
Cash	$ 2,417,830	$ -	$ -	$ 2,417,830
Bonds	27,571,791	-	-	27,571,791
Mutual funds	46,557,396	5,171,869	-	51,729,265
Hedge funds	-	-	33,457,838	33,457,838
Total investments, at fair value	$ 76,547,017	$ 5,171,869	$ 33,457,838	$ 115,176,724

There were transfers between levels during 2015 but no transfers in 2014.

The table below represents the change in fair value measurements for Level 3 investments held by the plans for the years ended September 30.

	2015	2014
Beginning balances	$ 33,457,838	$ 31,893,958
Realized gains	554,617	4,588,368
Fees	(204,757)	(79,614)
Unrealized losses	(3,485,723)	(2,944,874)
Purchases	14,100,000	-
Ending balances	$ 44,421,975	$ 33,457,838

The investment objective for the pension and post retirement plans seeks a positive long-term total return after inflation to meet the Hospital's current and future plan obligations.

Asset allocations combine tested theory and informed market judgment to balance investment risks with the need for high returns.

The Hospital's 401(k) plan covers eligible employees who elected to participate. Eligible employees may contribute a percentage of their salary. The Hospital matches 100% of the first 4% of gross pay deferred by employees for those employees who do not participate in the defined benefit plan. Plan contributions charged to operations were approximately $4,764,785 and $4,584,389 for 2015 and 2014, respectively.

The VNA has a defined contribution pension plan which covers substantially all of its employees who have met specified age and length of service requirements. Contributions to the Plan are based on 5% of eligible salaries and totaled approximately $504,943 and $463,475 for the years ended September 30, 2015 and 2014, respectively.

9. Functional Expenses

The Corporation and its subsidiaries provide general health care services to residents within its geographic location including pediatric care, cardiac catheterization, and outpatient surgery. Expenses by function are as follows:

	2015	2014
Health care services	$ 347,731,294	$ 348,719,365
General and administrative	122,555,118	124,868,311
	$ 470,286,412	$ 473,587,676

10. Commitments and Contingencies

The Corporation and its subsidiaries are parties to various lawsuits incidental to their business. Management believes that the lawsuits will not have a material adverse effect on their financial position, results of operations, and changes in net assets or cash flows.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 13,362,306	$ 79,026	$ -	$ 13,441,332	$ -	$ 1,742,691	$ 3,358,523	$ 2,300,545	$ 3,421,521	$ -	$ 24,264,612
Investments	107,365,636	28,697,270	-	136,062,906	-	-	18,604,941	7,476,983	133,813	-	162,278,643
Patient accounts receivable, net	37,976,959	-	-	37,976,959	-	997,949	-	2,895,357	8,601,329	-	50,471,594
Other receivables	4,131,254	-	-	4,131,254	24,500	55,407	1,241,613	622,506	-	-	6,075,280
Inventories	6,194,355	-	-	6,194,355	-	-	-	-	1,960,488	-	8,154,843
Due from affiliates	1,958,442	24,500	(1,958,442)	24,500	2,512,703	-	-	-	-	(2,537,203)	-
Prepaid expenses and other current assets	3,125,348	-	-	3,125,348	-	84,040	16,143	339,100	245,795	-	3,810,426
Debt service fund	1,304,613	-	-	1,304,613	-	-	-	-	-	-	1,304,613
Total current assets	175,418,913	28,800,796	(1,958,442)	202,261,267	2,537,203	2,880,087	23,221,220	13,634,491	14,362,946	(2,537,203)	256,360,011
Assets limited as to use											
Cash	183,677	-	-	183,677	-	-	-	-	-	-	183,677
Investments held in trust	926,080	-	-	926,080	-	-	-	-	-	-	926,080
Endowment investments	17,802,689	3,387,752	-	21,190,441	-	-	-	6,777,246	7,491,014	-	35,458,701
Investment in subsidiaries	-	19,281,447	-	19,281,447	-	-	-	-	-	(19,281,447)	-
Funds held in trust by others	3,584,118	-	-	3,584,118	-	-	-	-	4,049,023	-	7,633,141
Contributions receivable	20,366	2,146,420	-	2,166,786	-	-	-	-	750,000	-	2,916,786
Total assets limited as to use	22,516,930	24,815,619	-	47,332,549	-	-	-	6,777,246	12,290,037	(19,281,447)	47,118,385
Other assets											
Intangible assets, net	-	-	-	-	-	-	-	-	2,604,375	-	2,604,375
Other receivables	19,596,372	-	-	19,596,372	-	2,668,056	287,916	9,462	770,142	(20,513,394)	2,818,554
Deferred financing costs and other assets, net	2,187,006	-	-	2,187,006	-	-	-	-	-	-	2,187,006
Property, plant and equipment											
Land improvements	8,904,363	12,330,635	-	21,234,998	-	-	-	330,275	1,878,794	-	23,444,067
Buildings/leasehold improvements	152,295,547	-	-	152,295,547	-	1,062,737	-	2,285,699	18,038,855	-	173,682,838
Equipment/furniture	270,848,642	17,010	-	270,865,652	-	1,178,352	-	1,016,108	20,388,735	-	293,448,847
Accumulated depreciation	(283,857,352)	(166,376)	-	(284,023,728)	-	(1,200,400)	-	(2,029,102)	(9,913,775)	-	(297,167,005)
Construction in progress	2,785,773	-	-	2,785,773	-	-	-	-	94,222	-	2,879,995
Property, plant and equipment, net	150,976,973	12,181,269	-	163,158,242	-	1,040,689	-	1,602,980	30,486,831	-	196,288,742
	$ 370,696,194	$ 65,797,684	$ (1,958,442)	$ 434,535,436	$ 2,537,203	$ 6,588,832	$ 23,509,136	$ 22,024,179	$ 60,514,331	$ (42,332,044)	$ 507,377,073

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2015

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Liabilities and Net Assets											
Current liabilities											
Accounts payable	$ 33,209,795	$ 88,903	$ -	$ 33,298,698	$ -	$ 201,568	$ 93,932	$ 244,438	$ 3,334,297	$ -	$ 37,172,933
Accrued vacation and sick pay	10,112,002	-	-	10,112,002	-	1,500,450	-	691,888	1,385,608	-	13,689,948
Salaries, wages, payroll taxes and amounts withheld from employees	4,908,525	-	-	4,908,525	-	2,790,267	-	659,774	1,260,223	-	9,618,789
Due to affiliates	2,512,703	1,941,981	(1,958,442)	2,496,242	40,961	-	-	-	-	(2,537,203)	-
Due to third party payors	6,711,203	-	-	6,711,203	-	-	-	140,000	1,324,643	-	8,175,846
Other current liabilities	-	-	-	-	-	-	513,215	142,366	-	-	655,581
Current portion of long-term debt	5,495,740	-	-	5,495,740	-	-	-	-	-	-	5,495,740
Total current liabilities	62,949,968	2,030,884	(1,958,442)	63,022,410	40,961	4,492,285	607,147	1,878,466	7,304,771	(2,537,203)	74,808,837
Accrued pension and other postretirement benefits	52,989,394	-	-	52,989,394	-	-	-	-	479,011	-	53,468,405
Other liabilities	23,691,278	-	-	23,691,278	-	4,855,295	22,147,795	258,790	2,757,900	(22,081,291)	31,629,767
Long-term debt less current portion	102,938,747	-	-	102,938,747	-	-	-	-	-	-	102,938,747
Total liabilities	242,569,387	2,030,884	(1,958,442)	242,641,829	40,961	9,347,580	22,754,942	2,137,256	10,541,682	(24,618,494)	262,845,756
Net assets											
Unrestricted	103,203,168	63,657,520	-	166,860,688	2,496,242	(2,758,748)	754,194	19,859,923	39,412,015	(17,713,550)	208,910,764
Temporarily restricted	18,960,042	109,280	-	19,069,322	-	-	-	-	1,217,275	-	20,286,597
Permanently restricted	5,963,597	-	-	5,963,597	-	-	-	27,000	9,343,359	-	15,333,956
Total net assets	128,126,807	63,766,800	-	191,893,607	2,496,242	(2,758,748)	754,194	19,886,923	49,972,649	(17,713,550)	244,531,317
	$ 370,696,194	$ 65,797,684	$ (1,958,442)	$ 434,535,436	$ 2,537,203	$ 6,588,832	$ 23,509,136	$ 22,024,179	$ 60,514,331	$ (42,332,044)	$ 507,377,073

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 6,917,676	$ 334,893	$ -	$ 7,252,569	$ -	$ 1,901,701	$ 950,345	$ 1,675,245	$ 4,700,669	$ -	$ 16,480,529
Investments	128,450,331	31,541,423	-	159,991,754	-	-	16,769,765	7,523,944	140,576	-	184,426,039
Patient accounts receivable, net	36,373,069	-	-	36,373,069	-	2,378,629	-	2,740,706	5,990,550	-	47,482,954
Other receivables	4,156,260	-	-	4,156,260	24,500	289,393	1,322,262	-	-	-	5,792,415
Inventories	6,580,753	-	-	6,580,753	-	-	-	-	1,812,254	-	8,393,007
Due from affiliates	1,954,838	24,500	(1,954,838)	24,500	2,215,430	-	-	-	-	(2,239,930)	-
Prepaid expenses and other current assets	2,689,506	-	-	2,689,506	-	545,698	16,143	438,951	58,427	-	3,748,725
Debt service fund	1,304,562	-	-	1,304,562	-	-	-	-	-	-	1,304,562
Total current assets	188,426,995	31,900,816	(1,954,838)	218,372,973	2,239,930	5,115,421	19,058,515	12,378,846	12,702,476	(2,239,930)	267,628,231
Assets limited as to use											
Cash	182,862	-	-	182,862	-	-	-	-	-	-	182,862
Construction funds	561,676	-	-	561,676	-	-	-	-	-	-	561,676
Investments held in trust	925,227	-	-	925,227	-	-	-	-	-	-	925,227
Endowment investments	18,987,367	3,565,739	-	22,553,106	-	-	-	6,654,619	7,433,703	-	36,641,428
Investment in subsidiaries	-	19,281,447	-	19,281,447	-	-	-	-	-	(19,281,447)	-
Funds held in trust by others	6,985,614	-	-	6,985,614	-	-	-	-	4,362,996	-	11,348,610
Contributions receivable	20,366	2,750,421	-	2,770,787	-	-	-	-	750,000	-	3,520,787
Total assets limited as to use	27,663,112	25,597,607	-	53,260,719	-	-	-	6,654,619	12,546,699	(19,281,447)	53,180,590
Other assets											
Intangible assets, net	-			-	-	-	-	-	2,978,625	-	2,978,625
Other receivables	16,536,719	-	-	16,536,719	-	2,137,101	287,916	-	-	(16,380,950)	2,580,786
Deferred financing costs and other assets, net	2,315,752	-	-	2,315,752	-	-	-	-	-	-	2,315,752
Property, plant and equipment											
Land improvements	8,846,232	12,330,635	-	21,176,867	-	-	-	330,275	1,816,131	-	23,323,273
Buildings/leasehold improvements	150,910,346	-	-	150,910,346	-	1,046,733	-	2,238,496	16,849,576	-	171,045,151
Equipment/furniture	265,024,485	17,010	-	265,041,495	-	976,188	-	994,431	17,402,771	-	284,414,885
Accumulated depreciation	(265,615,130)	(104,684)	-	(265,719,814)	-	(973,022)	-	(1,937,034)	(5,430,921)	-	(274,060,791)
Construction in progress	1,691,863	-	-	1,691,863	-	-	-	-	435,918	-	2,127,781
Property, plant and equipment, net	160,857,796	12,242,961	-	173,100,757	-	1,049,899	-	1,626,168	31,073,475	-	206,850,299
	$ 395,800,374	$ 69,741,384	$ (1,954,838)	$ 463,586,920	$ 2,239,930	$ 8,302,421	$ 19,346,431	$ 20,659,633	$ 59,301,275	$ (37,902,327)	$ 535,534,283

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Balance Sheet
September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Liabilities and Net Assets											
Current liabilities											
Accounts payable	$ 25,786,034	$ 115,809	$ -	$ 25,901,843	$ -	$ 343,515	$ 197,453	$ 1,615,548	$ 8,298,829	$ -	$ 36,357,188
Accrued vacation and sick pay	11,281,701	-	-	11,281,701	-	1,595,316	-	-	1,346,711	-	14,223,728
Salaries, wages, payroll taxes and amounts withheld from employees	5,950,567	-	-	5,950,567	-	3,536,119	-	-	1,184,830	-	10,671,516
Due to affiliates	2,215,430	1,912,595	(1,954,838)	2,173,187	66,743	-	-	-	-	(2,239,930)	-
Due to third party payors	5,165,225	-	-	5,165,225	-	-	-	234,000	1,858,724	-	7,257,949
Other current liabilities	-	-	-	-	-	-	428,096	154,457	-	-	582,553
Current portion of long-term debt	5,342,305	-	-	5,342,305	-	-	-	-	134,675	-	5,476,980
Total current liabilities	55,741,262	2,028,404	(1,954,838)	55,814,828	66,743	5,474,950	625,549	2,004,005	12,823,769	(2,239,930)	74,569,914
Accrued pension and other postretirement benefits	43,216,010	-	-	43,216,010	-	-	-	-	372,651	-	43,588,661
Other liabilities	20,601,530	-	-	20,601,530	-	3,744,380	17,719,560	-	2,135,400	(17,789,969)	26,410,901
Long-term debt less current portion	108,587,802	-	-	108,587,802	-	-	-	-	-	-	108,587,802
Total liabilities	228,146,604	2,028,404	(1,954,838)	228,220,170	66,743	9,219,330	18,345,109	2,004,005	15,331,820	(20,029,899)	253,157,278
Net assets											
Unrestricted	138,173,767	67,562,541	-	205,736,308	2,173,187	(916,909)	1,001,322	18,628,628	33,152,392	(17,872,428)	241,902,500
Temporarily restricted	23,432,028	150,439	-	23,582,467	-	-	-	-	1,188,220	-	24,770,687
Permanently restricted	6,047,975	-	-	6,047,975	-	-	-	27,000	9,628,843	-	15,703,818
Total net assets	167,653,770	67,712,980	-	235,366,750	2,173,187	(916,909)	1,001,322	18,655,628	43,969,455	(17,872,428)	282,377,005
	$ 395,800,374	$ 69,741,384	$ (1,954,838)	$ 463,586,920	$ 2,239,930	$ 8,302,421	$ 19,346,431	$ 20,659,633	$ 59,301,275	$ (37,902,327)	$ 535,534,283

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Statement of Operations
Year Ended September 30, 2015

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Net revenues from services to patients	$ 339,282,362	$ -	$ -	$ 339,282,362	$ -	$ 29,975,826	$ -	$ 12,862,092	$ 73,345,489	$ -	$ 455,465,769
Provision for bad debt	(12,821,337)	-	-	(12,821,337)	-	(886,077)	-	(73,656)	(2,902,353)	-	(16,683,423)
Net revenue less provision for bad debt	326,461,025	-	-	326,461,025	-	29,089,749	-	12,788,436	70,443,136	-	438,782,346
Other operating revenues	30,874,305	963,970	-	31,838,275	555,885	8,944,425	6,145,615	4,169,099	2,355,099	(37,632,581)	16,375,817
Net assets released from restriction used for operations	577,092	4,254,553	-	4,831,645	-	-	-	-	-	-	4,831,645
	357,912,422	5,218,523	-	363,130,945	555,885	38,034,174	6,145,615	16,957,535	72,798,235	(37,632,581)	459,989,808
Operating expenses											
Salaries and wages	140,605,613	-	-	140,605,613	-	37,208,008	-	11,408,447	28,970,058	(6,067,435)	212,124,691
Employee benefits	51,698,355	-	-	51,698,355	-	6,855,301	-	2,680,705	6,892,411	(9,086,115)	59,040,657
Supplies	63,622,692	253,939	-	63,876,631	-	1,600,252	-	354,796	10,942,574	-	76,774,253
Purchased services	29,998,356	391,508	-	30,389,864	14,206	4,338,255	188,964	446,565	15,254,539	(11,025,150)	39,607,243
Other	40,208,162	34,629	-	40,242,791	218,624	9,708,321	7,204,478	873,982	3,261,737	(11,277,759)	50,232,174
Interest	3,553,690	-	-	3,553,690	-	-	-	-	416,000	(416,000)	3,553,690
Depreciation and amortization	23,639,711	61,692	-	23,701,403	-	227,378	-	92,068	4,932,855	-	28,953,704
Total expenses	353,326,579	741,768	-	354,068,347	232,830	59,937,515	7,393,442	15,856,563	70,670,174	(37,872,459)	470,286,412
Income (loss) from operations	4,585,843	4,476,755	-	9,062,598	323,055	(21,903,341)	(1,247,827)	1,100,972	2,128,061	239,878	(10,296,604)
Nonoperating gains											
Unrestricted investment income	228,240	-	-	228,240	-	-	-	-	-	-	228,240
Nonoperating expenses	-	(1,527,184)	-	(1,527,184)	-	-	-	-	-	-	(1,527,184)
Income from investments and realized gains	9,708,669	2,175,070	-	11,883,739	-	-	205,148	807,251	235,779	-	13,131,917
	9,936,909	647,886	-	10,584,795	-	-	205,148	807,251	235,779	-	11,832,973
Excess (deficit) of revenues over expenses	14,522,752	5,124,641	-	19,647,393	323,055	(21,903,341)	(1,042,679)	1,908,223	2,363,840	239,878	1,536,369
Net unrealized (losses) on investments	(16,107,490)	(3,912,099)	-	(20,019,589)	-	-	(204,449)	(676,928)	(6,162)	-	(20,907,128)
Transfer to affiliated entities	(19,764,884)	(5,117,563)	-	(24,882,447)	-	20,061,502	1,000,000	-	3,820,945	-	-
Net assets released from restrictions used for purchases of property and equipment	140,748	-	-	140,748	-	-	-	-	-	-	140,748
Donated equipment	-	-	-	-	-	-	-	-	81,000	(81,000)	-
Pension related changes other than periodic pension costs	(13,761,725)	-	-	(13,761,725)	-	-	-	-	-	-	(13,761,725)
Decrease in unrestricted net assets	$ (34,970,599)	$ (3,905,021)	$ -	$ (38,875,620)	$ 323,055	$ (1,841,839)	$ (247,128)	$ 1,231,295	$ 6,259,623	$ 158,878	$ (32,991,736)

The accompanying notes are an integral part of these consolidated financial statements.

Lawrence + Memorial Corporation and Subsidiaries
Consolidating Statement of Operations
Year Ended September 30, 2014

	Lawrence & Memorial Hospital	Lawrence & Memorial Corporation	Eliminating Entries	Obligated Group	L&M Systems, Inc.	LMPA	L&M Indemnity	VNA of Southeastern Connecticut, Inc.	Westerly Hospital	Eliminating Entries	Consolidated
Net revenues from services to patients	$ 337,129,192	$ -	$ -	$ 337,129,192	$ -	$ 29,333,784	$ -	$ 12,091,733	$ 74,974,391	$ -	$ 453,529,100
Provision for bad debt	(14,930,302)	-	-	(14,930,302)	-	(534,484)	-	(75,000)	(4,758,600)	-	(20,298,386)
Net revenue less provision for bad debt	322,198,890	-	-	322,198,890	-	28,799,300	-	12,016,733	70,215,791	-	433,230,714
Other operating revenues	28,151,061	2,958,303	-	31,109,364	486,265	4,787,661	5,376,504	4,140,108	2,963,560	(28,068,175)	20,795,287
Net assets released from restriction used for operations	671,797	204,406	-	876,203	-	-	-	-	-	-	876,203
	351,021,748	3,162,709	-	354,184,457	486,265	33,586,961	5,376,504	16,156,841	73,179,351	(28,068,175)	454,902,204
Operating expenses											
Salaries and wages	143,838,674	-	-	143,838,674	-	37,356,344	-	10,811,798	28,074,499	(6,613,808)	213,467,507
Employee benefits	51,044,718	-	-	51,044,718	-	6,483,081	-	2,598,219	6,454,031	(7,394,212)	59,185,837
Supplies	59,538,141	206,897	-	59,745,038	-	1,334,391	-	330,396	10,588,285	-	71,998,110
Purchased services	38,647,767	518,743	-	39,166,510	19,330	3,462,524	334,538	480,267	15,344,077	(4,332,235)	54,475,011
Other	34,490,156	42,546	-	34,532,702	122,200	7,849,748	5,486,160	937,952	4,066,583	(9,568,175)	43,427,170
Interest	3,542,721	8,500	-	3,551,221	-	-	-	-	419,698	(416,000)	3,554,919
Depreciation and amortization	22,728,484	61,692	-	22,790,176	-	234,268	-	107,318	4,347,360	-	27,479,122
Total expenses	353,830,661	838,378	-	354,669,039	141,530	56,720,356	5,820,698	15,265,950	69,294,533	(28,324,430)	473,587,676
(Loss) from operations	(2,808,913)	2,324,331	-	(484,582)	344,735	(23,133,395)	(444,194)	890,891	3,884,818	256,255	(18,685,472)
Nonoperating gains											
Unrestricted investment income	180,488	-	-	180,488	-	-	-	-	-	-	180,488
Income from investments and realized gains	8,608,113	355,103	-	8,963,216	-	-	203,572	652,017	13,359	-	9,832,164
Inherent contribution received from purchase of Westerly Hospital	-	-	-	-	-	-	-	-	5,284,752	-	5,284,752
	8,788,601	355,103	-	9,143,704	-	-	203,572	652,017	5,298,111	-	15,297,404
(Deficit) excess of revenues over expenses	5,979,688	2,679,434	-	8,659,122	344,735	(23,133,395)	(240,622)	1,542,908	9,182,929	256,255	(3,388,068)
Net unrealized gains on investments	31,059	1,515,218	-	1,546,277	-	-	(88,647)	570,458	-	-	2,028,088
Transfer to affiliated entities	(33,861,262)	12,237,912	-	(21,623,350)	(16,465)	20,865,372	-	-	774,443	-	-
Net assets released from restrictions used for purchases of property and equipment	139,360	867,140	-	1,006,500		-	-	-	-	-	1,006,500
Donated equipment	6,350	-	-	6,350		-	-	-	-	-	6,350
Pension related changes other than periodic pension costs	(4,281,516)	-	-	(4,281,516)		-	-	-	-	-	(4,281,516)
Decrease in unrestricted net assets	$ (31,986,321)	$ 17,299,704	$ -	$ (14,686,617)	$ 328,270	$ (2,268,023)	$ (329,269)	$ 2,113,366	$ 9,957,372	$ 256,255	$ (4,628,646)

The accompanying notes are an integral part of these consolidated financial statements.

SENATOR MARTIN M. LOONEY
PRESIDENT PRO TEMPORE

Eleventh District
New Haven, Hamden & North Haven

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420
www.SenatorLooney.cga.ct.gov

January 6, 2016

The Honorable George Jepsen
Attorney General, State of Connecticut
55 Elm St.
Hartford CT 06106

The Honorable Dr. Raul Pino
Acting Commissioner of Public Health
410 Capitol Ave., P.O Box 340308
Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino:

I write to urge each of your agencies to analyze fully the potential pricing and cost implications of Yale-New Haven Health Services Corporation's proposed acquisition of Lawrence and Memorial Health's operations, including its two acute care hospitals, outpatient facilities and the acquisition of Lawrence and Memorial Physician Association by Yale-New Haven's Northeast Medical Group. The transactions as proposed offer a clear route to the achievement of market power by the applicants, but offer little in the way of protection for consumers.

The recent release of data by a coalition of consumer, health care advocacy and labor organizations deepens my concerns. The report, entitled *Hospital Consolidation in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, describes patterns in hospital acute care inpatient discharge data that suggest that Connecticut's hospital markets are already highly concentrated and that the purchase of L+M by the Yale New Haven Health System will deepen that market concentration along the shoreline, where Yale-New Haven Health System is already a dominant actor.

The concerns raised in the report received powerful validation on December 15, when the National Bureau of Economic Research released the largest study of hospital pricing for privately insured patients in history. Based on 88 million individual records, the study shows definitively that "hospital prices are positively associated with indicators of hospital market power. Even after conditioning on many demand and cost factors, hospital prices in monopoly markets are 15.3% higher than those in markets with four or more hospitals."

I am concerned by the reported remarks of OHCA's spokesperson to the effect that the agency lacks the authority to conduct a cost and market analysis as part of the Certificates of Need for the proposed transaction. In my view, Public Act 14-168 provides more than ample statutory authority for OHCA to request and analyze price data from prior transactions. Although the even more detailed terms of Public Act 15-146 do not apply to the Yale-New Haven/L+M transactions, in 2014 the General Assembly added two new factors that OHCA must weigh in its analysis prior to approval, rejection or modification of a CON involving a change in ownership of a health care facility:

(11) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and

(12) Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to health care.

Any satisfactory demonstration that the proposed transactions will not adversely affect health care costs must rebut a presumption of market power, especially in light of heavy market concentration along the shoreline.

Therefore, I urge you to request and analyze data from the applicants on prices charged by the Hospital of St. Raphael before and after its acquisition by Yale-New Haven Hospital, and similar comparative data between current risk-adjusted prices at L+M and the Yale-New Haven Health System hospitals in Bridgeport, Greenwich and New Haven.

OHCA is already engaged in a process of dialogue with Yale-New Haven Hospital regarding the implementation of the plan for integrating St. Raphael's assets and operations into Yale-New Haven's operations. The agency has reviewed multiple CONs based on the asserted need to streamline operations and reduce duplicative services. Given that existing ongoing dialogue, it should be neither time consuming, nor difficult for the agency to request and receive before- and after- pricing information regarding the Hospital of St. Raphael.

The Attorney General bears responsibility for enforcing the Connecticut Anti-Trust Act. I understand that all information gathered pursuant to enforcement of the act is strictly confidential. However, I urge the Attorney General to investigate these issues as well by requesting and analyzing before-and-after pricing data regarding the Hospital of St. Raphael, and comparative risk-adjusted pricing information from L+M and Yale-New Haven.

Sincerely,

Martin Looney

Martin M. Looney
State Senate President Pro Tempore

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

January 14, 2016

The Honorable Martin M. Looney
President Pro Tempore – 11th District
State of Connecticut Senate
State Capitol
Hartford, CT 06106-1591

Re: Yale-New Haven Health Services Corporation's Proposed Affiliation with Lawrence + Memorial Corporation

Dear Senator Looney:

On January 11, 2016, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Yale-New Haven Health Services Corporation's affiliation with Lawrence + Memorial Corporation.

The Office of Health Care Access ("OHCA") works diligently to ensure that all of the guidelines and principles included in Conn. Gen. Stat. § 19a-639, as modified by Public Acts 14-168 and 15-146, are thoroughly evaluated for each certificate of need ("CON") application it receives. With respect to your specific concerns regarding the impact of hospital acquisitions on market prices, please know that OHCA intends on requesting additional information from Yale-New Haven Health Services Corporation in order to analyze the historical impact on pricing as a result of its acquisitions or affiliations with other hospitals in the state.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

January 14, 2016

The Honorable Leonard A. Fasano
Senate Minority Leader – 34th District
Suite 3400
Legislative Office Building
Hartford, CT 06106-1591

Re: Yale-New Haven Health Services Corporation's Proposed Affiliation with Lawrence + Memorial Corporation

Dear Senator Fasano:

On January 8, 2016, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Yale-New Haven Health Services Corporation's affiliation with Lawrence + Memorial Corporation.

The Office of Health Care Access ("OHCA") works diligently to ensure that all of the guidelines and principles included in Conn. Gen. Stat. § 19a-639, as modified by Public Acts 14-168 and 15-146, are thoroughly evaluated for each certificate of need ("CON") application it receives. With respect to your specific concerns regarding the impact of hospital acquisitions on market prices, please know that OHCA intends on requesting additional information from Yale-New Haven Health Services Corporation in order to analyze the historical impact on pricing as a result of its acquisitions or affiliations with other hospitals in the state.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, January 21, 2016 3:07 PM
To: Greer, Leslie
Cc: Ciesones, Ron; Carney, Brian; Riggott, Kaila
Subject: FW: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA
Attachments: L+M_L+MH Updated Financial Worksheets A_For OHCA.xlsx; YNHHS Updated Financial Worksheet A_For OHCA.xlsx

Please add to the original file.

Thank you,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Thursday, January 21, 2016 3:06 PM
To: Lazarus, Steven
Subject: RE: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Hi Steve-
Here are the Excel Files as you requested. Please let me know if these files meet your needs. Thanks, Karen

Karen M. Banoff, DNP, RN
Principal

203- 459-1601 (office)
203-209-0681 (mobile)

From: Lazarus, Steven [mailto:Steven.Lazarus@ct.gov]
Sent: Tuesday, January 19, 2016 3:28 PM
To: Karen Banoff
Subject: RE: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Karen,

Can you please forward pages 855-860, electronic copy (Excel) of the financial worksheets. Some of the print is too small to read on the paper copy.

Thanks,
Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Karen Banoff [mailto:kbanoff@kmbconsult.com]
Sent: Tuesday, January 05, 2016 7:41 AM
To: Martone, Kim
Cc: Lazarus, Steven; Greci, Laurie
Subject: Responses to Completeness Questions (DN: 15-32033 & 15-32032)- YNHHS & L+M/NEMG & L&MPA

Good morning and Happy New Year Kim-

As per OHCA's completeness letter, I am sending responses to the completeness questions for the above referenced dockets via email. As requested, an Adobe Acrobat and MS Word File is included for each. A cover letter pertaining to each application is also included.

I would appreciate receiving an email confirmation that the documents have been received.

Thank you for your time and attention to this matter.

Sincerely, Karen

Karen M. Banoff, DNP, RN
Principal
203- 459-1601 (office)
203-209-0681 (mobile)

LINE	Total Entity:L+M Hospital	FY 2014 Actual	FY 2015 Actual	FY 2016 Projected	FY 2016 Projected	FY 2016 Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$795,287,303	$843,024,228	$860,182,747	$14,094,145	$874,276,892	$894,590,057	$37,459,572	$932,049,629	$930,373,659	$53,320,158	$983,693,817	$967,588,605	$68,907,570	$1,036,496,176
2	Less: Allowances	$450,251,022	$485,513,042	$487,243,916	$8,281,757	$495,525,673	$521,291,544	$22,590,447	$543,881,991	$553,773,091	$32,780,153	$586,553,244	$590,539,350	$43,351,970	$633,891,321
3	Less: Charity Care	$5,449,069	$5,427,817	$5,893,713	$96,569	$5,990,282	$6,374,640	$266,928	$6,641,568	$6,894,811	$395,145	$7,289,956	$7,457,427	$531,086	$7,988,514
4	Less: Other Deductions	$2,458,020	$12,801,007	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787
	Net Patient Service Revenue	**$337,129,192**	**$339,282,362**	**$348,843,331**	**$5,715,818**	**$354,559,149**	**$348,722,086**	**$14,602,197**	**$363,324,283**	**$351,503,970**	**$20,144,860**	**$371,648,830**	**$351,390,041**	**$25,024,513**	**$376,414,554**
5	Medicare	$116,154,499	$120,428,761	$123,580,930	$1,924,467	$125,505,397	$123,539,459	$4,916,434	$128,455,893	$124,490,992	$6,782,601	$131,273,593	$124,452,023	$8,425,538	$132,877,561
6	Medicaid	$36,747,588	$38,099,829	$39,097,075	$608,840	$39,705,915	$39,083,955	$1,555,403	$40,639,358	$39,384,989	$2,145,799	$41,530,788	$39,372,661	$2,665,572	$42,038,233
7	CHAMPUS & TriCare	$10,981,081	$11,385,164	$11,683,166	$181,936	$11,865,102	$11,679,245	$464,793	$12,144,038	$11,769,202	$641,217	$12,410,419	$11,765,518	$796,538	$12,562,056
8	Other	($2,458,020)	($12,801,007)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)
	Total Government	**$161,425,149**	**$157,112,747**	**$156,159,384**	**$2,715,243**	**$158,874,627**	**$156,100,872**	**$6,936,630**	**$163,037,502**	**$157,443,396**	**$9,569,618**	**$167,013,013**	**$157,388,414**	**$11,887,649**	**$169,276,063**
9	Commercial Insurers	$163,214,231	$169,220,201	$173,649,464	$2,704,160	$176,353,624	$173,591,191	$6,908,316	$180,499,507	$174,928,235	$9,530,556	$184,458,791	$174,873,478	$11,839,126	$186,712,603
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,131,510	$5,320,340	$5,459,598	$85,020	$5,544,617	$5,457,766	$217,200	$5,674,965	$5,499,803	$299,644	$5,799,447	$5,498,081	$372,226	$5,870,307
12	Workers Compensation	$7,358,302	$7,629,074	$7,828,761	$121,914	$7,950,675	$7,826,134	$311,452	$8,137,586	$7,886,413	$429,673	$8,316,086	$7,883,944	$533,752	$8,417,696
13	Other	$0	$0	$5,746,124	$89,482	$5,835,606	$5,746,124	$228,599	$5,974,723	$5,746,124	$315,370	$6,061,494	$5,746,124	$391,761	$6,137,885
	Total Non-Government	**$175,704,043**	**$182,169,615**	**$192,683,947**	**$3,000,575**	**$195,684,522**	**$192,621,214**	**$7,665,567**	**$200,286,781**	**$194,060,574**	**$10,575,243**	**$204,635,817**	**$194,001,627**	**$13,136,865**	**$207,138,492**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$337,129,192**	**$339,282,362**	**$348,843,331**	**$5,715,818**	**$354,559,149**	**$348,722,086**	**$14,602,197**	**$363,324,283**	**$351,503,970**	**$20,144,860**	**$371,648,830**	**$351,390,041**	**$25,024,513**	**$376,414,554**
14	Less: Provision for Bad Debts	$14,930,302	$12,821,337	$13,803,283	$210,310	$14,013,593	$13,798,485	$537,280	$14,335,765	$13,908,561	$741,219	$14,649,780	$13,904,053	$920,763	$14,824,816
	Net Patient Service Revenue less provision for bad debts	**$322,198,890**	**$326,461,025**	**$335,040,048**	**$5,505,508**	**$340,545,556**	**$334,923,601**	**$14,064,917**	**$348,988,518**	**$337,595,409**	**$19,403,641**	**$356,999,050**	**$337,485,988**	**$24,103,750**	**$361,589,738**
15	Other Operating Revenue	$28,151,061	$30,874,305	31,185,817		$31,185,817	31,185,817		$31,185,817	31,185,817		$31,185,817	31,185,817		$31,185,817
17	Net Assets Released from Restrictions	$671,797	$577,092	$0		$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$351,021,748**	**$357,912,422**	**$366,225,866**	**$5,505,508**	**$371,731,374**	**$366,109,418**	**$14,064,917**	**$380,174,335**	**$368,781,227**	**$19,403,641**	**$388,184,868**	**$368,671,806**	**$24,103,750**	**$392,775,556**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$143,838,674	$140,605,613	$ 143,576,703	$603,987	$144,180,691	$140,019,192	$760,868	$140,780,059	$141,973,430	$754,514	$142,727,944	$143,983,025	$1,270,138	$145,253,163
2	Fringe Benefits	$51,044,718	$51,698,355	$ 54,026,420	$847,885	$54,874,305	$52,456,564	$1,228,742	$53,685,306	$52,771,303	$1,254,900	$54,026,203	$53,087,931	$1,407,884	$54,495,815
3	Physicians Fees	$38,647,767	$29,998,356	$ 30,254,332	$2,845,324	$33,099,655	$22,993,292	$4,677,729	$27,671,021	$22,533,426	$4,788,754	$27,322,180	$22,848,894	$4,921,640	$27,770,534
4	Supplies and Drugs	$59,538,141	$63,622,692	$64,288,904	$55,178	$64,344,082	$64,610,349	$345,629	$64,955,978	$65,540,738	$651,937	$66,192,675	$66,471,416	$917,694	$67,389,110
5	Depreciation and Amortization	$22,728,484	$23,639,711	$26,054,143	$77,061	$26,131,204	$27,572,414	$154,122	$27,726,536	$27,826,240	$154,122	$27,980,362	$28,839,752	$154,122	$28,993,874
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$3,542,721	$3,553,690	$3,368,376	$0	$3,368,376	$3,167,699	$0	$3,167,699	$2,973,808	$0	$2,973,808	$2,749,451	$0	$2,749,451
8	Malpractice Insurance Cost	$4,538,822	$4,818,820	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632
9	Lease Expense	$4,618,504	$4,647,875	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308
10	Other Operating Expenses	$25,332,830	$30,741,467	$ 30,490,536	$0	$30,490,536	$30,490,536	$0	$30,490,536	$30,795,441	$0	$30,795,441	*$29,255,669*	$0	$29,255,669
	TOTAL OPERATING EXPENSES	**$353,830,661**	**$353,326,579**	**$361,724,355**	**$4,429,435**	**$366,153,790**	**$350,974,986**	**$7,167,089**	**$358,142,075**	**$354,079,327**	**$7,604,227**	**$361,683,554**	**$356,901,079**	**$8,671,477**	**$365,572,556**
	INCOME/(LOSS) FROM OPERATIONS	**($2,808,913)**	**$4,585,843**	**$4,501,511**	**$1,076,073**	**$5,577,584**	**$15,134,432**	**$6,897,828**	**$22,032,260**	**$14,701,900**	**$11,799,414**	**$26,501,313**	**$11,770,727**	**$15,432,273**	**$27,202,999**
	NON-OPERATING REVENUE	**$8,788,601**	**$9,936,909**	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**		$8,262,701
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$5,979,688**	**$14,522,752**	**$12,764,212**	**$1,076,073**	**$13,840,285**	**$23,397,133**	**$6,897,828**	**$30,294,961**	**$22,964,601**	**$11,799,414**	**$34,764,014**	**$20,033,428**	**$15,432,273**	**$35,465,700**
	Principal Payments	**$5,152,609**	**$5,316,471**	$5,510,844	$0	$5,510,844	$5,725,738	$0	$5,725,738	$5,911,163	$0	$5,911,163	$6,137,126		$6,137,126
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**-0.8%**	**1.3%**	**1.2%**	**19.5%**	**1.5%**	**4.1%**	**49.0%**	**5.8%**	**4.0%**	**60.8%**	**6.8%**	**3.2%**	**64.0%**	**6.9%**
2	Hospital Non Operating Margin	**2.3%**	**2.6%**	**2.3%**	**0.0%**	**2.2%**	**2.3%**	**0.0%**	**2.2%**	**2.2%**	**0.0%**	**2.1%**	**2.2%**	**0.0%**	**2.1%**
3	Hospital Total Margin	**1.7%**	**4.1%**	**3.5%**	**19.5%**	**3.7%**	**6.4%**	**49.0%**	**8.0%**	**6.2%**	**60.8%**	**9.0%**	**5.4%**	**64.0%**	**9.0%**
D.	**FTEs**	**1,849**	**1,835**	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	14,153	14,076	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	449,789	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	TOTAL VOLUME	**472,263**	**463,865**	**469,289**	**3,641**	**472,930**	**469,160**	**11,259**	**480,419**	**469,017**	**14,967**	**483,984**	**468,900**	**18,035**	**486,935**

LINE	Total Entity: L+M w/o LMPA	FY 2014	FY 2015	FY 2016	FY 2016	FY 2016	FY 2017	FY 2017	FY 2017	FY 2018	FY 2018	FY 2018	FY 2019	FY 2019	FY 2019
		Actual	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$1,078,626,933	$1,138,758,476	$1,166,642,891	($15,527,210)	$1,151,115,681	$1,213,308,606	($24,164,292)	$1,189,144,314	$1,261,840,951	($9,784,371)	$1,252,056,580	$1,312,314,589	$3,738,813	$1,316,053,401
2	Less: Allowances	$615,856,880	$664,069,131	$673,832,103	($6,485,677)	$667,346,426	$717,135,552	($8,304,750)	$708,830,803	$762,088,601	$104,770	$762,193,372	$811,978,164	$8,494,495	$820,472,659
3	Less: Charity Care	$6,782,933	$6,124,509	$7,336,420	$37,861	$7,374,281	$7,629,877	$129,891	$7,759,768	$7,935,072	$231,593	$8,166,665	$8,252,475	$328,358	$8,580,833
4	Less: Other Deductions	$2,458,020	$12,801,007	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787
	Net Patient Service Revenue	**$453,529,100**	**$455,763,829**	**$467,272,580**	**($9,079,394)**	**$458,193,186**	**$470,341,390**	**($15,989,434)**	**$454,351,956**	**$473,615,490**	**($10,120,734)**	**$463,494,756**	**$473,882,163**	**($5,084,040)**	**$468,798,123**
5	Medicare	$161,243,669	$165,691,332	$169,559,164	($2,853,646)	$166,705,519	$170,162,485	($4,893,784)	$165,268,700	$171,320,254	($2,848,199)	$168,472,056	$171,414,554	($1,093,576)	$170,320,977
6	Medicaid	$48,109,726	$49,436,760	$50,590,792	($1,354,632)	$49,236,160	$50,770,802	($2,496,483)	$48,274,320	$51,116,242	($1,886,148)	$49,230,094	$51,144,378	($1,362,627)	$49,781,751
7	CHAMPUS & TriCare	$12,447,146	$12,790,482	$13,089,058	($276,461)	$12,812,597	$13,135,631	($493,466)	$12,642,165	$13,225,005	($335,557)	$12,889,447	$13,232,284	($200,110)	$13,032,174
8	Other	($2,458,020)	($12,801,007)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)
	Total Government	**$219,342,521**	**$215,117,567**	**$215,037,227**	**($4,484,738)**	**$210,552,489**	**$215,867,131**	**($7,883,733)**	**$207,983,399**	**$217,459,714**	**($5,069,904)**	**$212,389,810**	**$217,589,429**	**($2,656,314)**	**$214,933,115**
9	Commercial Insurers	$215,639,465	$221,587,554	$226,760,205	($4,072,006)	$222,688,199	$227,567,057	($7,250,433)	$220,316,624	$229,115,401	($4,516,815)	$224,598,587	$229,241,513	($2,170,433)	$227,071,080
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$9,955,354	$10,229,957	$10,468,761	$23,625	$10,492,386	$10,506,011	$109,366	$10,615,377	$10,577,493	$235,662	$10,813,155	$10,583,315	$343,995	$10,927,309
12	Workers Compensation	$8,591,760	$8,828,750	$9,034,845	($124,129)	$8,910,717	$9,066,993	($203,248)	$8,863,745	$9,128,684	($94,251)	$9,034,433	$9,133,708	($757)	$9,132,952
13	Other	$0	$0	$5,971,541	($422,145)	$5,549,396	$7,334,198	($761,386)	$6,572,812	$7,334,198	($675,427)	$6,658,771	$7,334,198	$1,232,319	$8,566,517
	Total Non-Government	**$234,186,579**	**$240,646,262**	**$252,235,353**	**($4,594,655)**	**$247,640,697**	**$254,474,259**	**($8,105,701)**	**$246,368,558**	**$256,155,776**	**($5,050,830)**	**$251,104,946**	**$256,292,734**	**($594,877)**	**$255,697,857**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$453,529,100**	**$455,763,829**	**$467,272,580**	**($9,079,394)**	**$458,193,186**	**$470,341,390**	**($15,989,434)**	**$454,351,956**	**$473,615,490**	**($10,120,734)**	**$463,494,756**	**$473,882,163**	**($3,251,190)**	**$470,630,973**
14	Less: Provision for Bad Debts	$20,298,386	$16,683,423	$17,177,163	($53,652)	$17,123,511	$17,239,519	($289,105)	$16,950,414	$17,359,178	($291,154)	$17,068,024	$17,368,924	($291,320)	$17,077,604
	Net Patient Service Revenue less provision for bad debts	**$433,230,714**	**$439,080,406**	**$450,095,417**	**($9,025,742)**	**$441,069,675**	**$453,101,871**	**($15,700,329)**	**$437,401,542**	**$456,256,312**	**($9,829,580)**	**$446,426,732**	**$456,513,239**	**($4,792,721)**	**$451,720,518**
15	Other Operating Revenue	$20,795,287	$16,375,817	$18,625,441	($4,621,670)	$14,003,771	$18,625,441	($9,243,341)	$9,382,100	$18,625,441	($9,243,341)	$9,382,100	$18,625,441	($9,243,341)	$9,382,100
17	Net Assets Released from Restrictions	$876,203	$4,831,645	$0		$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$454,902,204**	**$460,287,868**	**$468,720,858**	**($13,647,412)**	**$455,073,446**	**$471,727,312**	**($24,943,670)**	**$446,783,642**	**$474,881,753**	**($19,072,921)**	**$455,808,832**	**$475,138,680**	**($14,036,062)**	**$461,102,618**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$213,467,507	$212,124,691	$221,742,774	($16,503,691)	$205,239,083	$218,731,892	($32,626,276)	$186,105,616	$220,764,261	($33,138,558)	$187,625,703	$223,223,873	($32,878,788)	$190,345,085
2	Fringe Benefits	$59,185,837	$59,040,657	$61,335,944	($2,486,287)	$58,849,657	$59,361,624	($4,867,704)	$54,493,920	$59,610,824	($4,866,259)	$54,744,565	$59,979,697	($4,677,288)	$55,302,409
3	Physicians Fees	$54,475,011	$39,607,243	$36,262,759	$11,192,773	$47,455,533	$29,552,481	$16,362,803	$45,915,284	$29,230,792	$17,197,407	$46,428,199	$29,614,758	$18,070,023	$47,684,781
4	Supplies and Drugs	$71,998,110	$76,774,253	$77,727,905	($1,407,896)	$76,320,009	$78,132,953	($2,332,868)	$75,800,085	$79,257,684	($1,760,116)	$77,497,568	$80,382,942	($1,273,097)	$79,109,845
5	Depreciation and Amortization	$27,479,122	$28,953,704	$28,415,203	$40,565	$28,455,768	$30,071,062	$67,013	$30,138,075	$30,347,890	$64,653	$30,412,543	$31,453,247	$55,229	$31,508,476
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$3,554,919	$3,553,690	$3,368,376	$0	$3,368,376	$3,167,699	$0	$3,167,699	$2,973,808	$0	$2,973,808	$2,749,451	$0	$2,749,451
8	Malpractice Insurance Cost	$14,513,454	$17,152,933	$16,833,046	($1,285,561)	$15,547,485	$16,833,046	($2,571,122)	$14,261,924	$16,833,046	($2,571,122)	$14,261,924	$16,833,046	($2,571,122)	$14,261,924
9	Lease Expense	$6,969,829	$7,693,864	$7,964,369	($1,067,938)	$6,896,432	$7,964,369	($2,135,875)	$5,828,494	$7,964,369	($2,135,875)	$5,828,494	$7,964,369	($2,135,875)	$5,828,494
10	Other Operating Expenses	$21,943,887	$25,385,377	$23,767,337	($2,057,025)	$21,710,311	$20,618,407	($4,115,241)	$16,503,166	$21,103,061	($4,127,570)	$16,975,491	$21,576,050	($4,137,325)	$17,438,725
	TOTAL OPERATING EXPENSES	**$473,587,676**	**$470,286,412**	**$477,417,713**	**($13,575,060)**	**$463,842,653**	**$464,433,533**	**($32,219,270)**	**$432,214,263**	**$468,085,735**	**($31,337,441)**	**$436,748,294**	**$473,777,432**	**($29,548,243)**	**$444,229,190**
	INCOME/(LOSS) FROM OPERATIONS	**($18,685,472)**	**($9,998,544)**	**($8,696,855)**	**($72,353)**	**($8,769,207)**	**$7,293,779**	**$7,275,601**	**$14,569,379**	**$6,796,018**	**$12,264,521**	**$19,060,538**	**$1,361,248**	**$15,512,181**	**$16,873,429**
	NON-OPERATING REVENUE	**$15,297,404**	**$11,832,973**	**$8,858,736**	**$0**	$8,858,736	**$8,858,736**	**$0**	$8,858,736	**$8,858,736**	**$0**	$8,858,736	**$8,858,736**	**$0**	$8,858,736
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**($3,388,068)**	**$1,834,429**	**$161,881**	**($72,353)**	**$89,529**	**$16,152,515**	**$7,275,601**	**$23,428,115**	**$15,654,754**	**$12,264,521**	**$27,919,274**	**$10,219,984**	**$15,512,181**	**$25,732,165**
	Principal Payments	**$5,152,609**	**$5,316,471**	$5,510,844		$5,510,844	$5,725,738		$5,725,738	$5,911,163		$5,911,163	$6,137,126		$6,137,126
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**-4.1%**	**-2.2%**	**-1.9%**	**0.5%**	**-1.9%**	**1.5%**	**-29.2%**	**3.3%**	**1.4%**	**-64.3%**	**4.2%**	**0.3%**	**-110.5%**	**3.7%**
2	Hospital Non Operating Margin	**3.4%**	**2.6%**	**1.9%**	**0.0%**	**1.9%**	**1.9%**	**0.0%**	**2.0%**	**1.9%**	**0.0%**	**1.9%**	**1.9%**	**0.0%**	**1.9%**
3	Hospital Total Margin	**-0.7%**	**0.4%**	**0.0%**	**0.5%**	**0.0%**	**3.4%**	**-29.2%**	**5.2%**	**3.3%**	**-64.3%**	**6.1%**	**2.2%**	**-110.5%**	**5.6%**
D.	**FTEs**	**2,849**	**2,822**	2,821	(181)	2,641	2,711	(325)	2,386	2,701	(323)	2,378	2,691	(313)	2,378
	FTE reduction is a transfer to NEMG see separate CON														
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	17,288	17,000	17,243	211	17,454	17,081	393	17,474	16,900	574	17,474	16,753	755	17,508
2	Outpatient Visits	585,965	570,156	618,543	4,554	623,097	620,364	11,880	632,244	621,913	15,630	637,543	621,913	18,558	640,471
	TOTAL VOLUME	**603,253**	**587,156**	**635,786**	**4,765**	**640,551**	**637,445**	**12,273**	**649,718**	**638,813**	**16,204**	**655,017**	**638,666**	**19,313**	**657,979**

LINE	Total Entity:L+M Hospital	FY 2014 Actual	FY 2015 Actual	FY 2016 Projected	FY 2016 Projected	FY 2016 Projected	FY 2017 Projected	FY 2017 Projected	FY 2017 Projected	FY 2018 Projected	FY 2018 Projected	FY 2018 Projected	FY 2019 Projected	FY 2019 Projected	FY 2019 Projected
	Description	Results	Results	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON	W/out CON	Incremental	W/ CON
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$788,136,573	$839,272,512	$852,448,517	$14,023,919	$866,472,437	$886,546,458	$37,272,979	$923,819,437	$922,008,316	$53,052,862	$975,061,178	$958,888,649	$68,562,223	$1,027,450,872
2	Less: Allowances	$446,502,255	$483,244,808	$480,941,850	$8,211,581	$489,153,431	$514,682,289	$22,403,989	$537,086,278	$546,844,451	$32,513,069	$579,357,519	$583,278,646	$43,006,907	$626,285,554
3	Less: Charity Care	$5,424,367	$5,405,542	$5,866,995	$96,520	$5,963,515	$6,345,742	$266,793	$6,612,536	$6,863,555	$394,933	$7,258,487	$7,423,621	$530,802	$7,954,423
4	Less: Other Deductions	$2,458,020	$12,801,007	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787	$18,201,787	$0	$18,201,787
	Net Patient Service Revenue	**$333,751,931**	**$337,821,155**	**$347,437,885**	**$5,715,818**	**$353,153,703**	**$347,316,640**	**$14,602,197**	**$361,918,837**	**$350,098,524**	**$20,144,860**	**$370,243,384**	**$349,984,595**	**$25,024,513**	**$375,009,108**
5	Medicare	$114,777,095	$119,697,210	$122,862,324	$1,920,631	$124,782,955	$122,820,933	$4,906,633	$127,727,566	$123,770,627	$6,769,080	$130,539,707	$123,731,733	$8,408,743	$132,140,476
6	Medicaid	$36,357,088	$37,915,596	$38,918,186	$608,384	$39,526,570	$38,905,075	$1,554,238	$40,459,313	$39,205,902	$2,144,191	$41,350,094	$39,193,582	$2,663,575	$41,857,157
7	CHAMPUS & TriCare	$10,871,028	$11,337,033	$11,636,815	$181,911	$11,818,726	$11,632,894	$464,728	$12,097,622	$11,722,844	$641,128	$12,363,972	$11,719,160	$796,428	$12,515,588
8	Other	($2,458,020)	($12,801,007)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)	($18,201,787)	$0	($18,201,787)
	Total Government	**$159,547,191**	**$156,148,833**	**$155,215,538**	**$2,710,926**	**$157,926,463**	**$155,157,115**	**$6,925,599**	**$162,082,714**	**$156,497,586**	**$9,554,400**	**$166,051,986**	**$156,442,688**	**$11,868,745**	**$168,311,434**
9	Commercial Insurers	$161,745,469	$168,678,963	$173,139,286	$2,706,579	$175,845,865	$173,080,956	$6,914,496	$179,995,452	$174,419,278	$9,539,082	$183,958,360	$174,364,469	$11,849,716	$186,214,185
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,109,407	$5,328,430	$5,469,328	$85,499	$5,554,827	$5,467,486	$218,423	$5,685,909	$5,509,762	$301,332	$5,811,094	$5,508,031	$374,323	$5,882,354
12	Workers Compensation	$7,349,864	$7,664,928	$7,867,610	$122,989	$7,990,599	$7,864,959	$314,201	$8,179,160	$7,925,774	$433,465	$8,359,238	$7,923,283	$538,462	$8,461,745
13	Other	$0	$0	$5,746,124	$89,826	$5,835,950	$5,746,124	$229,477	$5,975,601	$5,746,124	$316,582	$6,062,706	$5,746,124	$393,267	$6,139,391
	Total Non-Government	**$174,204,740**	**$181,672,322**	**$192,222,347**	**$3,004,893**	**$195,227,240**	**$192,159,525**	**$7,676,597**	**$199,836,123**	**$193,600,938**	**$10,590,460**	**$204,191,398**	**$193,541,907**	**$13,155,768**	**$206,697,675**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$333,751,931**	**$337,821,155**	**$347,437,885**	**$5,715,818**	**$353,153,703**	**$347,316,640**	**$14,602,197**	**$361,918,837**	**$350,098,524**	**$20,144,860**	**$370,243,384**	**$349,984,595**	**$25,024,513**	**$375,009,108**
14	Less: Provision for Bad Debts	$14,966,698	$12,798,310	$13,779,946	$210,310	$13,990,256	$13,775,137	$537,280	$14,312,417	$13,885,471	$741,219	$14,626,690	$13,880,952	$920,763	$14,801,715
	Net Patient Service Revenue less provision for bad debts	**$318,785,233**	**$325,022,845**	**$333,657,939**	**$5,505,508**	**$339,163,447**	**$333,541,503**	**$14,064,917**	**$347,606,420**	**$336,213,053**	**$19,403,641**	**$355,616,694**	**$336,103,643**	**$24,103,750**	**$360,207,393**
15	Other Operating Revenue	$29,607,174	$30,854,159	31,179,479		$31,179,479	31,179,479		$31,179,479	31,179,479		$31,179,479	31,179,479		$31,179,479
17	Net Assets Released from Restrictions	$671,797	$577,092	$0		$0			$0			$0			$0
	TOTAL OPERATING REVENUE	**$349,064,204**	**$356,454,096**	**$364,837,419**	**$5,505,508**	**$370,342,927**	**$364,720,983**	**$14,064,917**	**$378,785,900**	**$367,392,533**	**$19,403,641**	**$386,796,174**	**$367,283,122**	**$24,103,750**	**$391,386,872**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$142,343,619	$140,640,103	$ 143,576,703	$603,987	$144,180,691	$140,019,192	$760,868	$140,780,059	$141,973,430	$754,514	$142,727,944	$143,983,025	$1,270,138	$145,253,163
2	Fringe Benefits	$50,942,363	$51,694,855	$ 54,026,420	$847,885	$54,874,305	$52,456,564	$1,228,742	$53,685,306	$52,771,303	$1,254,900	$54,026,203	$53,087,931	$1,407,884	$54,495,815
3	Physicians Fees	$37,964,369	$29,627,730	$ 29,986,525	$2,845,324	$32,831,849	$22,789,759	$4,677,729	$27,467,488	$22,333,964	$4,788,754	$27,122,718	$22,646,640	$4,921,640	$27,568,280
4	Supplies and Drugs	$59,512,480	$63,622,692	$64,288,904	$55,178	$64,344,082	$64,610,349	$345,629	$64,955,978	$65,540,738	$651,937	$66,192,675	$66,471,416	$917,694	$67,389,110
5	Depreciation and Amortization	$22,728,484	$23,639,711	$26,054,143	$77,061	$26,131,204	$27,572,414	$154,122	$27,726,536	$27,826,240	$154,122	$27,980,362	$28,839,752	$154,122	$28,993,874
6	Provision for Bad Debts-Other[b]				$0	$0		$0	$0		$0	$0		$0	$0
7	Interest Expense	$3,542,721	$3,553,690	$3,368,376	$0	$3,368,376	$3,167,699	$0	$3,167,699	$2,973,808	$0	$2,973,808	$2,749,451	$0	$2,749,451
8	Malpractice Insurance Cost	$4,538,822	$4,818,820	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632	$4,812,632	$0	$4,812,632
9	Lease Expense	$4,618,504	$4,647,875	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308	$4,852,308	$0	$4,852,308
10	Other Operating Expenses	$22,334,118	$27,882,477	$ 27,596,503	$0	$27,596,503	$27,596,503	$0	$27,596,503	$27,872,468	$0	$27,872,468	*$26,478,844*	$0	$26,478,844
	TOTAL OPERATING EXPENSES	**$348,525,480**	**$350,127,953**	**$358,562,515**	**$4,429,435**	**$362,991,950**	**$347,877,420**	**$7,167,089**	**$355,044,509**	**$350,956,891**	**$7,604,227**	**$358,561,119**	**$353,921,999**	**$8,671,477**	**$362,593,477**
	INCOME/(LOSS) FROM OPERATIONS	**$538,724**	**$6,326,143**	**$6,274,904**	**$1,076,073**	**$7,350,977**	**$16,843,563**	**$6,897,828**	**$23,741,391**	**$16,435,641**	**$11,799,414**	**$28,235,055**	**$13,361,123**	**$15,432,273**	**$28,793,396**
	NON-OPERATING REVENUE	**$8,788,601**	**$9,936,909**	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**	**$0**	$8,262,701	**$8,262,701**		$8,262,701
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$9,327,325**	**$16,263,052**	**$14,537,605**	**$1,076,073**	**$15,613,678**	**$25,106,264**	**$6,897,828**	**$32,004,092**	**$24,698,342**	**$11,799,414**	**$36,497,756**	**$21,623,824**	**$15,432,273**	**$37,056,097**
	Principal Payments	**$5,152,609**	**$5,316,471**	$5,510,844	$0	$5,510,844	$5,725,738	$0	$5,725,738	$5,911,163	$0	$5,911,163	$6,137,126		$6,137,126
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**0.2%**	**1.8%**	**1.7%**	**19.5%**	**2.0%**	**4.6%**	**49.0%**	**6.3%**	**4.5%**	**60.8%**	**7.3%**	**3.6%**	**64.0%**	**7.4%**
2	Hospital Non Operating Margin	**2.3%**	**2.6%**	**2.3%**	**0.0%**	**2.2%**	**2.3%**	**0.0%**	**2.2%**	**2.2%**	**0.0%**	**2.1%**	**2.2%**	**0.0%**	**2.1%**
3	Hospital Total Margin	**2.7%**	**4.6%**	**4.0%**	**19.5%**	**4.2%**	**6.9%**	**49.0%**	**8.4%**	**6.7%**	**60.8%**	**9.4%**	**5.9%**	**64.0%**	**9.5%**
D.	**FTEs**	**1,849**	**1,835**	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	14,153	14,076	14,212	179	14,391	14,083	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	449,789	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	TOTAL VOLUME	**472,263**	**463,865**	**469,289**	**3,641**	**472,930**	**469,160**	**11,259**	**480,419**	**469,017**	**14,967**	**483,984**	**468,900**	**18,035**	**486,935**

NON-PROFIT

Applicant: Yale New Haven Health System

Financial Worksheet (A)

Please provide one year of actual results and three years of projections of **Total Entity** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
LINE	**Total Entity:**	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2016**	**FY 2016**	**FY 2017**	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2018**	**FY 2018**	**FY 2019**	**FY 2019**	**FY 2019**
		Actual	**Actual**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
	Description	**Results**	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
A.	**OPERATING REVENUE**														
1	Total Gross Patient Revenue	$11,767,479,000	$12,297,456,000	$13,374,327,000	$599,124,000	$13,973,451,000	$13,298,161,000	$1,254,311,000	$14,552,472,000	$13,330,316,000	$1,319,830,000	$14,650,146,000	$13,379,236,000	$1,386,537,000	$14,765,773,000
2	Less: Allowances	$8,157,566,000	$8,473,579,000	$9,395,854,000	$346,059,000	$9,741,913,000	$9,333,090,000	$741,688,000	$10,074,778,000	$9,331,729,000	$797,652,000	$10,129,381,000	$9,346,867,000	$858,637,000	$10,205,504,000
3	Less: Charity Care	$139,796,000	$127,264,000	$147,836,000	$3,768,000	$151,604,000	$148,923,000	$7,888,000	$156,811,000	$149,896,000	$8,300,000	$158,196,000	$150,878,000	$8,719,000	$159,597,000
4	Less: Other Deductions	$58,682,000	$122,400,000	$182,106,000	$9,101,000	$191,207,000	$182,106,000	$18,202,000	$200,308,000	$182,106,000	$18,202,000	$200,308,000	$182,106,000	$18,202,000	$200,308,000
	Net Patient Service Revenue	**$3,411,435,000**	**$3,574,213,000**	**$3,648,531,000**	**$240,196,000**	**$3,888,727,000**	**$3,634,042,000**	**$486,533,000**	**$4,120,575,000**	**$3,666,585,000**	**$495,676,000**	**$4,162,261,000**	**$3,699,385,000**	**$500,979,000**	**$4,200,364,000**
5	Medicare	$1,102,618,000	$1,156,905,000	$1,198,850,000	$86,990,000	$1,285,840,000	$1,183,306,000	$175,699,000	$1,359,005,000	$1,189,982,000	$178,902,000	$1,368,884,000	$1,195,809,000	$180,751,000	$1,376,560,000
6	Medicaid	$391,367,000	$410,636,000	$425,524,000	$25,955,000	$451,479,000	$420,006,000	$52,423,000	$472,429,000	$422,376,000	$53,378,000	$475,754,000	$424,444,000	$53,930,000	$478,374,000
7	CHAMPUS & TriCare	$10,732,000	$11,261,000	$11,669,000	$6,715,000	$18,384,000	$11,518,000	$13,563,000	$25,081,000	$11,583,000	$13,810,000	$25,393,000	$11,639,000	$13,953,000	$25,592,000
8	Other	($55,517,000)	($122,400,000)	($182,106,000)	($9,101,000)	($191,207,000)	($182,106,000)	($18,202,000)	($200,308,000)	($182,106,000)	($18,202,000)	($200,308,000)	($182,106,000)	($18,202,000)	($200,308,000)
	Total Government	**$1,449,200,000**	**$1,456,402,000**	**$1,453,937,000**	**$110,559,000**	**$1,564,496,000**	**$1,432,724,000**	**$223,483,000**	**$1,656,207,000**	**$1,441,835,000**	**$227,888,000**	**$1,669,723,000**	**$1,449,786,000**	**$230,432,000**	**$1,680,218,000**
9	Commercial Insurers	$1,840,390,000	$1,989,967,000	$2,062,116,000	$116,568,000	$2,178,684,000	$2,070,557,000	$235,268,000	$2,305,825,000	$2,093,250,000	$239,550,000	$2,332,800,000	$2,117,455,000	$242,023,000	$2,359,478,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$97,042,000	$101,820,000	$105,512,000	$5,371,000	$110,883,000	$104,144,000	$10,848,000	$114,992,000	$104,731,000	$11,046,000	$115,777,000	$105,244,000	$11,160,000	$116,404,000
12	Workers Compensation	$24,803,000	$26,024,000	$26,968,000	$4,635,000	$31,603,000	$26,618,000	$9,362,000	$35,980,000	$26,768,000	$9,533,000	$36,301,000	$26,899,000	$9,631,000	$36,530,000
13	Other	$0	$0	$0	$3,064,000	$3,064,000	$0	$7,573,000	$7,573,000	$0	$7,659,000	$7,659,000	$0	$7,733,667	$7,733,667
	Total Non-Government	**$1,962,235,000**	**$2,117,811,000**	**$2,194,596,000**	**$129,638,000**	**$2,324,234,000**	**$2,201,319,000**	**$263,051,000**	**$2,464,370,000**	**$2,224,749,000**	**$267,788,000**	**$2,492,537,000**	**$2,249,598,000**	**$270,547,667**	**$2,520,145,667**
	Net Patient Service Revenue[a] (Government+Non-Government)	**$3,411,435,000**	**$3,574,213,000**	**$3,648,533,000**	**$240,197,000**	**$3,888,730,000**	**$3,634,043,000**	**$486,534,000**	**$4,120,577,000**	**$3,666,584,000**	**$3,666,584,000**	**$7,333,168,000**	**$3,699,384,000**	**$500,979,667**	**$4,200,363,667**
14	Less: Provision for Bad Debts	$123,743,000	$81,528,000	$105,127,000	$8,820,000	**$113,947,000**	$105,887,000	$17,537,000	**$123,424,000**	$106,583,000	$17,654,000	**$124,237,000**	$107,286,000	$17,664,000	**$124,950,000**
	Net Patient Service Revenue less provision for bad debts	**$3,287,692,000**	**$3,492,685,000**	**$3,543,404,000**	**$231,376,000**	**$3,774,780,000**	**$3,528,155,000**	**$468,996,000**	**$3,997,151,000**	**$3,560,002,000**	**$478,022,000**	**$4,038,024,000**	**$3,592,099,000**	**$483,315,000**	**$4,075,414,000**
15	Other Operating Revenue	$87,934,000	$88,397,523	$112,600,000	$9,313,000	**$121,913,000**	$115,978,000	$18,625,000	**$134,603,000**	$119,457,000	$18,625,000	**$138,082,000**	$123,040,000	$18,625,000	**$141,665,000**
17	Net Assets Released from Restrictions	$19,060,000	$21,197,477	$0		**$0**	$0	$0	**$0**	$0	$0	**$0**	$0	$0	**$0**
	TOTAL OPERATING REVENUE	**$3,394,686,000**	**$3,602,280,000**	**$3,656,004,000**	**$240,689,000**	**$3,896,693,000**	**$3,644,133,000**	**$487,621,000**	**$4,131,754,000**	**$3,679,459,000**	**$496,647,000**	**$4,176,106,000**	**$3,715,139,000**	**$501,940,000**	**$4,217,079,000**
B.	**OPERATING EXPENSES**														
1	Salaries and Wages	$1,366,381,000	$1,434,450,000	$1,471,076,000	$111,777,000	$1,582,853,000	$1,464,693,000	$220,020,000	$1,684,713,000	$1,494,063,000	$222,920,000	$1,716,983,000	$1,525,348,000	$225,493,000	$1,750,841,000
2	Fringe Benefits	$377,757,000	$424,022,000	$434,848,000	$31,756,000	$466,604,000	$429,113,000	$61,230,000	$490,343,000	$436,279,000	$61,774,000	$498,053,000	$445,533,000	$62,181,000	$507,714,000
3	Physicians Fees	$548,304,000	$565,197,000	$589,037,000	$22,261,000	$611,298,000	$597,313,000	$33,966,000	$631,279,000	$618,512,000	$34,176,000	$652,688,000	$640,614,000	$34,535,000	$675,149,000
4	Supplies and Drugs	$474,136,000	$481,650,000	$493,629,000	$38,648,000	$532,277,000	$496,851,000	$78,195,000	$575,046,000	$510,533,000	$80,226,000	$590,759,000	$525,236,000	$81,646,000	$606,882,000
5	Depreciation and Amortization	$192,072,000	$185,944,000	$197,286,000	$14,369,000	$211,655,000	$199,607,000	$30,394,000	$230,001,000	$193,522,000	$30,785,000	$224,307,000	$193,657,000	$31,804,000	$225,461,000
6	Provision for Bad Debts-Other[b]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$26,917,000	$24,188,000	$44,341,000	$1,684,000	$46,025,000	$45,505,000	$3,168,000	$48,673,000	$49,426,000	$3,001,000	$52,427,000	$48,812,000	$2,755,000	$51,567,000
8	Malpractice Insurance Cost	$9,731,000	$29,803,000	$38,435,000	$8,417,000	$46,852,000	$39,448,000	$16,833,000	$56,281,000	$41,316,000	$16,863,000	$58,179,000	$43,232,000	$16,840,000	$60,072,000
9	Lease Expense	$30,893,000	$31,740,000	$33,079,000	$3,982,000	$37,061,000	$32,940,000	$7,964,000	$40,904,000	$33,531,000	$7,985,000	$41,516,000	$34,163,000	$7,969,000	$42,132,000
10	Other Operating Expenses	$198,384,000	$265,629,000	$285,171,000	$8,494,000	$293,665,000	$230,956,000	$21,282,000	$252,238,000	$195,238,000	$21,858,000	$217,096,000	$150,242,000	$22,319,000	$172,561,000
	TOTAL OPERATING EXPENSES	**$3,224,575,000**	**$3,442,624,000**	**$3,586,902,000**	**$241,388,000**	**$3,828,290,000**	**$3,536,426,000**	**$473,052,000**	**$4,009,478,000**	**$3,572,420,000**	**$479,588,000**	**$4,052,008,000**	**$3,606,837,000**	**$485,542,000**	**$4,092,379,000**
	INCOME/(LOSS) FROM OPERATIONS	**$170,111,000**	**$159,656,000**	**$69,102,000**	**($699,000)**	**$68,403,000**	**$107,707,000**	**$14,569,000**	**$122,276,000**	**$107,039,000**	**$17,059,000**	**$124,098,000**	**$108,302,000**	**$16,398,000**	**$124,700,000**
	NON-OPERATING REVENUE	$34,189,000	($29,663,887)	$34,997,000	$4,429,000	**$39,426,000**	$49,298,000	$8,859,000	**$58,157,000**	$49,420,000	$8,859,000	**$58,279,000**	$49,533,000	$8,859,000	**$58,392,000**
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	**$204,300,000**	**$129,992,113**	**$104,099,000**	**$3,730,000**	**$107,829,000**	**$157,005,000**	**$23,428,000**	**$180,433,000**	**$156,459,000**	**$25,918,000**	**$182,377,000**	**$157,835,000**	**$25,257,000**	**$183,092,000**
	Principal Payments	$8,008,000	$16,472,000	$19,196,000	$2,755,000	**$21,951,000**	$20,027,000	$5,726,000	**$25,753,000**	$19,942,000	$5,911,000	**$25,853,000**	$21,957,000	$6,137,000	**$28,094,000**
C.	**PROFITABILITY SUMMARY**														
1	Hospital Operating Margin	**5.0%**	**4.5%**	**1.9%**	**-0.3%**	**1.8%**	**3.0%**	**3.0%**	**3.0%**	**3.0%**	**3.4%**	**3.0%**	**3.0%**	**3.3%**	**3.0%**
2	Hospital Non Operating Margin	**1.0%**	**-0.8%**	**1.0%**	**1.8%**	**1.0%**	**1.4%**	**1.8%**	**1.4%**	**1.3%**	**1.8%**	**1.4%**	**1.3%**	**1.8%**	**1.4%**
3	Hospital Total Margin	**6.0%**	**3.6%**	**2.8%**	**1.5%**	**2.8%**	**4.3%**	**4.8%**	**4.4%**	**4.3%**	**5.2%**	**4.4%**	**4.2%**	**5.0%**	**4.3%**
D.	**FTEs**	**16,037**	**16,230**	**16,322**	**1,411**	**17,733**	**16,382**	**2,712**	**19,094**	**16,418**	**2,704**	**19,122**	**16,454**	**2,704**	**19,158**
E.	**VOLUME STATISTICS[c]**														
1	Inpatient Discharges	**109,275**	**111,563**	**115,101**	**8,833**	**123,934**	**116,139**	**17,474**	**133,613**	**116,960**	**17,474**	**134,434**	**117,790**	**17,508**	**135,298**
2	Outpatient Visits	**1,754,308**	**1,857,501**	**1,828,007**	**313,826**	**2,141,833**	**1,843,660**	**632,244**	**2,475,904**	**1,859,472**	**637,543**	**2,497,015**	**1,875,446**	**640,471**	**2,515,917**
	TOTAL VOLUME	**1,863,583**	**1,969,064**	**1,943,108**	**322,658**	**2,265,766**	**1,959,799**	**649,718**	**2,609,517**	**1,976,432**	**655,017**	**2,631,449**	**1,993,236**	**657,979**	**2,651,215**

[a] Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b] Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c] Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Carney, Brian
Sent: Thursday, February 04, 2016 3:33 PM
To: nancy.rosenthal@ynnh.org
Cc: Greer, Leslie; Riggott, Kaila; Roberts, Karen; Lazarus, Steven; Ciesones, Ron
Subject: Completeness Letter (2nd) for Docket Number: 15-32033-CON
Attachments: 15-32033 2nd Completeness 2-4-2016.docx

Good afternoon Nancy,

Please see the attached completeness letter (2nd) in the matter of the proposed transfer of ownership of Lawrence+Memorial Corporation to Yale New Haven Health Services Corporation. In responding to the completeness letter questions, please follow the instructions included in the letter and provide the response document as an attachment only (no hard copies required). Please provide your written responses to OHCA no later than **April 4, 2016**.

Email to OHCA@ct.gov and cc: Brian.Carney@ct.gov, Ronald.Ciesones@ct.gov, Steven.Lazarus@ct.gov and Kaila.Riggott@ct.gov.

If you have any questions regarding the completeness letter, please contact Steve Lazarus at (860) 418-7012, Brian Carney at (860) 418-7014 or Ronald Ciesones at (860) 418-7030.

Sincerely,
Brian A. Carney

Ps. Please confirm receipt of this email and corresponding attachment.

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

February 4, 2016 Via Email Only

nancy.rosenthal@ynhh.org
Ms. Nancy Rosenthal
Vice President, Strategy and Regulatory Planning
Yale New Haven Health
5 Perryridge Road
Greenwich, CT 06830

RE: Certificate of Need Application: Docket Number: 15-32033-CON
Transfer of ownership of L+M Corporation to Yale New Haven Health Services Corporation
Certificate of Need Completeness Letter (2nd)

Dear Ms. Rosenthal:

On January 5, 2016, responses were received to OHCA's first completeness letter in the above referenced matter. OHCA requests additional information pursuant to Connecticut General Statutes §19a-639a(c). *Please electronically confirm receipt of this email as soon as you receive it.* Provide responses to the questions below in both a Word document and PDF format as an attachment to a responding email. ***Please email your responses to each of the following email addresses: OHCA@ct.gov; brian.carney@ct.gov; ronald.ciesones@ct.gov; steven.lazarus@ct.gov; and kaila.riggott@ct.gov.***

Paginate and date your response (i.e., each page in its entirety). Repeat each OHCA question before providing your response. Information filed after the initial CON application submission (e.g., completeness response letter, prefiled testimony, late file submissions, etc.) must be numbered sequentially from the Applicant's preceding document. Begin your submission using **Page 866** and reference "**Docket Number: 15-32033-CON**."

Pursuant to Section 19a-639a(c) of the Connecticut General Statutes, you must submit your response to this request for additional information no later than sixty days after the date this request was transmitted. Therefore, please provide your written responses to OHCA no later than **April 4, 2016**, otherwise your application will be automatically considered withdrawn.

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

1. Provide or address the following regarding prices, charges and cost savings as related to this proposal and past Yale New Haven Health Services Corporation ("YNHHSC") hospital affiliations:

    a. Explain the impact on prices charged to patients that received health care services at the Hospital of St. Raphael ("HSR") main and satellite campuses both before and after the acquisition of HSR by YNHHSC. Provide a detailed explanation for any increases or decreases in price structure, average pricing and pricing policies following the acquisition.

    b. Provide a detailed comparison of risk-adjusted prices for health care services currently provided at L+M, Yale-New Haven, Greenwich and Bridgeport Hospitals and provide supporting evidence. Identify any assumptions made in this comparison. Discuss whether and how Greenwich and Bridgeport Hospital's affiliation with the YNHHSC system has provided identifiable benefits to payers and consumers as a result of any changed pricing structure, in the 3 years immediately after these affiliations and at present.

    c. Describe in detail how the prices for health care services at L+M will be affected following the YNHHSC ownership change.

    d. Discuss in detail and provide the associated dollar amounts for any cost savings achieved at Greenwich Hospital, Bridgeport Hospital and HSR following their affiliation with YNHHSC. Specify the timeframes related to any identified cost saving initiatives for the Greenwich and Bridgeport affiliations.

    e. The response provided several examples where costs will increase (e.g., the fringe benefit package for NEMG employees and additional staff and supplies for an anticipated increase in volume). Complete the table below providing data on the incremental expenses for the first three years of the proposal for the combined health system.

Incremental Expenses of the Affiliation ($ in millions)	FY 2016	FY 2017	FY 2018

2. Page 26 of the Application indicates YNHHSC will commit $300 million to the proposal, however the response indicated a commitment of $316 million from the following sources:

   $163 million - L+M base operating cash flows
   $ 68 million - Incremental cash flows from synergies/efficiencies
   $ 85 million - YNHHSC
   $316 million

   Provide the following as it relates to the $300 million commitment of YNHHSC:

   a) verification of the exact dollar amount of the YNHHSC commitment and its funding sources;

   b) a detailed explanation of the sources of revenue that may be included as part of L+M's base operating cash flows;

   c) a breakdown of the $68 million in synergies/efficiencies.

3. It appears from the response on page 624 that YNHHSC's $300 million commitment includes significant contributions from the operations of L+M (approx. $215 million), while only $85 million is coming from YNHHSC. Provide the following:

   a) Specific details of how L+M's contribution ($215 million) will be funded, considering the L+M System had operating losses of more than $36 million in fiscal years (FY) 2013-2015 and only $35 million in incremental operating gains are projected cumulatively from FYs 2016-2019.

   b) If L+M is unable to achieve its funding level contribution from operations, how will the balance of the commitment be funded?

4. Has the financial performance (e.g., operating margin) of Bridgeport and Greenwich Hospitals improved as a result of their affiliations with YNHHSC? At what point in time after the affiliations in the 1990s did any financial impact (specific to the YNHHSC affiliation) begin to occur for these two hospitals? What financial impact on these two hospitals and their patients continues to be experienced as a result of the ongoing affiliation with the YNHHSC system? Provide details.

In addition, OHCA is requesting the Applicant provide, if available, the CON application material as filed with OHCA under Docket Number 96-513, related to YNHHSC's affiliation with Connecticut Health System, Inc., the former parent corporation of Bridgeport Hospital and the CON application material as filed with OHCA under Docket Number 97-559, related to YNHHSC's affiliation with Greenwich Health Care Services, Inc., the parent corporation of Greenwich Hospital. Include the complete application, including any post decision compliance filings and modification application material. (*Note: OHCA is requesting this information because it is unavailable due to State of*

Connecticut record retention laws that require OHCA to discard CON application material after 5 years).

If you have any questions concerning this letter, please feel free to contact Steve Lazarus (860) 418-7012, Ron Ciesones (860) 418-7030 or Brian Carney (860) 418-7014.

Greer, Leslie

From: Lazarus, Steven
Sent: Friday, February 05, 2016 10:27 AM
To: Rosenthal, Nancy
Cc: Carney, Brian; Ciesones, Ron; Greer, Leslie
Subject: RE: Completeness Letter (2nd) for Docket Number: 15-32033-CON

Thank you Nancy. Brian sent it Completeness Letter to the email address that was listed in the application. We'll make a note of the updated email address in this record.

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Rosenthal, Nancy [mailto:Nancy.Rosenthal@greenwichhospital.org]
Sent: Friday, February 05, 2016 9:43 AM
To: Lazarus, Steven
Cc: Carney, Brian; Ciesones, Ron; Greer, Leslie
Subject: Re: Completeness Letter (2nd) for Docket Number: 15-32033-CON

Email address is wrong. It's ynhh not ynnh. Thx.

This confirms I have received.

Sent from my iPhone

On Feb 5, 2016, at 9:21 AM, Lazarus, Steven <Steven.Lazarus@ct.gov> wrote:

> Nancy,
>
> This is the email that was sent to your attention, yesterday afternoon.
>
> Steve

Ps. **Please confirm receipt**.

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053
<image002.jpg>

From: Carney, Brian
Sent: Thursday, February 04, 2016 3:33 PM
To: nancy.rosenthal@ynnh.org
Cc: Greer, Leslie; Riggott, Kaila; Roberts, Karen; Lazarus, Steven; Ciesones, Ron
Subject: Completeness Letter (2nd) for Docket Number: 15-32033-CON

Good afternoon Nancy,

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Email to OHCA@ct.gov and cc: Brian.Carney@ct.gov, Ronald.Ciesones@ct.gov, Steven.Lazarus@ct.gov and Kaila.Riggott@ct.gov.

If you have any questions regarding the completeness letter, please contact Steve Lazarus at (860) 418-7012, Brian Carney at (860) 418-7014 or Ronald Ciesones at (860) 418-7030.

Sincerely,
Brian A. Carney

Ps. Please confirm receipt of this email and corresponding attachment.

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: www.ct.gov/ohca

<15-32033 2nd Completeness 2-4-2016.docx>

State of Connecticut
GENERAL ASSEMBLY
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

January 29, 2016

Honorable George Jepsen
Attorney General
55 Elm Street
Hartford, CT 06106

Honorable Dr. Paul Pino, M.D.
Acting Commissioner of Public Health
410 Capitol Avenue, P.O. Box 340308
Hartford, CT 06134

Dear Attorney General Jepsen and Acting Commissioner Pino,

In conjunction with a recent letter from State Senate President Pro Tempore Martin M. Looney, we are writing to respectfully request that your agency analyze fully the potential pricing and cost implications of Yale-New Haven Health Services Corporation's proposed acquisition of Lawrence and Memorial Health's operations, including its two acute care hospitals, outpatient facilities, and the acquisition of Lawrence and Memorial Physician Association by Yale-New Haven's Northeast Medical Group.

The proposed transactions offer a clear route to the achievement of market power by the applicants, but is less clear in terms of protection for consumers. The recent release of a report entitled, *Hospital Consolidation in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, provide evidence that suggests Connecticut's hospital markets are already highly concentrated. We have great concerns that the purchase of L+M by the Yale-New Haven Health System will deepen that market concentration along the shoreline, where Yale-New Haven Health System is already a dominant actor.

The concerns raised in the report were validated on December 15, 2015, when the National Bureau of Economic Research released its largest study of hospital pricing for privately insured patients in history. The study found, among other things, that hospital prices in monopoly markets are **15.3% higher** than those in markets with four or more hospitals.

We urge your respective offices to request and analyze data from the applicants on prices charged by the Hospital of St. Raphael before and after its acquisition by Yale-New Haven Hospital, and similar comparative data between current risk-adjusted prices at L+M and the Yale-New Haven Health System hospitals in Bridgeport, Greenwich, and New Haven. We share a responsibility to protect hospital patients, our constituents, from inflated prices in monopoly markets.

Thank you for your attention to this urgent matter. We look forward to hearing from you.

Sincerely,

Catherine A. Osten
State Senator, 19th District

Bob Duff
Senate Majority Leader
State Senator, 25th District

Gary Winfield
State Senator, 10th District

cc: Honorable Martin M. Looney, 11th District
State Senate President Pro Tempore

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

February 10, 2016

The Honorable Catherine A. Osten
State Senator – 19th District
Room 2100
Legislative Office Building
Hartford, CT 06106-1591

The Honorable Bob Duff
Senate Majority Leader
State Senator – 25th District
Room 3300
Legislative Office Building
Hartford, CT 06106-1591

The Honorable Gary Winfield
State Senator – 10th District
Room 2400
Legislative Office Building
Hartford, CT 06106-1591

Re: Yale-New Haven Health Services Corporation's Proposed Affiliation with Lawrence + Memorial Corporation

Dear Senators Osten, Duff and Winfield:

On January 8, 2016, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for Yale-New Haven Health Services Corporation's affiliation with Lawrence + Memorial Corporation.

The Office of Health Care Access ("OHCA") works diligently to ensure that all of the guidelines and principles included in Conn. Gen. Stat. § 19a-639, as modified by Public Acts 14-168 and 15-146, are thoroughly evaluated for each certificate of need ("CON") application it receives. With respect to your specific concerns regarding the impact of hospital acquisitions on market prices, please know that OHCA has requested additional information from Yale-New Haven Health Services Corporation in order to analyze the historical impact on pricing as a result of its acquisitions or affiliations with other hospitals in the state. Enclosed for your review is a copy of the letter requesting additional information from Yale-New Haven Health Services Corporation.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Enc. 15-32033-CON Completeness Letter dated February 4, 2016

Greer, Leslie

From: Martone, Kim
Sent: Thursday, March 03, 2016 10:20 AM
To: Hansted, Kevin
Cc: Greer, Leslie
Subject: FW: Docket No: 15-32033-CON and Docket No: 15-32032-CON
Attachments: Letter.pdf

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Thursday, March 03, 2016 10:18 AM
To: Martone, Kim
Subject: Docket No: 15-32033-CON and Docket No: 15-32032-CON

Please see attached letter.
Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

March 3, 2016

Kimberly Martone
Director of Operations
State of Connecticut Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 15-32033-CON (known as "Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation");
Docket Number: 15-32032-CON (known as "Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.")

Dear Kim:

In light of Governor Malloy's Executive Order No. 51, dated February 25, 2016, I am writing to inform you that the applicants in the above-referenced matters plan to proceed, within the applicable statutory and regulatory framework, to complete the Certificate of Need process as it relates to both applications. In particular, with respect to Docket Number: 15-32033, the applicants will timely submit their completeness questions and await a determination from OHCA that the subject application is complete. Once deemed complete, we expect that OHCA would conduct a hearing and render a decision within ninety (90) days of the date of the application being deemed complete. With respect to Docket Number: 15-32032-CON, it is our opinion that Executive Order No. 51 is inapplicable and thus, this application should proceed as it would have prior to the issuance of the Governor's Executive Order No. 51.

Finally, with respect to Docket No-32033-CON, I am writing to confirm that OHCA, to the extent that Executive Order No. 51 remains in effect, will deny the application pursuant to Executive Order No. 51 should the application proceed to the point within the regulatory process wherein OHCA is required to render a final decision.

If you have any questions, or disagree with our approach or interpretation, we would appreciate hearing from you as soon as possible.

Very truly yours,

Joan Feldman, Esq.

JWF:mg
4607846v2

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

March 3, 2016

Kimberly Martone
Director of Operations
State of Connecticut Office of Health Care Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number: 15-32033-CON (known as "Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation");
Docket Number: 15-32032-CON (known as "Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc.")

Dear Kim:

In light of Governor Malloy's Executive Order No. 51, dated February 25, 2016, I am writing to inform you that the applicants in the above-referenced matters plan to proceed, within the applicable statutory and regulatory framework, to complete the Certificate of Need process as it relates to both applications. In particular, with respect to Docket Number: 15-32033, the applicants will timely submit their completeness questions and await a determination from OHCA that the subject application is complete. Once deemed complete, we expect that OHCA would conduct a hearing and render a decision within ninety (90) days of the date of the application being deemed complete. With respect to Docket Number: 15-32032-CON, it is our opinion that Executive Order No. 51 is inapplicable and thus, this application should proceed as it would have prior to the issuance of the Governor's Executive Order No. 51.

Finally, with respect to Docket No-32033-CON, I am writing to confirm that OHCA, to the extent that Executive Order No. 51 remains in effect, will deny the application pursuant to Executive Order No. 51 should the application proceed to the point within the regulatory process wherein OHCA is required to render a final decision.

If you have any questions, or disagree with our approach or interpretation, we would appreciate hearing from you no later than March 9, 2016.

Very truly yours,

Joan Feldman, Esq.

JWF:mg
4607846v3

cc: Janet Brancifort, M.P.H., Deputy Commissioner
William Aseltyne, Esq.
Maureen Anderson, Esq.

YALE NEW HAVEN HEALTH

March 16, 2016

Ms. Kimberly Martone
Director of Operations
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Additional Materials Requested by OHCA

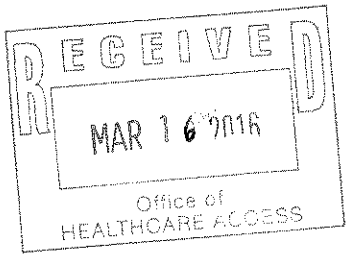
Dear Ms. Martone:

OHCA has requested copies of CON materials for Greenwich and Bridgeport Hospitals (Docket Numbers 96-513 and 97-559). Please note that these enclosed YNHHS archived materials are missing sections and therefore are not complete documents despite our best efforts to locate all related materials.

Please feel free to contact me at (203) 688-5721 with any questions.

Sincerely,

Nancy Rosenthal
Vice President, Strategy and Regulatory Planning



Copy to: Steven Lazarus
Brian Carney
Ronald Ciesones
Kaila Riggott

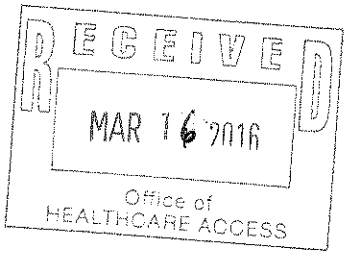
Enclosures

789 Howard Avenue
New Haven, CT 06519

789 Howard Avenue
New Haven, CT 06519

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Greenwich Health Care Services, Inc.
5 Perryridge Road
Greenwich, CT 06830



September 4, 1997

Commissioner Raymond Gorman
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Re: Application for CON, Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

Dear Commissioner Gorman:

Enclosed for review by the Office of Health Care Access are an original and five copies of a Certificate of Need application for the proposed affiliation between Yale-New Haven Health Services Corporation (YNHHSC) and Greenwich Health Care Services, Inc. (GHCS). The affiliation is designed to establish a strategic alliance between the two systems, whereby GHCS and its affiliates will become a local network within the health care system being developed by YNHHSC. As part of the affiliation, YNHHSC will become the parent corporation of GHCS.

This proposed affiliation is **not** a merger. No changes or reorganization of clinical services or beds among separate institutional providers within the YNHHSC system are proposed. In addition, there are no capital expenditures proposed as part of this affiliation.

The applicants are submitting this CON Application at the request of OHCA. However, the Applicants have questioned the applicability of the CON requirements to a corporate affiliation among nonprofit health care institutions or affiliates and therefore reserve their rights to challenge any determination that CON approval is required in order to implement the affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

The applicants request that the CON review and approval process be expedited to the greatest extent possible, without the requirement of a public hearing.

If you have any question or concerns, please contact Caroline Piselli at Yale-New Haven Health Services Corporation at 203-785-2609. We look forward to working with you and your staff on this CON.

Sincerely,

Gayle Cappozzalo
Executive Vice President
Strategy & System Development
Yale-New Haven Health Services Corporation

Frank A. Corvino
President & Chief Executive Officer
Greenwich Health Care Services, Inc.

cc: Jeanette C. Schreiber, Esq., Wiggin & Dana (Attorney to YNHHSC)
Andrew Schultz, Esq., (General Counsel of GHCS)

CVRLTR.DOC

APPLICATION

FOR

CERTIFICATE OF NEED

Corporate Affiliation of

Yale-New Haven Health Services Corporation

and Greenwich Health Care Services, Inc.

September 4, 1997

- LIST OF APPENDICES -

- LIST OF APPENDICES -

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134

APPLICATION FOR CERTIFICATE OF NEED:
FACILITIES OR PROVIDERS OTHER THAN
LONG TERM CARE

APPLICANTS: **Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.**

Note--At the time the application is filed, the applicant must be legally constituted to transact business in the State of Connecticut consistent with the provisions of the Connecticut General Statutes.

PROJECT TITLE: **Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.**

PROPOSED PROJECT ADDRESS: **789 Howard Avenue, New Haven, CT 06504**

- TABLE OF CONTENTS -

- LIST OF EXHIBITS -

OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED/MODIFICATION FILING FEE COMPUTATION SCHEDULE

000004

APPLICANT: Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc. PROJECT TITLE: Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc. DATE: , 1997 NEW CON: __X__ or Modification: _____ (Check one of the above) If new CON: Complete SECTION A If **modification:** Complete SECTION B	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (front desk) _____ _____ 2. Check red'd (D.O. Sec.) _____ _____ 3. Check correct (A.D.O.) _____ _____ 4. Check logged (D.O. Sec.) _____ _____ 5. Check rec'd (Comr. Sec.) _____ _____ 6. Other: _____ _____ _____

SECTION A - NEW CERTIFICATE OF NEED APPLICATION *** See Attached Note** 1. Check statute reference as applicable to CON application (see statute for detail): _____19a-154. Additional function or service, Change of Ownership prior to licensure. _____19a-155. Capital expenditure for major medical equipment exceeding $400,000 or other capital expenditure exceeding $1,000,000. 2. Enter $1,000 on "total Fee Due" line (SECTION C) if application is required pursuant to Section 19a-154 only, otherwise go on to line 3 of this section. 3. Section 19a-155 fee calculation (applicable if section 19a-155 is checked above **OR** if both 19a-154 and 19a-155 are checked): a. Base fee: _____ b. Additional Fee: (Capital Expenditure Assessment) _____ (To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied time .0005 and round to nearest dollar.) ($_____x.0005) c. Sum of base fee plus additional fee: (Lines a3a & A3b) _____ d. Enter the amount shown on line A3c. on "Total Fee Due: line (SECTION C).	$ 1,000.00 $ ____.00 $ 1,000.00
SECTION B - REQUEST FOR MODIFICATION OF PRIOR APPROVED CON 1. Check statute reference as applicable to the **original CON application** (see statute for detail or original CON authorization): _____19a-154. Additional function or service, Change of Ownership prior to licensure. _____19a-155. Capital expenditure for major medical equipment exceeding $400,000 or other capital expenditure exceeding $1,000,000. 2. Enter $1,000 on "total Fee Due" line (SECTION C) if section 19a-155 is not checked, and skip to SECTION C, otherwise go on to line 3 of this section. 3. Section 19a-155 fee calculation (applicable if section 19a-155 is checked above **OR** if both 19a-154 and 19a-155 are checked): a. Base fee: _____ b. Additional Fee: (Incremental Capital Expenditure Assessment) _____ (To calculate: Total requested incremental Capital expenditure including capitalized financing costs multiplied time .0005 and round to nearest dollar.) ($_____ __x.0005) c. Sum of Base Fee plus Additional Fee: _____ d. Enter the amount shown on line B3c. on "Total Fee Due: line (SECTION C).	$ 1,000.00 $ ____.00 $ ____.00
SECTION C TOTAL FEE DUE: _____	**$ 1,000.00**

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

THE FACE OF THIS DOCUMENT CONTAINS AN ARTIFICIAL FLEET LOGO WATERMARK - HOLD AT AN ANGLE TO VIEW

Fleet

Cashier's Check YALE NEW HAVEN HOSPITAL 1763870

Remitter

51-57
112

FLEET NATIONAL BANK
HARTFORD, CONNECTICUT
21079

Date AUG 05, 97

PAY $ *******1,000.00

TO THE ORDER OF $**********1,000*DOLLARS*AND*00*CENTS*

TREASURER STATE OF CT.****
****10 CAPITOL AVE ME# 13HCA****
HARTFORD, CT 06134********

SIGNATURE

SIGNATURE

2 SIGNATURE(S) REQUIRED IF OVER $25,000

⑈1763870⑈ ⑆011900571⑆ 0040623504⑈

Note: This Certificate of Need (CON) Application is being submitted at the request of OHCA. However, the Applicants have questioned the applicability of the CON requirements to a corporate affiliation among nonprofit health care institutions or affiliates and therefore reserve their rights to challenge any determination that CON approval is required in order to implement the affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06504

Greenwich Health Care System
5 Perryridge Road
Greenwich, CT 06830

000006

June 5, 1997

Honorable Raymond J. Gorman
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

RE: Affiliation of Yale New Haven Health Services Corporation and Greenwich Health Care System Letter of Intent

Dear Commissioner Gorman:

We are writing to inform the Office of Health Care Access (OHCA) of a proposed affiliation between Yale New Haven Health Services Corporation (YNHHSC, doing business as Yale New Haven Health System), the parent corporation of Yale-New Haven Hospital and Southern Connecticut Health System, Inc. (SCHS, the parent corporation of Bridgeport Hospital), and Greenwich Health Care System (GHCS, the parent corporation of Greenwich Hospital). The affiliation is designed to establish a strategic alliance between the two systems, enabling these organizations to remain competitive in a changing marketplace by enhancing quality of and access to care while controlling costs. As part of the affiliation, YNHHSC will become the parent corporation of GHCS. The governing boards and financial structures of each system will remain separate as will medical staff appointments and licensure.

This proposed affiliation will not involve the introduction of any new functions or services nor the expansion or termination of any functions or services. There will be no capital expenditures associated with the affiliation.

This letter is submitted as a letter of intent pursuant to section 19a-638 of the Connecticut General Statutes. The CON applicants will be Yale-New Haven Health System and Greenwich Health Care System. The CON application will seek approval as required for the affiliation described above. The hospitals will continue to operate at their present locations in New Haven, Bridgeport and Greenwich, Connecticut.

000007

Please forward a copy of the appropriate CON application forms and requests for any additional information to Gayle Capozzalo at Yale-New Haven Health System. The applicants would greatly appreciate the assistance of OHCA in expediting this CON process.

Thank you for your consideration.

Sincerely,

Frank Corvino
President and Chief Executive Officer
Greenwich Health Care System

Gayle Capozzalo, Executive Vice President
Strategy & System Development
Yale-New Haven Health System

FC/GC:jl

LOI

Attachment 1a

AFFIDAVIT

APPLICANT: Yale-New Haven Health Services Corporation

PROJECT TITLE: Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

I, Gayle Capozzalo, Executive Vice President, Strategy & System Devleopment
Name Position

of Yale-New Haven Health Services Corporation, being duly sworn, depose and state that the information submitted in this Certificate of Need Application Entitled "Corporate Affiliation of Yale New Health Services Corporation and Greenwich Health Care Services Inc." is accurate and correct to the best of my knowledge.

Signature

Executive Vice President, Strategy and System Development
Title

Subscribed and sworn to before me on 8/22/97
Date

Notary Public/~~Commissioner of Superior Court~~

My Commission Expires Jan. 31, 1998

Attachment 1b

AFFIDAVIT

APPLICANT: Greenwich Health Care Services, Inc.

PROJECT TITLE: Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

I, Frank A. Corvino, President and Chief Executive Officer
Name Position

of Greenwich Health Care Services, Inc., being duly sworn, depose and state that the information submitted in this Certificate of Need Application Entitled "Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services Inc." is accurate and correct to the best of my knowledge.

Signature

President and Chief Executive Officer
Title

Subscribed and sworn to before me on August 11, 1997
Date

~~Notary Public~~/Commissioner of Superior Court

Attachment 3a

000010

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134

APPLICATION FOR CERTIFICATE OF NEED

PROJECT TITLE: Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

I. General Information

A. Identification of Applicant

1. Specify Name and Address of Applicant.

NAME:	**ADDRESS:**
Yale-New Haven Health Services Corporation.	789 Howard Avenue
	New Haven, CT 06520

2. Specify the Name, Title, Address and Telephone Number of the Contact Person for this Application. The contact person shall be the person to whom all communications are directed.

NAME:	**ADDRESS:**
Caroline Piselli	Yale-New Haven Hospital
TITLE:	20 York Street
Director, Planning & Marketing (YNHH)	New Haven, CT 06504
	203-785-2609 (Telephone) 203-737-5013 (Telefax)

3. Specify the Name, Title, Address and Telephone Number of another person who may be contacted regarding this application, in the event that the contact person specified above is not available.

NAME:	**ADDRESS:**
Jeanette C. Schreiber, Esq.	Wiggin & Dana
TITLE:	One Century Tower
Attorney to YNHHSC	New Haven, CT 06508
	203-498-4334 Telephone) 203-782-2889 (Telefax)

Attachment 3b

000011

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134

APPLICATION FOR CERTIFICATE OF NEED

PROJECT TITLE: Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

I. General Information

A. Identification of Applicant

1. Specify Name and Address of Applicant.

NAME:	**ADDRESS:**
Greenwich Health Care Services, Inc.	5 Perryridge Road Greenwich, CT 06830

2. Specify the Name, Title, Address and Telephone Number of the Contact Person for this Application. The contact person shall be the person to whom all communications are directed.

NAME:	**ADDRESS:**
Andrew E. Schultz	Greenwich Health Care Services, Inc.
TITLE:	5 Perryridge Road
General Counsel to Greenwich Health Care Services, Inc.	Greenwich, CT 06830
	203-863-3925 (Telephone) 203-863-3927 (Telefax)

3. Specify the Name, Title, Address and Telephone Number of another person who may be contacted regarding this application, in the event that the contact person specified above is not available.

NAME:	**ADDRESS:**
Eugene J. Colucci	Greenwich Health Care Services, Inc.
TITLE:	5 Perryridge Road
Vice President, Finance & CFO	Greenwich, CT 06803
	203-863-3925 (Telephone) 203-863-3927 (Telefax)

CERTIFICATE OF NEED APPLICATION

Affiliations/Mergers

Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, Connecticut 06134

Names of Applicants: Yale-New Haven Health Services Corporation
Greenwich Health Care Services, Inc.

Name of Proposed Merged Entity Yale-New Haven Health Services Corporation will be the parent corporation in the affiliation, which is not a merger

Names of All Corporate Affiliates to be Merged Not Applicable

(General Instructions: Your response to the questions listed below should identify each Hospital and/or corporate entity where applicable. if the proposed affiliation/merger will not affect the Hospitals in any way, the relevant questions which follow may simply be answered as "Not Applicable".)

1. **Each Applicant should complete the Affidavits General Information Sheet included as follows:**

   a. **The corporate parent of each of the two Hospitals should complete the Affidavit entitled "Affidavit". (See Attachment 1)**

   Please see Attachments 1a and 1b.

   b. **Each Hospital should complete the Affidavit entitled "Acute Care Hospital Affidavit". (See Attachment 2)**

   Not applicable. This proposal involves the affiliation of two parent corporations and does not involve the merger of assets or clinical services. In addition, there are no capital expenditures associated with this proposal.

   c. **Each applicant should complete the General Information Sheet to identify primary and secondary contact people for this application. (See Attachment 3).**

   Please see Attachments 3a and 3b.

General Information

2. **Please describe the proposed merger which should also include the principle reason why the application should be approved. Further, please indicate the effective date of the proposed merger.**

Yale-New Haven Health Services Corporation (YNHHSC) and Greenwich Health Care Services, Inc. (GHCS) are pursuing a corporate affiliation whereby GHCS and its affiliates will become a local network within the regional health care system being developed by YNHHSC. This affiliation will enhance the ability of both the regional and local networks to continue their missions centered around serving the health care needs and promoting the health status of people in their communities, within a continually changing health care environment. Through this affiliation, YNHHSC seeks to add an additional local network and thus expand its fully integrated health care delivery system to better serve its

communities. YNHHSC provides a complete continuum of care, incorporating a full range of health care services, through its local vertical health care networks in a cost-effective manner measured by service and clinical outcomes.

Under the proposed affiliation agreement, Yale-New Haven Health Services Corporation will become the parent corporation (sole member) of Greenwich Health Care Services, Inc. (GHCS). GHCS is and will remain the parent company (sole member) of The Greenwich Hospital Association ("Greenwich Hospital"). Greenwich Hospital will remain a locally operated full service hospital. In connection with the affiliation, GHCS and Greenwich Hospital will create a foundation to hold and manage its endowment. The endowment will, at all times, be dedicated to use for the benefit of Greenwich Hospital, its affiliates and the Greenwich community.

This corporate affiliation is **not a merger**. As described more fully in the response to question 3, YNHHSC will have planning, coordinating and contracting functions and certain specified authority with respect to GHCS. This will support individual organizational flexibility, while providing each local vertical network with the benefits of a regional integrated system. The present organizational structures of YNHHSC and its affiliates and of GHCS and its affiliates are presented in Exhibits 1 and 2, respectively. The organizational structure following the proposed affiliation is presented in Exhibit 3.

The proposed YNHHSC-GHCS relationship continues the development by YNHHSC of a coordinated and integrated regional health care delivery system composed of strong local vertically integrated networks providing high quality, cost-effective health services while successfully operating in a managed care market place.

The developing YNHHSC system will assist affiliated providers and local systems to:

- Enhance the position of their local networks in accessing and accepting managed care contracts services for the enrolled population.

- Benefit from centralized managed care services.
- Share technology, services, management and programs to increase operating efficiencies.
- Positively affect the health status of the people and communities served by providing leadership in the promotion of community wellness, health education and accessible preventative health services.
- Collaborate to further develop a continuum of quality health care for the communities served
- Facilitate health care in Connecticut by working with local communities, employers and providers to maintain appropriate access to health education and care.

Each local vertical network within the YNHHSC system shall continue its long history of community involvement and shall subscribe to a set of values that includes quality, excellence, education, research, integrity and community service. The YNHHSC system will continue to serve patients as the number one priority, working closely with physicians and other health care providers to create an environment which is satisfying and rewarding to its employees.

The effective date of the affiliation will be immediately after CON approval.

3. **Provide a description of the legal structure, management and governance of each health care facility, including all corporate affiliates. Provide a detailed description of the legal structure, management and governance of the proposed merged entity resulting from the merger. Include an explanation of the anticipated cost savings in your response.**

Both YNHHSC and GHCS are non-stock corporations which are tax-exempt under section 501(c)(3) of the Internal Revenue Code. YNHHSC and its affiliates are described below.

Yale-New Haven Health Services Corporation (YNHHSC):	YNHHSC is a Connecticut non-stock, nonprofit, tax-exempt corporation with the primary purpose of supporting Yale-New Haven Hospital. In 1996, YNHHSC became the sole corporate member of SCHS, the parent of Bridgeport Hospital. YNHHSC has been charged with the development of a full service integrated healthcare delivery system.
Yale-New Haven Hospital, Inc. (YNHH):	YNHH is a Connecticut non-stock, nonprofit, tax-exempt corporation that operates a 900-bed academic medical center that offers a full array of primary to quaternary patient services. YNHH is the primary teaching hospital for the Yale University School of Medicine. YNHHSC is the sole member of YNHH.
Yale-New Haven Ambulatory Services Corporation (YNHASC):	YNHASC is a Connecticut non-stock, nonprofit corporation that operates ambulatory services businesses. YNHHSC is the sole member of YNHASC.
YNHH-MSO, Inc.	YNHH-MSO, Inc. is a Connecticut for-profit corporation that provides administrative and other support services to physician practices. YNHHSC is the sole shareholder of YNHH-MSO, Inc.
York Enterprises, Inc.:	York Enterprises is a Connecticut for-profit company that serves as the parent company of certain for-profit affiliates of YNHHSC. York Enterprises also serves as the network administrator of a pharmacy network. YNHHSC is the sole shareholder of York Enterprises.
Medical Center Realty, Inc. (MCR):	MCR is a for-profit company which owns or holds leases on YNHH-affiliated real estate, such as physician office buildings, commercial space and parking garages. York Enterprises is the sole shareholder of MCR.

Medical Center Pharmacy & Home Care, Inc. (MCP):	MCP is a for-profit company which runs a retail pharmacy with multiple locations. York Enterprises is the sole shareholder of MCP.
Harbor Health Plan, Inc. (Harbor):	Harbor Health Plan is a Connecticut for-profit stock corporation established in 1995 to develop and operate a Medicaid managed care program in Connecticut. YNHHSC is the sole shareholder of Harbor.
Century Collections Agency, Inc.	Century Collections Agency is a Connecticut for-profit corporation that provides hospitals and other healthcare providers with comprehensive and professional accounts receivable management services. YNHHSC affiliates own a majority of the stock in Century Collections.

Following the affiliation in 1996, YNHHSC is the parent corporation (sole member) of Southern Connecticut Health System (SCHS). SCHS and its affiliates are described below:

Southern Connecticut Health System, Inc. (SCHS)	SCHS is a Connecticut non-stock. nonprofit, tax-exempt corporation which promotes and carries out charitable, scientific and educational activities. YNHHSC is the sole member of SCHS.
Bridgeport Hospital (BH):	Bridgeport Hospital is a Connecticut non-stock, nonprofit, tax-exempt corporation that operates a 425 bed medical center. SCHS is the sole member of BH.
Bridgeport Hospital Foundation (The Foundation):	The Foundation is a non-stock, nonprofit tax-exempt corporation providing fund-raising support for SCHS, BH and other non-profit healthcare organizations affiliated with SCHS. SCHS is the sole member of the Foundation.

NovaMed Corporation (NovaMed):	NovaMed is a Connecticut for-profit, diversified health services company. SCHS is the sole shareholder of NovaMed
Ahlbin Centers for Rehabilitation Medicine, Inc. (ACRM):	ACRM is a Connecticut non-stock, nonprofit, tax-exempt corporation that provides comprehensive inpatient and outpatient rehabilitation services. SCHS is the sole member of ACRM.
United Home Care, Inc. (UHC)	UHC is a Connecticut non-stock, nonprofit, tax-exempt corporation that provides home health care services to patients within the Fairfield and New Haven county areas. SCHS is the sole member of UHC.
SCHS Properties, Inc.:	SCHS Properties is a Connecticut non-stock, nonprofit, tax-exempt corporation that owns or holds real estate properties. SCHS is the sole member of SCHS Properties.

Greenwich Health Care Services, Inc. and its affiliates are described below:

Greenwich Health Care Services, Inc. (GHCS)	GHCS is a Connecticut non-stock. nonprofit, tax-exempt corporation which promotes and carries out charitable, scientific and educational activities.
The Greenwich Hospital Association (GH)	The Greenwich Hospital Association is a Connecticut non-stock, nonprofit, tax-exempt corporation that operates a 160 bed hospital. GHCS is the sole member of Greenwich Hospital Association.
The Perryridge Corporation (PC)	The Perryridge Corporation is a non-stock, nonprofit, tax-exempt corporation that owns The Greenwich Hospital Pavilion. GHCS is the sole member of PC.

Greenwich Health Services, Inc. (GHSI)	GHSI is a for-profit corporation whose primary purpose is to furnish facility and administrative support for physician practices. GHCS is the sole stockholder of GHSI.
Greenwich Nursing and Healthcare Registry, Inc. (Registry)	The Registry is a Connecticut non-stock, nonprofit corporation that previously operated as an agent in securing private nursing services for patients. The assets of the Registry have been sold. GHCS is the sole member of Greenwich Nursing and Healthcare Registry, Inc.
Future Care, Inc.	Future Care, Inc. is a for-profit corporation which previously operated a retail pharmacy located at 4 Deerfield Drive in Greenwich. The assets of this pharmacy have been sold. GHCS is the sole shareholder of Future Care.

As previously discussed, YNHHSC will become the parent corporation (sole member) of GHCS, thus adding the Greenwich Health Care Services local network to the YNHHSC system. The regional YNHHSC system will continue to be overseen by the YNHHSC parent board. Boards will remain at each of the corporate entities with specific responsibilities and functions.

There are no current plans to consolidate services; therefore no short-term cost savings are anticipated as a result of changes in legal structure, management or governance.

4. **Provide a current and proposed corporate organizational chart for each corporate parent before and after completion of the proposed merger. Each parent corporation and all of its corporate affiliates should be identified on these charts.**

As stated above, YNHHSC and GHCS are not merging; a corporate affiliation is proposed.

The current corporate organizational chart for Yale-New Haven Health Services Corporation and its affiliates is presented in Exhibit 1. The current corporate organizational chart for Greenwich Health Care Services, Inc. and its affiliates is presented in Exhibit 2. The proposed corporate organizational chart for YNHHSC and its affiliates after the affiliation with GHCS is presented in Exhibit 3.

5. **If any changes in the current certificates of incorporation, bylaws and other relevant legal documents for each corporate parent and its affiliates have taken place since the last submission of required documents for annual reporting for FY 1996, please provide a revision of only those specific documents which have changed.**

Since the last annual reporting submission, certificates of incorporation and bylaws have changed for the following YNHHSC affiliates:

- YNHH-MSO, Inc.
- United Home Care, Inc.
- Ahlbin Centers for Rehabilitation Medicine, Inc.

Pre-affiliation certificates of incorporation and bylaws are presented in Exhibit 4.

With respect to GHCS and its affiliates, no changes have been made to the certificates of incorporation or bylaws since the most recent annual OHCA filing.

6. **Provide the legal documents described in Question #5 above for the proposed merged entity as well.**

As noted above, the transaction is not a merger. Accordingly, YNHHSC and GHCS will each continue to have separate governing documents, although YNHHSC will become the sole member of GHCS. The certificates of incorporation and bylaws for YNHHSC and GHCS will be amended prior to the closing of the affiliation. The post-affiliation amended certificates of incorporation and bylaws of GHCS and its affiliates will reflect the terms of the affiliation agreement. However, these documents are not yet final.

7. **Please provide a list of the names and representation of all proposed members of the Board of Directors of the proposed merger entity and explain how the Directors are to be appointed. Specify how officers and standing committees will be designated. Include the proposed dates that the Board and each standing committee will be created and will become active.**

As part of the proposed affiliation GHCS will appoint three members (one permanent, two temporary) to the Board of Directors of YNHHSC. Individuals to fill those directorships have not been named but will be identified prior to the closing of the affiliation. Election of the Directors of GHCS shall be provided for in the revised GHCS bylaws consistent with Article IV, Section 4.2 of the System Affiliation agreement (Exhibit 5). Officers and standing committees shall be designated as stated in each entity's Bylaws. The Boards and standing committees are presently existing and active.

8. **Describe the role and oversight authority (financial and policy decision-making) of the merged Board of Directors for the proposed merged entity.**

Since this affiliation is not a merger, the Boards of YNHHSC and GHCS will not merge. Following the affiliation, as further defined in Article IV of the System Affiliation Agreement (Exhibit 5), YNHHSC will have the following responsibility with respect to GHCS:

- Approve GHCS strategic plans, operating budgets and capital budgets.
- Approve GHCS incurrence of debt over an agreed amount.
- Designate a member of GHCS Board and approve/consult with respect to other GHCS Board appointments as further described in Article IV, Section 4.2 of the System Affiliation Agreement (Exhibit 5).
- Approve material changes to GHCS' or its affiliates' bylaws or certificates of incorporation.
- Approve affiliations by GHCS or its affiliates with other healthcare providers.
- Approve change of name, sale of assets, merger, consolidation or reorganization of GHCS or its affiliates.

- Approve major programmatic change at GHCS or its affiliates, if so initiated by GHCS.

9. **Please provide a copy of the agreement that will accomplish the proposed merger.**

   The System Affiliation Agreement between YNHHSC and GHCS is attached as Exhibit 5.

10. **Please provide copies, certified by the corporate secretary of each corporate parent, of the resolutions of the Board of Trustees of each corporate parent approving the proposed merger.**

    The Boards of YNHHSC and GHCS have authorized the proposed affiliation. The board resolutions are attached as Exhibits 6 and 7.

Licensure and Complement Changes

11. **Please provide a detailed description of the proposed licensure of beds and services due to the merger, the planning underway to obtain such licensure and the anticipated date of licensure by the Department of Public Health and Addiction Services.**

    Not applicable. This proposal is for an affiliation, not a merger. YNHHSC and GHCS are parent corporations and as such are not licensed by the Department of Public Health (DPH).

    The licensure of beds and services at Yale-New Haven Hospital, Inc. (YNHH), Bridgeport Hospital (BH), and Greenwich Hospital (GH) will not be altered as part of the proposed affiliation between the parent corporations. Currently, these affiliates are licensed by the DPH (Appendix A). Any proposed changes or reorganization of clinical services or beds among individual institutional providers within YNHHSC following the affiliation will be reviewed as appropriate by OHCA through a separate CON process.

12. **Provide a table identifying the existing and proposed licensed bed configuration for each of the two Hospitals before and after the merger.**

Not applicable. This proposal is for an affiliation, not a merger. As noted, YNHHSC and GHCS are parent corporations and as such are not licensed by the Department of Public Health (DPH).

The licensed bed configuration at YNHHSC and GHCS are provided in Exhibit 8. No changes are proposed.

13. **Provide a detailed description and status of the Applicants' efforts to obtain all other required federal, state and local approvals governing the proposed merger. Your response must include a legal opinion regarding continued not-for-profit status with the Internal Revenue Service and a discussion of any potential antitrust problems resulting from the merger.**

YNHHSC and GHCS have submitted a filing to the Federal Trade Commission and the Antitrust Division of the Department of Justice pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976. The parties made the Hart-Scott-Rodino filing on August 1, 1997. The parties were notified on August 12, 1997, that the transaction has received "early termination" of the waiting period which means that the federal agencies do not intend to further review or challenge the affiliation. Representatives of YNHHSC and GHCS have notified and provided information to the office of the Attorney General of the State of Connecticut.

Legal counsel have analyzed the antitrust aspects of the affiliation and do not believe that there are any significant antitrust problems resulting from the affiliation.

Because this affiliation is between two nonprofit, tax-exempt entities, the transaction should not present risks to the 501(c) (3) status of either entity. Letters from counsel for each of the applicants regarding the continuation of tax exempt status are provided in Exhibit 10.

14. **Describe the involvement of the medical staff, employees and community in the planning process for the proposed merger.**

The leadership of the medical staffs of Yale-New Haven Hospital (YNHH), Bridgeport Hospital (BH) and Greenwich Hospital (GH) have participated in the planning of the proposed affiliation in many ways. Physician input was sought on a number of relevant issues. Prior to the announcement of the affiliation, special meetings were held to update the Chiefs of Services and letters were sent to all three hospitals' medical staffs. After the announcement, all three hospitals' medical staff publications ran a story describing the proposed affiliation. Over the last few months, the Chiefs of Staff of all three hospitals, as well as certain Chiefs of Service, have been meeting informally to discuss opportunities to coordinate medical education and research. Additional medical staff members will become involved in these discussions as appropriate. Finally, members of all three hospital medical staffs have been and will continue to be part of ongoing communications with those involved in planning for the affiliation.

Employees of YNHH, BH and GH participated in the planning for the proposed affiliation in several ways. Hospital managers were updated regularly on the status of discussions and were solicited for input. Prior to the announcement of the affiliation, special management meetings were held to update and answer questions from the managers. At that point, managers updated employees under their supervision and funneled questions/feedback to senior management to be addressed. In addition, a letter describing the affiliation was distributed to all employees. Moreover, after the announcement, the hospitals' newsletters ran a detailed story describing the proposed affiliation. In the future, employees will be solicited for input and assistance in helping management evaluate options for improving quality, access and cost effectiveness throughout the system.

The community has been involved through representatives on the parent companies' and hospitals' boards, as well as through news stories in local papers and a news conference and a press release announcing the affiliation. In addition, prior to the announcement, many community representatives, including political and community leaders, hospital auxiliaries, volunteers and donors, other local providers and payers, were informed about the proposed affiliation via letters, phone call or facsimile.

Clinical Services

15. **Please provide a chart depicting all changes to services provided on each campus of the two Hospitals as of the date of affiliation, compared to the current status and location of these services. For each service, the Hospitals must indicate the following.**

    a. Relocations
    b. Terminations
    c. Additions
    d. Duplications
    e. Anticipated scheduling for future changes.

    No changes to services provided at YNHH, BH or GH are planned as part of the proposed affiliation. As part of the annual business planning process, clinical programs will be reviewed to determine whether any changes in service would be indicated. Any proposed changes or reorganization of clinical services or beds among separate institutional providers within the YNHHSC system will be reviewed, as appropriate, and submitted to OHCA through a separate CON process.

16. **In the same format as Question #15 above, please list those programs and services of the two Hospitals and all affiliates which have yet to be integrated and include a projected timetable for their eventual integration.**

    There are no plans to integrate clinical programs and services at YNHH, BH or GH as part of this affiliation CON.

17. **Please provide the same information requested in Question #16 above, for all non-health care related services, functions and programs of the Applicants and their corporate affiliates.**

    YNHHSC has recently received CON approval for the development and implementation of an integrated information system. The goal of this project is to enable all YNHHSC affiliates to communicate electronically and to standardize information and systems wherever possible. This new information system will have the flexibility and capacity to serve the needs of GHCS as well as future YNHHSC affiliates.

Except as described above regarding the information system, there are no plans in place to integrate non-health care related services. In the future, opportunities may be explored for potential cost savings in areas such as selected business services, purchasing and insurance.

Financial Information

18. **Provide an itemized list of all capital expenditures associated with the proposed merger.**

Not applicable. There are no capital expenditures proposed as part of this proposed affiliation.

19. **How will the proposed capital expenditures be financed? Identify the sources of funding of any equity contribution (fund raising, funded depreciation, etc.) and debt financing (tax-exempt bonds, conventional bank financing, etc.). Provide evidence of the financial feasibility of the proposed merger and the interest of any lenders for the debt financing specified above.**

Not applicable. There are no capital expenditures proposed as part of this proposed affiliation. Therefore, financing is not required.

20. **Please describe the current financial condition of each corporate parent and the anticipated effect of the proposed merger. Specifically address the impact of the combined level of uncompensated care on the proposed merged entity.**

Not applicable. The current sound financial conditions of each corporate parent will continue following the affiliation. Likewise, the level of uncompensated care of YNHH, BH and GH will continue following the affiliation. Audited financial statements for YNHHSC and GHCS are presented in Appendix B.

21. **Provide a summary of projections of revenue, expense and volume statistics for the current fiscal year, plus fiscal years 1998, 1999 and 2000 for each Hospital with the merger proposal, without the merger proposal, and incrementally due to the merger proposal (See Attachment 3.)**

This is an affiliation, not a merger. The financial projections for YNHHSC and GHCS are the same with or without the affiliation. The requested projections are provided in Appendix C.

Other Review Criteria

22. **Discuss the impact of the proposed merger and the rates and financial condition of each Hospital including the continuing ability of each Hospital to operate effectively and efficiently, and to meet its financial obligations consistent with principles of sound financial management.**

This proposal involves an affiliation between two parent corporations: YNHHSC (the parent corporation of YNHH and SCHS, (the parent corporation of BH) and GHCS (the parent corporation of GH). This affiliation will maintain the current sound financial conditions of all three hospitals and their ability to operate effectively and efficiently. The proposed affiliation will not impact the published rates or financial condition of any of the three hospitals. All three hospitals have recently undergone redesign and reengineering initiatives to ensure cost effective delivery of care, and subsequently have implemented ongoing Continuous Quality Improvement (CQI) processes.

23. **Discuss the proposed merger's contribution to the cost effectiveness of health care delivery in the region (including any reduction in FTE's, economies of scale, improvements in productivity and cost containment, reduction in licensed beds/excess capacity, and the integration of non-clinical services such as accounting, laundry, purchasing, etc.). This discussion should include the degree to which the proposed merger is likely to achieve appropriate health service area objectives at the most reasonable financial cost.**

The proposed affiliation will contribute to the cost effectiveness of health care delivery in the region as follows:

- Coordinate operations through senior management committees to address clinical and non-clinical issues and thereby increase efficiencies.
- Improve the quality and cost-effective care within the YNHHSC system by sharing clinical and non-clinical best practices among system hospitals.

- Continue to deliver health care services in a cost effective manner.

24. Please list and describe all cost savings expected due to the proposed merger.

Please refer to question # 23.

25. Please provide a copy of any consultant's report received by the Applicants' relating to an operational efficiency analysis of the proposed merger.

Not applicable. Operational efficiency analysis was not performed.

26. Please comment on the needs of the public that currently are not being met and describe how the proposed merger would help to meet such needs.

YNHHSC and GHCS are committed to identifying, targeting and serving their respective communities' health care needs. The proposed relationship between YNHHSC and GHCS is intended to respond to the needs of the public for improved access to cost effective/coordinated healthcare services. This need has been expressed through the public's move to managed care benefit plans and structures. Communications about the features and benefits of the proposed system will assist the community in making informed choices about hospital provider groups and payor plans. In addition, the integrated YNHHSC system and the high-quality continuum of care delivered by it will be available to a broader geographic area including people of all socioeconomic classes with a wide range of health care needs. The intent of the affiliation is to utilize the combined system's expertise in delivering primary through quaternary health care services to improve the health status of participating segments of the communities served.

27. Discuss how the proposed merger will serve the public interest.

The proposed affiliation will serve the public interest by:

- Providing access to a patient-focused continuum of integrated healthcare services and clinical centers of excellence through convenient local access points
- Continuing to build and strengthen community health resources dedicated to improving the health status of the population served

- Ensuring a stable base of qualified professionals through the initiation, development, maintenance and oversight of educational programs for health care professionals
- Initiating, developing and maintaining programs of scientific research related to the care of the sick and injured
- Enabling long-term partnerships that bring the critical resources of care under one umbrella to manage various aspects of health
- Providing high quality, cost effective, convenient services to patients and other beneficiaries

28. Discuss how the proposed merger will affect the quality of health care delivery in the combined Hospitals' service area. Please provide copies of each Hospital's most recent Department of Public Health and Addiction Services licensing survey.

Not applicable. This proposal involves an affiliation not a merger.

One of the key goals of the affiliation is to maintain and improve quality. This will occur through the sharing of system-wide clinical best practices.

Please refer to Appendix D for the Hospital Licensing Surveys for YNHH, BH and GH.

29. Discuss how the proposed merger will contribute to an improvement in access to health care services in the combined Hospitals' service area.

The proposed affiliation is designed to enable the GHCS local delivery system to remain competitive in a changing marketplace by improving access to care and enhancing quality of care. Acting as a collective of local vertical networks within a regional integrated health care system, the YNHHSC system will continue to provide comprehensive health care services to each local service area. As part of the YNHHSC system, each local network can improve access to care by expanding:

- the overall geographic area for care and referrals
- the array of services available for people in the communities served by the hospitals
- the level of shared resources and expertise among affiliates
- options for patients covered by managed care contracts.

30. Describe the relationship of the proposed merger to the most recent State Health Plan.

The proposed affiliation between YNHHSC and GHCS supports the following policies contained in the Connecticut State Health Plan:

Policy AIC-II

Access to high quality patient care along with cost effectiveness should remain an important consideration.

As stated above, a primary goal of the proposed affiliation is to continue to improve community access to the system. The expanded geographic area will improve accessibility to YNHHSC's services for a greater proportion of the population. Ongoing efforts to improve the quality, cost effectiveness and the array of needed health care services in each local service area represent primary goals for YNHHSC and GHCS.

Policy AIC-IV

The SHCC supports the Certificate of Need Program in Connecticut in order to assure access to needed services while avoiding unnecessary capital expenditure.

The improved access to quality health care, described above, can be achieved through the proposed affiliation without any capital expenditure (Please refer to the responses to questions 18 and 19).

31. Describe the relationship of the proposed merger to each Hospital's long range plan.

Both YNHHSC and GHCS have similar missions and share the primary mission of improving the health of the populations they serve.

The mission of YNHHSC is to benefit, uphold and promote the welfare, programs and activities of YNHH and other affiliates and to benefit the communities served by the system. The GHCS vision is to be a regional, economically viable, integrated healthcare delivery

system which excels on the basis of cost effectiveness, customer satisfaction, documentable quality and compassion.

The proposed YNHHSC-GHCS affiliation expands the broad, geographic coverage of the combined YNHHSC network while preserving a strong local GHCS network. This relationship is anticipated to strengthen the individual providers and enhance managed care contracting and patient preference.

Long range plans recognize that the organization and financing of healthcare has changed. In order to carry out the missions, institutions must become increasingly efficient and proactively enhance quality, improve access and control costs of care. The proposed affiliation will support these activities to further the institutions' missions and long range plans.

32. Please provide a copy of the long range plan for the proposed merged entity. If a long range plan for the proposed merged entity has not been completed, please indicate the date on which this plan is expected to be completed.

Not applicable. This is not a merger.

33. Describe how the proposed merger affects the interests of consumers and payers of health care services based on the merger proposal's contribution to quality, accessibility and cost effectiveness.

Please refer to the answers to questions #26 and #27.

34. Discuss whether the proposed merger will result in the elimination of any unnecessary duplication of services.

Not applicable. Due to the distinct nature of the markets served independently by the local networks currently within YNHHSC and the GHCS local network, we do not anticipate that substantial unnecessary duplication of services will exist. However, if and as such services are identified, YNHHSC will act to create a more efficient organization.

35. Describe how the proposed merger affects the technical, financial and managerial efficiency and expertise of the staff at each Hospital?

Each local network, including affiliated organizations, will benefit from the voluntary sharing of expertise and non-clinical best practices. In addition, as discussed before, it is expected that there are certain areas in which efficiency and efficacy can be enhanced as a result of this shared knowledge.

36. Describe any applied research or educational programs that would be developed or affected as a result of the proposed merger.

Shared information between local networks, facilitated by the affiliation, will inevitably enhance both provider education and research endeavors. The combined impact of this information transfer will be to improve the quality of care delivered at each local network and their affiliates as noted in the answer to question #28.

37. Describe how the proposed merger would impact the patient-physician mix of each Hospital.

The proposed affiliation will not affect the current patient-physician mix at any of the hospitals.

38. Describe any improvements in productivity and cost containment each Hospital would make as a result of the proposed merger.

Please refer to the responses to questions #22 and #23.

39. Discuss how the proposed merger will affect or alter current physician referral patterns at each hospital.

This is an affiliation, not a merger. The proposed affiliation is not expected to affect or alter current physician referral patterns at any of the hospitals.

40. Discuss how the proposed merger will affect or alter current preferred provider network participation at each hospital.

This is an affiliation, not a merger. Article II System Goals and Objectives, Sections 2.1.2 and 2.1.3 of the System Affiliation Agreement (please refer to Exhibit 5) includes the following system goals with respect to preferred provider network and other managed care participation:

2.1.2 Provide centralized managed care services by the System and develop and administer the System's managed care arrangements to increase the number of managed care patients served by the System, and enhance each System Member's ability to seek and accept regional, statewide, and state/federal government managed care contracts for enrolled populations;

2.1.3 Assist each System Member to develop and work effectively with local and regional physician organizations, physician-hospital organizations, management service organizations and primary care organizations; including doing so with existing organizations of those types

41. Discuss how the proposed merger will effect or alter discount agreement contracts currently in effect at each hospital.

The proposed affiliation is not expected to affect or alter discount agreement contracts currently in effect at any affiliated hospital.

EXHIBIT 1

Current Structure of Yale-New Haven Health Services Corporation and Affiliated Companies

Yale-New Haven Health Services Corporation

ORGANIZATION CHART

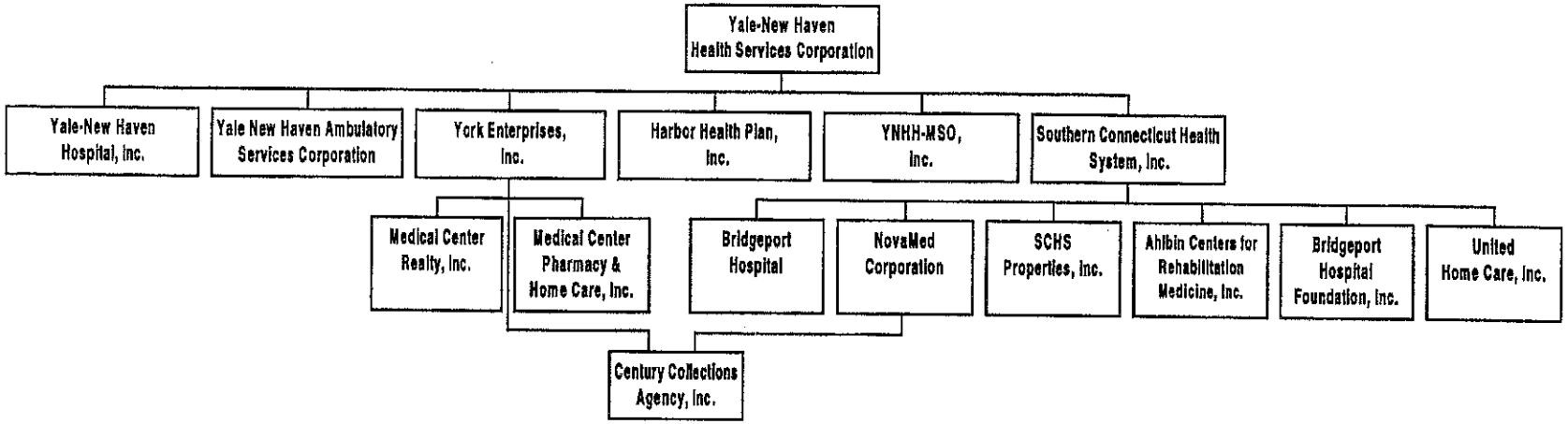


EXHIBIT 2

Current Structure of Greenwich Health Care Services, Inc.

and Affiliated Companies

Greenwich Health Care Services, Inc.

ORGANIZATION CHART

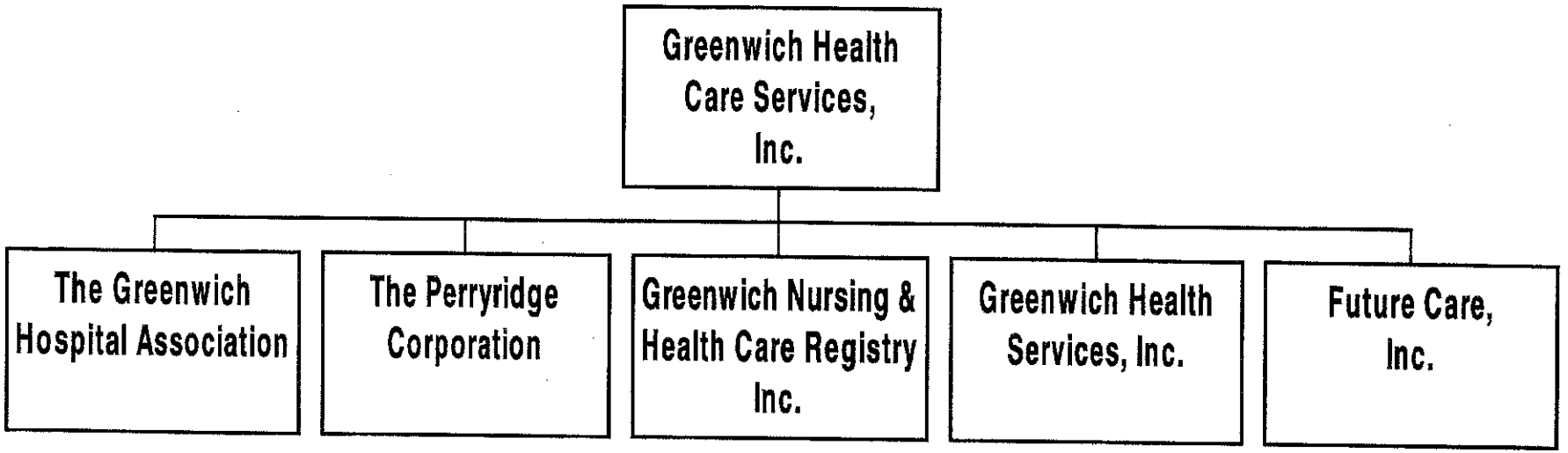


EXHIBIT 3

Proposed Post-Affiliation Structure

Yale-New Haven Health Services Corporation

ORGANIZATION CHART: POST-AFFILIATION

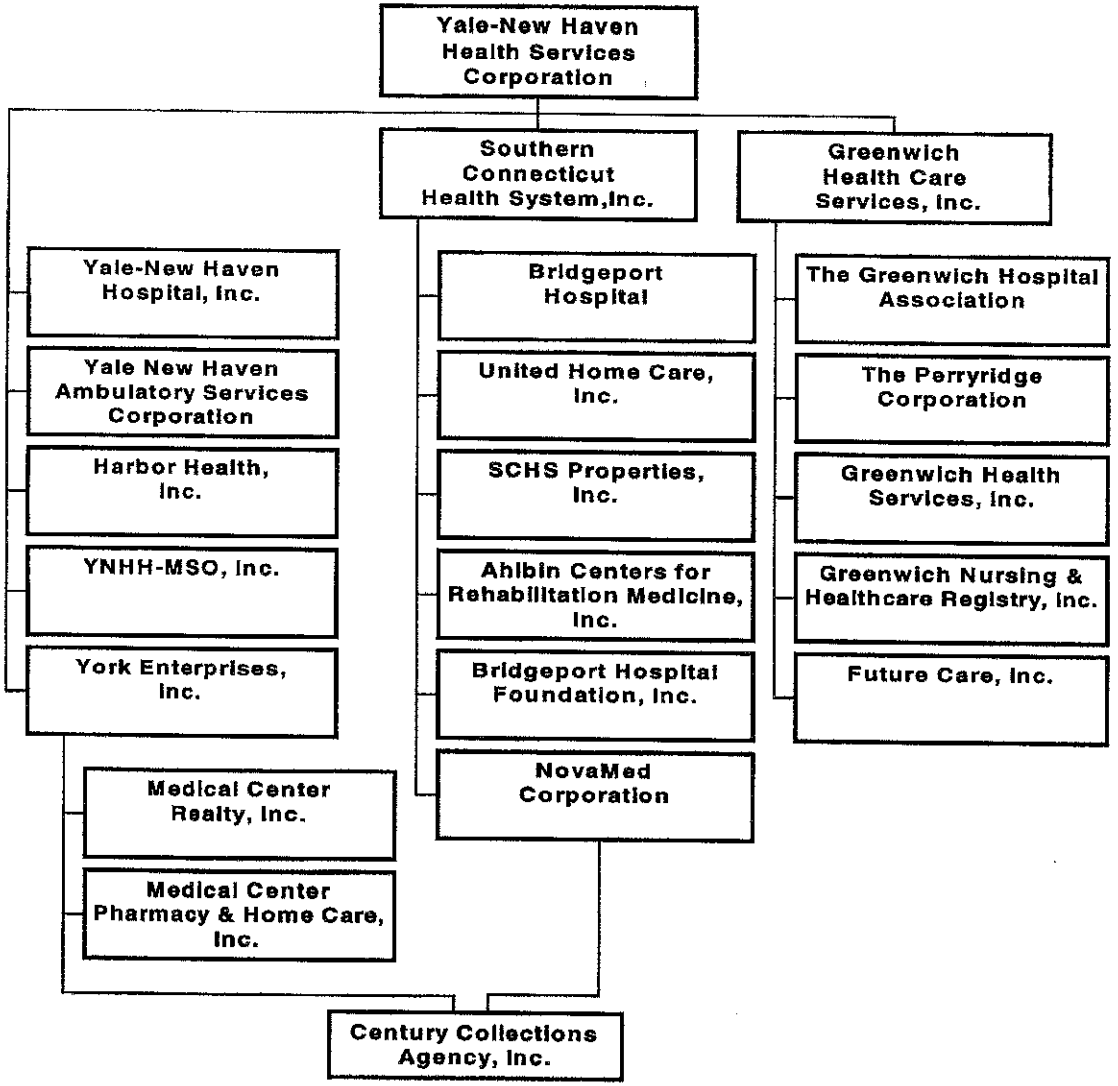


EXHIBIT 4

Pre-Affiliation Certificates of Incorporation

and Corporate Bylaws

- Yale-New Haven Health Services Corporation and Affiliates

YNHH-MSO, INC. **000041**

CERTIFICATE OF INCORPORATION

The undersigned incorporator hereby forms a corporation under the Stock Corporation Act of the State of Connecticut.

1. The name of the Corporation is YNHH-MSO, Inc.

2. The nature of the business to be transacted and the purposes to be promoted or carried out by the Corporation are to engage in any lawful act or activity for which corporations may be formed under the Stock Corporation Act of the State of Connecticut.

3. The designation of each class of shares, the authorized number of shares of each such class, and the par value of each share thereof are as follows:

The capital stock of the Corporation consists of Twenty Thousand (20,000) shares of Common Stock, par value One One-hundreth of One Dollar ($0.01) per share.

4. The minimum amount of capital with which the Corporation shall commence business is One Thousand Dollars ($1,000.00).

5. The duration of the Corporation is perpetual.

I hereby declare, under the penalties of false statement, that the statements made in the foregoing Certificate are true.

Dated at New Haven, Connecticut, this 21st day of November, 1996.

Merton G. Gollaher, Jr.
Incorporator

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BYLAWS

of

YNHH-MSO, INC.

ARTICLE I - OFFICES

Section 1. Principal Office. The principal office of the Corporation shall be at 789 Howard Avenue, New Haven, Connecticut or such other places as the Board of Directors may determine from time to time.

Section 2. Other Offices The Corporation may establish other offices in such other places, in the State of Connecticut or elsewhere, as the Board of Directors may from time to time appoint or the business of the Corporation may require.

ARTICLE II - MEETINGS OF SHAREHOLDERS

Section 1. Annual Meeting.

(a) The annual meeting of the shareholders shall be held in the State of Connecticut at a time and place to be designated by the Board of Directors in a notice of the meeting.

(b) Notice in writing of the time and place of the annual meeting shall be served upon each stockholder of record not less than ten (10) nor more than sixty (60) days prior to the date set for such meeting. Such notice must be served personally or by mail; if by mail, it shall be directed to the stockholder at his last known post office address.

(c) Such other business as may be properly brought before any shareholders meeting may be transacted at the annual meeting of the shareholders.

Section 2. Special Meetings.

(a) Special meetings of the shareholders may be called at any time by the President, the Board of Directors, or the holders of not less than ten percent (10%) of all of the shares of stock
outstanding and entitled to vote at such meeting.

(b) Notice of a special meeting of the shareholders shall be given in writing to all shareholders of record entitled to vote upon the subject of such meeting, not less than ten (10) nor more than sixty (60) days prior to the date set for such meeting, by serving notice personally upon each such stockholder or by mailing such notice to each stockholder at his last known address.

(c) Business transacted at all special meetings shall be confined to the purpose or purposes set forth in the notice.

Section 3. Quorum. The holders of a majority of the shares issued, outstanding, and entitled to vote present in person or by proxy shall be requisite and shall constitute a quorum

to do business at all meetings of the shareholders; provided, however, that the shareholders present at a duly organized meeting may continue to do business until adjournment notwithstanding the withdrawal of sufficient shareholders to leave less than a quorum present. In the event a quorum fails to attend, those present may adjourn the meeting to such time and place as they may determine, and further notice, except the announcement of such adjourned meeting prior to such adjournment, shall be unnecessary.

Section 4. Waiver. Notwithstanding any provisions of the foregoing sections, any meeting of the shareholders of this Corporation may be held at any time and at any place within or without the state of Connecticut and any action may be taken thereat if timely notice be waived in writing by every stockholder having the right to vote in person or by proxy at such meeting. Similarly, the annual meeting of the shareholders of this Corporation may be held at the principal office of the corporation if timely notice be waived in writing by every stockholder of record of the Corporation.

Section 5. Proxy. At each meeting of the shareholders, each stockholder having the right to vote shall be entitled to vote in person or by proxy appointed by an instrument duly executed in writing by the stockholder or his duly authorized attorney-in-fact and filed with the Secretary of the Corporation at or prior to such meeting; such proxy shall be invalid after the expiration of eleven (11) months from the date of its execution unless the stockholder executing it shall have otherwise therein specified its duration. The proxy shall be revocable at the will of the stockholder unless the appointment of a proxy form conspicuously states that it is irrevocable and the appointment is coupled with an interest. Appointments coupled with an interest include the appointment of : (1) a pledgee; (2) a person who purchased or agreed to purchase the shares; (3) a creditor of the Corporation who extended credit under the terms requiring the appointment; (4) an employee of the Corporation whose employment contract requires the appointment; or (5) a party to a voting agreement created under the Connecticut General Statutes. An appointment made irrevocable is revoked when the interest with which it is coupled is extinguished. No proxy shall be valid after three years from the date of its execution.

Section 6. Voting. Each stockholder shall have one vote for each share of voting stock standing in his name upon the records of the Corporation and entitled to vote at the meeting. All elections shall be had and all questions decided by a majority of votes cast constituting a quorum. Unless a secret ballot is demanded by the holders of at least ten percent (10%) of the shares outstanding and entitled to vote, voting may be by open ballot.

Section 7. Determination of Shareholders of Record. The Board of Directors may fix a time, not less than ten (10) nor more than sixty (60) days prior to the date of any meeting of the shareholders, or the date fixed for the payment of any dividend or distribution, or the date for the allotment of rights, or the date when any change or conversion or exchange of shares will be made or go into effect, or the date for any other circumstance requiring the determination of the shareholders of record, as a record date for the determination of the shareholders entitled to notice of and to vote at any such meeting, or entitled to receive payment of any such dividend or distribution, or to receive any such allotment of rights, or to exercise the rights in respect to any such change, conversion, or exchange of shares. In such

case, only such shareholders as shall be shareholders of record on the date so fixed shall be entitled to notice of and to vote at any such meeting, or to receive payment of such dividend, or to receive such allotment or rights, or to exercise such rights, as the case may be, notwithstanding any transfer of any shares on the books of the Corporation after any record date fixed as aforesaid. The Board of Directors may close the books of the Corporation against transfers of shares during the whole or any part of such period, and in such case, written or printed notice thereof shall be mailed, at least ten (10) days before the closing thereof, to each stockholder of record at the address appearing on the records of the Corporation or supplied by him to the Corporation for the purpose of notice. While the stock transfer books of the Corporation are closed, no transfer of shares shall be made thereon. Transferees of shares which are transferred on the books of the Corporation between the date fixed by the Board of Directors and the date of such meeting shall not be entitled to notice of or to vote at such meeting.

Section 8. Stockholder Action Without a Meeting. Any action which, under the Connecticut General Statutes, may be taken at a meeting of shareholders may be taken without a meeting pursuant to a written consent setting forth the action so taken or to be taken, signed by all of the persons who would be entitled to vote upon such action at a meeting or their duly authorized attorneys. Such unanimous written consent or consents shall have the same force and effect as a vote of shareholders at a meeting duly held. Such unanimous written consent or consents shall be filed by the Secretary of the Corporation with the minutes of the meetings of shareholders.

ARTICLE III - DIRECTORS

Section 1. Number.

(a) The Board of Directors of the Corporation shall consist of not less than three (3) nor more than ten (10) persons. The number of directors shall be established, and may be increased or decreased from time to time, within such range by a majority vote of the shareholders of the Corporation.

Section 2. Qualification. The members of the Board of Directors, each of whom shall be an individual who is active and diligent in meeting the obligations of a director and who is committed to promoting and supporting the welfare, success, and purposes of the Corporation, need not be a stockholder of the Corporation or a resident of the State of Connecticut.

Section 3. Duties of Directors.

(a) Management. The Board of Directors shall have the control and general management of the property, affairs, and business of the Corporation. Except as hereinafter provided, the Directors shall, in all cases, act as a board regularly convened by a majority, and they may adopt such rules and regulations for the conduct of their meetings and the

management of the Corporation as they may deem proper and as shall not be inconsistent with any of the Certificate of Incorporation, these By-Laws or the laws of the State of Connecticut.

(b) Committees. The Board of Directors may appoint from among its members an Executive Committee, a Finance Committee, and such other committees as the Board may from time to time determine desirable. All such committees shall consist of not less than two (2) Directors and shall possess and exercise all powers of the Board to the extent delegated by the Board during the intervals between Board of Directors meetings and to the extent permitted by law.

Section 4. Meetings.

(a) Annual Meeting. The annual meeting of the Board of Directors shall be held immediately following the annual meeting of the shareholders, within the state of Connecticut at the time and place to be designated in the notice thereof.

(b) Regular Meetings. Regular meetings of the Board of Directors shall be held at such times and places, within or without the State of Connecticut, as the Board of Directors may determine.

(c) Special Meetings. Special meetings of the Board of Directors may be held at any time and place within or without the State of Connecticut.

(d) Participation. The Board of Directors my participate in any meeting by, or conduct any meeting through the use of, any means of communication by which all directors participating may simultaneously hear each other during the meeting. A director participating in a meeting by these means is deemed to be present in person at the meeting.

Section 5. Notice of Meetings.

(a) How Given. Except for regular meetings of the Board of Directors which may be held without notice of the date, time, place or purpose of the meeting, notice in writing of all meetings of the Board of Directors shall be given to each Director at least two (2) days prior to the day designated for the meeting. Notice shall be given either personally or by mail. If by mail, it shall be mailed to the Director at his last known residence, unless the Director shall have filed with the Board of Directors a written request that notice intended for him be sent to some other address, in which event it shall be mailed to the address designated in such request.

(b) Waiver. Notwithstanding any of the foregoing provisions, meetings of the Board of Directors may be held at any time or place, within or without the state of Connecticut. Notice may be waived by a director provided such waiver shall be in writing, signed by such Director entitled to the notice and filed with the corporate records. A Director's attendance at or participation in a meeting waives any required notice to him/her unless the director at the beginning of the meeting, or promptly upon his arrival, objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

(c) Adjournment. Whenever any meeting of the Board of Directors shall have been duly organized and announced to be adjourned to a definite time and place, it shall not be necessary to give notice of said adjourned meeting other than such announcement of the time and place at which such adjourned meeting will be held.

Section 6. Quorum. A majority of the Directors prescribed, or if no number is prescribed, then the number in office immediately before the meeting begins, shall constitute a quorum for the transaction of business.

Section 7. Term and Removal. Each Director shall be elected by a majority vote of the Shareholders at the annual shareholders meeting or any other meeting called for such purpose to serve until the next annual meeting or until his successor shall be duly elected and qualified, and may be removed at any time from his position as Director by a vote of the holders of a majority of the shares of stock outstanding and entitled to vote. Such removal shall be voted, however, only at a special meeting of the shareholders called for such purpose.

Section 8. Vacancies. If the office of any Director shall become vacant by reason of death, resignation, retirement, disqualification, removal from office, or for any other cause, the Board of Directors may fill such vacancy by a person of its choosing until the next annual meeting of the shareholders. A majority of those directors present constituting a quorum shall be required to effect any election of Directors to fill vacancies or to decide any question.

Section 9. Action Without a Meeting. Action to be taken at a board of directors' meeting may be taken without a meeting if the action is taken by all the members of the board of directors. The action shall be evidenced by one or more written consents describing the action taken, signed by each director, and included in the minutes or filed with the corporate records reflecting the action taken. A consent has the effect of a meeting vote and may be described as such in any document.

ARTICLE IV - OFFICERS

Section 1. Name, Number, and Election.

(a) Officers of the Corporation shall be a President, a Secretary, and a Treasurer, and such other officers as the Board of Directors may from time to time appoint.

(b) The officers of the Corporation shall be elected by a majority vote of the Board of Directors at their annual meeting or any other special meeting called for such purpose.

Section 2. Powers and Duties. The respective officers of the Corporation shall perform such duties and possess such powers as are ordinarily performed and possessed by such officers of similar corporations, and shall perform such other duties and possess such other powers as may from time to time be conferred on or assigned to them by the Board of Directors.

Section 3. Qualifications and Election.

(a) The officers need not be members of the Board of Directors.

(b) The offices may be held by any one person, provided he is otherwise qualified.

(c) Each officer shall be elected for a term of one (1) year, or until his successor has been elected and qualified.

Section 4. Removal.

(a) Any officer may be removed from his office by a majority vote of the Board of Directors at the annual meeting or a special meeting of the Board of Directors called for that purpose.

(b) Any office held by a person who is also a Director of the Corporation shall be deemed vacant upon the removal of such Director by the shareholders of the Corporation, in the manner hereinbefore provided.

Section 5. Vacancies. In the event of the death, disability, or removal for any cause whatsoever of an officer of the Corporation, the vacancy so created shall be filled by a majority vote of the Board of Directors at the annual meeting or a special meeting called for that purpose.

Section 6. Compensation. Compensation to be paid officers of the Corporation shall be determined by the Board of Directors from time to time, but in no event shall the officers be entitled to any compensation except reasonable compensation for services actually rendered to the Corporation in effecting one or more of its objectives or purposes or as a direct or indirect beneficiary of the Corporation's stated purposes.

ARTICLE V - INDEMNITY OF DIRECTORS AND OFFICERS

Section 1. Indemnity. Each Director and officer of the Corporation shall be indemnified by the Corporation against fines, penalties, judgments, settlements, attorneys' fees, interest, penalties (including but not limited to those imposed by the Internal Revenue Service), and other expenses reasonably incurred by him on account of or in defense of any action, suit, or proceeding to which he should be made a party by reason of his being or having been a Director or an officer or acting in any other corporate capacity of the Corporation or employed by it in any other capacity (whether or not he continues to be a Director or an officer at the time of incurring or being subject to such expenses), except (a) actions, suits, or proceedings in which he shall be adjudged not to have acted in good faith and, in the cases of conduct in his official capacity, in the reasonable belief that his action was in the best interests of the Corporation, or, in all other cases that his conduct was at least not opposed to the best interests of the Corporation, and, in the case of any criminal proceeding, he had no reasonable cause to believe that his conduct was unlawful; (b) in connection with a proceeding by or in the right of the Corporation in which he was adjudged liable to the Corporation; or (c) in connection with any other proceeding charging improper personal benefit to him whether or not involving action in his official capacity, in which he was adjudged liable on the basis that personal benefit was improperly received by him. The foregoing right of indemnification shall not exclude other rights to which any Director or officer may be entitled as a matter of law and shall be deemed consistent with Connecticut General Statutes or other state or federal statutes as may be applicable. The Corporation may

procure insurance to cover such corporate indemnity to the extent permitted by the insurance carrier and may be paid in full by the Corporation.

Section 2. Authorization of Indemnification. The Corporation may not indemnify a director or officer unless the Board of Directors, by a majority vote of a quorum consisting of Directors not at the time parties to the proceeding, (a) have determined that indemnification is permissible in the circumstances because he met the standard of conduct set forth in the Connecticut General Statutes and (b) have authorized the indemnification. In the event that a quorum cannot be obtained or special legal counsel has been selected by the Board of Directors to make the determination then the authorization of indemnification shall be in accordance with the Connecticut General Statutes.

ARTICLE VI - CAPITAL STOCK

Section 1. Certificates of Stock. The certificates of each class of stock shall be numbered in the order issued and signed by the President and the Secretary.

Section 2. Transfers. Transfers of the stock shall be made on the books of the Corporation only by the person named in the certificate or his duly constituted attorney-in-fact, and only upon the surrender of the certificate therefor unless the certificate has been damaged, mutilated or destroyed.

Section 3. Cancellation of Certificates. All certificates of stock exchanged or returned to the Corporation for transfer or cancellation shall be marked "Cancelled" with the date of cancellation by the Secretary, and shall be immediately pasted in the certificate book to the stubs from which they were detached when issued.

Section 4. Lost certificates. Any person claiming a certificate of stock to be lost or destroyed shall make an affidavit or affirmation to that effect, and the Board of Directors may, in their discretion, require the owner of the lost or destroyed certificate or his legal representative to furnish to the Corporation a bond in such sum as they may see fit, not exceeding the total value of the shares, to indemnify the Corporation against any claim that may be made against it on account of the alleged loss of any such certificate. Upon complying with the foregoing requirements, a new certificate of the same tenor and for the same number of shares as the one alleged to be lost or destroyed shall be issued by the Board of Directors.

Section 5. Replacement of Damaged or Mutilated Certificates. A new certificate may be issued in lieu of a certificate previously issued that may be defaced, worn, damaged, or mutilated upon surrender or cancellation of a part of the old certificate sufficient in the opinion of the Secretary to duly identify the defaced, damaged, worn, or mutilated certificate and to protect the Corporation against loss or liability. Where sufficient identification is lacking, indemnity satisfactory to the Secretary may be required as in the case of a lost certificate.

ARTICLE VII - CHECKS, NOTES, AND BILLS OF EXCHANGE

Section 1. Execution. All checks and drafts on the Corporation's bank accounts, all bills of exchange and promissory notes, and all acceptances, obligations, and other instruments for the payment of money shall be signed by such officer or officers as shall be authorized or directed to do so from time to time by the Board of Directors.

ARTICLE VIII - DIVIDENDS

Section 1. Declaration and Payment. Dividends upon the outstanding stock of the Corporation, subject to the provisions of the Certificate of Incorporation, may be declared by the Board of Directors at any regular or special meeting pursuant to law. Dividends may be paid in property or in shares of capital stock.

ARTICLE IX - FISCAL YEAR

Section 1. Fiscal Year. The Corporation shall be on a fiscal year ending September 30th, unless otherwise determined by the Board of Directors and consistent with the Internal Revenue Code.

ARTICLE X - AMENDMENTS

Section 1. Amendments. These By-Laws may be amended, altered or repealed by the affirmative vote of a majority of the Directors at any regular meeting of the Directors or at any special meeting of the Directors called for that purpose, provided that any by-law that fixes a greater quorum or voting requirement for shareholders than is required by the Certificate of Incorporation, these By-Laws or by law of the State of Connecticut may only be adopted, amended, or repealed by an affirmative vote of a majority of the shares outstanding and entitled to vote therefor.

AMENDED AND RESTATED

ARTICLES OF ASSOCIATION

REHABILITATION CENTER OF FAIRFIELD COUNTY, INC.

1. The name of the corporation is REHABILITATION CENTER OF FAIRFIELD COUNTY, INC.

2. The nature of the activities to be conducted and the purposes to be promoted or carried out by the corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as the same may be amended from time to time (the "Code"), and shall include the following:

A. To assist disabled persons and their families in finding and making effective use of resources which will be helpful to them in developing their abilities and in living purposeful lives.

B. To assist communities in developing necessary and appropriate resources for disabled persons.

C. To establish and maintain rehabilitation programs and services which are appropriate and realistic.

D. To create a climate of acceptance of disabled persons which will enable them to contribute to the full extent of their competence and to the well-being of the community.

E. To engage in any lawful act or activity for which a corporation may be organized under the Nonstock Corporation Act of the State of Connecticut.

3. The Corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

4. The classes, rights, privileges, qualifications, obligations, and the manner of election or appointment of members are as follows: There shall be but one member, Southern Connecticut Health System, Inc., which shall have the right to vote for the election of the Board of Directors in accordance with the bylaws, and shall have all of the other rights, privileges, and obligations usually or by law accorded to the members of a nonstock nonprofit corporation and not conferred thereby or by the Articles of Association or bylaws upon the Board of Directors of the corporation.

5. No part of the net earnings of the corporation shall inure to the benefit of or be distributable to the corporation's directors, officers or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of these Articles of Association, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal Income Tax under Section 501(c)(3) of the Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

6. Upon any dissolution or termination of the existence of the corporation, all of its property and assets shall, after payment of the lawful debts of the corporation and the expenses of its dissolution or termination, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or

other governing document) to Southern Connecticut Health System, Inc., so long as it is at that time an organization that qualifies as an exempt organization under Section 501(c)(3) of the Code, or, if at the time of the dissolution or termination of existence of the corporation, Southern Connecticut Health System, Inc. is not in existence or does not qualify as an exempt organization under Section 501(c)(3) of the Code, to Bridgeport Hospital, so long as it is at that time an organization that qualifies as an exempt organization under Section 501(c)(3) of the Code, or, if at the time of the dissolution or termination of existence of the corporation, neither Southern Connecticut Health System, Inc. nor Bridgeport Hospital is then in existence or qualifies as an exempt organization under Section 501(c)(3) of the Code, to one or more other charitable, scientific or educational organizations located in the service area of the Corporation and qualified as exempt organizations under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the board of directors may determine.

7. References to sections of the Code shall be deemed references to the Internal Revenue Code of 1986, as the same may be amended from time to time, and to the corresponding provisions of any future United States Internal Revenue Law.

000054

CERTIFICATE AMENDING OR RESTATING CERTIFICATE OF INCORPORATION
61-38 Rev. 4/89
NonStock Corporation

STATE OF CONNECTICUT
SECRETARY OF THE STATE
30 TRINITY STREET
HARTFORD, CT 06106

1. Name of Corporation

Rehabilitation Center of Fairfield County, Inc.

2. The Certificate of Incorporation is: (Check One)

☒ A. Amended only, pursuant to Conn. Gen. Stat. §33 - 473.

☐ B. Amended and restated, pursuant to Conn. Gen. Stat. §33 - 474(c).

☐ C. Restated only, pursuant to Conn. Gen. Stat. §33 - 474(a).

(Set forth here the resolution of amendment and/or restatement. Use a 8 1/2 X 11 attached sheet if more space is needed).

RESOLVED, that the Certificate of Incorporation of the Rehabilitation Center of Fairfield County, Inc. shall be amended to reflect the change of the name of the corporation to the "Ahlbin Centers for Rehabilitation Medicine, Inc."

☐ D. Restated and superseded pursuant to Conn. Gen. Stat. §33 - 474(d).
(Set forth here the resolution of amendment and/or restatement. Use a 8 1/2 X 11 attached sheet if more space is needed).

(If 2A is checked, go to 5 to complete this certificate. If 2B or 2C is checked, complete 3A or 3B. If 2D is checked, complete 4)

3. (Check one)

☐ A. This certificate purports merely to restate but not to change the provisions of the original Certificate of Incorporation as supplemented and amended to date, and there is no discrepancy between the provisions of the original Certificate of Incorporation as supplemented and amended to date, and the provisions of this Restated Certificate of Incorporation. (If 3A is checked, go to 5 to complete this certificate).

☐ B. This Restated Certificate of Incorporation shall give effect to the amendment(s) and purports to restate all those provisions now in effect not being amended by such new amendment(s). (If 3B is checked, check 4, if true, and go to 5 to complete this Certificate).

4. (Check, if true)

☐ This restated Certificate of Incorporation was adopted by the greatest vote which would have been required to amend any provision of the Certificate of Incorporation as in effect before such vote and supersedes such Certificate of Incorporation.

5. The manner of adopting the resolution was as follows: (Check one A, or B, or C).

☒ A. By the board of directors and members, pursuant to Conn. Gen. Stat. §33 - 473.
Vote of Members: (Check (i) or (ii)).

(i) ☒ No members are required to voted as a class; the member's vote was as follows:

Vote Required for Adoption 1 Vote Favoring Adoption 1

(ii) ☐ There are members of more than one class entitled to vote as a class. The designation of each class required for adoption of the resolution and the vote of each class in favor of adoption were as follows:
(Use an 8 1/2 x 11 attached sheet if more space is needed).

☐ B. By the board of directors acting alone, pursuant to Conn. Gen. Stat. § 33 - 473(b)(2).

The number of affirmative votes required to adopt such resolution is: _____

The number of directors' votes in favor of the resolution was: _____

We hereby declare, under the penalties of false statement, that the statements made in the foregoing certificate are true:

(Print or Type)	Signature	(Print or Type)	Signature
Name of Pres. ~~Asst. Pres.~~ Sally Gammon		Name of Sec/~~Asst. Sec.~~ ~~Sandra~~ Jarva Weiss	Sandra Jarva Weiss

☐ C. The resolution was adopted by vote of at least two-thirds of the incorporators before the organization meeting of the corporation, and approved in writing by all applicants for membership entitled to vote.

We (at least two-thirds of the incorporators) hereby declare, under the penalties of false statement, that the statements made in the foregoing certificate are true.

Signed	Signed	Signed
Signed	Signed	Signed

Dated at Bridgeport this 3rd day of October , 19 96

APPROVED by all subscribers, if none, so state: _____
(Use an 8 1/2 X 11 attached sheet if more space is needed)

Rec, CC, GS: (Type or Print)
Collin P. Baron, Esq.
Pullman & Comley, LLC
850 Main Street, P.O. Box 7006
Bridgeport, CT 06601-7006

Please provide filer's name and complete address for mailing receipt

000056

SECRETARY OF THE STATE
30 TRINITY STREET
P.O. BOX 150470
HARTFORD, CT 06115-0470

OCTOBER 7,1996

M. TOUPONSE
PULLMAN & COMLEY
850 MAIN ST.
BRIDGEPORT, CT 06601

RE: Acceptance of Business Filing

This letter is to confirm the acceptance of a filing for the following business:

REHABILITATION CENTER OF FAIRFIELD COUNTY, INC. THE

Work Order Number: 1996138487-001
Business Filing Number: 0001640769
Type of Request: CERTIFICATE OF AMENDMENT
Date Accepted: OCT 04 1996
Time Accepted: 12:30 PM
'ork Order Payment Received: .00
ayment Received: 35.00
Account Balance: 575.00
Customer Id: 000443
Business Id: 0081271

If applicable for this type of request, a summary of the business information we have on record is enclosed.

If you would like copies of this filing you must complete a Request for Corporate Copies and submit it with the appropriate fee.

Commercial Recording Division
SUSAN LOGATTO

BYLAWS

OF

AHLBIN CENTERS FOR REHABILITATION MEDICINE, INC.

TABLE OF CONTENTS

BYLAWS
OF
AHLBIN CENTERS FOR REHABILITATION MEDICINE, INC.

(The "Center")

ARTICLE I

PURPOSES

Section 1.1 Objectives. The objectives and purposes for which the Center exists are as follows:

A. To promote and carry out a program for the medical care, social education, vocational training and the rendering of other assistance to disabled and handicapped people regardless of age and regardless of the cause of the handicap.

B. To provide for its regional citizens opportunities to achieve health, productivity and self esteem when they are challenged by injury or illness.

C. To promote and carry on any educational activities relating to the medical care to, and rehabilitation of, the sick and injured and the promotion of health which, in the opinion of the Board of Directors, may be justified by the facilities, personnel or funds that are, or can be made, available

D. To promote and carry on scientific research related to the care and rehabilitation of the sick and injured insofar as, in the opinion of the Board of Directors, such research can be carried on in, or in connection with, the Center.

E. To participate, insofar as circumstances warrant, in any activity designed and carried on to promote the general health of the community.

F. To do all such other things necessary, suitable and proper for the accomplishment of any of the purposes of the Center or attainment of any of the objectives of the Center herein mentioned either alone or in association with other individuals, corporations, partnerships or other entities, and in general, to do and perform such acts and transact such business in connection with the purposes and objectives of the Center not inconsistent with law, including but not limited to the following:

1. to acquire, lease, hold, manage, sell, mortgage and otherwise dispose of such real or personal property as may be convenient or necessary to carry out the purposes herein mentioned.

2. to borrow money and to issue bonds, debentures, notes and other evidences of indebtedness and obligations and to mortgage, pledge and otherwise charge any or all of its properties and assets to secure the payment thereof.

3. to solicit, receive and expend donations, bequests and/or legacies for any purposes or objectives of the Center.

4. to make gifts of real and personal property to corporations, trusts, funds, foundations, or other entities organized and operated exclusively for charitable, scientific or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholders or individuals and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation.

Section 1.2 Limitations. The Center is organized exclusively for charitable, health care, educational, and scientific purposes as a non-profit organization.

ARTICLE II

OFFICES

Section 2.1 Principal Office. The principal office of the Center shall be at such place in the United States as the Board of Directors shall from time to time designate.

Section 2.2 Additional Offices. The Center may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Corporation may require.

ARTICLE III

MEMBERSHIP

Section 3.1 Sole Member. The Center shall have but one member, Southern Connecticut Health System, Inc., which shall have the right to elect the Board of Directors of the Center in accordance with these Bylaws, and shall have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock nonprofit corporation and not conferred thereby or by the Articles of Association or Bylaws upon the Board of Directors of the Center.

Section 3.2 Rights, Powers and Privileges. In addition to such other rights, powers and privileges as it may have by law, the Center's sole member shall have the following rights, powers and privileges:

A. To approve the long range development plans, annual operating and capital budgets, programs and expenditures requiring Certificate of Need approval by appropriate governmental bodies, and plans that materially affect the growth, operations and development of the Center.

B. To elect and remove members of the Board of Directors of the Center and non-voting directors in accordance with the provisions of these Bylaws.

C. To elect and remove any officer of the Center in accordance with the provisions of these Bylaws.

D. To vote upon all matters on which members are entitled to vote under the Nonstock Corporation Act of the State of Connecticut.

E. To act on any other matters on which action by the member is provided for in these Bylaws.

Section 3.3 Meetings of the Member. The annual meeting of the member shall be held on such day and at such time and place as may be designated by the Board of Directors or the Chairman of the Board of Directors for the purposes set forth in Sections 3.1 and 3.2 herein and for the transaction of any other business as may properly come before such meeting. Regular meetings of the member shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the member may be called at any time by the Board of Directors, the Chairman of the Board of Directors, the Chief Executive Officer or the member. Each such request for a special meeting shall state the purposes for which the requested meeting is to be called. The member shall cast one vote on each matter submitted to a vote at each regular, annual and special meeting. Except as otherwise provided, any action required to be, or which may be, taken at any regular, annual or special meeting of the member may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the member.

Section 3.4 Notice of Meeting. A notice of each meeting of the member shall be given in writing to the member not less than seven days or more than fifty days before the date of the meeting. Each notice shall state the place, day and hour of the meeting. The general purpose for which a special meeting is called shall be stated in the notice thereof, and no other business shall be transacted at the meeting.

Section 3.5 Waiver of Notice. Notice of any meeting of the member may be waived in writing by the member.

ARTICLE IV

BOARD OF DIRECTORS

Section 4.1 General Powers. Subject to the rights, powers and privileges accorded to the member by law, the Articles of Association or these Bylaws, the activities, property and affairs of the Center shall be managed by the Board of Directors, which shall exercise all of the powers and responsibilities conferred upon the Board of Directors by the Connecticut Nonstock Corporation Act, the Articles of Association and these Bylaws as each may be amended from time to time.

Section 4.2 Number of Directors and Qualification. The Board of Directors shall consist of not less than ten and not more than sixteen persons, which number shall be fixed from time to time by the member. At each annual meeting of the member, the directors shall be elected by the member to take office immediately following such annual meeting. The member shall elect to the Board of Directors as directors or as non-voting directors all of the persons who are directors or non-voting directors of the member, respectively, and no other persons shall be so elected.

A person who is an ex-officio director with vote of the Board of Directors of the member and who is elected to the Board of Directors shall be an ex-officio director with vote of the Board of Directors and shall be considered a director for all purposes of these Bylaws except he shall not be subject to the age or term of office provisions.

The member also may elect non-voting directors. Non-voting directors shall receive notice of, and shall be entitled to attend and speak at, meetings of the Board of Directors and shall be eligible to serve as voting members of committees. Such non-voting directors shall be subject to the age and term of office provisions of these Bylaws, but shall not count toward quorum requirements, shall not have voting rights, shall not be considered in calculating the number of directorships and shall not be considered directors for any other purpose under these Bylaws.

Except as otherwise provided in this Section 4.2, a director who has attained age 72 shall be ineligible to continue to serve as a director after the annual meeting of the Board of Directors next following the date the director attains age 72.

Section 4.3 Terms of Directors. Directors shall hold office for a term of four years or until their successor has been elected and qualified, except that a director may be elected for a term of less than four years as provided in Section 4.12 or if the member deems it necessary to serve the objective that the terms of office of approximately one-fourth of all directors shall expire at each annual meeting. A director shall cease to be in office upon his death, resignation, removal or cessation of his term as a director of the member. At each annual meeting, the

member shall elect directors to succeed the directors whose terms are then expiring and to fill any new directorships fixed by the member. Such directors shall take office immediately following such annual meeting. No director shall serve more than two successive terms of three or more years. Not included in this limitation shall be a term of less than three years due to effectuating staggered terms or due to a director completing a term due to the death, removal or resignation of another director. Also not included in this limitation shall be any term served prior to March 30, 1995. A director who has served two successive terms of three or more years may again serve as a director following the expiration of a period of not less than one year during which time such individual does not serve as a director.

Directors ex-officio shall hold office for a term of one year or until their successors are elected and qualified or, if sooner, until they no longer are serving in the positions that entitle such persons to such ex-officio directorships.

Non-voting directors shall be elected for a term of four years or until their successors are elected and qualified and shall be subject to the terms of office provisions described in these Bylaws.

Section 4.4 Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall elect the subordinate officers of the Center and shall transact such other business relating to the affairs of the Center as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 4.5 Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the Chief Executive Officer, or upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 4.6 Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 4.7 Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 4.8 Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Center, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 4.9 Participation by Conference. A director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 4.10 Resignation of Directors. Any director and any non-voting director may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 4.11 Removal of Directors. Any director and any non-voting director may be removed from office, with or without cause, at any time, regardless of the term for which such director may have been elected, by the member at any regular, annual or special meeting.

Section 4.12 Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the member may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect directors to serve until the next annual meeting.

ARTICLE V

COMMITTEES

Section 5.1 Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Center. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Development Committee, Director Affairs Committee, Finance Committee, Investment Committee, and Management Affairs Committee.

Section 5.2 Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors or others by the Chairman of the Board of Directors. The Chairman of the Board of Directors may

increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 5.3 Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 5.4 Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

Section 5.5 Audit Committee. The Audit Committee shall cause an annual audit to be made of the books, accounts and records of the Center by certified public accountants under the supervision of the Audit Committee. The Audit Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.6 Development Committee. The Development Committee shall recommend policies and procedures for the development, growth, and management of the endowment funds of the Center and shall consider funding requests from affiliates. The Development Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.7 Director Affairs Committee. The Director Affairs Committee shall develop criteria for membership on the Board of Directors and its committees and shall consider the eligibility requirements and qualification specified in these Bylaws, as well as the interest and participation in Center matters of the individuals under consideration. It shall nominate for election members of the Board of Directors and shall assist in the selection of individuals for committee assignments. The Director Affairs Committee also shall review the performance of directors and recommend amendments to the Center's and Auxiliary's Bylaws and shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.8 Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Center and shall monitor and oversee the financial performance of the Center. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.9 Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Center and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the Center. The Investment Committee shall perform such other functions as a duly adopted

resolution of the Board of Directors may provide. The Chief Executive Officer and the Treasurer shall be members of the Investment Committee.

Section 5.10 Management Affairs Committee. The Management Affairs Committee shall establish performance goals for the Chief Executive Officer and President and shall conduct annual evaluations of their performance. It shall also review and recommend to the Board of Directors human resource, fringe benefit, and compensation policies and monitor compliance therewith and shall act in an advisory capacity to the Chief Executive Officer. The Management Affairs Committee also shall perform such other functions as a duly adopted resolution of the Board of Director may provide.

Section 5.11 Professional and Quality Review Committee. The Professional and Quality Review Committee shall compile and review information relating to the care and treatment of patients for the purposes of establishing mechanisms and policies for evaluating and improving quality of health care and reducing morbidity and mortality, performance improvement and risk management functions related to patient care and safety. The Professional and Quality Review Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

ARTICLE VI

OFFICERS

Section 6.1 Principal and Subordinate Officers. The principal officers of the Center shall be Chairman of the Board, Vice Chairmen of the Board, Chief Executive Officer, President, Secretary, and Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the Chief Executive Officer or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more offices may be held by the same person provided that the same individual shall not simultaneously occupy the offices of (i) Chief Executive Officer or President and (ii) Secretary. The Chairman of the Board and Vice Chairmen shall be selected from among members of the Board of Directors.

Section 6.2 General Authority and Duties. All officers and agents of the Center shall have such authority and perform such duties in the management of the Center as may be provided in these bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 6.3 Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the member at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the Chief Executive Officer or any other principal officer to whom the Chairman of

the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal, whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights. An individual may not serve in the office of Chairman of Vice Chairman for more than four consecutive one year terms. Not included in this limitation shall be any term served prior to March 30, 1995 or any partial term served to fill a vacancy.

Section 6.4 Removal. Any officer or agent may be removed by the member whenever in its judgment the best interests of the Center will be served by so doing. Any subordinate officer or agent may also be removed by the Chief Executive Officer, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 6.5 Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 6.6 Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 6.7 Chairman of the Board. The Chairman of the Board shall preside at the annual meeting of the Center and at all meetings of the Board of Directors, shall appoint members of all committees and the chairmen thereof, and shall perform such duties as the Board of Directors may from time to time assign to the Chairman of the Board and such other duties as are usual to this office.

Section 6.8 Vice Chairmen of the Board. The Vice Chairmen of the Board shall perform the duties of the Chairman of the Board in the event of the Chairman's absence or disability and shall assist the Chairman of the Board in such duties as the Chairman of the Board may from time to time assign to the Vice Chairmen of the Board.

Section 6.9 Chief Executive Officer. The Chief Executive Officer shall be responsible for seeing that the resolutions and actions of the Board of Directors are carried into effect, and for reporting to the Board of Directors on the conduct and management of the affairs of the Center.

Section 6.10 President. The President shall exercise general supervision of the business and affairs of the Center and over its officers and employees. The President shall have the authority to appoint and remove employees of the Center, including management level officers, and may delegate to such officers and employees such authority as he deems appropriate provided,

however, he shall be responsible for their actions. The President shall have such additional duties and responsibilities as are assigned to him by the Chief Executive Officer.

Section 6.11 Treasurer. The Treasurer shall have supervision over the receipt and custody of the Center's funds, and shall cause to be kept correct and complete books and records of account, including full and accurate accounts of receipts and disbursements in books belonging to the Center, and in general shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer. The Treasurer shall render to the Chairman of the Board, the Chief Executive Officer and the Board of Directors promptly upon its completion an annual report of the financial condition and operation of the Center prepared and certified by the independent certified auditors appointed by the Board of Directors.

Section 6.12 Secretary. The Secretary shall keep minutes of the proceedings of the Board of Directors shall give or cause to be given all notices in accordance with the provisions of these Bylaws or as required by law; and shall be custodian of the corporate records and of the seal of the Center. The Secretary also shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer.

ARTICLE VII

INDEMNIFICATION OF CENTER DIRECTORS, NON-VOTING DIRECTORS, CORPORATORS, OFFICERS, EMPLOYEES AND AGENTS

Section 7.1 Rights of Indemnification. Directors, non-voting directors, officers, employees, and agents shall have the rights of indemnification provided by Section 33-454a of the Connecticut General Statutes.

Section 7.2 Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-454a of the Connecticut General Statutes, incurred in defending a proceedings, may be paid by the Center in advance of the final disposition of such proceeding when authorized by the Board of Directors upon agreement, by or on behalf of the individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Center as authorized under the Bylaws.

ARTICLE VIII

THE AUXILIARY OF AHLBIN CENTERS FOR REHABILITATION MEDICINE, INC.

Section 8.1 Purpose. The purposes of the Auxiliary shall be to promote the objectives of the Center and support its activities throughout the community. The Auxiliary shall not act contrary to the policies set forth by the Center's Board of Directors.

Section 8.2 Operation of Auxiliary. The Auxiliary shall have the right pursuant to its Constitution and Bylaws. to elect its officers, maintain its own bank accounts and collect membership dues.

Section 8.3 Adoption and Amendment of Constitution or Bylaws. The Auxiliary shall have the authority, subject to the review and approval of the Center's Board of Directors. to adopt and amend their Constitution and Bylaws.

ARTICLE IX

MISCELLANEOUS PROVISIONS

Section 9.1 Amendment. These Bylaws may be amended or repealed, and new Bylaws may be adopted, at any regular, annual or special meeting of the member. Any notice of a meeting of the member at which these Bylaws are to be amended or repealed, or new Bylaws are to be adopted, shall be given in writing not less than seven days or more than fifty days prior to such meeting and shall include notice of such proposed action..

Section 9.2 Fiscal Year. The fiscal year of the Center shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 9.3 Seal. The seal of the Center shall be circular in form and shall bear the name of the Corporation and shall be in such form as the Board of Directors may determine.

Section 9.4 Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President, Chief Executive Officer, or such officer or officers of the Center as the Board of Directors shall specify from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures.

Section 9.5 Execution of Deeds and Contracts. Subject to the general directions of the Board of Directors, all deeds and mortgages made by the Center and all other written contracts, agreements and undertakings to which the Center shall be a party shall be executed in

its name by the Chief Executive Officer, President or such other officer as may be specified by the Board of Directors or authorized by the Chief Executive Officer or President and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to such instruments.

Section 9.6 Conflict of Interest. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Corporation, the provisions of Section 33-457 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the legal effect of such contract or transaction.

Section 9.7 Connecticut General Statutes. Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

Section 9.8 Pronouns. References herein to the masculine shall include references to the feminine, references to the singular shall include references to the plural and references to the plural shall include references to the singular, where the context of the language involved so permits or requires.

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AMENDED AND RESTATED

CERTIFICATE OF INCORPORATION

UNITED HOME CARE, INC.

(the "Corporation")

1. The name of the Corporation is United Home Care, Inc.

2. The nature of the business to be transacted, or the purposes to be promoted or carried out by the Corporation are as follows:

   a. United Home Care, Inc. shall operate to provide home health care services in accordance with a plan of care established by the client's physician. Services provided by United Home Care, Inc. shall include skilled nursing, physical therapy, occupational therapy, medical social work and homemaker home health aide services. The goal in providing these services is to promote, maintain and restore health, prevent disease and disability, prevent inappropriate institutionalization, and to maintain terminally ill persons in comfort and dignity during the end stages of life. In addition, United Home Care, Inc. shall assist in the development of sound community health programs by coordinating its programs with those of other health, social and welfare agencies, both private and public, including governmental bodies.

   b. The Corporation may engage in or pursue such other purposes as may lawfully be engaged in or pursued by corporations formed under The Connecticut Revised Nonstock Corporation Act of the Connecticut General Statutes.

3. The Corporation is nonprofit, and the Corporation shall not have or issue shares of stock or pay dividends. The Corporation shall have but one member, Southern Connecticut Health System, Inc., which shall have all of the rights, powers and privileges provided in the Bylaws and by the State of Connecticut. Subject to the rights, powers and privileges accorded to Southern Connecticut Health System, Inc., the Corporation shall be governed by its Board of Directors.

4. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986 or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1986.

5. No part of the net earnings of the Corporation shall inure to the benefit of any private individual and no substantial part of the activities of the Corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation, or in any way participating in, or intervening in (including the publishing or distributing of statements) any political campaign on behalf of any candidate for public office. No part of the Corporation's net earnings shall be distributable to its directors or officers, provided, that nothing herein shall restrict the right of the Corporation to reasonably compensate its officers and directors or any of them, for services rendered to the Corporation, or to reimburse any of them for expenses, disbursements or liabilities properly made or incurred for or on account of the Corporation.

6. Upon dissolution or termination of the existence of the Corporation, all of its property and assets shall, after payment of all liabilities of the Corporation and of all expenses of such dissolution or termination, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Southern Connecticut Health System, Inc. or to such affiliate of Southern Connecticut Health System, Inc. as Southern Connecticut Health System, Inc. shall designate at the time of such dissolution or termination, as long as Southern Connecticut Health System, Inc. or such designated affiliate, as the case may be, is, at the time of such dissolution or termination, an organization that qualifies as an exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986 or, if, at the time of such dissolution or termination, Southern Connecticut Health System, Inc. is not in existence or does not qualify, or does not designate any affiliate of Southern Connecticut Health System, Inc. that qualifies, as an exempt organization under Section 501(c)(3) of the Internal Revenue Code of 1986, to one or more other charitable, scientific or educational organizations located in the service area of the Corporation and qualified under Section 501(c)(3) of the Internal Revenue Code of 1986, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Directors of the Corporation shall determine. No part of the Corporation's assets shall ever be distributed to its directors or officers, or inure to the benefit of any private individual.

7. Any reference herein to a section of the Internal Revenue Code of 1986 shall mean such section as it is constituted at the time of the execution of this Certificate of Incorporation and as it may hereafter be amended, added to or otherwise changed, and shall also include any other provisions of similar purpose which may hereafter become applicable to the Corporation.

8. Other provisions:

a. This Certificate of Incorporation may be amended upon the occurrence of all of the following: (i) approval of the proposed amendment by a majority of all members of the Board of Directors, (ii) recommendation of the proposed amendment by the Board of Directors to the member and (iii) the approval of the proposed amendment by the member. For any meeting of the Board of Directors or of the member at which the Board of Directors or the member, as the case may be, is to consider a proposed amendment to this Certificate of Incorporation, notice of such meeting shall be given in the manner required by the Bylaws and shall state that the purpose, or one of the purposes, of the meeting is to consider the proposed amendment and shall contain or be accompanied by a copy or summary of the proposed amendment.

b. The Bylaws of the Corporation may be amended or repealed by the member upon the approval of, and recommendation of, the Board of Directors as provided in the Bylaws.

c. Directors may only be removed from the Board of Directors for cause as provided in the Bylaws.

9. The liability of a Director to the Corporation and the member shall be limited to the full extent provided in Section 33-1026(b)(4) of the Connecticut Revised Nonstock Corporation Act as it may be amended from time to time.

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AMENDED AND RESTATED

BYLAWS OF

UNITED HOME CARE, INC.

(the "Corporation")

ARTICLE I

GENERAL

The Corporation shall operate to provide home health care services in accordance with a plan of care established by the client's physician. Services provided by the Corporation shall include skilled nursing, physical therapy, occupational therapy, medical social work, homemaker home health aide services, and such other services as shall be authorized by the Board of Directors. The goal in providing these services is to promote, maintain and restore health, prevent disease and disability, prevent inappropriate institutionalization, and to maintain terminally ill persons in comfort and dignity during the end stages of life. In addition, the Corporation shall assist in the development of community health programs by coordinating its program with those of other health, social and welfare agencies, both private and public, including appropriate governmental bodies.

ARTICLE II
MEMBERSHIP

2.1 Sole Member. The Corporation shall have but one member, Southern Connecticut Health System, Inc. (the "Member"), which shall have all of the rights, powers and privileges provided in these Bylaws and by the State of Connecticut. Subject to the rights, powers and privileges accorded to Southern Connecticut Health System, Inc., the Corporation shall be governed by its Board of Directors.

2.2 Rights, Powers and Privileges. The Member shall have the following rights, powers and privileges:

(i) To approve of (a) the annual strategic plan and operating and capital budgets for the operation of the business of the Corporation, (b) any certificate of need program of the Corporation or any other expenditure, plan or program of the Corporation that is reasonably likely to have a material effect on the growth, operation or development of the Corporation, (c) the incurrence by the Corporation of any indebtedness aggregating in excess of $50,000 through any single transaction or series of related transactions and, if the total indebtedness of the Corporation is in excess of $100,000 for any fiscal year of the Corporation, the incurrence of any indebtedness during such fiscal year and (d) any sale,

assignment, encumbrance, lease or other transfer of any material assets of the Corporation not in the ordinary course of the Corporation's business.

(ii) To approve of each fundraising plan submitted by the Corporation with respect to its fundraising activities and to manage centrally the charitable contributions, endowments and other cash or investment assets of the Corporation.

(iii) To vote upon all matters on which members are entitled to vote under The Connecticut Revised Nonstock Corporation Act (as amended from time to time), including, without limitation, (a) any sale, lease, exchange or other disposition of all or substantially all of the assets of the Corporation, (b) any merger or consolidation involving the Corporation and (c) the liquidation or dissolution of the Corporation; and to vote on (x) any contract to manage or administer the Corporation or a substantial part of the business of the Corporation, (y) the creation or acquisition of any new affiliate of the Corporation and (z) any direct or indirect participation by the Corporation in any affiliation, network, system or alliance of health care providers for the provision of health care services.

(iv) To elect and remove the Directors in accordance with the provisions of these Bylaws.

(v) To approve all amendments to the Certificate of Incorporation, Bylaws and other governance documents of the Corporation in accordance with the provisions of these Bylaws.

(vi) To approve any name change of the Corporation or the use of any trade name.

(vii) To act on any other matters on which action by members is required or permitted by these Bylaws.

2.3 Member Meetings. The annual meeting of the Member shall be held on such day and at such time and place as may be designated by the Board of Directors or the Chairman of the Board for the purposes set forth in Section 2.2 herein and for the transaction of any other business as may properly come before such meeting. Regular meetings of the Member shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Member may be called at any time by the Board of Directors, the Chairman of the Board, the Chief Executive Officer, the President or the Member. Each such request for a special meeting shall state the purposes for which the requested meeting is to be called. The Member shall cast one vote on each matter submitted to a vote at each regular, annual or special meeting. Any action required to be, or which may be, taken at any regular, annual or special meeting of the Member may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the Member and filed with the minutes of the meetings of the Member.

2.4 Notice of Meeting. A notice of each meeting of the Member shall be given in writing to the Member not less than ten (10) days nor more than fifty (50) days before the date of such meeting. Each notice shall state the place, day and hour of the meeting. The general purpose for which a special meeting is called shall be stated in the notice thereof, and no other business shall be transacted at the meeting.

2.5 Waiver of Notice. Notice of any meeting of the Member may be waived in writing by the Member.

ARTICLE III
BOARD OF DIRECTORS

3.1 Powers and Duties. Subject to the rights, powers and privileges accorded to the Member, the activities, property and affairs of the Corporation shall be managed and conducted by the Board of Directors. Each Director is expected to attend at least fifty percent (50%) of the meetings of the Board of Directors and actively serve on all Committees to which he or she is appointed.

3.2 Number of Directors and Qualifications. The Board of Directors shall consist of not less than ten (10) nor more than twenty-two (22) Directors. At each annual meeting of the Member, the Directors shall be elected by the Member to take office immediately following such annual meeting. At each of the first, second and third annual meetings of the Member following April 15, 1997, the Member shall elect to the Board of Directors of the Corporation as Directors (i) each individual who was a Director on April 15, 1997, if the term of such individual has expired, such individual is eligible for reelection and such individual has not, as of the date of such annual meeting, either resigned or been removed from the Board of Directors and (ii) such other individuals as the Member shall then deem appropriate. On or before April 15, 2000, each of the Directors then in office shall submit their resignations as Directors effective April 15, 2000, or they otherwise may be removed by the Member. Upon such Directors' resignation or removal and at each annual meeting of the Member thereafter, the Member shall elect to the Board of Directors of the Corporation as Directors each individual who is then serving on the Board of Directors of the Member, and no others, such that the Board of Directors of the Corporation shall be identical in composition to the Board of Directors of the Member.

3.3 Terms of Directors. The Directors shall be elected at annual meetings of the Member and shall hold office until the annual meeting following expiration of their term of office or until the election of their successors. Directors shall be elected for a term of three (3) years, except that a Director may serve less than three (3) years if such Director is removed or resigns, or is appointed to fill a vacancy as provided in Section 3.10. An individual shall cease to be a Director upon his death, resignation, removal or, if such Director is also a member of the Board of Directors of the Member, the cessation of such Director's term as a director of the Member.

No Director may serve on the Board of Directors for more than two consecutive full terms. Following the second consecutive term of service, one year must elapse before an individual shall again be eligible to serve on the Board of Directors. Notwithstanding the foregoing, a Director may be eligible for service beyond two consecutive terms if necessary to complete an elected term of office.

3.4 Honorary Director. The privilege of Honorary Director shall be extended to a person as the Board of Directors may elect. The Honorary Director shall retain the privilege of attending meetings and participating in discussion but shall not serve as a voting Director. The term shall be lifetime.

3.5 Board Meetings. The Board of Directors may hold its meetings, annual, regular or special, at such place or places within or without the State of Connecticut as it may from time to time by resolution determine or as shall be specified or fixed in the notice thereof, if any. An annual meeting of the Board of Directors for the election of the Board Officers (as defined in Section 5.1) and for the transaction of such other business as shall come before the Board of Directors at such meeting shall be held on such date, and at such time, as shall be specified in a resolution adopted by the Board of Directors then in effect. Regular meetings of the Board of Directors shall be held at least ten (10) times annually on such dates, and at such times, as shall be specified in a resolution adopted by the Board of Directors then in effect, or, if there shall not be any such resolution then in effect, as shall be specified in the notices of such meetings. Special meetings of the Board of Directors shall be held whenever called by the Chairman of the Board or by at least two (2) of the Directors then in office.

3.6 Notice of Meeting. No notice need be given of an annual meeting of the Board of Directors, unless otherwise required by statute or these Bylaws. At least seven (7) days' written or oral notice of each special or regular meeting stating the time and place of the meeting shall be given to each Director. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need be specified in the notice or waiver of notice of such meeting unless otherwise required by statute or these Bylaws.

3.7 Quorum, Adjournment and Manner of Acting. A majority of the Directors shall constitute a quorum for the transaction of business at all meetings of the Board of Directors. Any meeting of the Board of Directors may be adjourned from time to time by a majority vote of the Directors present at such meeting. In the absence of a quorum for any such meeting, a majority of the Directors present thereat may adjourn such meeting to another time and place until a quorum shall be present. Notice of any adjourned meeting need not be given unless the meeting shall have been adjourned for more than three days. The act of a majority of the Directors present at any meeting at which a quorum is present at the time of the act shall be the act of the Board of Directors, except as may be otherwise specifically provided by statute or these Bylaws. One or more Directors may participate in a meeting of the Board of Directors by use of a conference telephone or similar communications equipment which allows all persons participating in the meeting to communicate with one another. Any action required to be, or which may be, taken at any regular, annual or special meeting of the Board of Directors may be taken without a

meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by each member of the Board of Directors and filed with the minutes of the meetings of the Board of Directors or with the corporate records.

3.8 Resignation. Any Director may resign from the Board of Directors at any time by giving written notice to the Chairman of the Board. Such resignation shall take effect at the time specified therein. Unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

3.9 Removal. A Director may be removed from the Board of Directors only by the Member for cause; provided, however, that such action of the Member shall have been approved by the affirmative vote of three-quarters (3/4) of the directors then serving on the Board of Directors of the Member. Such action of the Member may be taken at any annual, regular or special meeting only if such meeting was called for the purpose of the proposed removal and due notice of the proposed removal shall have been given to the Member stating that the purpose, or one of the purposes, of such meeting is the proposed removal. The Director involved shall be given an opportunity to be present and to be heard at any meeting at which his removal is considered. No Director removed pursuant to this Section 3.9 shall subsequently hold or be nominated or proposed for any directorship or office at the Corporation. For purposes of this Section 3.9, "cause" with respect to any Director shall mean: (i) any act or omission of such Director that constitutes a breach of fiduciary duty by such Director under any applicable law, rule or regulation; or (ii) any vote by such Director in favor of a resolution approved by the Board of Directors if, as a consequence of the actions taken or not taken in connection with the implementation of such resolution, the Corporation or any affiliate of the Corporation (a) violates a law, rule or regulation to the material detriment of the Corporation or such affiliate or (b) takes an action specifically prohibited by, or fails to take any action required by, the Affiliation Agreement, dated as of April 2, 1997, between the Corporation and the Member.

3.10 Vacancies. Any vacancy on the Board of Directors may be filled only by the Member. The person elected to fill such vacancy is to hold office as a Director for the unexpired portion of the term of his or her predecessor. A Director elected to fill a vacancy shall complete the unexpired term of the Director he or she replaces and shall not then become ineligible for serving two consecutive terms of office as provided in Section 3.3 of these Bylaws.

ARTICLE IV
COMMITTEES

4.1 The Chairman of the Board shall designate members to constitute a Committee unless otherwise stated in these Bylaws. The Chairman of the Board, the President and the Chief Executive Officer are members ex-officio of all Committees except the Nominating Committee. Committee members except the Committee chairman and members of the Executive and Finance Committees may be selected from sources other than the active Board of Directors. With the

exception of the Executive Committee, Committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation.

4.2 There shall be an Executive Committee, a Nominating Committee, a Finance Committee, a Planning and Development Committee, a Personnel Committee, a Community Relations and Fund Raising Committee, a Professional Advisory Committee, and such additional Committees of the Board of Directors with such duties and responsibilities as are provided in these Bylaws or as the Chairman of the Board may from time to time direct. Except as provided in these Bylaws, members of Committees shall be appointed at the annual meeting of the Board of Directors or at any regular or special meeting of the Board of Directors called for the purpose of appointing members of Committees and shall serve at the pleasure of the Board of Directors or until their successors are elected.

4.3 The Executive Committee shall consist of the Chairman of the Board, the Vice Chairmen, Secretary, Treasurer, Chairman of the Finance Committee, Chairman of the Planning and Development Committee and the Chief Executive Officer, all of whom shall be Directors. Except as otherwise expressly provided in these Bylaws or any amendment thereto, the Executive Committee shall exercise all the powers of the Board of Directors in the intervals between meetings of the Board of Directors and shall report its doings to the Board of Directors as requested.

4.4 The Nominating Committee shall consist of five (5) members. The Nominating Committee shall annually offer nominations for Board Officers to fill any vacancies caused by the expiration of a Board Officer's term at the end of that year. The chairman of the Nominating Committee shall be elected from its members by a majority vote of the Committee.

4.5 The Finance Committee shall consist of not less than five (5) and not more than nine (9) members of the Board of Directors including the Treasurer. Except as otherwise expressly provided in these Bylaws or any amendment thereto, the Finance Committee shall keep the Board of Directors advised on all business and financial matters, including, but not limited to, monthly and yearly financial reports and any changes in financial policy. In addition, it shall make recommendations relative to investment funds and report to the Board of Directors the status of all investment funds on at least a quarterly basis. It shall prepare and present in cooperation with the President and the Chief Executive Officer all budgets for the calendar and fiscal year and shall have responsibility for making recommendations with respect to maintaining or renovating the Corporation's headquarters, grounds, furnishings and equipment.

4.6 The Planning and Development Committee shall consist of not less than five (5) members. Except as otherwise expressly provided in these Bylaws or any amendment thereto, the Planning and Development Committee shall be responsible for making recommendations with respect to planning, evaluating and interpreting the strategic direction of the Corporation in cooperation with the President and the Chief Executive Officer. In addition, it shall plan and

present an orientation program for new members of the Board of Directors and assume responsibility for evaluation of the Corporation's programs.

4.7 The Personnel Committee shall consist of not less than five (5) members. Except as otherwise expressly provided in these Bylaws or any amendment thereto, the Personnel Committee shall: (a) Annually develop, review and recommend changes in the employment policies for all employees, (b) Consult with the President and the Chief Executive Officer on matters concerning staff, (c) Recruit and assist with the training and supervision of the Corporation's volunteers and (d) Hear and decide grievances from eligible employees.

4.8 The Community Relations and Fund Raising Committee shall consist of not less than three (3) members. Except as otherwise expressly provided in these Bylaws or any amendment thereto, the Community Relations and Fund Raising Committee shall evaluate public awareness of the services of the Corporation and make recommendations with respect to programs to improve the Corporation's relationships with the public. In addition, the Community Relations and Fund Raising Committee shall make recommendations for the development of programs for fundraising, provide liaisons with funding sources and prepare and supervise distribution of the annual report and general information pamphlets.

4.9 The Professional Advisory Committee shall consist of not less than six (6) members and shall have as members at least one physician, one public health nurse, one therapist (representing at least one of the skilled therapy services provided by the Corporation) and one medical social worker. Except as otherwise expressly provided in these Bylaws or any amendment thereto, the Professional Advisory Committee shall make recommendations with respect to the implementation, monitoring and integration of the various components of the Corporation's quality assurance program, including the annual review of applicable policies on scope of services, admission and discharge criteria, medical and dental supervision, plans of treatment, clinical records, personnel qualifications, standards of care and professional issues regarding patient care. In addition, the Professional Advisory Committee shall have such other functions and responsibilities as may be set forth in the State of Connecticut Department of Public Health Regulations.

4.10 Each Committee of the Board of Directors shall act in accordance with the following procedures: The Committee shall adopt a schedule of regular meetings and shall hold additional special meetings on the call of the chairman of the Committee or any two members of the Committee; notice of each such meeting shall be given in the manner provided for notice of regular meetings of the Board of Directors; a majority of voting members of the Committee shall constitute a quorum for all business; the act of a majority of voting members of the Committee present at any meeting duly held at which a quorum is present at the time of the act shall be the act of the Committee; and, if less than a quorum is present at any Committee meeting, a majority of the voting members of the Committee present may adjourn such meeting from time to time without notice.

4.11 The Chairman of the Board, except as otherwise expressly provided in these Bylaws or any amendment thereto: (a) Shall designate Committee officers; (b) Shall determine the term of office of Committee members and officers; and (c) May remove any member or officer of a Committee.

ARTICLE V
OFFICERS

5.1 Officers and Qualifications. The Officers of the Corporation shall be the Chairman of the Board, the two Vice Chairmen of the Board, the Secretary, the Treasurer, the President, the Chief Executive Officer and such other Officers as shall be determined by the Board of Directors in accordance with Section 5.9 of these Bylaws. All Officers, other than those Officers that are employees of the Corporation (including, without limitation, the President), shall be members of the Board of Directors (such Officers being, the "Board Officers").

5.2 Term and Election of Officers. Each Board Officer (other than the Chief Executive Officer) shall be elected by the Board of Directors at the Board of Directors' annual meeting and shall hold office for a term of two years or until his successor shall have been duly elected and qualified, or until he or she shall have resigned or been removed; provided, however, that it shall be the policy of the Corporation that no such Board Officer shall hold office for more than two consecutive terms of two years except in the case of an emergency. The Chief Executive Officer shall be appointed by the Board of Directors and shall at all times be the same individual as is serving as the Chief Executive Officer of the Member. The President shall be appointed by the Chief Executive Officer after consultation with the Board of Directors. The Officers that are not Board Officers shall be appointed by the President after consultation with the Chief Executive Officer. The President and each Officer that is not a Board Officer shall hold office until a successor is chosen and qualified, or until the death, resignation or removal of such Officer, whichever event shall first occur.

5.3 The Chairman. The Chairman of the Board shall preside at each meeting of the Board of Directors and at each meeting of the Executive Committee. He or she shall see that all orders and resolutions of the Board of Directors and of Committees of the Board of Directors are carried into effect. In general, he or she shall perform all duties incident to the office of Chairman and such other duties as may from time to time be assigned to him or her by these Bylaws or by the Board of Directors. He or she shall be an ex-officio member with a vote on all Committees, except the Nominating Committee, and may call a meeting of any such Committee at any time.

5.4 Vice Chairmen of the Board. The Vice Chairmen of the Board shall have such general responsibility as may be assigned to him or her from time to time by the Board of Directors, and he or she shall perform all such other duties as from time to time may be assigned to him or her by the Board of Directors. At the request of the Chairman of the Board, or in case of his or her absence or inability to act, either Vice Chairman of the Board designated by the

Board of Directors shall perform the duties of the Chairman of the Board, and when so acting shall have all the powers of, and be subject to all the restrictions upon, the Chairman of the Board.

5.5 Treasurer. The Treasurer shall have overall responsibility for the funds, securities, financial record keeping, methods of disbursement and collection, and means of protection of corporate assets, and shall render to the Chairman of the Board and to the Directors at the meetings of the Board of Directors, or whenever they require it, a statement of transactions and financial condition of the Corporation. The Treasurer shall have oversight responsibility for the chief financial employee of the Corporation, and shall be a member of the Finance Committee.

5.6 Secretary. The Secretary shall keep the minutes of the meetings of the Board of Directors; be the custodian of the corporate records and of the seal of the Corporation; and, in general, perform all the duties incident to the office of Secretary and such other duties as from time to time may be assigned by the Board of Directors or the Chairman.

5.7 Chief Executive Officer: In addition to all other duties and responsibilities of the Chief Executive Officer specified in these Bylaws, the Chief Executive Officer shall be responsible for seeing that the resolutions and actions of the Board of Directors are carried into effect, and for reporting to the Board of Directors on the conduct and management of the affairs of the Corporation.

5.8 Additional Duties. All Officers shall perform such other duties as are usually incidental to their respective offices and such duties as are expressly prescribed for them elsewhere in these Bylaws and as may be assigned or delegated to them from time to time by the Board of Directors.

5.9 Other Officers. The Board of Directors may from time to time appoint such other Officers as the Board of Directors may deem necessary or advisable, each of whom shall hold office for such period and have such authority and perform such duties as the Board of Directors may from time to time determine.

5.10 Removal of Officers. Irrespective of term of office, but subject to any written contract rights: (i) the President may be removed at any time by the Chief Executive Officer after consultation with the Board of Directors; and (ii) each other Officer that is not a Board Officer may be removed at any time by the President after consultation with the Chief Executive Officer.

5.11 Vacancies. Except as otherwise provided in these Bylaws, if the office of: (i) any Board Officer becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term by the Board of Directors by the appointment of a current member of the Board of Directors to such office; (ii) the President becomes vacant due to death, resignation or removal, the vacancy may be filled for the unexpired term by the Chief Executive Officer after consultation with the Board of Directors; and (iii) any other Officer becomes vacant due to death,

resignation or removal, the vacancy may be filled for the unexpired term by the President after consultation with the Chief Executive Officer.

5.12 Rights of Indemnification. The Corporation shall indemnify each Director, officer, employee and agent to the extent provided under Part VII, Section (E) of Chapter 602 of the Connecticut Revised Nonstock Corporation Act as it may be amended from time to time.

ARTICLE VI
PRESIDENT

6.1 President. The President shall be an employee of the Corporation and shall serve at the pleasure of the Chief Executive Officer, subject to consultation with the Board of Directors. Subject to the control of the Chief Executive Officer in consultation with the Board of Directors, the President shall, in general, supervise and control all the business and affairs of the Corporation and shall, except in any case in which the Chief Executive Officer, after consultation with the Board of Directors, shall otherwise direct, have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. In addition to such other authority given to the President hereunder, the President shall have the authority to appoint, remove and supervise all non-officer employees of the Corporation and to delegate such authority, and to direct the services provided by the Corporation. The President also shall have such duties and responsibilities as are assigned to him or her by the Chief Executive Officer and shall report and be responsible to the Chief Executive Officer.

6.2 Resignation. The President may resign his or her office by giving written notice thereof to the Chairman of the Board.

ARTICLE VII
TYPES OF FUNDS

7.1 The Current Unrestricted Fund. The current unrestricted funds will account for all resources over which the Board of Directors has discretionary control to use in carrying on the operations of the Corporation in accordance with its charter and these Bylaws. Subject to the rights, powers and privileges of the Member under these Bylaws, the Board of Directors may designate portions of the current unrestricted fund for specific purposes, projects, or investment as an aid in the planning of expenditures and the conservation of assets. The Corporation may wish to maintain separate accounts for such designations within the current unrestricted fund and to segregate the designated and undesignated portions of the fund within the fund-balance section of the unrestricted fund-balance sheet. It should be recognized that the Board of Directors has the authority to change or reverse its own action. Accordingly, amounts designated by the Board of Directors should not be included with donor-restricted funds and the term "restricted" should not be used in connection therewith.

7.2 Current Restricted Fund. Current restricted funds will be established to account for resources currently available for use but expendable only for operating purposes specified by

the donor or grantor. Such resources may originate from gifts, grants, income from endowment funds, or other similar sources where the donor has specified the operating purposes for which the funds are to be used.

7.3 Land, Building and Equipment Fund. Land, building and equipments funds will be used to accumulate the net investment in fixed assets and to account for the unexpended resources contributed specifically for the purpose of acquiring or replacing land, building, or equipment for use in the operations of the Corporation. Mortgages or other liabilities relating to these assets will also be included in this fund. When additions to land, buildings, or equipment used in carrying out the Corporation's program and supporting services are acquired with unrestricted fund resources, the amount expended for such assets should be transferred from the unrestricted fund to the plan fund balance. Gains or losses on the sale of fixed assets should be reflected as income items in the plan fund accounts. The proceeds from the sale of fixed assets that are not legally required to be reinvested in fixed assets should be transferred to the unrestricted fund; such transfers should be reflected as direct reductions and additions to the respective fund balances.

7.4 Endowment Funds. Endowment funds will represent the principal amount of gifts and bequests accepted with the donor-stipulation that the principal be maintained intact in perpetuity, until the occurrence of a specified event, or for a specified period, and only the income from investment thereof be expended either for general purposes or for purposes specified by the donor. Net gains or losses from the sale of the specific investments or other property donated to the organization will be accounted for in this fund. If endowment income is subject to donor-restriction as to use, it should be credited, as earned, to the appropriate restricted fund and thereafter treated accordingly. If endowment income is not subject to donor-imposed restrictions, it should be credited, as earned, to the appropriate revenue account of the unrestricted fund. When restrictions on endowment fund principal lapse, the resources released should be transferred to the unrestricted fund or to a specific restricted fund according to the terms of the original gift of bequest.

ARTICLE VIII
CONFLICT OF INTEREST POLICY

8.1 Statement of Policy. Directors and employees shall be deemed fiduciaries in their relationships with the Corporation. In addition to and overriding the standards of conduct which are necessary to satisfy statutory requirements regarding such relationships, no Director or employee shall undertake or continue in any personal or business interest which is, has become, or gives the appearance of being in conflict with the interest of the Corporation. It shall be the duty of each Director or employee to disclose promptly and fully, in the case of an employee to the President and in the case of a Director to the Executive Committee, any facts which may give rise to a potential conflict of interest situation with respect to the interests of the Corporation. If either the President or the Executive Committee determines that the matter is one which should

be reviewed by the Board of Directors, the President or the Executive Committee shall submit the facts promptly to the Board of Directors for consideration.

ARTICLE IX
LOANS, CHECKS AND DEPOSITS

9.1 Loans. Subject to the rights, powers and privileges of the Member set forth in Section 2.2(i) of these Bylaws, no loans in excess of five thousand ($5,000.00) dollars shall be contracted on behalf of the Corporation and no evidences of indebtedness in excess of ten thousand ($10,000.00) dollars shall be issued in its name unless authorized by a resolution of the Board of Directors. Such authority may be general or confined to specific instances.

9.2 Checks, Drafts, etc. All checks, drafts or order for the payment of money, notes, bills of exchange and other evidences of indebtedness issued in the name of the Corporation shall be signed or endorsed with the signatures or facsimile signatures of such officers or agents of the Corporation as the Board of Directors shall from time to time designate by name or title, or, in lieu of any action by the Board of Directors, as the Chairman of the Board shall designate.

9.3 Deposits. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Directors may select or, in lieu of any action by the Board of Directors, as the Treasurer may select.

ARTICLE X
CORPORATE RECORDS AND FINANCIAL STATEMENTS

10.1 Corporate Records. The Corporation shall keep at its principal place of business an original or a copy of the minutes of the meetings of the Board of Directors and its Bylaws, including all amendments thereto, certified by the Secretary.

10.2 Financial Statements. At intervals of not more than twelve months the Corporation shall prepare a balance sheet showing its financial condition as of a date not more than four months prior thereto and a statement of receipts and disbursements respecting its operations for the twelve months preceding such date. The balance sheet and statement shall be audited by an independent public accountant and shall be deposited at the principal office of the Corporation and be kept for at least ten years from such date.

10.3 Annual Report and Fiscal Year. The Board of Directors shall cause to be prepared and shall present at the annual meeting an annual report. The annual report shall be filed with the minutes of the meetings of the Board of Directors. The fiscal year of the Corporation shall begin on July 1 and end on the following June 30, inclusive.

ARTICLE XI
MISCELLANEOUS PROVISIONS

11.1 Notice. Any notice required or permitted to be given under these Bylaws shall be deemed to have been delivered if delivered in person or if sent by United States mail or by telegraph, charges prepaid, telex, or facsimile to such person at the address shown on the records of the Corporation or supplied by him or her to the Corporation for the purpose of notice. If such notice is sent by mail, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail.

11.2 Amendments. These Bylaws may be amended or repealed, and new Bylaws may be adopted, upon the occurrence of all of the following: (i) approval of the proposed change by a majority vote of the members of the Board of Directors at any regular, annual or special meeting of the Board of Directors; (ii) recommendation of the proposed change by the Board of Directors to the Member; and (iii) the approval of the proposed change by the Member at any regular, annual or special meeting of the Member. For any meeting of the Board of Directors or of the Member at which the Board of Directors or the Member, as the case may be, is to consider amending or repealing these Bylaws, or adopting new Bylaws, notice of such meeting shall be given in the manner required by these Bylaws (or, if notice is not otherwise required by these Bylaws, no later than two (2) days prior to such meeting) and shall set forth the general nature of the proposed change.

ARTICLE XII
PARLIAMENTARY AUTHORITY

12.1 The parliamentary authority of the Board of Directors shall be Robert's Rules of Order Revised in all cases in which they are applicable and in which they are not inconsistent with the Bylaws.

Dated: May 19, 1997

EXHIBIT 5

System Affiliation Agreement

CONFIDENTIAL

SYSTEM AFFILIATION AGREEMENT

BY AND AMONG

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

GREENWICH HEALTH CARE SERVICES, INC.

AND

THE GREENWICH HOSPITAL ASSOCIATION

July 24, 1997

TABLE OF CONTENTS

SYSTEM AFFILIATION AGREEMENT

THIS SYSTEM AFFILIATION AGREEMENT is made and entered as of July 24, 1997, by and among **YALE-NEW HAVEN HEALTH SERVICES CORPORATION**, a Connecticut nonstock corporation having its principal office at 789 Howard Avenue, New Haven, Connecticut 06504, and **GREENWICH HEALTH CARE SERVICES, INC.**, a Connecticut nonstock corporation having its principal office at 5 Perryridge Road, Greenwich, Connecticut 06830 and **THE GREENWICH HOSPITAL ASSOCIATION**, a Connecticut nonstock corporation having its principal office at 5 Perryridge Road, Greenwich, Connecticut 06830.

W I T N E S S E T H:

WHEREAS, the parties deem it to be consistent with and in furtherance of their respective charitable purposes and in the best interests of their communities and constituencies to become permanently affiliated;

WHEREAS, a permanent affiliation between the parties will allow coordination of the provision of patient care services, which should reduce duplication of resources, increase efficiencies and decrease costs to health care consumers; provide additional patient access to specialized services; and enhance clinical, medical educational, clinical research, marketing, planning, finance, human resources, information systems and management services and expertise;

WHEREAS, the parties have determined that a permanent affiliation can best be developed and implemented through the planning and coordination efforts of Yale-New Haven Health Services Corporation, which shall become the sole member of Greenwich Health Care Services, Inc.;

WHEREAS, the parties intend Yale-New Haven Health Services Corporation to direct and implement the System's activities and to have various leadership responsibilities and powers with respect to Greenwich Health Care Services, Inc., as more fully set forth in this Agreement, while allowing the parties and their affiliates, to a significant and meaningful extent, to retain their unique traditions, constituencies, and philanthropic support; and

WHEREAS, each party considers it in its best interest to enter into a permanent affiliation on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements and covenants hereinafter set forth and for other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I

DEFINITIONS

In addition to the words and terms defined elsewhere in this Agreement, the following words and terms shall have the following meanings:

1.1 "Act" shall mean The Connecticut Revised Nonstock Corporation Act, as amended, Chapter 602 of the Connecticut General Statutes, or successor provisions.

1.2 "Affiliate" shall mean, with respect to any Entity, any other Entity which at the time Affiliate status is being determined is directly or indirectly Controlling or Controlled by or under direct or indirect common Control with such Entity. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject Entity, or (b) direct or cause the direction of the subject Entity's day-to-day operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

1.3 "Agreement" shall mean this System Affiliation Agreement.

1.4 "CEO" shall mean the YNHHS President and Chief Executive Officer.

1.5 "Closing" shall mean the consummation of the transactions contemplated by this Agreement, which shall occur on the date five business days after the last of the conditions in Article XII has been satisfied to the reasonable satisfaction of the parties, or waived by the parties in writing, or on such other date upon which the parties mutually agree but not later than June 30, 1998 unless such date is extended by written agreement of the parties. "Closing Date" shall mean the date upon which the Closing actually occurs.

1.6 "Code" shall mean the Internal Revenue Code of 1986, as amended, and any corresponding provision of any future United States Internal Revenue law.

1.7 "Corporate Documents" shall mean, as the context requires, the Certificate of Incorporation or similar charter document, Bylaws and other agreements that address the powers and governance of a corporation.

1.8 "Effective Date" shall mean the date on which the last of the conditions specified in Article XII hereof shall have been satisfied.

1.9 "Entity" shall mean a corporation, association, partnership, trust, limited liability company, organization, business or any other entity.

1.10 "Fiscal Year" shall mean the twelve month period ending September 30.

1.11 "Foundation" shall mean a tax-exempt foundation to be established by GHCS and Greenwich Hospital as more fully described in Article VI.

1.12 "GHCS" shall mean Greenwich Health Care Services, Inc.

1.13 "GHCS Network" (sometimes referred to as the "member(s) of the GHCS Network") shall mean GHCS and all then existing GHCS Affiliates; provided that none of YNHHS or SCHS or any other Entity that is an Affiliate of GHCS solely by reason of common Control by YNHHS, nor the Foundation shall be included in the definition of the GHCS Network.

1.14 "Goals and Objectives" shall mean the goals and objectives for the System, as set forth in Section 2.1; it being understood that the Goals and Objectives will be adjusted by YNHHS based on market and other trends and changes affecting the System in a manner consistent with the authority retained by Greenwich Hospital and GHCS, respectively, under Section 4.5 and Article XIII hereof.

1.15 "Greenwich Hospital" shall mean The Greenwich Hospital Association.

1.16 "Local Network" shall mean, respectively, the GHCS Network or the YNHH Network or the SCHS Network; and "Local Networks" shall mean the GHCS Network and the YNHH Network and the SCHS Network collectively.

1.17 "Local Plans" shall have the meaning given to such term in Section 7.2.

1.18 "Managed Care Contract" shall mean any agreement between a provider and any payor, employer or any intermediary organization acting on behalf of itself, a payor, or an employer to provide covered health care services on any basis, including but not limited to a fee-for-service basis, a risk-sharing basis, a capitated basis or under any other arrangement in which there are incentives to utilize the contracting provider for covered services.

1.19 "Major Programmatic Changes" shall mean GHCS' or a GHCS Affiliate's creation of any major new health care service, establishment of any new location for the delivery of health care services, addition or deletion of a major clinical program, substantial alteration of a health care facility or clinic and any other major modification of services, programs or facilities.

1.20 "Primary Service Area" shall mean as to GHCS the cities and towns listed on **Exhibit A**.

1.21 "SCHS" shall mean Southern Connecticut Health System, Inc.

1.22 "SCHS Network" shall mean SCHS and all then existing Affiliates, provided that none of YNHHS or GHCS or their respective Affiliates shall be included in the definition of the SCHS Network.

1.23 "System" shall mean YNHHS and all the System Members insofar as they are acting or are required to act as a unified health care delivery system pursuant to this Agreement and such other agreements as may be entered into by YNHHS with any other

System Member, it being acknowledged that when acting as a part of the System YNHHS is acting in its capacity as the institution directed and empowered to manage the System as contemplated hereby and to exercise the rights and privileges granted to it in this Agreement.

1.24 "System Member" shall mean each Local Network and each Entity that hereafter (a) affiliates with YNHHS such that YNHHS exercises Control over such Entity, or (b) merges into or consolidates with YNHHS or any Entity that is part of either Local Network or any Entity that hereafter becomes an Affiliate of YNHHS; unless otherwise specified in this Agreement, an Entity of which YNHHS is sole member and as to which YNHHS possesses rights substantially similar to those granted to YNHHS herein is a System Member.

1.25 "YNHH" shall mean Yale-New Haven Hospital.

1.26 "YNHH Network" (sometimes referred to as "member(s) of the YNHH Network") shall mean YNHH and all then existing YNHH Affiliates, provided that YNHHS shall not be included in the definition of YNHH Network, and provided further that none of GHCS or SCHS or any of their respective Affiliates shall be included in the definition of the YNHH Network.

1.27 "YNHHS" shall mean Yale-New Haven Health Services Corporation.

1.28 "YSM" shall mean Yale University, a Connecticut specially chartered corporation, acting through its School of Medicine.

ARTICLE II

SYSTEM GOALS AND OBJECTIVES

Section 2.1 **System Goals and Objectives**. The Goals and Objectives for the System are as follows:

2.1.1 Create and coordinate an integrated, regional health care delivery system composed of local, vertically integrated networks that provides high quality, cost-effective health services and that successfully operates in a managed care marketplace;

2.1.2 Provide centralized managed care services by the System and develop and administer the System's managed care arrangements to increase the number of managed care patients served by the System, and enhance each System Member's ability to seek and accept regional, statewide, and state/federal government managed care contracts for enrolled populations;

2.1.3 Assist each System Member to develop and work effectively with local and regional physician organizations, physician-hospital organizations, management service

organizations and primary care organizations; including doing so with existing organizations of those types;

2.1.4 Provide leadership in the development of improved health care delivery, health professional education, and research programs;

2.1.5 Actively support healthcare in Connecticut by working with local communities and providers to maintain appropriate access to care;

2.1.6 Provide for the sharing of technology, services, management and programs to increase operating efficiencies in an effort to reduce capital costs of System Members.

2.1.7 Work to ensure the long-term financial viability of YNHHS and each System Member by assisting System Members in providing quality health care in Connecticut and throughout the Northeast;

2.1.8 Provide coordination for clinical services, medical, nursing, and other health professional education, research, fund raising, finance, strategic planning, marketing, human resources, information systems and such other administrative and management activities important to System Members as YNHHS and each System Member shall identify in an effort to enhance quality, reduce duplication of resources, increase efficiencies, maintain and improve the System Members' financial condition, and decrease costs to health care consumers;

2.1.9 Recognize the importance of physicians to the success of the System and assist System Members to maintain active and productive medical staffs; and

2.1.10 Achieve such other objectives as YNHHS, with Local Network input, shall establish as necessary or appropriate to the successful implementation and operation of the System and as shall be consistent with the authority retained by Greenwich Hospital and GHCS, respectively, under Section 4.5 and Article XIII hereof.

ARTICLE III

THE ROLES OF YNHHS AND OF THE GHCS NETWORK IN THE SYSTEM

Section 3.1 **YNHHS' Role**. YNHHS' role in the System is to lead a statewide healthcare delivery and healthcare financing system dedicated to providing high quality, cost-effective services to the communities it serves. The specific actions to be undertaken by YNHHS in fulfilling this role include:

(a) Develop, manage, coordinate and lead the System in a manner consistent with this Agreement;

(b) Develop strategies for the System by which the System shall pursue the Goals and Objectives, including developing System-wide strategic plans, System operating budgets and System capital budgets in a timely manner;

(c) Subject to Section 4.5, organize and coordinate the provision of services of all System Members to ensure that the System provides high quality, cost-effective and coordinated health care services in a manner that balances each System Member's needs with System-wide strategies;

(d) Provide leadership in the promotion of community wellness, health education and accessible preventive health services;

(e) Enhance collaboration among the Local Networks, YSM and other health-care institutions, colleges and schools in the initiation, development, maintenance and oversight of (i) educational programs for health professionals and the public, and (ii) programs of scientific research related to the care of the sick and injured, in each case of consistently high quality;

(f) Pursue System-wide Managed Care Contracts, within the specifications and conditions of the contracting authority granted by each Local Network and affiliated physician organization(s);

(g) Provide information collection and management capabilities to improve the quality and cost-effectiveness of health care delivery and to foster medical research and education;

(h) Establish and coordinate management objectives, incentives and performance measures for the System, and coordinate such for all System Members; and

(i) Provide guidance and support for local strategic plans, local network operating and capital budgets, day-to-day management functions, the development and implementation of managed care strategies, and local and regional clinical management initiatives.

Section 3.2 **Role of the GHCS Network**. The role of the GHCS Network in the System includes accomplishing the following specific actions in a manner that is consistent with the Goals and Objectives and under the direction of the GHCS and Greenwich Hospital Boards or the senior managers to which such responsibilities are delegated:

(a) Develop, manage and coordinate a local, vertically integrated network (including physicians, ambulatory and extended care services) in conjunction with Greenwich Hospital medical staff and YNHHS;

(b) Provide high quality, cost-effective services to the local community and to patients referred to it for clinical services;

(c) Develop, maintain and nurture key local community relationships, and to this end work with other local community organizations in the coordination and provision of health services;

(d) Collaborate through YNHHS with YSM and other healthcare institutions, colleges and schools in the initiation, development and maintenance of (i) graduate physician medical education programs, (ii) educational programs for other health professionals and the public, and (iii) sites for scientific research related to the care of the sick and injured, in each case of consistently high quality;

(e) Disseminate through YNHHS information developed by the GHCS Network as appropriate for System-wide functions and System oversight of Local Network operations; this may include information as to: financial, human resources, information systems, government relations, community and public relations, planning and marketing, managed care, purchasing, business and new product development and legal;

(f) Develop and maintain medical staff relationships;

(g) Coordinate clinical program development with YNHHS;

(h) Maintain day-to-day management functions with consultation, oversight of senior management and, if necessary, assistance from YNHHS, subject to rights granted to YNHHS to approve certain actions as specified in this Agreement;

(i) Develop and maintain relationships with local physician organizations and/or physician-hospital organizations; and

(j) Undertake the foregoing actions and otherwise participate in the System, including without limitation the discharge of its other obligations pursuant to this Agreement, in a timely fashion and in a manner that contributes to YNHHS' development and operations of the System.

ARTICLE IV

GOVERNANCE OF GHCS

The following sets forth certain rights granted to YNHHS and the CEO in connection with the governance of GHCS and the GHCS Network. In accordance with Section 12.2.1, the substance of this Article IV shall be incorporated into the Corporate Documents of GHCS, Greenwich Hospital and their Affiliates. Any conflict between the terms of this Article IV and such Corporate Documents shall be determined by reference to such Corporate Documents.

Section 4.1 **GHCS Network Governance**. The following governance provisions shall apply to GHCS and the GHCS Network, and GHCS and YNHHS hereby covenant to maintain compliance with the following:

(a) YNHHS shall become the sole member of GHCS, and GHCS shall remain the sole member of Greenwich Hospital and the sole member or sole shareholder, as applicable, of all other GHCS Affiliates of which Greenwich Hospital is not the sole member or sole shareholder;

(b) GHCS shall cause the Boards of Directors of GHCS and each of the other GHCS Affiliates to be composed of the persons composing the Board of Greenwich Hospital, (except for (i) the Foundation, (ii) any Affiliates approved as provided in Section 7.10 hereof if at the time of approval a different Board structure is consented to by YNHHS and (iii) any Affiliates having a board of directors comprised exclusively of senior management personnel employed by YNHHS);

(c) GHCS shall not without the written consent of YNHHS amend, modify, alter or rescind, or permit any member of the GHCS Network to amend, modify, alter or rescind, any of the Corporate Documents relating to GHCS or to that member;

(d) GHCS shall not adopt, or permit any member of the GHCS Network to adopt, any resolution, rule, regulation or procedure that would in any way limit, reduce the rights of YNHHS pursuant to or otherwise affect the covenants set forth in this Section 4.1;

(e) the Boards of Directors of GHCS and Greenwich Hospital and their Affiliates shall include a designee named by YNHHS, and the YNHHS designee on the GHCS Board and the Boards of Greenwich Hospital and any such Affiliates shall be a voting member of any executive or similar committee of GHCS, Greenwich Hospital and any such Affiliates, all as more particularly described in Section 4.4; and

(f) the Boards of Directors of GHCS and Greenwich Hospital will be self-perpetuating as contemplated in Section 33-1055 and 33-1083(c) of the Act as such Act is in effect and interpreted as of the date hereof, except insofar as is necessary for the YNHHS designee to be at all times a member of such Boards, and subject to the powers reserved to YNHHS and described in Sections 4.2 and 4.3.

Section 4.2 **Election of GHCS Directors**.

4.2.1 The GHCS and Greenwich Hospital Boards of Directors shall elect directors as hereinafter specified. The Boards of Directors of GHCS, Greenwich Hospital and each other member of the GHCS Network, except the Foundation which shall have a board of

directors determined in accordance with Article VI of this Agreement and except other members of the GHCS Network permitted to have different board composition pursuant to Section 4.1(b), shall at all times be composed of the same persons, who shall initially be the Trustees of Greenwich Hospital immediately prior to the Closing and the YNHHS designee. YNHHS shall at all times have the right to designate one representative of YNHHS to serve as a director of GHCS at the pleasure of YNHHS, and the GHCS Board shall promptly elect and remove such designee as from time to time instructed by YNHHS. Subject to the foregoing, the GHCS Board shall nominate persons to serve as GHCS directors as vacancies occur on the GHCS Board in the ordinary course due to expiration of term, death, voluntary resignation or removal pursuant to Section 4.3 below or as otherwise provided in the GHCS Bylaws. All persons nominated by the GHCS Board shall have the background and experience appropriate to that position. No person shall be elected a director of GHCS unless such person's election is approved by the YNHHS Board of Directors, except as provided below. For each such vacancy, the GHCS Board shall nominate one (1) person. If the YNHHS Board fails to approve such nominee within thirty days of receipt in writing of the proposed nominee's name, then: (a) the GHCS Board will promptly nominate two other individuals to that Board position; (b) the YNHHS Board may approve either of such nominees in which case the nominee so approved shall be promptly elected by the GHCS Board as a GHCS director, or the YNHHS Board may reject both of such nominees, and the lack of approval within thirty days of receipt in writing of the proposed nominees' name shall be deemed rejection in which case the GHCS Board shall promptly nominate two other individuals to that Board position; (c) the YNHHS Board may approve either of such additional nominees in which case the nominee so approved shall be promptly elected by the GHCS Board as a director; and (d) the YNHHS Board may reject both of such additional nominees and the lack of approval within thirty days of receipt in writing of the proposed nominees' name shall be deemed rejection in which case the choice of which of any of the foregoing proposed persons to name as a GHCS director shall be made by the Chairman of the Board of GHCS (which Chairman shall be elected by a majority vote of the GHCS directors) after consultation with the CEO and the Chairman of the Board of YNHHS. Until a new director of GHCS is elected in accordance with this section, the director previously holding the seat as to which an election is occurring (unless such director shall have been removed) shall, if willing and able to do so, continue to hold that position.

4.2.2 Similar governance provisions shall be applicable for Greenwich Hospital and each other member of the GHCS Network.

Section 4.3 Removal of GHCS Directors.

4.3.1 The Board of Directors of YNHHS, upon the affirmative vote of two-thirds of the YNHHS directors then in office, may direct the GHCS Board to remove any GHCS director specifically identified in the vote of the YNHHS directors: (a) if such director is convicted of a crime or commits any act of moral turpitude such that his continued service as a director could prove embarrassing or otherwise detrimental to GHCS, any member of the GHCS Network or the System, or (b) for breaching such director's fiduciary obligations, or breaching or causing GHCS or Greenwich Hospital to breach any law, rule or regulation, in each case where such conduct is materially detrimental to GHCS, any member of the GHCS

Network or the System, or (c) for breaching or causing GHCS or Greenwich Hospital to breach this Agreement and failing to cease such breach or causing of breach immediately and permanently upon notice thereof from YNHHS. If so directed in accordance with the foregoing provisions the GHCS Board shall promptly remove the designated director, unless the removal is directed pursuant to clause (b) or (c) above and a majority of the GHCS Board determine (within ten days of notice from YNHHS directing removal of a director) that an Arbitral Tribunal be appointed as provided in the following paragraph; provided, however, that a request for an Arbitral Tribunal shall not be available, and such director or directors shall be immediately removed, if the removal is directed as the result of an act or omission similar to that which has previously been submitted to an Arbitral Tribunal and the Tribunal previously concluded that such act or omission met the standards for removal under the foregoing clause (b) or (c). The Arbitral Tribunal shall determine whether the conduct of such director is such as to meet the standards for removal under the foregoing clauses (b) or (c) and whether the director acted in good faith. Such removal shall be immediately carried out if the Arbitral Tribunal determines that such conduct meets such standards, unless (x) the Arbitral Tribunal determines that such director or directors acted in good faith (which determination shall be made taking into account whether such director or directors acted upon the advice of competent independent legal counsel) and (y) such director or directors stop(s) such conduct immediately and permanently or, if such is not possible, take(s) within a reasonable time all actions reasonably available to mitigate the detriment resulting from such conduct to the fullest extent possible. YNHHS will not act to remove a GHCS director other than pursuant to this Section 4.3. GHCS and its directors agree that the process described in this Section 4.3 is the exclusive process to be pursued in the event YNHHS directs removal of a director. The parties and the GHCS directors (present and future) accept and agree that a determination by the Arbitral Tribunal pursuant to this Section respecting removal of a GHCS director at the direction of YNHHS will be final and binding on the parties hereto. It is expressly agreed that the exercise by the directors of GHCS of any rights reserved to them under this Agreement will not by itself constitute grounds for YNHHS to direct the removal of any of such directors.

In the event the appointment of an Arbitral Tribunal shall be requested pursuant to the preceding paragraph, such Tribunal shall consist of three members, with each of GHCS and YNHHS to appoint one member within ten days of the request for an Arbitral Tribunal and the remaining member to be agreed upon by the first two. If GHCS and YNHHS do not so agree within seven days of the request for an Arbitral Tribunal, either party can request that the American Arbitration Association appoint a third party who shall be unaffiliated with the parties hereto and their Affiliates. A determination of a majority of the three members shall constitute a determination of the Tribunal, and such determination shall be final and binding upon the parties. The members of such tribunal will take into account such matters and such evidence as they shall deem appropriate, will not be bound by any formal rules of procedure or of evidence and will be requested to reach a determination with all reasonable dispatch, but in any event shall use all reasonable efforts to reach a determination within sixty days of the request for an Arbitral Tribunal.

4.3.2 Similar governance provisions shall be applicable for Greenwich Hospital and GHCS' other Affiliates.

Section 4.4 **YNHHS Board Designee to GHCS**. YNHHS shall have the right at all times to have one person designated by it serve as a director of GHCS, of Greenwich Hospital and of each of their Affiliates. Such person shall be designated by the CEO. GHCS shall promptly cause any such designee to be elected as a director of GHCS, Greenwich Hospital and each of their Affiliates to enjoy all rights and privileges enjoyed by the directors of GHCS/Greenwich Hospital and each of their Affiliates. Notwithstanding Section 4.3, YNHHS shall have the sole right to remove its designee from the GHCS Board, the Greenwich Hospital Board and the boards of their Affiliates. If GHCS, Greenwich Hospital or any of their Affiliates has an active executive committee, or any committee that has been delegated all or most of the Board's power to act, the YNHHS designee shall serve as a voting member of that committee.

Section 4.5 **Reserved Powers**. The Greenwich Hospital Board of Directors or Board of Trustees, as the case may be, will exercise authority over and be responsible for the matters listed in Schedule 4.5 hereto.

Section 4.6 **Exercise of Authorities**. Each of GHCS and Greenwich Hospital agrees that the authority granted to it and to its Board of Directors or Board of Trustees, as the case may be, will not be exercised in a manner inconsistent with the intent of the parties hereto that YNHHS shall perform the functions and exercise the rights allocated to it by this Agreement, and YNHHS agrees that the authority granted to it, to its Board of Directors and to the CEO will not be exercised in a manner inconsistent with the intent of the parties hereto that GHCS, Greenwich Hospital and their respective Boards shall perform the functions and exercise the rights allocated to them by this Agreement.

ARTICLE V

GOVERNANCE OF YNHHS

This Article V sets forth certain aspects of the governance structure for YNHHS. The substance of this Article V shall be, in accordance with Section 12.2.2, incorporated into the Corporate Documents of YNHHS and any conflict between the terms of this Agreement and the YNHHS Corporate Documents shall be determined by reference to such Corporate Documents.

Section 5.1 **YNHHS Governance**. YNHHS covenants that it shall from and after the Closing Date (a) not amend, modify, alter or rescind any of the Corporate Documents relating to YNHHS so as to deprive the GHCS Network of the benefits of this Agreement, and (b) not adopt any resolution, rule, regulation or procedure that would affect the covenants in clause (a) of this paragraph. If YNHHS should establish an executive committee, or any committee that has been delegated all or most of the YNHHS Board of Directors' power to act, a GHCS permanent member of the YNHHS Board shall be a voting member on such committee.

Section 5.2 **Ex Officio Director**. From and after the Closing Date, the chairperson of the GHCS Board shall, by virtue of holding that office, be a Director of YNHHS during that person's tenure in such office. Ex Officio Directors of YNHHS are counted in determining a quorum of the YNHHS Board, and the GHCS Chairperson shall have full voting rights on the YNHHS Board.

Section 5.3 **Elected Directors**. On or before the Closing Date, GHCS shall propose two persons acceptable to YNHHS as directors of YNHHS (the "GHCS Directors"). If not previously accomplished, at the first meeting of the YNHHS Board of Directors following the Closing Date, the YNHHS Board shall elect as Directors the GHCS Directors. The terms of the GHCS Directors shall expire as set forth in Section 5.4 below. The foregoing notwithstanding, GHCS shall always have the same number of permanently allocated directorships as any new System Member with respect to which YNHHS is the sole member or with respect to which YNHHS possesses substantially similar or lesser rights than those granted to YNHHS in this Agreement, if such new System Member has annual expenses for the fiscal year last completed at the time such new System Member affiliates with YNHHS less than the product of (x) the quotient determined by dividing the annual expenses of Bridgeport Hospital (for the 1997 Fiscal Year) by the annual expenses of Greenwich Hospital (for the 1997 Fiscal Year) times (y) the annual expenses of Greenwich Hospital for the fiscal year last completed at the time such new System Member affiliates with YNHHS, it being acknowledged that the ex officio position of the GHCS Chairperson is a permanently allocated directorship. The preceding sentence shall only apply as to relationships where YNHHS does not have the legal power to (a) elect or cause the election of one-third or more of the governing body of the new System Member or (b) direct or cause the direction of substantial aspects of the subject Entity's day-to-day operations. For purposes of this Section 5.3, a directorship that expires or ceases within five years of being established as a contractual right will not be considered a permanently allocated directorship. The GHCS Directors and any other individuals nominated for positions as YNHHS Directors in accordance with this Article V shall be, at the time of their nomination, directors of GHCS.

Section 5.4 **Terms of GHCS Directors**. As designated by GHCS in connection with the proposal for election as specified in Section 5.3, the term of one GHCS Director shall expire one year following his election and the term of a second GHCS Director shall expire two years following his election. Each of such two GHCS Directors is hereinafter referred to as a "Transition GHCS Director." Upon the expiration of the term of a Transition GHCS Director, such Transition GHCS Director's directorship shall be eliminated and the number of YNHHS directors shall be reduced accordingly. Prior to such expiration, GHCS and YNHHS may mutually agree to remove such Transition GHCS Director without cause, and in any event GHCS shall have the right to fill any vacancy arising in any directorship as to which it has the right to nominate a director.

Section 5.5 **Geographic Diversity**. YNHHS will use its best efforts to assure that the YNHHS Board of Directors reflects, to the extent reasonably possible, the geographic diversity of the service area of the System.

ARTICLE VI

STRUCTURE AND GOVERNANCE OF THE FOUNDATION

Section 6.1 **The Foundation**. On or before the Closing Date, GHCS and Greenwich Hospital shall cause the Foundation to be incorporated as a Connecticut nonstock corporation, in accordance with the Act. The Foundation shall seek and obtain recognition of its exemption from federal taxation under the Code as a supporting organization of Greenwich Hospital. The Foundation's mission shall be to hold, manage and distribute the endowment of Greenwich Hospital (to the extent specified in Section 6.3) to, or for the benefit of, the GHCS Local Network, exclusively, so long as a member or members of the GHCS Local Network provide or arrange for the delivery of health care to the Greenwich community.

Section 6.2 **Governance of the Foundation**. The Foundation shall be governed by a self-perpetuating Board of Directors, which shall initially consist of the current directors of GHCS and the YNHHS-designated director referred to below. The current members of GHCS (and any replacement of any thereof by the Board of Directors of the Foundation upon the resignation or death of any such member) shall be the sole members of the Foundation, and such members shall not be entitled to vote for the election of directors but shall be entitled to vote with respect to those matters contemplated by Parts VIII through XI of the Act. YNHHS shall have the right at all times to have one person designated by it serve as a member of the Board of Directors of the Foundation. The Board of the Foundation shall promptly cause any such designee to be elected as a director of the Foundation. YNHHS shall have the sole right to remove and replace its designee. If the Foundation has an executive committee, or any committee that has been delegated all or most of the Foundation Board's power to act, the YNHHS designee shall serve as a voting member of that committee. The Corporate Documents of the Foundation will reflect the substance of this Article VI and will contain appropriate provisions preventing amendment, modification, alteration or rescission thereof without the written consent of Greenwich Hospital and YNHHS.

Section 6.3 **Transfer of Funds**. On the Closing Date, GHCS or Greenwich Hospital shall transfer the endowment fund, which currently has an approximate market value of $43.5 million, (such amount, subject to appreciation, additions and reductions in accordance with this Article VI is hereinafter referred to as the "Principal") to the Foundation to be held, managed and distributed in accordance with the mission of the Foundation, as set forth in its Certificate of Incorporation, and with any and all restrictions placed on such funds by the donor thereof or by law.

Section 6.4 **Use of Funds**.

6.4.1 Income. Within ninety (90) days after the end of each Fiscal Year the Board of Directors of the Foundation shall cause cash interest and dividend income earned on the Principal during such Fiscal Year, net of costs and expenses of the Foundation during such Fiscal Year, to be distributed to GHCS or Greenwich Hospital to be used in accordance with the missions of GHCS or Greenwich Hospital, respectively; provided that in no event

shall the annual amount so distributed be less than the greater of (a) $800,000 and (b) five percent (5%) of the aggregate value of the Principal and any other holdings of the Foundation determined using the average market value, calculated on a quarterly basis, for the three Fiscal Years prior to such Fiscal Year.

6.4.2 Principal. From time to time GHCS or Greenwich Hospital may request the distribution of all or a portion of the Principal to a member of the GHCS Network. Any such request shall describe the proposed use of such funds, shall include a statement as to how such use is consistent with the mission of the Foundation and shall contain such other information as the Foundation directors shall request. No such distribution shall be made except with the approval of the governing boards of each of the Foundation and GHCS, provided that the Board of the Foundation shall not approve any such request that is inconsistent with the mission of the Foundation and any restrictions placed on such funds by the donor(s). The Board of Directors of the Foundation shall base its decision with respect to any such request for a principal distribution solely on whether acceding to such request is in the best interests of the GHCS Network and consistent with the interests of the Greenwich community.

Section 6.5 Fund-Raising. From and after the Closing Date, the Foundation shall undertake fund-raising only for the benefit of the GHCS Network at the request of and in coordination with GHCS. The Foundation shall use reasonable efforts to cause donors to direct pledges and gifts made from and after the Closing to a member of the GHCS Network, provided, however, that the Foundation shall not be required to attempt to redirect a pledge or gift if such will significantly limit the amount of such pledge or gift.

Section 6.6 Staffing. The Foundation shall not directly employ any officers, senior management or other staff. The Foundation shall obtain all such staff and any services as shall be necessary to accomplish its mission from a member of the GHCS Network, which member of the GHCS Network shall provide such staff and services to the Foundation at the actual cost thereof.

Section 6.7 Offices. The Foundation shall maintain its offices on the campus of Greenwich Hospital or another member of the GHCS Network.

Section 6.8 Existing Indebtedness. The Foundation shall become and remain an Obligated Group Member under the Bond Indenture. GHCS and Greenwich Hospital agree that they will pay or cause to be paid, before the Foundation pays or is caused to pay, any amounts due with respect to such Bonds and any other existing indebtedness of Greenwich Hospital when and as due. YNHHS hereby approves and consents to all such payments by GHCS and Greenwich Hospital. (The capitalized terms used in this Section 6.8 and not defined in this Agreement are used herein as defined in the Master Trust Indenture, dated as of March 1, 1996, by and among Greenwich Hospital, GHCS and Fleet National Bank.)

Section 6.9 Third Party Beneficiary. The parties hereby agree that the Foundation is an intended third party beneficiary of the provisions of this Article VI and shall, upon its creation, have the right to enforce the terms of this Article VI.

ARTICLE VII

ALLOCATION OF RIGHTS AND RESPONSIBILITIES

Certain of the rights and responsibilities of GHCS and of YNHHS in connection with their affiliation are set forth in this Article VII. Each party agrees and covenants with the other that it will fulfill its responsibilities as set forth herein, and that in exercising its rights set forth herein it will do so using its reasonable judgment taking into account the Goals and Objectives and the authorities of the parties under this Agreement, including without limitation the rights of Greenwich Hospital under Section 4.5.

Section 7.1 **System Planning and Implementation**. YNHHS shall establish the System's mission and to that end shall plan and organize the System's provision of clinical services, clinical research, managed care contracting services and support systems on an integrated and cost-effective basis. The planning, organization and implementation of all such activities shall be consistent with the Goals and Objectives with the understanding that each Local Network must cooperate with and assist YNHHS to the full extent necessary to enable YNHHS to operate a successful, integrated System.

Section 7.2 **Local Planning**. GHCS shall prepare or cause to be prepared each year a strategic plan and related capital and operating budgets (collectively, the "Local Plans") for the GHCS Network as a whole and separately for each member of the GHCS Network. The Local Plans shall be consistent with the Goals and Objectives, and shall be prepared annually in a format acceptable to YNHHS and at the same time that YNHHS prepares its annual strategic plan and budgets. YNHHS shall review and approve the Local Plans, and neither GHCS nor any member of the GHCS Network shall implement any portion of the Local Plans unless and until such time as the Local Plan has been approved by YNHHS (provided that, pending approval of any new Local Plan, GHCS and members of the GHCS Network may continue operation in accordance with the most recently approved Local Network capital and operating budgets, with allowances for (a) non-significant variations from such budgets, (b) expenditures necessary to address insured casualty losses, and (c) expenditures required to comply with applicable laws and regulations or to comply with contractual obligations existing on the date hereof or incurred consistent with approved Local Plans.) YNHHS agrees to act promptly to review the Local Plans. Before or at the Closing, or as otherwise agreed by the parties, GHCS shall prepare and deliver to YNHHS transition Local Plans for the period from the Closing Date through the end of GHCS' 1998 Fiscal Year, and such transition Local Plans, including any provisions therein regarding transfers to the Foundation, shall be subject to review and approval by YNHHS as and to the extent provided in this Section 7.2.

As to each organization in which GHCS or any member of the GHCS Network participates through an equity interest or by Board representation, the annual capital and operating budgets for that organization, and its strategic plans, shall (to the extent such can be obtained by GHCS by reasonable, diligent effort) be reviewed by GHCS with YNHHS prior to the adoption or approval of such budgets and plans so that YNHHS has a reasonable opportunity to comment on such budgets and plans.

Section 7.3 **Implementation of Local Plans**. Once the Local Plans have been approved by YNHHS, GHCS shall use its best efforts to cause the Local Plans to be implemented in accordance with their terms, and shall not modify the Local Plans in any material respect, or deviate therefrom in any material respect, without the prior written approval of YNHHS.

Section 7.4 **Incurrence of Debt**. Neither GHCS nor any member of the GHCS Network shall incur any "debt" or enter into any line of credit except as specifically contemplated by the Local Plans or unless such debt or line of credit is otherwise approved by YNHHS. For purposes of this paragraph, "debt" shall include (a) the guaranty of a financial obligation of a third party (other than the guaranty on behalf of another GHCS Network member where the guaranty is otherwise permitted pursuant to this Section 7.4); (b) all obligations for money borrowed, except for money borrowed from another member of the GHCS Network for purposes consistent with the Local Plans; and (c) capital leases for the acquisition of equipment or real estate, except a capital lease entered into in any Fiscal Year as to which total payments under the lease will not exceed $75,000 over the term of the lease, provided the total payments under all such capital leases entered into in any year (measured over the terms of those leases) shall not exceed $150,000 (and all such capital leases shall be a part of the Local Plans (as defined in Section 7.2) in subsequent years.)

Section 7.5 **Transfer of Assets**. GHCS agrees that neither it nor any member of the GHCS Network shall sell, assign, encumber, lease, or otherwise transfer any assets (other than immaterial assets transferred in the ordinary course) except (a) as specifically provided for in the Local Plans approved by YNHHS, (b) as otherwise approved by YNHHS or (c) to another GHCS Network member consistent with the Local Plans.

Section 7.6 **Relationships with Teaching Institutions**. YNHHS shall coordinate and have the right to participate in negotiations involving, and the right to approve, any new undergraduate or graduate medical education relationship or agreement entered into by GHCS or any other member of the GHCS Network, including renewals or any material amendments of agreements as to graduate or undergraduate medical education in effect prior to the Closing Date. Without limiting the generality of the foregoing sentence, YNHHS shall coordinate and lead all discussions relating to affiliations and affiliation agreements between YSM and each Local Network.

Section 7.7 **Mergers, Consolidations, and Dissolutions**. Except with the prior consent of YNHHS, neither GHCS nor any other member of the GHCS Network shall enter into discussions or negotiations with any Entity, or solicit any such discussions or negotiations, or solicit any offer from any Entity, in respect of, nor shall GHCS or any member of the GHCS Network conclude: (a) the sale by GHCS or any such member of all or a substantial part of its assets, (b) any merger or a consolidation involving GHCS or any such member, or (c) any contract to manage or administer GHCS, any such member or a substantial part of the business of GHCS or any such member. Except with the prior consent of YNHHS, neither GHCS nor any member of the GHCS Network shall liquidate or dissolve or file for bankruptcy or similar protection.

Section 7.8 Managed Care Relationships.

7.8.1 Grant of Authority to Contract. YNHHS shall have the exclusive right to negotiate with third party payors, employers and intermediary organizations and commit on behalf of GHCS and the other members of the GHCS Network all terms and conditions of all new or renewed Managed Care Contracts. All Managed Care Contracts shall be consistent with the managed care strategies and policies established from time to time by YNHHS for the System. YNHHS agrees that it will negotiate contracts and arrangements pursuant to this Section 7.8 in good faith to provide the GHCS Network and other System Members the best rate for each System Member in light of then current market conditions, payor requirements and managed care strategies and policies of the System. YNHHS shall not intentionally cause Greenwich Hospital to subsidize other System Members under direct non-risk Managed Care Contracts between payors and Greenwich Hospital other than subsidization that is immaterial to Greenwich Hospital. YNHHS agrees that all risk contracts entered into on behalf of a member of the GHCS Network shall be consistent with the Local Plan then in effect, and GHCS agrees that the Local Plan shall take into account the need for the GHCS Network to (i) take financial and medical service risk, (ii) manage the premium paid to the relevant provider group, (iii) adjust costs to reflect then current and expected market conditions, and (iv) accept that risk contracting may result in significant losses (within loss limits, after taking into account mitigating actions that may be taken in response to such losses, deemed appropriate by the Greenwich Hospital Board and set forth in the then effective Local Plan).

7.8.2 Managed Care Strategies and Policies. The managed care strategies and policies for the System shall outline the type of reimbursement arrangement (e.g., fee-for-service, capitation, percent of premium) and delegated responsibilities (e.g., claims processing, utilization management, credentialing) sought by the System and the third party payors, employers and intermediary organizations targeted by the System. Such System strategies and policies shall be developed and revised from time to time by YNHHS senior management, including the senior management of GHCS and each other Local Network, through regular YNHHS management meetings and, as necessary, System-wide managed care committees. GHCS shall participate, through such meetings and committees in setting the basic contract parameters for Greenwich Hospital and other members of the GHCS Network.

7.8.3 GHCS Obligations. GHCS shall participate in all Managed Care Contracts undertaken by the System that are consistent with the managed care strategies and policies for the System in effect from time to time. GHCS shall operate, and cause the members of the GHCS Network to operate, within such YNHHS' managed care policies. GHCS agrees that it shall, and shall cause the other members of the GHCS Network to, execute such attorney-in-fact or other agreements as YNHHS shall reasonably request to give effect to the provisions of this Section 7.8. GHCS and all members of the GHCS Network shall provide for all YNHHS sponsored products their best competitive pricing based on comparable products. Each member of the GHCS Local Network shall offer the managed care products of System-owned managed care companies to their employees.

7.8.4 GHCS Obligations Concerning Physician Organizations. GHCS shall use its best efforts to obtain in a timely manner for YNHHS contracting authority, within

specified terms and conditions, from local physician-hospital organizations (or similar entities) in which Greenwich Hospital participates and/or such organization's associated physician organization; and as necessary to effectively market competitive managed care products in the GHCS Network's market area, GHCS shall use its best efforts to obtain in a timely manner in cooperation with YNHHS such contracting authority, or such contractual alternative as may be reasonable in the circumstances, from local physicians and physician organizations.

7.8.5 Administration of Managed Care Contracts. All Managed Care Contracts entered into by a member of the GHCS Network, directly or through the attorney-in-fact arrangements described in this Section 7.8, or any local physician-hospital organizations (or similar entities) in which Greenwich Hospital participates shall be managed by YNHH-MSO, Inc.'s contract management department; and GHCS shall use its best efforts to cause Greenwich Physicians Association and other local physician "IPAs" to utilize YNHH-MSO, Inc.'s contract management department. In each such case, the organization utilizing the contract management services of YNHH-MSO, Inc. shall pay YNHH-MSO, Inc. a commercially reasonable fee for such services. GHCS and other members of the GHCS Network shall be responsible for compliance with their respective obligations pursuant to Managed Care Contracts and for interacting with payors with respect to such obligations.

7.8.6 GHCS-Specific Managed Care Contracts. GHCS may cause YNHHS to negotiate a managed care arrangement with a payor critical to GHCS service area, unless YNHHS has determined, pursuant to its managed care policies, that the System should not enter into a relationship with such payor.

Section 7.9 Local Network Development. GHCS shall use its best efforts to develop a local integrated network as part of the strategy contemplated by the Local Plans.

Section 7.10 Affiliations, Systems, and Alliances. Neither GHCS nor any other member of the GHCS Network currently participates directly or indirectly in any affiliation, network, system or alliance of health care providers for the provision of health care services except as shown on Schedule 7.10. Neither GHCS nor any other member of the GHCS Network shall (a) create or acquire any Affiliate, or (b) participate directly or indirectly in any affiliation, network, system, or alliance of any kind, including without limitation an alliance of health care providers for the provision of health care services, in which GHCS or any member of the GHCS Network does not now participate, in either case without the prior approval of YNHHS. Nothing contained herein shall prevent or restrict GHCS or any member of the GHCS Network from participating in any affiliation, network, system or alliance of health care providers listed on Schedule 7.10.

Section 7.11 System Name; Entity Name. The tradename for the System shall be Yale-New Haven Health, provided, however, the System may operate under another trade name if the System so elects. GHCS and its Affiliates shall use the System tradename in association with their own names in accordance with System policies. Neither GHCS nor any other member of the GHCS Network shall change its name or adopt a trade name without the prior written consent of YNHHS. YNHHS shall not cause a change in the name of any member of the GHCS Network without the prior written consent of GHCS.

Section 7.12 **Selection of Chiefs.** YNHHS shall be consulted in the recruitment and selection of Chiefs of Service or other comparable positions for GHCS facilities.

Section 7.13 **Advertising, Marketing and Promotional Activities.** YNHHS shall, in consultation with GHCS, develop System-wide advertising, marketing and promotional policies. The advertising, marketing, and promotional plans developed by GHCS shall be consistent with such YNHHS policies.

Section 7.14 **Compliance with Laws, etc.** Each of YNHHS and GHCS shall use their best efforts to comply, and shall cause each member of their respective Local Networks to use its best efforts to comply, with all laws, rules and regulations applicable to its business and shall obtain and preserve all licenses and accreditation necessary or useful to the conduct of the business.

Section 7.15 **Selection of Auditors and Accounting.** The YNHHS Board of Directors, acting alone and without approval of any other entity, will have the right to appoint auditors, establish internal audit programs and set accounting policies and procedures for GHCS, Greenwich Hospital and their Affiliates.

Section 7.16 **Corporate Services.** GHCS senior management shall participate in the decision-making process relating to the development and implementation of corporate services functions, including without limitation the centralized accounting, purchasing and other "back office" functions, managed care contract administration and management services organization functions. YNHHS shall offer services, when available, to GHCS, and GHCS shall obtain, or establish a plan to obtain as soon as is reasonably possible, such services from YNHHS or an Affiliate designated by YNHHS upon the terms established by YNHHS for members of the System. In connection with the development and implementation of such corporate services functions, YNHHS shall examine the feasibility of such services, which examination shall include consideration of the economics of providing such services, the management benefits thereof, and such other matters as YNHHS may deem appropriate.

Section 7.17 **Initiate Programmatic Changes.** A Major Programmatic Change affecting a member of the GHCS Network shall be initiated solely through GHCS' inclusion of such Major Programmatic Change in a Local Plan (as defined in Section 7.2), provided that YNHHS shall have the right to approve any decision by GHCS or any other member of the GHCS Network with respect to Major Programmatic Changes. Only GHCS may initiate a change as to the services, programs or facilities of the members of the GHCS Network, and GHCS may only do so through the Local Plans. GHCS shall not, nor shall it allow any member of the GHCS Network to, commence a Major Programmatic Change without the prior approval of YNHHS.

Section 7.18 **Utilization Review and Quality Assurance and Improvement.** Each member of the GHCS Network shall be responsible for utilization review activities within its facility and shall be responsible for related quality assurance and improvement activities, provided all such activities shall be conducted in a manner consistent with all Managed Care

Contracts and policies applicable to the members of the GHCS Network and in a manner so as to assure the provision of quality, cost-effective services.

Section 7.19 Fund-Raising and Endowment. Each member of the GHCS Network and the Foundation shall undertake such fund-raising as may be necessary from time to time to assure that the GHCS Network has sufficient capital to implement the Local Plans and shall coordinate such efforts with YNHHS. New endowments may be created by any member of the GHCS Network with monies derived from gifts, bequests, fund-raising activities, and other such endowment sources.

ARTICLE VIII

YNHHS MANAGEMENT AND OPERATIONS

Section 8.1 YNHHS Management. The responsibilities of certain principal officers of YNHHS shall be substantially as follows:

8.1.1 CEO. The CEO will manage the relationship between YNHHS and the System Members so as to achieve the Goals and Objectives, consistent with the authority of the Boards of Greenwich Hospital and GHCS, respectively, under Section 4.5 and Article XIII hereof. The CEO will be responsible for implementing programs that are consistent with the Goals and Objectives and with the strategies and policies established by YNHHS, as well as with such Greenwich Hospital and GHCS authority.

8.1.2 GHCS President. The positions of President and Chief Executive Officer of GHCS and Greenwich Hospital shall be held by the same person, and such person shall be appointed by the CEO in consultation with and with the consent of the GHCS Board of Directors. The President and Chief Executive Officer of GHCS/Greenwich Hospital will be employed by YNHHS and will be elected as an Executive Vice President of YNHHS, and as such shall fully participate as a member of the YNHHS senior management group in the development of YNHHS's strategy, policies and plans. The President and Chief Executive Officer of GHCS/Greenwich Hospital shall report jointly to the GHCS/Greenwich Hospital Boards and to the CEO. The CEO shall periodically evaluate the President and Chief Executive Officer of GHCS/Greenwich Hospital, and in connection therewith shall determine the terms and conditions of that person's employment and compensation, provided the CEO shall consult with the Chairman of the GHCS Board of Directors. The CEO shall have the exclusive right, if the CEO deems it appropriate, to remove the GHCS/Greenwich Hospital President and Chief Executive Officer, provided the CEO shall consult with the GHCS/Greenwich Hospital Board Chairman prior to taking any such action.

8.1.3 Other GHCS Officers. The Chief Financial Officer of GHCS, the officer responsible for GHCS' planning and marketing functions, the officer in charge of Greenwich Hospital operations, the officer in charge of GHCS' human resources function, and such other officers of GHCS as the CEO shall from time to time designate, shall become members of the YNHHS management team, be employed by YNHHS, and be assigned full

time to GHCS and Greenwich Hospital, provided, if the CEO designates any such other officer of GHCS to be employed by YNHHS, then that officer shall be employed by YNHHS and that officer shall be offered employment with a salary equivalent to his then existing salary, and provided further that YNHHS shall do so in a manner that does not cause a breach of any contract then existing with any such officer. The foregoing members of GHCS senior management shall hold the same positions for Greenwich Hospital. YNHHS will charge GHCS and Greenwich Hospital for the actual cost of these persons' salaries, bonuses and benefits. Notwithstanding the fact that these officers will be employed by YNHHS, each of them shall report directly to the President and Chief Executive Officer of GHCS. Each of these officers will have an indirect reporting relationship to the YNHHS counterpart for the relevant functional area. The Chief Medical Officer of GHCS will participate fully with other members of the YNHHS management team if not employed by YNHHS. The CEO shall determine the future configuration of the YNHHS staff. Except as described above, the officers of GHCS Affiliates shall be appointed by the President and Chief Executive Officer of GHCS after consultation with the CEO.

Section 8.2 **Committee Structure**. An important interface between YNHHS and GHCS will be through YNHHS management committees. These committees will include the participation of key GHCS personnel to ensure GHCS involvement in YNHHS planning and operations. The CEO shall establish such committees as may be necessary or desirable from time to time and appoint appropriate individuals.

ARTICLE IX

REPRESENTATIONS AND WARRANTIES

YNHHS hereby represents and warrants to GHCS, and GHCS hereby represents and warrants to YNHHS, that the statements set forth in this Article are as to each of them true and correct as of date hereof, and, except with respect to the representations and warranties set forth in Sections 9.4 and 9.5, will be true and correct on the Effective Date and the Closing Date.

Section 9.1 **Authority to Enter into Agreement; Enforceability**. It has full corporate power and authority to enter into and to carry out the terms and provisions of this Agreement, and the transactions contemplated hereby, without obtaining the approval or consent of any other party or authority (other than any regulatory approvals required under Connecticut law and other than the expiration of any applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. §§ 7A et seq. which period shall have expired on or prior to the Closing Date); all corporate proceedings have been taken and all corporate authorizations have been obtained by such party and its Affiliates which are necessary to authorize the execution and delivery of this Agreement; and this Agreement is a legal, valid and binding obligation of such party enforceable in accordance with its terms.

Section 9.2 **Organization and Standing.** It and each of its Affiliates is a corporation duly organized, validly existing and in good standing under the laws of the State

of Connecticut. Each such corporation has all requisite corporate power and authority to own, lease, and operate its properties and to carry on its business as it is now being conducted. Complete and correct copies of the Certificate of Incorporation and Bylaws of each party and its Affiliates, as amended to date, have been delivered to the other party.

Section 9.3 **Financial Statements**. It has provided the other party with the audited balance sheets and income statements of such party and its Affiliates for the most recent three (3) Fiscal Years for which audited statements are available, together with the most recent unaudited balance sheet and income statement of such party. The foregoing financial statements (a) are in accordance with the books and records of such party and its Affiliates, and (b) fairly present the financial condition and results of operations for such party and its Affiliates as of the dates and for the periods indicated in accordance with generally accepted accounting principles applied on a consistent basis, except as may be noted therein. Each party and its Affiliates have no material liabilities or obligations, whether contingent or absolute, direct or indirect, or matured or unmatured, which are not shown or provided for in the most recent of such financial statements or which have not otherwise been disclosed to the other parties.

Section 9.4 **Litigation**. Except as otherwise disclosed in writing in Schedule 9.4, each party represents and warrants that there are no suits, actions, or legal, administrative, arbitration or other proceedings or governmental investigations pending, filed, or initiated by, or to the best of its knowledge, threatened against or directly involving the party or any of its Affiliates that may materially and adversely affect the operations, financial status or tax-exempt status of such party or its Affiliates or their ability to perform hereunder.

Section 9.5 **Compliance with Laws and Other Instruments**. To the best of its knowledge, the business and operations of each party and its Affiliates have been and are being conducted in substantial accordance with all applicable laws, ordinances, and rules and regulations of all authorities, the violation of which, individually or in the aggregate, would materially and adversely affect the business or operations of that party or its Affiliates. Except for laws and regulations that commonly apply to health care institutions in Connecticut, and matters, if any, reflected in the financial statements referred to in Section 9.3, each party and its Affiliates are not subject to any restriction of any kind or character which may materially and adversely affect their business or operations. Neither the execution and delivery of this Agreement, nor the consummation of the affiliation contemplated hereby, will conflict with, result in a violation or breach of any term or provision of, or constitute a default under the Corporate Documents of each party or its Affiliates, or any statute, order, judgment, writ, injunction, decree, license, permit, rule or regulation of any court or any governmental or regulatory body, or any indenture, mortgage, lease, contract, agreement, instrument, commitment or other arrangement to which any party or any of its Affiliates is a party or by which it is or may be bound, which conflict, violation, breach or default would materially and adversely affect the operations of the party or any of its Affiliates.

Section 9.6 **Insurance**. Each party and its Affiliates have continuously maintained and currently maintain fire, casualty, liability, professional liability and all other insurance (including self-insurance) coverages necessary in their respective businesses and operations.

Such insurance policies or programs cover the property, business, and operations of such party and its Affiliates in amounts and against losses and risks such as are generally maintained for comparably situated businesses.

Section 9.7 **Material Misstatements or Omissions**. No representation or warranty by a party contained in this Agreement or in any certificate or Schedule furnished to the other parties under this Agreement contains any untrue statement of a material fact or omits to state a material fact necessary to make the statements and facts contained therein not materially misleading.

ARTICLE X

COVENANTS

From and after the date hereof and through the Closing Date, each party hereby agrees to keep, perform, and fully discharge the following covenants and agreements.

Section 10.1 **Interim Conduct of Business**. Each party shall use its best efforts and shall cause its Affiliates to use their best efforts to (a) preserve, protect and maintain the businesses, properties and assets of the party and its Affiliates; (b) operate the businesses of the party and its Affiliates as a going concern consistent with prior practices and in the ordinary course of business except that YNHHS shall continue to pursue System development; (c) preserve the goodwill of all individuals having business or other relations with it or them, including physicians, employees, patients, customers and suppliers; (d) prepare all documents called for by this Agreement and required to facilitate the consummation of the transactions contemplated herein; and (e) enter into no new undergraduate or graduate medical education affiliation with any university, medical school, or teaching institution other than YSM. Each party shall provide the other parties promptly with interim financial statements and any material management reports of the party and its Affiliates as and when they become available. The GHCS Network shall not make or cause its Affiliates to make, any material changes in its Corporate Documents, except for changes expressly authorized by this Agreement.

Section 10.2 **Preserve Accuracy of Representations and Warranties**. Each party shall take, and shall cause its Affiliates to take, no action that would render any representation and/or warranty contained in Article IX of this Agreement inaccurate as of the Closing Date. Each party shall promptly notify the other party of any lawsuits, claims, administrative actions, investigations, or other proceedings asserted or commenced against the party or any of its Affiliates, or its or their officers, directors, or members involving in any material way the businesses, properties, assets or tax-exempt status of the party or its Affiliates. Each party shall promptly notify the other party in writing of any facts or circumstances which come to the party's attention and which the party reasonably believes causes, or through the passage of time may cause, any of the representations and warranties as to it or its Affiliates contained in Article IX to be false or inaccurate.

Section 10.3 **Access to Information**. Each party shall give, and shall cause its Affiliates to give, to the other party and to appropriate representatives of each (defined for purposes of this paragraph as a party's directors, officers, employees, agents, or advisors) access, during normal business hours, to such properties, books, records, contracts and other documents pertaining to the businesses, properties and assets of the party and its Affiliates, as may be reasonably requested and appropriate in order for each party to perform its obligations hereunder. Officers and employees of a party and its Affiliates shall be available on a regular and frequent basis to confer with appropriate representatives of the other party to report material operational matters and the general status of ongoing operations. Each party shall cooperate in keeping the other party fully informed and shall promptly provide notice to the other party of any unexpected emergency or other unanticipated adverse change in the business or prospects of the party and its Affiliates.

Section 10.4 **Maintain Books and Accounting Practices**. Each party shall maintain, and cause its Affiliates to maintain, its and their books of account in the usual, regular and ordinary manner in accordance with generally accepted accounting principles consistently applied and shall make no change in any of their accounting methods or practices without the prior written approval of the other party.

Section 10.5 **System Alliances In GHCS Service Area**. All decisions as to whether the System shall enter into strategic or other alliances in the GHCS Primary Service Area shall be made by the Board of Directors of YNHHS or YNHHS senior management if such decision-making is so delegated by such Board. GHCS shall participate in the evaluation of any such opportunity and in such decision-making through its representation on the YNHHS Board of Directors and the participation of GHCS senior management in the System planning process.

ARTICLE XI

INDEMNIFICATION

Section 11.1 **Indemnification**. Each party agrees to indemnify and hold the other party and its Affiliates and their respective directors and officers (collectively a "Section 11.1 indemnified party") forever harmless from and against any and all liabilities, demands, claims, actions, or causes of action, assessments, judgments, losses, costs, damages or expenses, including reasonable attorneys' fees, sustained or incurred by a Section 11.1 indemnified party and not otherwise reimbursed by insurance (other than self-insurance) resulting from or arising out of or by virtue of any false or misleading representation or warranty made herein by such party or any of its Affiliates or non-compliance with or breach by such party or any of its Affiliates of any of the covenants, commitments or obligations of this Agreement to be performed by such party or any of its Affiliates.

The right to indemnification set forth in this Section 11.1 shall survive termination of this Agreement, except that such right shall expire two (2) years after the Closing Date with respect to any false or misleading representation or warranty.

Section 11.2 Indemnification Notice. In the event that any claim is asserted against a Section 11.1 indemnified party as to which such party is entitled to indemnification hereunder, such party (the "indemnified party") shall promptly after learning of such claim notify the party obligated to indemnify it (the "indemnifying party") thereof in writing; provided, however, that the failure of the indemnified party to give prompt notice of such claim shall not relieve the obligation of the indemnified party with respect to such claim. Except to the extent otherwise provided by the terms of applicable insurance policies (other than self-insurance), the indemnifying party shall have the right, upon written notice to the indemnified party within ten (10) days after receipt from the indemnified party of notice of such claim, to conduct at its expense the defense against such claim in its own name, or, if the indemnifying party shall fail to give such notice, it shall be deemed to have elected not to conduct the defense of the subject claim, and in such event the indemnified party shall have the right to conduct such defense and to compromise and settle the claim without prior consent of the indemnifying party. In the event that the indemnifying party elects to conduct the defense of the subject claim, the indemnified party will cooperate with and make available to the indemnifying party such assistance and materials as may be reasonably requested by it, all at the expense of the indemnifying party, and the indemnified party shall have the right at its expense to participate in the defense, provided that the indemnified party shall have the right to compromise and settle the claim only with the prior written consent of the indemnifying party, unless otherwise provided by the terms of applicable insurance policies (other than self-insurance).

ARTICLE XII

CONDITIONS PRECEDENT

Section 12.1 List of Conditions Precedent. The obligations of each party to effect the transactions contemplated hereby are subject to the satisfaction of each of the following conditions:

12.1.1 Each and every representation and warranty by the other party contained in this Agreement (including the representations and warranties contained in Sections 9.4 and 9.5) or in any certificate, Exhibit or Schedule furnished to the other party pursuant hereto shall be true and complete in all material respects on and as of the Closing Date as though made on such date.

12.1.2 The other party shall have performed and complied with all covenants and conditions required by this Agreement to be performed or complied with by it prior to or on the Closing Date.

12.1.3 The party shall have received a certificate of a duly authorized officer of the other party, dated as of the Closing Date, certifying (a) that there have been no material adverse changes in the other party's business or operations prior to the Closing Date, and (b) that the representations and warranties of the other party and its Affiliates contained in Article IX (including the representations and warranties contained in Sections 9.4 and 9.5) are true

and complete on and as of the Closing Date in all material respects as if made on and as of such date.

12.1.4 No suit or action by any party or any investigation, inquiry, or proceeding by any governmental authority, or any legal or administrative proceeding shall have been instituted or threatened on or before the Closing Date which: (a) questions the validity or legality of this Agreement or any transaction contemplated hereby, or (b) seeks to enjoin any transaction contemplated hereby, or (c) seeks material damages on account of the consummation of any transaction contemplated hereby.

12.1.5 No change shall have occurred or have been announced or proposed prior to the Closing Date in the laws, rules, regulations, or policies of any governmental authority which might reasonably be expected to materially and adversely affect the consummation of this transaction or the benefits to be derived by any party therefrom.

12.1.6 Opinions of counsel for each party shall have been delivered to the other party in form and content reasonably satisfactory to the other party.

12.1.7 The party shall have received certified resolutions of the governing body of the other party, dated prior to the Closing Date, evidencing authorization to adopt the changes to the party's Corporate Documents required hereby.

12.1.8 Any applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. §§ 7A et seq., shall have expired, and no judicial action or other proceeding shall have been instituted by any governmental authority or agency, or by any other person before any court or governmental authority or agency which challenges or seeks to restrain or prohibit the performance of this Agreement.

12.1.9 The parties shall have obtained all governmental consents and regulatory approvals required for the consummation of the transaction contemplated by this Agreement, each in form and content acceptable to each party.

12.1.10 Each party shall have completed its respective due diligence investigation of the other party and shall be satisfied with the results of such investigation.

Section 12.2 Additional Conditions Precedent. The obligations of YNHHS to effect the transactions contemplated hereby are subject to the satisfaction of Sections 12.2.1 and 12.2.3 below, and the obligation of GHCS to effect the transactions contemplated hereby are subject to the satisfaction of Section 12.2.2 below.

12.2.1 In accordance with the Act, and effective on or before the Closing Date, GHCS will amend its Certificate of Incorporation and Bylaws in a manner acceptable to YNHHS and to GHCS to reflect the agreements and commitments made in this Agreement. In addition GHCS shall cause its Affiliates to amend their Corporate Documents (if necessary) to reflect the agreements and commitments made in this Agreement on or before the Closing Date.

12.2.2 In accordance with the Act, and effective on or before the Closing Date, YNHHS will amend its Certificate of Incorporation and Bylaws in a manner acceptable to YNHHS and to GHCS to reflect the agreements and commitments made in this Agreement.

12.2.3 In accordance with the Act and the Code, and effective on or before the Closing Date, GHCS and Greenwich Hospital shall cause to be formed the Foundation, and the Certificate of Incorporation and Bylaws of the Foundation will be filed and adopted, respectively, in such forms as are acceptable to YNHHS reflecting the agreements and commitments made in this Agreement.

Section 12.3 Termination of Agreement; Waiver of Conditions Precedent. In the event the Closing has not occurred on or before June 30, 1998, then this Agreement shall terminate and be of no further force and effect, unless otherwise provided in a writing executed by both parties. By proceeding on the Closing Date, each party shall be conclusively deemed to have accepted or waived fulfillment of all conditions set forth in Section 12.1 or elsewhere in this Agreement, unless otherwise provided in a writing executed by both parties at such time.

ARTICLE XIII

REIMBURSEMENT AND FEES

Section 13.1 Basic GHCS Network Support. In consideration for the services to be performed by YNHHS on behalf of the GHCS Network as the institution responsible for developing and leading the System following the Closing Date, GHCS agrees that it will pay to YNHHS: (a) the full cost of compensation and any contractual obligations of those GHCS employees who become employed by YNHHS pursuant to Sections 8.2.2 and 8.2.3 hereof, (b) the direct payment for such services as "MSO Services" (so called), access fees for information systems, etc., and the cost of consolidated hospital services (e.g., business office services), which services shall be developed and implemented in accordance with Section 7.16, in each case on a basis such that acute care hospitals, or entities comprised predominantly of one or more acute care hospitals, make payments to YNHHS on an equal and ratable basis, and (c) a percentage of the annual operating expenses of the GHCS Network as specified by YNHHS, which percentage is currently set at one percent (1%) of such expenses. YNHHS may raise such percentage, upon appropriate notice to the Local Networks to allow for incorporation of such rate change in the regular planning and budgeting process, to permit YNHHS to change the then existing method of paying for corporate services and to pursue the System functions (as opposed to functions relating exclusively to an individual System Member) included from time to time in the Goals and Objectives; provided that no increase in such percentage shall result in acute care hospitals, or entities comprised predominantly of one or more acute care hospitals, making payments to YNHHS other than on an equal and ratable basis. YNHHS shall use all such fees to pay for corporate services and to pursue the System functions (as opposed to functions relating exclusively to an individual System Member) included from time to time in the Goals and Objectives. GHCS shall pay the full amount required by clauses (a) and (b) above on a monthly basis. GHCS

shall pay the amount required by clause (c) above by paying monthly one-twelfth of the applicable percentage of the actual operating expenses of the GHCS Network over the preceding twelve month period. On or before ninety (90) days after the end of each Fiscal Year, the parties shall (if necessary) calculate any adjustment required to be made to the clause (c) payment based upon actual operating expenses for the GHCS Network in the preceding Fiscal Year. Except as provided in this Section, the GHCS Network will provide economic support to YNHHS only as provided in Section 13.2 below.

Section 13.2 Additional GHCS Network Support. YNHHS may request additional economic support, over and above the amounts established pursuant to Section 13.1, from the GHCS Network, either through a higher percentage of annual expenses or a request for a capital contribution, to achieve the Goals and Objectives. GHCS shall consider such request in good faith and if the GHCS Board determines such to be in GHCS' and the System's best interests, taking into account the payments being made to YNHHS by other System Members, GHCS shall increase the percentage of expenses paid to the YNHHS or provide such other support to YNHHS as the GHCS Board shall approve.

ARTICLE XIV

TERM

The term of this Agreement is perpetual unless terminated by a written agreement executed by both parties or as otherwise specifically provided herein.

ARTICLE XV

MISCELLANEOUS

Section 15.1 Strict Compliance. No failure by any party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement shall constitute a waiver of any such breach of such covenant, agreement, term or condition. No waiver of any breach shall affect or alter this Agreement, but each and every covenant, agreement, term and condition of this Agreement shall continue in full force and effect.

Section 15.2 Notices. All notices, requests, approvals, demands and other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given and to be effective when delivered personally (including delivery by express or courier services) or, if mailed, three (3) business days after being deposited in the United States mail as registered or certified matter, postage prepaid, return receipt requested, addressed to parties at the addresses set forth in Schedule 15.2 or to such other address as either party may designate by notice to the other parties.

Section 15.3 Amendments. Except as provided herein, neither this Agreement nor any term or provision hereof may be changed, waived, discharged or terminated except by the written agreement of the parties.

Section 15.4 Captions. The captions to this Agreement are for convenience of reference only and in no way define, limit or describe the scope or intent of this Agreement or any part hereof, nor in any way affect this Agreement or any part hereof.

Section 15.5 Assignment. This Agreement shall be assignable by a party only upon the prior written consent of the other party.

Section 15.6 Controlling Law. This Agreement shall be construed, and the rights and liabilities of the parties hereto determined, in accordance with the internal laws of the State of Connecticut; provided, however, that the conflicts of law principles of the State of Connecticut shall not apply to the extent that they would operate to apply the laws of another state.

Section 15.7 Severability. If any provision of this Agreement shall for any reason be held to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid or unenforceable provision were omitted.

Section 15.8 Confidentiality. Each party agrees to not provide a copy of this Agreement or any portion hereof to any person not a party hereto, and to not discuss the contents hereof, or the negotiations or discussions with respect hereto, with any person not a party hereto, other than with that party's Affiliates, legal counsel, auditors and other professional advisors, and except as required by applicable law, provided the parties shall consult as to the need for and timing of the disclosure of this Agreement to any governmental authority. Notwithstanding the foregoing, to coordinate the efforts and improve the position of YNHHS in attracting new System Members the CEO may disclose such information concerning this Agreement as he considers necessary to insure the success of the System.

Section 15.9 Successors and Assigns. This Agreement shall inure to the benefit of and be binding upon the parties hereto, and their respective successors and permitted assigns.

Section 15.10 Expenses. Each party agrees to pay its own expenses incurred in connection with the creation of the System and the transactions contemplated hereby.

Section 15.11 Remedies. In addition to other remedies available at law or provided for herein, the parties shall be entitled to restraint by injunction of the violation, or attempted or threatened violation, of any condition or provision of this Agreement, or to a decree specifically compelling performance of any such condition or provision.

Section 15.12 Entire Agreement. This Agreement, including any Exhibits or Schedules attached hereto, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof.

Section 15.13 **Cross References**. Unless otherwise stated, all references to Exhibits and Schedules in the text of this Agreement are to the Exhibits and Schedules of this Agreement.

Section 15.14 **Execution in Counterparts**. This Agreement may be executed in two (2) or more counterparts, each of which shall be an original, but all of which taken together shall constitute one and the same Agreement.

Section 15.15 **Change in Governing Law or Regulation.** If the application of any present or future law, regulation, ordinance or order, can reasonably be expected to adversely affect the respective rights of any party hereunder, including without limitation a party's ability to exercise its governance responsibilities and, in the case of YNHHS, to undertake managed care contracting on behalf of the GHCS Network in accordance with the terms of this Agreement, YNHHS and GHCS shall negotiate in good faith to amend this Agreement to restore to such party the affected rights so as to achieve the original intent of YNHHS and GHCS. Notwithstanding the failure of the parties to agree upon such an amendment to this Agreement despite good faith negotiations, this Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have executed this Agreement on the day and year first written above.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____
F. Patrick McFadden
Chairman of the Board of Directors

By: _____
Joseph A. Zaccagnino
President and Chief Executive Officer

GREENWICH HEALTH CARE SERVICES, INC.

By: _____
Donald J. Kirk
Chairman of the Board of Directors

By: _____
Frank A. Corvino
President and Chief Executive Officer

THE GREENWICH HOSPITAL ASSOCIATION

By: _____
Donald J. Kirk
Chairman of the Board of Directors

By: _____
Frank A. Corvino
President and Chief Executive Officer

SYSTEM AFFILIATION AGREEMENT

EXHIBIT A

GHCS PRIMARY SERVICE AREA

Portchester, NY
Rye, NY
New Canaan, CT
Greenwich, CT
Stamford, CT
Darien, CT

SCHEDULE 4.5

SUMMARY OF AUTHORITIES OF GREENWICH HOSPITAL BOARD OF TRUSTEES

i. Establish a mission for Greenwich Hospital consistent with the Greenwich Hospital Corporate Documents approved by YNHHS.

ii. Operate and manage Greenwich Hospital within approved Local Plans in accordance with Section 7.2.

iii. Develop local vertically integrated network in conjunction with Greenwich Hospital medical staff and YNHHS.

iv. Develop and approve Greenwich Hospital strategic plans, operating budgets and capital budgets in a timely manner for approval by YNHHS.

v. Solely grant medical staff membership and credential local physicians.

vi. Initiate and approve major programmatic changes locally through the planning and budgeting process, subject to the approval of YNHHS.

vii. Oversee Utilization Management/Quality Assurance and Improvement Programs.

viii. Solely conduct self-evaluation of Board.

ix. Determine community need.

x. Solely approve any proposed changes to the YNHHS Bylaws or Certificate of Incorporation that would diminish the rights of the GHCS and Greenwich Hospital Boards established in the definitive agreements.

xi. Approve any merger, sale, conversion, dissolution, affiliation or joint venture, subject to approval by YNHHS.

xii. Approve changes to Greenwich Hospital bylaws or certificate of incorporation, subject to approval by YNHHS.

xiii. Solely make provision for charity care.

xiv. Solely oversee community relations/local public policy.

xv. Undertake fund-raising efforts in coordination with YNHHS.

xvi. Nominate and elect members of the GHCS/Greenwich Hospital Board in accordance with Article IV of this Agreement.

SYSTEM AFFILIATION AGREEMENT

SCHEDULE 7.10

Contractual affiliation with:

The Osborn Retirement Community
101 Theall Road
Rye, New York 10580

SCHEDULE 9.4

MATERIAL ADVERSE LITIGATION

YNHHS:

None

GHCS:

None

SCHEDULE 15.2

NOTICES

If to YNHHS, then to:	Joseph A. Zaccagnino President and Chief Executive Officer Yale-New Haven Health Services Corporation 789 Howard Avenue New Haven, CT 06504
with copies to:	Virginia D. Roddy, Esq. Director of Legal Affairs Yale-New Haven Health Services Corporation 789 Howard Avenue New Haven, CT 06504
and:	Terence Jones, Esq. Wiggin & Dana One Century Tower New Haven, CT 06508-1832
If to GHCS, then to:	Frank A. Corvino President and Chief Executive Officer Greenwich Health Care Services, Inc. 5 Perryridge Road Greenwich, CT 06830
with copies to:	Andrew Schultz, Esq. Greenwich Health Care Services, Inc. 5 Perryridge Road Greenwich, CT 06830
and:	James D. Cooper, Esq. Cravath, Swaine & Moore Worldwide Plaza 825 Eighth Avenue New York, NY 10019-7475

EXHIBIT 6

Resolution of Yale-New Haven Health Services Corporation

Board of Directors

YALE-NEW HAVEN HEALTH SERVICES CORPORATION, INC.

I certify that the following is a true and exact copy of a resolution passed by the Board of Directors of Yale-New Haven Health Services Corporation, Inc. on June 20, 1997, and that said resolution continues in full force and effect as of the date of this certification:

NOW, THEREFORE, BE IT RESOLVED that the Corporation enter into the System Affiliation Agreement with GHCS, in a form consistent with the summary of principal terms presented at this meeting, with such changes or additions thereto as may be deemed necessary, appropriate or desirable by the President and Chief Executive Officer of the Corporation (the "CEO") and the Chairman of the Board of Directors in their discretion, and that the CEO and the Chairman be authorized to execute and deliver, for and on behalf of the Corporation, the System Affiliation Agreement, and that the Officers be, and each of them hereby is, authorized to execute and deliver, for and on behalf of the Corporation, such other documents, certificates, applications, filings and agreements with private or public entities or agencies as any such Officer, in his or her sole discretion, deems necessary, appropriate or advisable to effect the transactions contemplated by the System Affiliation Agreement, including without limitation filings pursuant to the Hart-Scott-Rodino Antitrust Improvements Act, applications for Certificates of Need from the Connecticut Office of Health Care Access, and requests for private letter rulings or determination letters from the Internal Revenue Service, the execution and delivery thereof by such Officer or Officers to be conclusive evidence of authorization and approval hereunder.

Marna P. Borgstrom
Secretary
Yale-New Haven Health Services Corporation, Inc.

DATED: July 31, 1997

EXHIBIT 7

Resolution of Greenwich Health Care Services, Inc.

Board of Directors

GREENWICH HEALTH CARE SERVICES, INC.

I certify that the following is a true and exact copy of a resolution passed by the Directors of Greenwich Health Care Services, Inc. (the "Corporation") on July 15, 1997, and that said resolution continues in full force and effect as of the date of this certification:

NOW, THEREFORE, BE IT RESOLVED that, subject to certain commitments by YNHHS being satisfactorily resolved, the Corporation enter into the System Affiliation Agreement with YNHHS, in a form consistent with the summary of principal terms presented at this meeting, with such changes or additions thereto as may be deemed necessary, appropriate or desirable by the President and Chief Executive Officer of the Corporation (the "CEO") and the Chairman of the Board of Directors in their discretion, and that the CEO and the Chairman be authorized to execute and deliver, for and on behalf of the Corporation, and cause the Corporation to perform its obligations under the System Affiliation Agreement, and that the Officers be, and each of them hereby is, authorized to execute and deliver, for and on behalf of the Corporation, such other documents, certificates, applications, filings and agreements with private or public entities or agencies as any such Officer, in his or her sole discretion, deems necessary, appropriate or advisable to effect the transactions contemplated by the System Affiliation Agreement, including without limitation filings pursuant to the Hart-Scott-Rodino Antitrust Improvements Act, applications for Certificates of Need from the Connecticut Office of Health Care Access, and requests for private letter rulings or determination letters from the Internal Revenue Service, the execution and delivery thereof by such Officer or Officers to be conclusive evidence of authorization and approval hereunder.

FURTHER RESOLVED that the Officers be, and they hereby are, directed to bring to this Board for approval proposed amendments to the Certificate of Incorporation and Bylaws of the Corporation reflecting such changes as may be necessary or desirable to consummate the transactions contemplated by the System Affiliation Agreement.

FURTHER RESOLVED that the Officers be, and each of them hereby is, authorized, empowered and directed to do and perform all other acts and things deemed by any of them necessary, appropriate or advisable to carry out the intent of the foregoing resolutions.

FURTHER RESOLVED that all actions heretofore taken by any Officer or agent of the Corporation in connection with any matter referred to or contemplated in the foregoing resolutions are hereby approved, ratified and confirmed in all respects.

Peter B. Griffin
Secretary
Greenwich Health Care Services, Inc.

DATED: August 11, 1997

EXHIBIT 8

Licensed Bed Configuration

LICENSED BED CONFIGURATION

PRE-AFFILIATION

	YNHHSC*	GHSC
General Hospital Beds	1,203	160
Bassinets	122	18
TOTAL	1,325	178

* Includes Yale-New Haven Hospital and Bridgeport Hospital

POST-AFFILIATION

	YNHHSC**
General Hospital Beds	1,363
Bassinets	140
TOTAL	1,503

** Includes Yale-New Haven Hospital, Bridgeport Hospital and Greenwich Hospital

EXHIBIT 9

Legal Opinions Regarding Tax Exempt Status

- Yale-New Haven Health Care Services Corporation

- Greenwich Health Care Services, Inc.

Wiggin & Dana

Counsellors at Law

Offices in New Haven and Hartford

One Century Tower
New Haven, Connecticut
06508-1832
Telephone 203.498.4400
Telefax 203.782.2889

Melinda A. Agsten
203.498.4326

August 18, 1997

Mr. Joseph A. Zaccagnino
President & Chief Executive Officer
Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Dear Mr. Zaccagnino:

I am writing about the federal tax exemption status of Yale-New Haven Health Services Corporation ("YNHHSC") and its related entities currently exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code ("the Code"). You have asked for an opinion concerning the effect on their respective section 501(c)(3) exemptions of the affiliation between YNHHSC and Greenwich Health Care Services, Inc. ("GHCS"), the parent corporation of Greenwich Hospital Association ("GHA") and other subsidiary corporations.

I understand the facts as follows. The proposed affiliation will be effected by having YNHHSC become the sole member of GHCS, which, along with GHA and at least one other GHA controlled corporation, is currently exempt from federal income taxation under section 501(c)(3) of the Code and not a private foundation. Other than the membership change for GHCS and certain other governance changes related to board composition and the broadening of YNHHSC's purpose to include serving as the parent organization of GHCS and supporting GHA, YNHHSC will experience no further significant governance, structural, or operating changes as a result of the affiliation, and the affiliation will not alter YNHHSC's purposes of promoting health care in a charitable manner. You have represented that no activities forbidden to or improper for entities maintaining exemption under section 501(c)(3), including but not limited to private inurement, excessive private benefit, political activity, or excessive unrelated trade or business activity, will be conducted.

Under these circumstances, in my opinion the affiliation between YNHHSC and GHCS will not affect the tax status of YNHHSC and its affiliated entities currently exempt under section 501(c)(3). It is my further view that approval of the affiliation by the Internal Revenue Service ("IRS") is not required. The IRS must be notified of the affiliation

by both YNHHSC and GHCS and must also receive copies of the amended corporate documents. This notification should be made either when the next Form 990's are filed or prior to that time by letters to the District Director.

Very truly yours,

Melinda A. Agsten

MAA:cas

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Greenwich
Hartford
New Haven
Bonita Springs
Naples
Palm Beach

August 19, 1997

Greenwich Health Care Services, Inc.
The Greenwich Hospital Association
5 Perryridge Road
Greenwich, CT 06830

Ladies and Gentlemen:

You have requested our opinion as to certain federal income tax consequences to Greenwich Health Care Services, Inc. ("GHCS"), a Connecticut nonstock corporation, resulting from the execution and delivery of and performance by GHCS of its obligations under that certain System Affiliation Agreement dated July 24, 1997 (the "Affiliation Agreement") by and among Yale-New Haven Health Services Corporation ("YNHHS"), GHCS and The Greenwich Hospital Association ("GHA"), a Connecticut nonstock corporation the sole member of which is GHCS, pursuant to which GHCS and YNHHSC will, subject to the terms and conditions of the Affiliation Agreement, become permanently affiliated (the "Affiliation"). Except as otherwise provided, capitalized terms not defined herein have the meanings set forth in the Affiliation Agreement. All section references, unless otherwise indicated, are to the Internal Revenue Code of 1986, as amended (the "Code").

Pursuant to the Affiliation Agreement, among other things and except as otherwise provided therein:

(1) With respect to the creation of the Affiliation: (a) YNHHS will become the sole member of GHCS and GHCS will remain the sole member of GHA and (b) GHCS will not, without the consent of YNHHS, amend any of the Corporate Documents relating to GHCS;

(2) With respect to the Foundation: (a) GHCS and GHA will cause the Foundation to be incorporated and thereafter seek and obtain recognition of its exemption from federal taxation under the Code as a supporting organization of GHA, (b) the Foundation will hold, manage and distribute the endowment of GHA which funds will be transferred to the Foundation on the Closing Date, (c) the Foundation will be governed by a self-perpetuating Board of Directors including a designee of YNHHS; the initial members of the Foundation shall be the current members of GHCS, (d) the net income of the Foundation will be distributed annually to GHCS or GHA to be used in accordance with their respective missions, (e) GHCS or GHA may request that the Foundation distribute to a member of the GHCS Network all or a portion of the Principal, (f) Foundation staff and services needs shall be obtained from a member of the GHCS Network at cost, and (g) the Foundation will become obligated with respect to certain bonds issued in connection with that certain Master Trust Indenture dated as of March 1, 1996 by and among GHA, GHCS and Fleet National Bank;

(3) With respect to the authority granted YNHHS: YNHHS will have responsibility for and control over among other things: (a) establishing the System's mission, (b) planning and organizing the System's provision of services, research, managed care contracting services and support systems on an integrated and cost-effective basis, (c) approval of the GHCS' Network strategic plans and related capital and operating budgets and any proposed modifications to same, (d) whether GHCS will incur any debt or lines of credit or transfer any assets, (e) approval of any sale, merger, consolidation, liquidation, dissolution or bankruptcy filing by or involving GHCS, (f) approval of any contract to manage or administer GHCS, (g) negotiations, contracts, strategies, policies, and operations relating to managed care relationships, (h) approval of GHCS affiliations with any other alliance of health care providers, (i) consulting as to recruitment and selection of GHCS Facility Chiefs of service, (j) appoint auditors, establish internal audit programs and set accounting policies for GHCS, GHA and their affiliates, (k) approval of GHCS Major Programmatic changes and decisions regarding same, and (l) coordinate and promote interfacing regarding the System through various management committees.

(4) As to reimbursement and fees, GHCS will pay to YNHHS (a) the compensation costs of GHCS employees who become employed by YNHHS, (b) the direct payment for services, access fees for information systems and costs of consolidated

hospital services (e.g. business office services) on an equal and pro rata basis to other members of the System, and (c) a percentage of the annual operating expenses of the GHCS network as specified by YNHHS.

Such description of the transaction, Affiliation and Affiliation Agreement set forth above and our opinion as stated herein, are qualified in their entirety by the terms of the Affiliation Agreement, and are based upon and subject to the following: (1) at all times prior to the date of the Affiliation Agreement and through the date hereof GHCS and GHA have been organized and operated in such a manner as to satisfy all requirements necessary to be treated as Section 501(c)(3) organizations exempt from federal income tax, (2) the accuracy of the description of the goals of the System and description of the benefits to be derived by GHCS and GHA from the Affiliation and membership in the System contained in the Affiliation Agreement, (3) the Affiliation Agreement and related transactions being effected in accordance with the provisions of the Affiliation Agreement, (4) the performance by GHCS and GHA of their respective obligations under the Affiliation Agreement will be conducted in such a manner as does not adversely impact their qualification as Section 501(c)(3) organizations exempt from federal income tax, or cause them to fail to satisfy any requirements relating thereto, (5) other than performing their respective obligations under the Affiliation Agreement, GHCS and GHA will not engage in or refrain from performing any activity or taking any action which would adversely impact their qualification as Section 501(c)(3) organizations exempt from federal income tax, or cause them to fail to satisfy any requirements relating thereto, (6) the accuracy of the representations and compliance with the covenants contained in the Affiliation Agreement made by the respective parties thereto, insofar as they relate to or affect the tax treatment of the transactions contemplated in or by the Affiliation Agreement, which representations and/or covenants shall be satisfied and/or true and correct, as the case may be, at all times through and/or after the date of the Affiliation Agreement and Closing, and (7) with respect to the formation of the Foundation: (a) other than as required pursuant to the Affiliation Agreement, the Foundation will be organized and operated exclusively as a tax exempt supporting organization of GHA under Section 509(a) and Section 501(c)(3) and in compliance with all requirements relating thereto, and (b) other than with respect to the requirements of the Code, the transfer of the endowment fund as described in Section 6.3 of the Affiliation Agreement (the "Endowment Fund") will be made in compliance with all applicable laws, rules, and regulations and any

agreements, understandings or conditions to which or with respect to which GHCS or GHA is a party or otherwise obligated.

In rendering our opinion, we have considered the applicable provisions of the Code, Treasury Regulations, pertinent judicial authorities, interpretive rulings of the Internal Revenue Service and such other authorities as we have considered relevant as of the date of this opinion, and any subsequent change therein may adversely affect the conclusions reached in this opinion and such opinion may not then be relied upon.

Our review of applicable interpretive rulings included a review of certain private letter rulings ("PLR(s)"), including but not limited to Private Letter Ruling 9726020, and certain Internal Revenue Service ("IRS") announcements (specifically the text of IRS Continuing Education, Exempt Organizations Technical Instruction Program for FY 1997, and that certain IRS Checklist for Hospital Joint Operating Agreement Applicants dated July 9, 1996 and issued by the IRS' Exempt Organization Technical Branch 1 (the "IRS Information")). While the IRS Information may not be relied upon as authority for setting or sustaining a technical tax position, such information is instructive and provides guidance as to how the IRS is likely to rule given the absence of other authority in the area.

A review of the IRS Information indicates that a facts and circumstances test will be applied in analyzing the potential impact on participants of affiliation and joint operating agreements such as the Affiliation Agreement. Except as specifically noted below, the terms of the Affiliation Agreement substantially comply with the requirements of the IRS Information. The delegation of authority by GHCS / GHA to YNHHS is one of the most important and specifically described factors contained in the IRS Information. The following factors are identified by the IRS Information as being relevant to the determination of whether sufficient authority has been delegated to YNHHSC. As indicated below, certain of the agreements contained in the Affiliation Agreement differ from those that the IRS Information would expect in an arrangement intended to be without adverse affect on the tax-exempt status of the parties:

(a) with respect to the delegation of authority to YNHHS to establish budgets, YNHHS is given authority to approve budgets but is not specifically granted authority to initiate budgeting / establish budgets,

(b) with respect to the delegation of authority to YNHHS to monitor and audit each participating entity's compliance with its directives, YNHHS is given authority to appoint auditors, establish internal audit programs and set accounting policies and procedures for GHCS, GHA and their Affiliates. (For purposes of our opinion we assume that such authority will be exercised in order to actually monitor and audit each of such entities.) The IRS Information expects that YNHHS will reserve the right to audit to itself,

(c) with respect to the delegation of authority to YNHHS to direct that services be undertaken or not be undertaken by GHCS / GHA, YNHHS is given authority to approve Major Programmatic Changes included in a Local Plan but only GHCS may initiate a change as to the services, programs or facilities of the members of the GHCS Network (and only through Local Plans) and YNHHS does not have express authority to direct that GHCS / GHA refrain from being a provider of specific services,

(d) with respect to the delegation of authority to YNHHS to enter into agreements that bind participating entities, particularly agreements with managed care providers, YNHHS is given the exclusive right to negotiate with third party payors, employers and intermediary organizations and commit on behalf of GHCS and the other members of the GHCS Network to all terms and conditions of all new or renewed Managed Care Contracts but GHCS is responsible for transactions involving members of the GHCS Network, and GHCS shall participate in setting the basic contract parameters for the Members of the GHCS Network,

(e) with respect to the delegation of authority to YNHHS to hire and fire personnel, (i) the CEO of YNHHS has responsibility for / control over appointing the President and Chief Executive Officer of GHCS and GHA, setting the terms of his/her employment and compensation and the removal of such person and (ii) various officers of GHCS including officers designated by the CEO of YNHHS are to be employed directly by YNHHS, but there are no specific provisions as to the hiring and firing of personnel and, while it is unlikely as a practical matter that a director of GHCS would be elected without YNHHS approval, YNHHS does not have authority to block the election of GHCS directors,

(f) with respect to the delegation of authority to YNHHS to grant hospital staff privileges, YNHHS will be consulted in the recruitment and selection of Chiefs of Services or other comparable positions for GHCS facilities, but the authority of the Board of Trustees of

GHA includes the authority to solely grant medical staff membership and credential local physicians,

(g) with respect to the delegation of authority to YNHHS to set or approve fees and prices, YNHHS is given authority to approve Local Plans and budgets but is not specifically authorized to initiate and set or approve fees and prices charged by GHCS and the members of the GHCS Network, and

(h) with respect to the delegation of authority to YNHHS to re-allocate income among the participating entities to balance income and expenses to assure financial integration and to achieve mutual objectives, YNHHS is given authority to obtain from GHCS certain payments based on a percentage of annual operating expenses of the GHCS Network as specified by YNHHS, which percentage may be raised upon Notice to the Local Networks and provided no increase in such percentage may result in acute care hospitals, or entities comprised predominantly of one or more acute care hospitals, making payments to YNHHS other than on an equal and ratable basis, but the terms "equal" and "ratable" basis are not defined in the Affiliation Agreement and there are no other provisions therein which provide for the re-allocation of income among members of the System.

Based on our examination of the foregoing items and subject to the limitations set forth herein and the above discussion, we are of the opinion that it is more likely than not that:

(i) Notwithstanding the differences that may be drawn between the relationships created by the Affiliation Agreement and the IRS Information, the execution and delivery of and performance by GHCS and GHA of their respective obligations under the Affiliation Agreement will not adversely affect GHCS' or GHA's status as exempt from federal income tax pursuant to Section 501(a) as an entity organized and operated as described in Section 501(c)(3); and

(ii) assuming compliance with the other relevant provisions of the Code relating to the formation and operation of the Foundation, the transfer of the Endowment Fund to the Foundation and the Foundation's becoming and remaining an Obligated Group Member under the Bond Indenture will not jeopardize the tax exempt status of GHA, GHCS and/or the Foundation.

This opinion is rendered solely with respect to certain United States federal income tax consequences of the Affiliation under the Code as specifically set forth herein, and does not extend to the income, or other potential tax consequences of the Affiliation under the laws of any State, or any political subdivision of any State, or any other jurisdiction. Furthermore, no opinion is expressed as to the United States federal or state tax treatment of the transaction under any other provisions of the Code and regulations, or as to the tax treatment of any conditions existing at the time of, or effects resulting from, the transaction that is not specifically covered by this opinion. This opinion is being furnished only to GHCS and solely for its benefit in connection therewith and may not be used or relied upon for any other purpose and may not be circulated, quoted or otherwise referred to for any other purpose without our prior express written consent except that this opinion may be included as an exhibit to GHCS's certificate of need application dated August, 1997.

Very truly yours,

Cummings & Lockwood

C&LDOC: S3426731.DOC 08/19/97

APPENDIX A

Department of Public Health License

- Yale-New Haven Hospital
- Bridgeport Hospital
- The Greenwich Hospital Association

000147

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0044

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Yale-New Haven Hospital, Inc. of New Haven, CT, d/b/a Yale-New Haven Hospital is hereby licensed to maintain and operate a General Hospital.

Yale-New Haven Hospital is located at 20 York Street, New Haven, CT with:
Julia McNamara as President of the Governing Board
Joseph A. Zaccagnino as Administrator,
Edwin C. Cadman, M.D. as Chief of Medical Staff,
Diana Weaver, D.N.S., R.N. as Director of Nursing Services.

The maximum number of beds shall not exceed at any time:

808 General Hospital beds,

92 Bassinets.

This license expires **September 30, 1997** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 1995. RENEWAL
Satellites:
Weller Building

Stephen A. Harriman

Stephen A. Harriman, Commissioner
Department of Public Health

000148

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0040

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Bridgeport Hospital of Bridgeport, CT, d/b/a Bridgeport Hospital is hereby licensed to maintain and operate a General Hospital.

Bridgeport Hospital is located at 267 Grant Street, Bridgeport, CT.

The maximum number of beds shall not exceed at any time:

395 General Hospital beds,

30 Bassinets.

This license expires **March 31, 1998** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 1996.

Satellites:
Trumbull/Monroe Satellite Center, 15 Corporate Drive, Trumbull
Psychiatric Day Hospital, 1046 Fairfield Avenue, Bridgeport
Park City Hospital Site, 695 Park Avenue, Bridgeport
Geriatric Partial Hospital, 305 Boston Ave., Stratford
Child Partial Hospital, 305 Boston Ave., Stratford

License revised 5/7/97 to reflect:
Addition of 2 new satellites effective 4/3/97

Stephen A. Harriman, Commissioner
Department of Public Health

000149

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0045

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

The Greenwich Hospital Association of Greenwich, CT, d/b/a Greenwich Hospital is hereby licensed to maintain and operate a General Hospital.

Greenwich Hospital is located at 5 Perryridge Road, Greenwich, CT with:

Bruce L. Warwick as President of Governing Board,
Frank Corvino as Administrator,
Peter Bogdan, M.D. as Chief of Medical Staff,
Dorothy Taylor, R.N. as Director of Nursing Services.

The maximum number of beds shall not exceed at any time:

160 General Hospital beds,

18 Bassinets.

This license expires September 30, 1997 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 1995.

License revised 9/18/96 to reflect:

Decrease of 46 beds and 3 bassinets effective 8/9/96

Stephen A. Harriman, Commissioner
Department of Public Health.

APPENDIX B

Audited Financial Statements

- Yale-New Haven Health Services Corporation
- Greenwich Health Care Services

Audited Combined Special-Purpose Financial Statements and Other Financial Information

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Years ended September 30, 1996 and 1995

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Audited Combined Special-Purpose Financial Statements and Other Financial Information

Years ended September 30, 1996 and 1995

Contents

ERNST & YOUNG LLP

Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103

Phone: 860 247 3100

Report of Independent Auditors

Board of Trustees
Yale-New Haven Health Services Corporation

We have audited the accompanying combined special-purpose balance sheets of Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation (collectively the "entities") as of September 30, 1996 and 1995, and the related combined special-purpose statements of operations and changes in net assets for the years then ended. These financial statements are the responsibility of the entities' management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

The accompanying combined special-purpose financial statements were prepared in connection with certain financing agreements discussed in Note 1 and do not include statements of cash flows or complete footnotes to financial statements as required by generally accepted accounting principles for general-purpose financial statements.

In our opinion, except for the omission of the statements and footnote information discussed in the preceding paragraph, the combined special-purpose financial statements referred to above present fairly, in all material respects, the combined financial position of the entities at September 30, 1996 and 1995, and the combined results of their operations and changes in net assets for the years then ended in conformity with generally accepted accounting principles.

As discussed in Note 2 to the financial statements, Yale-New Haven Health Services Corporation and the Hospital changed their method of accounting for contributions and fund classifications, and changes in carrying value of investments to conform with the provisions of Statements of Financial Accounting Standards Nos. 116, 117 and 124.

This report is intended solely for the information and use of the Board of Trustees, management and Fleet Bank and should not be used for any other purpose.

Ernst + Young LLP

February 24, 1997

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Combined Special-Purpose Balance Sheets

	September 30 1996	1995 (Restated)
Assets		
Current assets:		
Cash	$ 24,436,812	$ 19,314,417
Short-term investments	209,195,325	185,432,276
Accounts receivable, less allowance	71,430,073	69,111,068
Other current assets	22,807,333	21,866,547
Inventories	2,273,613	2,223,080
Prepaid expenses	3,740,744	3,496,385
Amounts deposited with trustee	2,843,146	4,015,907
Total current assets	336,727,046	305,459,680
Other assets:		
Marketable securities	93,313,229	82,448,656
Escrow funds for long-term debt	1,596,627	1,454,820
Deferred financing costs and bond discount, less amortization	5,719,282	5,447,770
Other	33,523,635	31,175,214
	134,152,773	120,526,460
Property, plant and equipment:		
Land and land improvements	10,167,533	10,167,533
Buildings and fixtures	303,013,128	301,577,139
Equipment	146,513,916	132,617,834
Leasehold improvements	10,995,030	8,219,729
Capital leases	6,241,491	6,241,491
	476,931,098	458,823,726
Less accumulated depreciation and amortization	208,530,859	180,273,727
	268,400,239	278,549,999
Construction in process	1,440,559	850,872
Funds reserved for plant improvements and expansion (short-term investments)	46,373,133	44,314,199
	316,213,931	323,715,070
	$ 787,093,750	$ 749,701,210

	September 30 1996	1995 (Restated)
Liabilities and net assets		
Current liabilities:		
Accounts payable	$ 34,821,758	$ 36,299,339
Accrued expenses	68,028,232	65,767,602
Due to third parties--Medicare and other cost settlements	40,006,012	41,334,723
Current portion of long-term debt	6,144,524	4,570,554
Total current liabilities	149,000,526	147,972,218
Long-term debt, less current portion:		
Mortgage payable	148,060,000	155,070,000
Capital lease obligation	5,250,633	5,609,254
Other	18,838,300	21,614,203
	172,148,933	182,293,457
Other noncurrent liabilities:		
Accrued postretirement benefits other than pensions	23,230,000	23,215,000
Deferred revenues and liabilities	100,087,502	100,304,704
Other	3,322,497	2,876,414
	126,639,999	126,396,118
Net assets:		
Unrestricted	222,579,723	183,074,292
Temporarily restricted	106,672,089	99,912,645
Permanently restricted	10,052,480	10,052,480
	339,304,292	293,039,417
	$ 787,093,750	$ 749,701,210

See Report of Independent Auditors and accompanying notes.

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Combined Special-Purpose Statements of Operations

	Year ended September 30	
	1996	1995
		(Restated)
Revenues:		
Patient service related	$ 469,861,125	$ 445,083,009
Other operating revenues	17,454,409	16,084,827
	487,315,534	461,167,836
Expenses:		
Salaries, wages and benefits	207,352,876	198,232,591
Supplies and other expenses	234,020,381	231,845,128
Depreciation and amortization	29,698,388	28,558,716
Bad debt expense	4,964,958	2,493,846
Interest	12,241,232	13,029,882
	488,277,835	474,160,163
Recovery of expenses from grants, other institutions, etc.	(38,223,709)	(38,459,266)
	450,054,126	435,700,897
Income from operations	37,261,408	25,466,939
Nonoperating gains:		
Income from investments	11,495,719	8,179,611
Realized gains on marketable securities	688,043	330,845
	12,183,762	8,510,456
Other nonoperating expenses–loss on investment in subsidiaries	(1,708,844)	(1,636,371)
Excess of revenues over expenses before taxes and extraordinary item	47,736,326	32,341,024
Provision for federal and state taxes	90,043	22,739
Provision for extraordinary loss on extinguishment of debt	(10,651,281)	
Excess of revenues over expenses	$ 36,995,002	$ 32,318,285

See Report of Independent Auditors and accompanying notes.

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Combined Special-Purpose Statements of Changes in Net Assets

	Year ended September 30	
	1996	1995
		(Restated)
Unrestricted net assets:		
Excess of revenues over expenses	$ 36,995,002	$ 32,318,285
Unrealized appreciation (depreciation)	(538,806)	1,135,948
Transfer from temporarily restricted net assets for plant assets	2,731,353	8,350,364
Other	317,882	373,665
Increase in unrestricted net assets	39,505,431	42,178,262
Temporarily restricted net assets:		
Income from investments	3,473,598	3,075,091
Realized gains	2,970,758	2,234,328
Unrealized appreciation on marketable securities	3,364,882	7,180,000
Funds released for plant assets	(2,731,353)	(8,350,364)
Bequests, gifts and grants	1,624,574	1,051,552
Other	(1,943,015)	(1,993,316)
Increase in temporarily restricted net assets	6,759,444	3,197,291
Increase in permanently restricted net assets–bequests		750
Increase in net assets	46,264,875	45,376,303
Net assets at beginning of year	293,039,417	247,663,114
Net assets at end of year	$ 339,304,292	$ 293,039,417

See Report of Independent Auditors and accompanying notes.

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Notes to Combined Special-Purpose Financial Statements

September 30, 1996

1. Financing Agreement and Principles of Combination

The accompanying combined special-purpose financial statements were prepared in connection with a Loan and Security Agreement (the "Agreement") dated September 23, 1994, as amended, and modified on September 19, 1996, between Fleet Bank and Yale-New Haven Ambulatory Services Corporation ("ASC"), a subsidiary of Yale-New Haven Health Services Corporation (the "Corporation"). The Corporation has guaranteed payment by ASC of amounts due under notes issued pursuant to the Agreement and certain other amounts specified in a Guaranty Agreement dated September 23, 1994, as amended, and modified on September 19, 1996.

The organizations included in the combined special-purpose financial statements include the Corporation and its wholly-owned subsidiaries, Yale-New Haven Hospital and ASC. All significant intercompany transactions have been eliminated.

2. Adoption of New Accounting Standards

Certain 1995 amounts for Yale-New Haven Health Services Corporation and the Hospital, both tax exempt entities, have been restated to conform to the 1996 presentation including FASB Opinions 116, 117 and 124.

The details of the restatement for the Hospital as of October 1, 1994 are as follows:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Net assets at October 1, 1994, as previously reported	$156,506,385	$29,052,018	$39,021,665	$ 224,580,068
Adjustment for the cumulative effect on prior years of applying retroactively the new accounting standards for fund classifications and fair value accounting	(43,803,677)	67,663,336	(28,969,935)	(5,110,276)
Net assets at October 1, 1994, as restated	112,702,708	96,715,354	10,051,730	219,469,792
Increase in net assets for the year ended September 30, 1995	26,756,430	3,197,291	750	29,954,471
Net assets at September 30, 1995, as restated	$139,459,138	$99,912,645	$10,052,480	$ 249,424,263

The restated amounts for Health Services Corporation were not significant to the combined financial statements.

ERNST & YOUNG LLP

Goodwin Square
225 Asylum Street
Hartford, Connecticut 06103

Phone: 860 247 3100

Report of Independent Auditors on Other Financial Information

Board of Trustees
Yale-New Haven Health Services Corporation

Our audits were conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The combining special-purpose balance sheets, combining special-purpose statements of operations and combining special-purpose statements of changes in net assets are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in our audits of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Ernst & Young LLP

February 24, 1997

	Yale-New Haven Health Services Corporation	Yale-New Haven Hospital	Yale-New Haven Ambulatory Services Corporation	Eliminations	Combined
Liabilities and net assets					
Current liabilities:					
Accounts payable	$ 1,439,068	$ 33,336,815	$ 3,638,859	$ (3,592,984)	$ 34,821,758
Accrued expenses	584,269	66,701,533	742,430		68,028,232
Due to third parties-Medicare and other cost settlements		40,006,012			40,006,012
Current portion of long-term debt		3,110,000	3,034,524		6,144,524
Total current liabilities	2,023,337	143,154,360	7,415,813	(3,592,984)	149,000,526
Long-term debt, less current portion:					
Mortgage payable		148,060,000			148,060,000
Capital lease obligation			5,250,633		5,250,633
Other			18,838,300		18,838,300
		148,060,000	24,088,933		172,148,933
Other noncurrent liabilities:					
Accrued postretirement benefits other than pensions		23,230,000			23,230,000
Deferred revenues and liabilities		100,087,502			100,087,502
Other		3,322,497			3,322,497
		126,639,999			126,639,999
Net assets:					
Unrestricted	54,421,318	168,158,405	3,811,395	(3,811,395)	222,579,723
Temporarily restricted		106,672,089			106,672,089
Permanently restricted		10,052,480			10,052,480
	54,421,318	284,882,974	3,811,395	(3,811,395)	339,304,292
	$ 56,444,655	$ 702,737,333	$ 35,316,141	$ (7,404,379)	$ 787,093,750

	Yale-New Haven Health Services Corporation	Yale-New Haven Hospital	Yale-New Haven Ambulatory Services Corporation	Eliminations	Combined
	(restated)	*(restated)*			
Liabilities and net assets					
Current liabilities:					
Accounts payable	$ 1,167,302	$ 40,611,762	$ 1,808,109	$ (7,287,834)	$ 36,299,339
Accrued expenses	372,591	64,667,392	727,619		65,767,602
Due to third parties-Medicare and other cost settlements		41,334,723			41,334,723
Current portion of long-term debt		2,790,000	1,780,554		4,570,554
Total current liabilities	1,539,893	149,403,877	4,316,282	(7,287,834)	147,972,218
Long-term debt, less current portion:					
Mortgage payable		155,070,000			155,070,000
Capital lease obligation			5,609,254		5,609,254
Other			21,614,203		21,614,203
		155,070,000	27,223,457		182,293,457
Other noncurrent liabilities:					
Accrued postretirement benefits other than pensions		23,215,000			23,215,000
Deferred revenues and liabilities		100,304,704			100,304,704
Other		2,876,414			2,876,414
		126,396,118			126,396,118
Net assets:					
Unrestricted	43,615,154	139,459,138	3,205,172	(3,205,172)	183,074,292
Temporarily restricted		99,912,645			99,912,645
Permanently restricted		10,052,480			10,052,480
	43,615,154	249,424,263	3,205,172	(3,205,172)	293,039,417
	$ 45,155,047	$ 680,294,258	$ 34,744,911	$ (10,493,006)	$ 749,701,210

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital
and Yale-New Haven Ambulatory Services Corporation

Combining Special-Purpose Statements of Operations

Year ended September 30, 1996

	Yale-New Haven Health Services Corporation	Yale-New Haven Hospital	Yale-New Haven Ambulatory Services Corporation	Eliminations	Combined
Revenues:					
Patient service related		$ 450,686,822	$ 19,174,303		$ 469,861,125
Other operating revenue	$ 21,188,105	783,077	313,705	$ (4,830,478)	17,454,409
	21,188,105	451,469,899	19,488,008	(4,830,478)	487,315,534
Expenses:					
Salaries, wages and benefits	2,125,019	199,661,579	5,566,278		207,352,876
Supplies, utilities and other	5,988,690	225,899,071	9,265,610	(7,132,990)	234,020,381
Depreciation and amortization	4,042	26,998,493	2,695,853		29,698,388
Bad debt expense		4,616,267	348,691		4,964,958
Interest		10,133,487	2,107,745		12,241,232
Recovery of expense from grants, other institutions, etc.		(40,526,221)		2,302,512	(38,223,709)
	8,117,751	426,782,676	19,984,177	(4,830,478)	450,054,126
Income (loss) from operations	13,070,354	24,687,223	(496,169)	–	37,261,408
Nonoperating gains:					
Income from investments		11,347,669	148,050		11,495,719
Realized gains on marketable securities		688,043			688,043
		12,035,712	148,050		12,183,762
Other revenue (expenses)–loss on investment in subsidiaries	(2,102,621)			393,777	(1,708,844)
Excess of revenues over expenses before taxes and extraordinary item	10,967,733	36,722,935	(348,119)	393,777	47,736,326
Provision for federal and state taxes	44,385		45,658		90,043
Provision for extraordinary loss on extinguishment of debt		(10,651,281)			(10,651,281)
Excess of revenue over expenses	$ 10,923,348	$ 26,071,654	$ (393,777)	$ 393,777	$ 36,995,002

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Combining Special-Purpose Statements of Operations (continued)

Year ended September 30, 1995

	Yale-New Haven Health Services Corporation *(restated)*	Yale-New Haven Hospital *(restated)*	Yale-New Haven Ambulatory Services Corporation	Eliminations	Combined
Revenues:					
Patient service related		$ 427,011,258	$ 18,071,751		$ 445,083,009
Other operating revenue	$ 18,792,777	1,083,082	307,371	$ (4,098,403)	16,084,827
	18,792,777	428,094,340	18,379,122	(4,098,403)	461,167,836
Expenses:					
Salaries, wages and benefits	458,075	192,390,296	5,384,220		198,232,591
Supplies, utilities and other	(114,546)	228,376,731	9,187,712	(5,604,769)	231,845,128
Depreciation and amortization		26,079,942	2,478,774		28,558,716
Bad debt expense		2,005,138	488,708		2,493,846
Interest		10,764,349	2,265,533		13,029,882
Recovery of expense from grants, other institutions, etc.		(39,965,632)		1,506,366	(38,459,266)
	343,529	419,650,824	19,804,947	(4,098,403)	435,700,897
Income (loss) from operations	18,449,248	8,443,516	(1,425,825)	–	25,466,939
Nonoperating gains:					
Income from investments		8,092,253	87,358		8,179,611
Realized gains on marketable securities		330,845	--		330,845
		8,423,098	87,358		8,510,456
Other revenue (expenses):					
Loss on investment in subsidiaries	(2,996,349)			1,359,978	(1,636,371)
Excess of revenues over expenses before taxes	15,452,899	16,866,614	(1,338,467)	1,359,978	32,341,024
Provision for federal and state taxes	1,228		21,511		22,739
Excess of revenue over expenses	$ 15,451,671	$ 16,866,614	$ (1,359,978)	$ 1,359,978	$ 32,318,285

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Combining Special-Purpose Statements of Changes in Net Assets

Year ended September 30, 1996

	Yale-New Haven Health Services Corporation	Yale-New Haven Hospital	Yale-New Haven Ambulatory Services Corporation	Eliminations	Combined
Unrestricted net assets:					
Excess of revenues over expenses	$ 10,923,348	$ 26,071,654	$ (393,777)	$ 393,777	$ 36,995,002
Unrealized appreciation (depreciation)	(117,184)	(421,622)			(538,806)
Transfer from temporarily restricted net assets for plant assets		2,731,353			2,731,353
Other		317,882	1,000,000	(1,000,000)	317,882
Increase in unrestricted net assets	10,806,164	28,699,267	606,223	(606,223)	39,505,431
Temporarily restricted net assets:					
Income from investments		3,473,598			3,473,598
Realized gains		2,970,758			2,970,758
Unrealized appreciation on marketable securities		3,364,882			3,364,882
Funds released for plant assets		(2,731,353)			(2,731,353)
Bequests, gifts and grants		1,624,574			1,624,574
Other		(1,943,015)			(1,943,015)
Increase in temporarily restricted net assets		6,759,144			6,759,444
Increase in net assets	10,806,164	35,458,711	606,223	(606,223)	46,264,875
Net assets at beginning of year	43,615,154	249,424,263	3,205,172	(3,205,172)	293,039,417
Net assets at end of year	$ 54,421,318	$ 284,882,974	$ 3,811,395	$ (3,811,395)	$ 339,304,292

Yale-New Haven Health Services Corporation, Yale-New Haven Hospital and Yale-New Haven Ambulatory Services Corporation

Combining Special-Purpose Statements of Changes in Net Assets (continued)

Year ended September 30, 1995

	Yale-New Haven Health Services Corporation	Yale-New Haven Hospital	Yale-New Haven Ambulatory Services Corporation	Eliminations	Combined
	(restated)	*(restated)*			
Unrestricted net assets:					
Excess of revenues over expenses	$ 15,451,671	$ 16,866,614	$ (1,359,978)	$ 1,359,978	$ 32,318,285
Unrealized appreciation (depreciation)	(29,839)	1,165,787			1,135,948
Transfer from temporarily restricted net assets for plant assets		8,350,364			8,350,364
Other		373,665			373,665
Increase (decrease) in unrestricted net assets	15,421,832	26,756,430	(1,359,978)	1,359,978	42,178,262
Temporarily restricted net assets:					
Income from investments		3,075,091			3,075,091
Realized gains		2,234,328			2,234,328
Unrealized appreciation on marketable securities		7,180,000			7,180,000
Funds released for plant assets		(8,350,364)			(8,350,364)
Bequests, gifts and grants		1,051,552			1,051,552
Other		(1,993,316)			(1,993,316)
Increase in temporarily restricted net assets		3,197,291			3,197,291
Increase in permanently restricted net assets–bequests		750			750
Increase in net assets	15,421,832	29,954,471	(1,359,978)	1,359,978	45,376,303
Net assets at beginning of year	28,193,322	219,469,792	4,565,150	(4,565,150)	247,663,114
Net assets at end of year	$ 43,615,154	$ 249,424,263	$ 3,205,172	$ (3,205,172)	$ 293,039,417

Coopers & Lybrand

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a professional services firm

000166

GREENWICH HEALTH CARE SERVICES, INC. and SUBSIDIARIES

CONSOLIDATED FINANCIAL STATEMENTS and SUPPLEMENTAL INFORMATION

For the year ended September 30, 1996

GREENWICH HEALTH CARE SERVICES, INC. and SUBSIDIARIES

Index

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a professional services firm

000168

Report of Independent Accountants

Board of Directors
Greenwich Health Care Services, Inc.
Greenwich, Connecticut

We have audited the accompanying consolidated balance sheet of Greenwich Health Care Services, Inc. ("GHCS") and Subsidiaries as of September 30, 1996, and the related consolidated statements of operations, changes in net assets, and cash flows for the year then ended. These financial statements are the responsibility of GHCS's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Greenwich Health Care Services, Inc. and Subsidiaries as of September 30, 1996 and the consolidated results of their operations and their consolidated cash flows for the year then ended, in conformity with generally accepted accounting principles.

As discussed in Note 2 to the financial statements, Greenwich Health Care Services, Inc. and Subsidiaries adopted the provisions of Statement of Financial Accounting Standards No. 117, "Financial Statements of Not-for-Profit Organizations", and Statement of Financial Accounting Standards No. 116, "Accounting for Contributions Received and Contributions Made".

Coopers + Lybrand L.L.P.

Stamford, Connecticut
December 5, 1996.

Greenwich Health Care Services, Inc. and Subsidiaries

Consolidated Balance Sheet
September 30, 1996

ASSETS:

Current assets:	
Cash and cash equivalents	$ 18,472,612
Marketable securities (Note 6)	7,496,582
Patient accounts receivable, less allowance for doubtful accounts of $3,600,000 (Note 15)	16,395,244
Other receivables	830,059
Inventories	483,674
Prepaid expenses and other current assets	1,040,138
Total current assets	44,718,309
Assets whose use is limited (Notes 5, 6 and 16):	
Trustee assets - indenture	53,970,272
Trustee assets - self-insurance	4,531,876
By board designation	34,751,392
Total assets whose use is limited	93,253,540
Investments - deemed held for restricted purposes (Note 6)	40,463,429
Property and equipment, net (Note 7)	54,446,653
Construction in progress (Notes 8 and 16)	14,621,521
Pledges receivable (Note 9)	16,653,643
Charitable remainder trusts	1,363,500
Property held in trust	1,055,300
Deferred financing costs, net	2,051,834
Other assets	68,140
Total assets	$ 268,695,869

LIABILITIES and NET ASSETS:

Current liabilities:	
Accounts payable and accrued expenses	$ 6,155,182
Accrued salaries and vacation	4,072,941
Accrued interest payable (Note 16)	888,347
Due to third-party payors (Note 15)	13,755,171
Other current liabilities (Notes 12, 13 and 14)	3,372,797
Total current liabilities	28,244,438
Due to third-party payors (Note 15)	4,000,000
Estimated liability - self-insurance (Note 11)	3,684,052
Bonds payable, net (Note 16)	61,887,000
Other long-term liabilities (Notes 12, 13 and 14)	7,626,860
Commitments and contingencies (Notes 8, 10, 11 and 15)	-
Total liabilities	105,442,350
Net assets (Note 4):	
Unrestricted	105,542,425
Temporarily restricted	41,678,166
Permanently restricted	16,132,928
Total net assets	163,253,519
Total liabilities and net assets	$ 268,695,869

See notes to consolidated financial statements.

Greenwich Health Care Services, Inc. and Subsidiaries

Consolidated Statement of Operations
For the year ended September 30, 1996

Unrestricted revenue and other support:	
Net patient service revenue (Notes 3 and 15)	$ 94,110,960
Other revenue	4,050,712
Net assets released for restrictions to support operations	4,953,007
Total revenue and support	103,114,679
Expenses (Note 18):	
Salaries and fees	52,106,789
Employee benefits (Notes 12, 13 and 14)	9,792,543
Supplies and expenses	25,709,261
Depreciation and amortization	6,624,746
Provision for doubtful accounts, net of recoveries of $1,136,000	3,157,326
Total expenses	97,390,665
Income from operations	5,724,014
Nonoperating gains and losses (Note 18)	5,839,978
Excess of revenue and gains over expenses and losses	11,563,992
Net assets released from restrictions for acquisition of property and equipment	3,891,350
Reclassification from temporarily restricted net assets (Note 2)	4,725,009
Increase in unrestricted net assets	$ 20,180,351

See notes to consolidated financial statements.

Greenwich Health Care Services, Inc. and Subsidiaries

Consolidated Statement of Changes in Net Assets
For the year ended September 30, 1996

Unrestricted net assets:	
Excess of revenue and gains over expenses and losses	$ 11,563,992
Net assets released from restrictions for acquisitions of property and equipment	3,891,350
Reclassifications from temporarily restricted net assets (Note 2)	4,725,009
Increase in unrestricted net assets	20,180,351
Temporarily restricted net assets:	
Cumulative effect of change in accounting (Note 2)	682,427
Reclassifications to unrestricted net assets (Note 2)	(4,725,009)
Contributions, pledges and legacies	18,782,016
Interest and investment income	1,508,414
Gains from disposals of securities	1,116,606
Net assets released from restrictions to support operations	(4,953,007)
Net assets released from restrictions for acquisitions of property and equipment	(3,891,350)
Increase in temporarily restricted net assets	8,520,097
Permanently restricted net assets:	
Contributions	5,322
Increase in permanently restricted net assets	5,322
Increase in net assets	28,705,770
Net assets, beginning of year	134,547,749
Net assets, end of year	$ 163,253,519

See notes to consolidated financial statements.

Greenwich Health Care Services, Inc. and Subsidiaries

000172

Consolidated Statement of Cash Flows
For the year ended September 30, 1996

Cash flows from operating activities and gains and losses:	
Excess of revenues and gains over expenses and losses	$ 11,563,992
Adjustments to reconcile to net cash provided by operating activities and gains and losses:	
Depreciation and amortization, net of gain on sale of property and equipment	6,624,746
Net assets released to support operations	(4,953,007)
Pension expense accrual	40,919
Other postretirement and postemployment benefit expense accrual	13,904
Unrealized gain on marketable debt securities	(19,606)
Write-off of construction in progress	66,637
Investment income on assets whose is limited	(255,279)
Self insurance expense accrual	(535,470)
Changes in assets and liabilities:	
Decrease in patient accounts receivable	5,718,278
Change in other current assets	(46,238)
Decrease in assets whose use is limited	380,478
Increase in other assets	(257)
Increase in other liabilities	3,413,371
Increase in due to third-party payors	4,257,886
Payments for professional self-insurance claims and expenses	(380,478)
Net cash provided by operating activities and gains and losses	25,889,876
Cash flows from investing activities:	
Capital expenditures	(14,803,205)
Proceeds from sale of property and equipment	347,316
Increase in marketable securities	(3,739,078)
Investment in assets whose use is limited	(9,772,785)
Investment of bond proceeds into trust funds	(60,095,401)
Use of trust funds to pay capitalized interest	1,184,464
Use of trust funds for construction in progress	6,368,388
Capitalized interest on trust funds	(1,427,723)
Increase in investments	(192,404)
Net cash used in investing activities	(82,130,428)
Cash flows from financing activities:	
Proceeds from bonds payable	61,667,208
Bond issuance costs	(2,092,427)
Collections of contributions and pledges	7,274,999
Net cash provided by financing activities	67,049,780
Net increase in cash and cash equivalents	10,809,228
Cash and cash equivalents at beginning of year	7,663,384
Cash and cash equivalents at end of year	$ 18,472,612
The following is supplemental information relating to the statements of cash flows:	
Noncash investing and financing activities:	
Additions to construction in progress financed by retainage payable	$ 363,902
Pledges and trusts received for temporarily restricted purposes	$ 17,811,978
Interest, income and realized gains on investments held for temporarily restricted purposes	$ 2,625,020

See notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Organization and Basis of Presentation

Greenwich Health Care Services, Inc. ("GHCS") is the parent corporation for a group of wholly-owned subsidiaries consisting of The Greenwich Hospital Association (the "Hospital"); The Perryridge Corporation ("Perryridge"); Greenwich Health Services, Inc. ("GHSI"); Greenwich Nursing and Health Care Registry, Inc. ("Registry"); and Future Care, Inc. ("Future Care").

The consolidated financial statements of GHCS and its subsidiaries are presented in accordance with guidance of the American Institute of Certified Public Accountants' audit and accounting guide, "Health Care Organizations." For purposes of display, the Consolidated Statement of Operations presents transactions deemed by management to be ongoing, major, or central to the provision of health care services and to the planning and oversight functions of GHCS as revenues and expenses. Peripheral or incidental transactions are reported as gains and losses. Gains and losses deemed by management to be closely related to ongoing operations are classified as operating; other gains and losses are classified as nonoperating.

Investment income on assets held for malpractice self insurance is included in other revenues. Other investment income available for unrestricted purposes is reported in nonoperating gains, as is unrestricted contribution income.

2. Summary of Significant Accounting Policies

Principals of Consolidation:

The consolidated financial statements include the accounts of GHCS and its wholly-owned subsidiaries. All significant intercompany accounts and transactions are eliminated in consolidation. The consolidation of these for-profit and not-for-profit entities is not necessarily indicative of the legal extent of assets available to settle liabilities of the individual entities.

Changes in Accounting and Related Matters:

In fiscal 1996, GHCS and its subsidiaries have adopted the provisions of Statement of Financial Accounting Standards No. 117, "Financial Statements of Not-for-Profit Organizations" ("SFAS 117"). This Statement, among other things, requires classification of an organization's net assets and its revenues, expenses, gains and losses into three classes - permanently restricted (previously referred to as "endowment"), temporarily restricted (previously referred to as "specific purpose" and "restricted building funds"), and unrestricted (previously referred to as "general funds") - and imposes certain changes in the form of financial statement display. In addition, SFAS 117 specifies that income from investments, as well as gains and losses on investments, are to be treated as increases or decreases in unrestricted net assets unless the use of such income, gains, or losses is temporarily or permanently restricted by explicit donor stipulation or by law.

Continued

Upon adoption, the provisions of SFAS 117 are required to be retroactively applied. Accordingly, fund balances, as previously reported at September 30, 1995, have been restated to reflect the retroactive application of SFAS 117 as follows:

	General Funds/ Unrestricted Net Assets	Specific Purpose and Restricted Building Funds/ Temporarily Restricted Net Assets	Endowment Funds/ Permanently Restricted Net Assets
As previously reported	$ 77,860,022	$ 29,412,848	$ 27,274,879
Adjustments for retroactive adoption of SFAS 117	7,502,052	3,645,231	(11,147,283)
As restated	$ 85,362,074	$ 33,058,079	$ 16,127,596

The effect of the adoption of SFAS 117 was to increase the excess of revenues over expenses of unrestricted net assets for fiscal 1996 by approximately $3,050,000.

Effective October 1, 1995, GHCS and its subsidiaries adopted the provisions of Statement of Financial Accounting Standards No. 116, "Accounting for Contributions Received and Contributions Made" ("SFAS 116"). Among other things, this Statement requires that contributions received, including unconditional promises to give, be recognized as revenues or support of either unrestricted, temporarily restricted, or permanently restricted net assets, as appropriate, in the period received, at their fair values. Unconditional promises to give cash are recorded at net present value, less an allowance for doubtful collectibility, to approximate fair value; subsequent accrual of the interest element of such pledges is accounted for as contribution income. Further, GHCS's beneficiary rights under irrevocable charitable remainder trusts, which previously were excluded from the financial statements, are included in such unconditional promise to give. Conditional promises to give are not recorded as revenue or support until the condition upon which they depend has been substantially met. In addition, the expirations of donor-imposed restrictions are now recognized in the period in which the restriction expires and, somewhat different from previous treatment, available temporarily restricted net assets are now applied for such purposes before unrestricted net assets are applied.

GHCS has accounted for the adoption of SFAS 116 as a change in accounting as of October 1, 1995. The cumulative effect of this adoption was to increase assets by approximately $1,355,000, liabilities by approximately $673,000 and temporarily restricted net assets by a net amount of approximately $682,000 as of October 1, 1995, with no effect on unrestricted net assets. GHCS has elected to adopt the provisions of SFAS 116 regarding expiration of restrictions prospectively. The effect of adopting SFAS 116 was to increase the excess of revenues and gains over expenses and losses of unrestricted net assets for the fiscal year ended September 30, 1996 by approximately $4,053,000.

Also, during fiscal 1996, certain reclassifications totaling $4,725,009 were made of temporarily restricted fund balances to unrestricted fund balances, to reflect donor's intent, the result of which was to increase the excess of revenues and gains over expenses and losses of unrestricted net assets for fiscal 1996 by approximately $422,000.

Use of Estimates:

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents:

Cash and cash equivalents include highly liquid investments purchased with a maturity of three months or less.

Concentration of Credit Risk:

Cash and cash equivalents are maintained primarily within two regional banks and one investment bank-sponsored money market fund. It is GHCS's policy to monitor the financial strength of these institutions and funds on an ongoing basis.

Marketable Securities and Investments:

Marketable securities and investments, except for certain debt securities, are stated at the lower of aggregate cost or market value. Certain debt securities are deemed to be held to maturity and are, therefore, stated at amortized cost. The amortized cost of such debt securities is adjusted for amortization of premiums and accretion of discounts to maturity. The cost of marketable securities or investments received as donations or bequests is deemed to be their fair market value at the date of gift. In calculating realized gains and losses, cost is determined on a specific identification basis.

Net Patient Service Revenue and Patient Accounts Receivable:

Revenue from patient services is recorded at the Hospital's established rates. Deductions for contractual allowances under third-party reimbursement agreements and courtesy discounts are recorded to arrive at net patient service revenue. Net patient service revenue and patient accounts receivable are recorded when patient services are performed. Adjustments and settlements under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Charity Care:

The Hospital provides care to patients who meet certain criteria under its charity care policy without requiring payment or at amounts less than its established and contractual payment rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as patient service revenue. For purposes of financial reporting, Medicare and other contractual allowances and bad debts are not deemed to be charity care. Services to patients who otherwise meet the Hospital's criteria for charity care may qualify for alternate sources of reimbursement from certain free care and other funds, charitable trusts or pools, and will therefore be recorded as revenue in the period the services are provided. If it is subsequently determined that such alternate sources are not available, the related receivable is written off and amounts involved are reflected as charity care in the period of such determination.

Restricted Net Assets:

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Hospital in perpetuity. Some of the income on permanently restricted net assets is unrestricted to the Hospital.

When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Certain donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Inventories:

Inventories are stated at the lower of cost, using the first-in, first-out method, or market.

Property and Equipment:

Property and equipment are stated at cost or, if donated, fair market value at date of donation. Depreciation is provided using the straight-line method over the estimated useful lives of the assets.

Charitable Remainder Trusts:

The Hospital is the ultimate beneficiary of certain charitable remainder trusts and similar arrangements. Under most of these arrangements, the Hospital is not currently receiving any distributions, but will be entitled to the remaining assets in the trust upon the death of the donor and any other named beneficiaries. In certain cases, use of such assets ultimately to be received by the Hospital is restricted to specific purposes.

Deferred Financing Costs:

Issuance costs related to the Hospital's 1996 tax-exempt bond issuance are being amortized over the life of the debt using a method that approximates the interest method, and the amortization is included in interest cost. Amortization for the fiscal year ended September 30, 1996 was $40,593.

Debt Issuance Discount:

The discount from face value at which debt has been issued is reflected as a reduction of the carrying value of such debt. This discount is amortized over the life of the debt using a method that approximates the interest method, and the amortization is included in interest cost. Amortization for the year ended September 30, 1996 was $19,792.

Capitalization of Interest:

During the construction period of qualifying assets, the related interest cost on the Hospital's tax-exempt borrowings, net of the related interest earned on the investments acquired with the unexpended proceeds of such borrowings, is capitalized and included in construction in progress.

Income Taxes:

GHCS and its subsidiaries, with the exception of Future Care and GHSI, are not-for-profit organizations and are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code.

Future Care and GHSI are for-profit subsidiaries who have available, as of September 30, 1996, unused operating loss carryforwards of approximately $540,000 and $1,176,000, respectively. The carryforwards, which are available to offset future taxable income, expire in various years through 2011. Deferred tax assets at September 30, 1996 total approximately $1,166,000, and relate primarily to the tax effects of net operating loss carryforwards and a reserve for doubtful accounts. Deferred tax liabilities are negligible. The deferred tax assets have been offset by valuation allowances of equal amounts. Due to continuing losses of the two for-profit subsidiaries, there was no current tax provision or benefit in fiscal 1996, and the deferred benefits of approximately $156,000 were offset by provisions to increase the valuation allowance by corresponding amounts.

3. Net Patient Service Revenue

Net patient service revenue for the year ended September 30, 1996 includes the following:

Gross patient service revenue	$ 158,018,193
Less, Contractual and other allowances	63,907,233
	$ 94,110,960

4. Net Assets

Temporarily restricted net assets are available for the following purposes at September 30, 1996:

Hospital's major facility renovation project	$ 36,567,056
Other specified capital expenditures	735,622
Indigent care	2,055,192
Specified health care services and operations	1,236,975
Education	983,321
	$ 41,578,166

Permanently restricted net assets at September 30, 1996 are restricted as follows:

Principal to be held in perpetuity, with income expendable to support health care services and other activities (reported as nonoperating gains)	$ 13,046,376
Principal to be held in perpetuity, with income to be spent for restricted purposes as specified by donor (reported as additions to temporarily restricted net assets until released upon satisfaction of restriction)	3,086,552
	$ 16,132,928

Unrestricted net assets at September 30, 1996 include the following:

Designated by Board of Directors for:	
Depreciation fund	$ 19,018,245
Quasi endowment - capital gains	13,673,791
Auxiliary	1,432,248
Undesignated	71,418,141
	$ 105,542,425

5. Assets Whose Use is Limited

Assets whose use is limited consist of the following at September 30, 1996:

Trustee assets - indenture (see Note 16):	
Cash and cash equivalents	$ 13,088
Marketable securities	53,957,184
	$ 53,970,272
Trustee assets - self-insurance:	
Cash and cash equivalents	$ 2,888
Marketable securities, net of valuation allowance of $34,031	4,471,988
Accrued interest receivable	57,000
	$ 4,531,876
By board designation:	
Cash and cash equivalents	$ 960,063
Marketable securities	33,791,329
	$ 34,751,392

6. Marketable Securities and Investments

Cost and market values for marketable securities and investments as of September 30, 1996 are summarized as follows:

	Cost	Market Value
Marketable securities in current assets:		
Debt securities	$ 7,496,582	$ 7,547,492
Assets whose use is limited:		
Trustee assets - self-insurance:		
Debt securities	$ 4,506,019	$ 4,471,988
By board designation:		
Debt securities at amortized cost	$ 8,492,647	$ 8,518,995
Debt securities - other	676,512	732,569
Equity securities	6,653,176	7,818,866
Other securities	17,968,994	18,448,304
	$ 33,791,329	$ 35,518,734
Investments:		
Debt securities at amortized cost	$ 16,173,236	$ 16,193,973
Debt securities - other	226,252	297,502
Equity securities	8,606,903	10,114,314
Other securities	15,457,038	16,103,623
	$ 40,463,429	$ 42,709,412

Unrealized gains and losses relating to marketable equity securities as of September 30, 1996 are as follows:

	Gross Unrealized Gains	Gross Unrealized Losses
Board designated	$ 1,451,725	$ (286,035)
Investments	$ 1,877,920	$ (370,509)

Debt securities as of September 30, 1996 were invested as follows (based on cost):

	U.S. Treasuries and Federal Agencies	Corporate Bonds
Marketable securities in current assets	100%	-
Assets whose use is limited:		
Trustee assets - self-insurance	100%	-
Board designated	99%	1%
Investments	99%	1%

Equity securities as of September 30, 1996 were invested as follows (based on cost):

	Consumer Staples	Financial	Capital Goods	Consumer Cyclical	Other Industries with Concentration of 10% or Less
Board designated	16%	19%	11%	22%	32%
Investments	16%	19%	11%	22%	32%

Other securities consist of investments in short-term funds, mutual funds and Fleet commingled funds.

7. Property and Equipment

Property and equipment, at cost, and accumulated depreciation as of September 30, 1996, are as follows:

Land and leasehold improvements	$ 4,591,856
Buildings	44,416,852
Fixed equipment	23,313,017
Movable equipment	32,266,277
	104,588,002
Less, Accumulated depreciation	(50,141,349)
	$ 54,446,653

8. Construction in Progress

Construction in progress at September 30, 1996 represents accumulated costs for the Hospital's major facility renovation project. The Hospital received approval on February 9, 1995 from the State of Connecticut Commission on Hospitals and Health Care for a Certificate of Need application for the facility renovation project in the amount of $107.3 million. The project is expected to be completed in 2000.

The project is expected to be financed primarily by temporarily restricted funds, qualifying restricted contributions and investment income anticipated to be received and proceeds from the issuance by the Hospital in March 1996, of approximately $63 million in tax-exempt bonds (see Note 16).

The Hospital has entered into various contractual arrangements related to this project.

Upon completion of a construction in progress project, the cost of that project is transferred to appropriate property and equipment categories and depreciation will commence.

9. Pledges Receivable

Pledges receivable, for unconditional promises to give at September 30, 1996, reflect the following:

Amounts due in less than one year	$ 2,654,997
Amounts due in one to five years	14,609,909
Amounts due in more than five years	3,000,000
	20,264,906
Less: Unamortized discount	(3,515,563)
Allowance for uncollectibles	(95,700)
Pledges receivable, net	$ 16,653,643

Substantially all pledges receivable relate to promises to contribute to the Hospital's major facility renovation project (see Note 8), and are, therefore, a component of temporarily restricted net assets. Pledges receivable and contributions exclude letters of intent which are not legally binding and gifts conditional on events that have not yet occurred. GHCS and its subsidiaries have received conditional promises to give totaling $2,038,495, which, if ultimately received will be restricted for the facility project.

10. Lease Commitments

GHCS and its subsidiaries lease various building space and equipment under operating leases and have long-term commitments under service contracts expiring at various dates through fiscal 2004. Expenses relating to those agreements were approximately $930,000 for fiscal 1996.

Future minimum rental payments at September 30, 1996 under noncancellable operating leases and service contracts are approximately as follows:

1997	$ 426,000
1998	240,000
1999	178,000
2000	181,000
2001 and thereafter	184,000
	$ 1,209,000

11. Medical Malpractice and Self Insurance Arrangements

The Hospital has a policy of self-insuring a portion of its professional liability insurance coverage. Prior to 1985, the Hospital had commercial occurence-basis insurance coverage. Since 1985, the self-insurance portion of the Hospital's commercial claims-made insurance coverage includes deductible limits of $1,000,000 per claim and $3,000,000 in the aggregate annually.

The Hospital's estimated professional self-insurance liability represents its best estimate of losses, under its self-insurance arrangements, from asserted and unasserted claims including those identified under the Hospital's incident reporting system.

The Hospital has established an irrevocable trust for the purpose of setting aside assets for self-insurance purposes. Under the trust agreement, the trust assets can only be used for payment of malpractice losses, related expenses, and the cost of administering the trust. The assets of and contributions to the trust are included in the balance sheet. These funds held by the trustee are invested in marketable securities and recorded at the lower of cost or market.

The Hospital is also self-insured, subject to certain umbrella and stop-loss coverage limits, for its employee health plan and workers compensation. The Hospital accrues its best estimate of retained liability for occurrences through each balance sheet date.

12. Pension Plan

GHCS and its subsidiaries have a noncontributory defined benefit pension plan covering substantially all employees. GHCS's funding policy is to make the minimum annual contribution required by applicable regulations. The pension plan's assets are principally invested in investment grade bonds and stocks.

The following table sets forth the funded status of GHCS's pension plan at September 30, 1996:

Actuarial present value of benefit obligations:	
Vested	$ 37,325,000
Accumulated	$ 37,550,000
Projected	$ 46,760,140
Plan assets at fair value	65,572,594
Plan assets in excess of projected benefit obligation	18,812,454
Unrecognized net gain	(13,841,645)
Unrecognized prior service cost	(1,039,630)
Unrecognized net assets at October 1, 1987 being amortized over 18 years	(7,366,426)
Net accrued pension liability	$ (3,435,247)

Net pension expense for fiscal 1996 included the following components:

Service cost	$ 2,298,960
Interest cost on projected benefit obligation	3,411,499
Actual return on assets	(6,635,526)
Net amortization and deferral	965,986
Net pension expense	$ 40,919

For purposes of calculating pension expense, the assumed discount rate was 7.5% for fiscal 1996 (vs. 8.5% in fiscal 1995) For purposes of calculating pension expense, the expected long-term rate of return on plan assets was estimated to be 8.5% for 1996, and future annual compensation increases were estimated at 5.0% for fiscal 1996 (vs. 5.5% in fiscal 1995). The effect of these changes in assumptions was to increase pension expense for 1996 by approximately $450,000.

The September 30, 1996 valuation of year-end benefit obligations reflects a increase of the discount rate assumption to 8.0% the effect of which was to decrease the actuarial present value of the projected benefit obligation ("PBO") by approximately $3,500,000 at September 30, 1996. The impact of this change on fiscal 1997 expense is expected to be a decrease of approximately $525,000.

13. Postretirement Medical and Life Insurance Benefits

GHCS and its subsidiaries provide certain health care and life insurance benefits for eligible retired and active employees. These plans are unfunded. Substantially all of GHCS's full-time employees may become eligible for these applicable benefits after three months of service. Employees who were eligible for these benefits at the time of their retirement, who retired prior to August 1, 1992 and who met the requirements to receive an immediate pension plan benefit are provided continued free hospitalization services rendered by the Hospital throughout their retirement. Health benefits are also provided to eligible dependents. In addition, the eligible retired employees are provided certain life insurance coverage at no cost.

As of October 1, 1991, GHCS adopted the provisions of Statement of Financial Accounting Standards No. 106, "Accounting for Postretirement Benefits Other Than Pensions", and elected the immediate recognition approach for the initial transition obligation. Effective August 1, 1992, GHCS eliminated these postretirement medical and life insurance benefits for all future retirees. However, in conjunction with a 1994 early retirement benefits program, limited postretirement medical benefits were granted to employees who accepted the one-time early retirement offer.

A reconciliation of the status of the plan to amounts reported on GHCS's balance sheet is as follows at September 30, 1996:

Accumulated postretirement benefit obligation	$ 2,114,772
Unrecognized net gain	283,241
Accrued postretirement benefit liability	2,398,013
Less, Current portion (included in other current liabilities)	(210,000)
Long-term portion (included in other liabilities)	$ 2,188,013

Net periodic postretirement medical and life insurance benefit full cost for fiscal 1996 consisted of interest cost of $151,000.

A 9.5% annual rate of increase in the per capita costs of covered health care benefits was assumed for 1996, gradually decreasing to 5.5% by the year 2005. Increasing the assumed health care cost trend rates by one percentage point would increase the accumulated postretirement benefit obligation as of September 30, 1996 by approximately $110,000, and increase the net periodic postretirement medical and life insurance benefit cost for fiscal 1996 by approximately $8,800. A discount rate of 8.0% was used to determine the APBO at September 30, 1996 (vs. 7.5% used at September 30, 1995).

14. Postemployment Disability and Leave of Absence and Other Benefits

GHCS follows Statement of Financial Accounting Standards No. 112, "Employers' Accounting for Postemployment Benefits", ("SFAS 112") to account for the estimated liability for providing future medical benefits to employees on long-term disability or leave of absence. SFAS 112 establishes accounting standards for employers who provide benefits to former or inactive employees after employment but before retirement.

The following reconciles amounts reported in GHCS's balance sheet as of September 30, 1996:

Accrued postemployment disability and leave of absence benefit liability	$ 2,247,300
Less, Current portion (included in other current liabilities)	(560,000)
Long-term portion (included in other long-term liabilities)	$ 1,687,300

During fiscal 1996, GHCS became self-insured for workers' compensation costs. The impact of this change was to increase the accrued liability for postemployment disability and leave of absence benefits by $160,000 at September 30, 1996.

15. Reimbursement Arrangements

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements.

A substantial portion of net patient service revenue is derived from funds provided on behalf of patients under federal (Medicare) and other governmental programs. The Hospital is reimbursed for inpatient services rendered to Medicare patients based on the Federal Prospective Payment System (PPS), whereby payment is made at a predetermined rate according to patient diagnosis. Payments for Medicaid patients and Medicare outpatients are based primarily on defined cost. Revenue from these sources is subject to audit by the applicable agencies.

All net patient service revenue from sources other than Medicare and Medicaid is subject to regulatory review by the State of Connecticut.

The current Connecticut regulatory reimbursement system includes a 6% Connecticut sales tax on nongovernmental cash receipts for hospital services; an 11% gross earnings tax on earnings, as defined, from services covered by nongovernmental payors; mechanisms for disproportionate share and emergency assistance payments to hospitals; and a "compliance" cap on net revenues. Compliance adjustments for annual over-collections of authorized net revenues have, by statute, been able to be assessed by the State in succeeding years either through reductions in net revenue caps, deductions from a hospital's disproportionate share payments from the State, or four equal quarterly payments by the hospital.

Pursuant to certain understandings arrived at in June 1996, many in the industry understood that compliance for fiscal 1995, which would otherwise have become payable in fiscal 1997, was not expected to be assessed, and that there would be no compliance imposed for fiscal 1996 and subsequent years. In October 1996, however, pursuant to existing State law, the Hospital, along with certain other hospitals in the State, made a first quarterly installment payment pertaining to compliance for fiscal 1995. The hospitals have also been informed that the State interprets Connecticut law as requiring the collection of cash compliance for fiscal 1996, which would be payable to the State on and after October 1, 1997.

The Hospital's patient receivables and liability to third party and other payors include its best estimate of net amounts owed related to the State's programs for sales tax, gross earnings tax, disproportionate share, and compliance. The impact of these items are reflected in arriving at net revenues. The Hospital's tax payments to the State have been and are expected to continue to exceed disproportionate share payments by the State to the Hospital.

Patient accounts receivable at September 30, 1996, before allowances for doubtful accounts, consisted of approximately the following:

Medicare and Medicaid	$ 5,223,000
Commercial insurance	5,583,000
Self-pay patients	3,427,000
Other third-party payors (none over 10%)	5,762,000
	$ 19,995,000

16. Bonds Payable

Bonds payable consist of the following at September 30, 1996:

State of Connecticut Health and Educational Facilities Authority:	
Tax-exempt bonds, Series A	$ 62,905,000
Less, Discount, net of accumulated amortization of $19,792	(1,018,000)
	$ 61,887,000

The State of Connecticut Health and Educational Facilities Authority ("CHEFA") issued $62,905,000 of its Revenue Bonds, the Greenwich Hospital, Series A, dated March 1, 1996, consisting of $12,760,000 of Serial Bonds and $50,145,000 of Term Bonds, the proceeds of which have been loaned by CHEFA to the Hospital for the master facility renovation project. The Series A Revenue Bonds outstanding at September 30, 1996 bear interest at rates ranging

from 4.6% to 5.8%. Principal amounts related to the Serial Bonds mature annually each July 1, 2001 through 2009, and the Term Bonds mature on July 1, 2016 and July 1, 2026 in the amounts of $15,115,000 and $35,030,000, respectively. However, annual payments to a sinking fund are required from July 1, 2001 through July 1, 2026 to retire such Term Bonds. Interest is due semi-annually on January 1 and July 1, commencing July 1, 1996.

Aggregate principal payments required by the Hospital for the Bonds for fiscal 1997 through 2001 are as follows:

1997	$ -
1998	-
1999	-
2000	-
2001	1,160,000

Required payments on the Series A Revenue Bonds by the Hospital are to a trustee in the amounts sufficient to provide for the payment of principal, interest and sinking fund installments as the same become due, and certain other payments. Payment of the principal and interest on the Series A Bonds on the regularly scheduled due dates for the payment therefor are insured in accordance with a financial guaranty insurance policy which was issued simultaneously with the delivery of the Series A Bonds by MBIA Insurance Corporation. Additionally, the Hospital has granted a collateral interest to CHEFA on its gross receipts.

Pursuant to the State of Connecticut Health and Educational Authority Trust Indenture ("Trust Indenture") dated March 1, 1996, the Hospital is required to maintain certain funds with a trustee for specified purposes and time periods. These funds can be used only for the purposes specified in the Trust Indenture. Assets held by the trustee pursuant to the indenture as of September 30, 1996 are designated as follows:

Construction account	$ 41,772,925
Capitalized interest account	7,475,350
Debt service reserve fund	4,717,025
Debt service fund	4,972
	$ 53,970,272

Assets held by the trustee pursuant to the indenture consist of cash, money market fund investments and guaranteed investment contracts with two institutions, for which all costs approximated market value at September 30, 1996. A summary of such investments at September 30, 1996 is as follows:

	Interest Rate	Amount
Cash	-	$ 13,088
Money Market Funds	-	199,882
Guaranteed Investment Contracts	5.63% and 6.78%	53,757,302
		$ 53,970,272

A description of the funds is as follows:

Construction Account - Bond proceeds, after the allocation of certain specified amounts, were required to be deposited in the Construction Account and may be applied only toward the payment of costs of the Project.

Capitalized Interest Account - A portion of the proceeds of the Bonds was required to be deposited into the Capitalized Interest Account. The Capitalized Interest Account pays the scheduled interest payments related to the borrowings for the construction costs through 1998. Interest earnings are transferred to the Construction Account during the construction period.

Debt Service Reserve Fund - The Hospital is required to maintain the Debt Service Reserve Fund in an amount to at least cover the maximum aggregate annual debt service payment. Interest earnings from the fund are to be transferred to the Construction Account during the construction period.

Debt Service Fund - The Hospital is required to pay amounts semiannually to cover payment of principal and interest as required by the Bond documents. Payments will be made from this fund for required debt service payments.

Total interest cost incurred on the bonds, including amortization of deferred financing costs and debt issuance discounts, was approximately $1,817,000 for fiscal 1996, all of which was capitalized. Total interest earned on the funds held by the trustee for fiscal 1996 was approximately 1,433,000, all of which was capitalized.

Pursuant to the bond agreements, the Hospital is required to comply with a variety of covenants and a debt service coverage ratio. In addition, events of default on other indebtedness or indebtedness guaranteed by the Hospital can result in an event of default on the bonds. The Parent is part of the "obligated group", with the Hospital, in connection with the bonds.

17. Subsidiary Matters

GHCS sold, at negligible losses, the business and certain assets of the Registry (effective September 1, 1995) and of Future Care (effective October 25 ,1995), and effectively ceased operations of these subsidiaries at those dates. The operations of both of these subsidiaries have been immaterial to consolidated results in recent years. During fiscal 1996, the remaining net assets of these two subsidiaries were remitted to the Parent.

18. Supplemental Operating Data

GHCS and its subsidiaries provide general health care services to residents primarily within their geographic location. Functional expenses related to their operating activities for the fiscal year ended September 30, 1996 are as follows:

Health care services	$ 67,086,639
General and administrative	30,304,026
	$ 97,390,665

Nonoperating gains and losses for the fiscal year ended September 30, 1996 consisted of:

Unrestricted contributions	$ 1,633,055
Gains on sales of investments	3,241,415
Interest and investment income	2,590,804
Fund-raising expenses	(1,166,759)
Greenwich Health at Greenwich Hospital program	(300,906)
Other	(157,631)
	$ 5,839,978

19. Fair Value of Financial Instruments

The following methods and assumptions were used by GHCS in estimating the fair value of its financial instruments:

Cash and Cash Equivalents - The carrying amount reported in the balance sheet for cash and cash equivalents approximates its fair value.

Assets Whose Use is Limited - These assets consist primarily of cash, marketable securities and interest receivable.

Marketable Securities and Investments - Fair values are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

Pledges Receivable - The carrying amount reported in the balance sheet for pledges receivable approximates its fair value.

Estimated Third-Party Payor Settlements - The carrying amount reported in the balance sheet for estimated third-party payor settlements approximates its fair value.

Long-Term Debt - Fair values of the Hospital's bonds payable are based on current traded value. The fair value of the Hospital's remaining long-term debt is estimated using discounted cash flow analyses, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements.

The carrying amounts and fair values of GHCS and subsidiaries' financial instruments at September 30, 1996 are as follows:

	Carrying Amount	Fair Value
Cash and cash equivalents	$ 18,472,612	$ 18,472,612
Marketable securities	7,496,582	7,547,492
Assets whose use is limited:		
Trustee assets - indenture	53,970,272	53,970,272
Trustee assets - self-insurance	4,531,876	4,531,876
By board designation	34,751,392	36,478,797
Investments	40,463,429	42,709,412
Pledges receivable	16,653,643	16,653,643
Estimated third-party payor settlements	17,755,171	17,755,171
Long-term debt	61,887,000	63,535,000

20. New Pronouncement

In November 1995, the Financial Accounting Standards Board issued SFAS No. 124 "Accounting for Certain Investments Held by Not-for-Profit Organizations". It requires, among other things, that investments in equity securities with readily determinable fair values and all investments in debt securities be reported at fair value with gains and losses included in a statement of operations or statement of changes in net assets. This statement is effective for fiscal years beginning after December 15, 1995. The Hospital has elected not to adopt this statement early.

Supplemental Information

Report of Independent Accountants

To the Board of Directors of
Greenwich Health Care Services, Inc.:

The audited consolidated financial statements of GHCS and its subsidiaries and our report thereon are presented in the preceding section of this report. Our audit was conducted for the purpose of forming an opinion on the basic consolidated financial statements taken as a whole. The consolidating information presented hereinafter is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position and results of operations of the individual companies. The consolidating information has been subjected to the auditing procedures applied in our audit of the basic consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic consolidated financial statements taken as a whole. As discussed in Note 2 to the financial statements, GHCS adopted the provisions of Statement of Financial Accounting Standards No. 117, "Financial Statements of Not-for-Profit Organizations", and Statement of Financial Accounting Standards No. 116, "Accounting for Contributions Received and Contributions Made".

Coopers + Lybrand L.L.P.

Stamford, Connecticut
December 5, 1996.

Greenwich Health Care Services, Inc. and Subsidiaries

Consolidating Balance Sheet
September 30, 1996

ASSETS:	GHCS	The Greenwich Hospital Association	Eliminations	Total Obligated Group	The Perryridge Corporation	Greenwich Health Services, Inc.	Future Care, Inc.	Greenwich Nursing and Healthcare Registry	Eliminations	Consolidated
Current assets:	$ -	$ 18,179,593	$ -	$ 18,179,593	$ 95,222	$ 197,797	$ -	$ -	$ -	$ 18,472,612
Cash and cash equivalents	29,675	6,200,769	-	6,230,444	1,266,138	-	-	-	-	7,496,582
Marketable securities	-	16,395,244	-	16,395,244	-	-	-	-	-	16,395,244
Patient accounts receivable, net	122	801,958	-	802,080	27,979	-	-	-	-	830,059
Other receivables	-	483,674	-	483,674	-	-	-	-	-	483,674
Inventories	-	960,045	-	960,045	-	80,093	-	-	-	1,040,138
Prepaid expenses and other current assets	409,699	-	(406,563)	1,136	-	(1,136)	-	-	-	-
Due from affiliates	121,807	-	-	121,807	-	-	-	-	(121,807)	-
Investment in subsidiaries										
Total current assets	561,303	43,041,283	(406,563)	43,194,023	1,389,339	256,754	-	-	(121,807)	44,718,309
Assets whose use is limited:										
Trustee assets - indenture	-	53,970,272	-	53,970,272	-	-	-	-	-	53,970,272
Trustee assets - self insurance	-	4,531,876	-	4,531,876	-	-	-	-	-	4,531,876
By board designation	-	34,751,392	-	34,751,392	-	-	-	-	-	34,751,392
Total assets whose use is limited	-	93,253,540	-	93,253,540	-	-	-	-	-	93,253,540
Investments	-	40,463,429	-	40,463,429	-	-	-	-	-	40,463,429
Property and equipment, net	-	42,572,153	-	42,572,153	11,859,166	215,332	-	-	-	54,446,653
Construction in progress	-	14,621,521	-	14,621,521	-	-	-	-	-	14,621,521
Pledges receivable	-	16,653,643	-	16,653,643	-	-	-	-	-	16,653,643
Charitable remainder trusts	-	1,363,500	-	1,363,500	-	-	-	-	-	1,363,500
Property held in trust	-	1,055,300	-	1,055,300	-	-	-	-	-	1,055,300
Deferred financing costs	-	2,051,834	-	2,051,834	-	-	-	-	-	2,051,834
Other assets	-	68,140	-	68,140	-	-	-	-	-	68,140
Total assets	$ 561,303	$ 255,144,343	$ (406,563)	$ 255,297,083	$ 13,048,507	$ 472,086	$ -	$ -	$ (121,807)	$ 268,695,869

Continued

Greenwich Health Care Services, Inc. and Subsidiaries

Consolidating Balance Sheet, Continued
September 30, 1996

LIABILITIES and NET ASSETS:	GHCS	The Greenwich Hospital Association	Eliminations	Total Obligated Group	The Perryridge Corporation	Greenwich Health Services, Inc.	Future Care, Inc.	Greenwich Nursing and Healthcare Registry	Eliminations	Consolidated
Current liabilities:	$ -	$ 6,145,118	$ -	$ 6,145,118	$ 10,064	$ -	$ -	$ -	$ -	$ 6,155,182
Accounts payable and accrued expenses	-	4,072,941	-	4,072,941	-	-	-	-	-	4,072,941
Accrued salaries and vacation	-	888,347	-	888,347	-	-	-	-	-	888,347
Accrued interest payable	-	13,755,171	-	13,755,171	-	-	-	-	-	13,755,171
Due to third party payors	7,000	3,070,573	-	3,077,573	-	295,224	-	-	-	3,372,797
Other current liabilities	-	353,606	(406,563)	(55,055)	-	55,055	-	-	-	-
Due to affiliates										
Total current liabilities	7,000	28,285,656	(406,563)	27,884,095	10,064	350,279	-	-	-	28,244,436
Due to third party payors	-	4,000,000	-	4,000,000	-	-	-	-	-	4,000,000
Estimated liability - self insurance	-	3,684,052	-	3,684,052	-	-	-	-	-	3,684,052
Bonds payable, net	-	61,887,000	-	61,887,000	-	-	-	-	-	61,887,000
Other long-term liabilities	-	7,626,860	-	7,626,860	-	-	-	-	-	7,626,860
Total liabilities	7,000	105,483,570	(406,563)	105,082,007	10,064	350,279	-	-	-	105,442,350
Net assets/stockholder's equity:	554,303	91,949,679	-	92,503,982	13,038,443	121,807	-	-	(121,807)	105,542,425
Unrestricted	-	41,578,166	-	41,578,166	-	-	-	-	-	41,578,166
Temporarily restricted	-	16,132,928	-	16,132,928	-	-	-	-	-	16,132,928
Permanently restricted										
Total net assets	554,303	149,660,773	-	150,215,076	13,038,443	121,807	-	-	(121,807)	163,253,519
Total liabilities and net assets	$ 561,303	$ 255,144,343	$ (406,563)	$ 255,297,083	$ 13,048,507	$ 472,086	$ -	$ -	$ (121,807)	$ 268,695,869

Greenwich Health Care Services, Inc. and Subsidiaries

Consolidating Statement of Operations
For the year ended September 30, 1996

	GHCS	The Greenwich Hospital Association	Total Obligated Group	The Perryridge Corporation	Greenwich Health Services, Inc.	Future Care, Inc.	Greenwich Nursing and Healthcare Registry	Eliminations	Consolidated
Unrestricted revenue and other support:	$ -	$ 94,110,960	$ 94,110,960	$ -	$ -	$ -	$ -	$ -	$ 94,110,960
Net patient service revenue	-	2,978,298	2,978,298	627,696	995,250	42,364	-	(592,896)	4,050,712
Other revenue	-	4,953,007	4,953,007	-	-	-	-	-	4,953,007
Net assets released from restrictions to support operations	-	102,042,265	102,042,265	627,696	995,250	42,364	-	(592,896)	103,114,679
Total revenue and support									
Expenses:	-	51,590,553	51,590,553	-	503,942	12,294	-	-	52,106,789
Salaries and fees	-	9,662,435	9,662,435	-	127,746	2,362	-	-	9,792,543
Employee benefits	4,390	25,610,504	25,614,894	215,390	494,078	23,797	-	(636,896)	25,709,261
Supplies and expenses	-	6,184,030	6,184,030	406,975	53,741	-	-	-	6,624,746
Depreciation and amortization	-	2,954,306	2,954,306	-	202,770	250	-	-	3,157,326
Provision for doubtful accounts, net of recoveries	4,390	95,961,828	95,966,218	622,365	1,382,275	38,703	-	(638,896)	97,390,685
Total expenses	(4,390)	6,060,437	6,056,047	5,331	(387,025)	3,661	-	46,000	5,724,014
Income (loss) from operations	(364,037)	-	(364,037)	-	-	-	-	364,037	-
Equity gain (loss) in affiliates	64,403	5,742,865	5,807,268	58,624	967	18,341	758	(46,000)	5,839,978
Nonoperating gains and losses	(304,024)	11,803,302	11,499,278	63,955	(386,058)	22,002	758	364,037	11,563,992
Excess (deficiency) of revenue and gains over expenses and losses	-	3,891,350	3,891,350	-	-	-	-		3,891,350
Net assets released from restrictions for acquisition of property and equipment	-	4,725,009	4,725,009	-	-	-	-	-	4,725,009
Reclassifications from temporarily restricted net assets	1,231,565	(1,231,565)	-	-	-	-	-	-	-
Forgiveness of intercompany receivable	(103,196)	578,578	475,380	-	-	-	(475,380)	-	-
Transfers (to) from affiliates	-	-	-	-	255,000	-	-	(255,000)	-
Capitalization of intercompany advance	-	-	-	-	-	(66,659)	-	66,659	-
Return of investment to Parent									
Increase (decrease) in unrestricted net assets before cumulative effect of change in accounting	824,343	19,766,674	20,591,017	63,955	(131,035)	(44,657)	(474,622)	175,696	20,180,351
Cumulative effect of change in accounting	(19,438,356)	19,438,356	-	-	-	-	-	-	-
Increase (decrease) in unrestricted net assets	$ (18,614,013)	$ 39,205,030	$ 20,591,017	$ 63,955	$ (131,035)	$ (44,657)	$ (474,622)	$ 175,696	$ 20,180,351

Appendix C

Financial Projections

REQUESTED FACILITY (DEPARTMENT) WITHOUT THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO.
CON PROJECT Affiliation with Greenwich Health Care Services, Inc.
APPLICANT Yale-New Haven Health Services Corporation
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$573,023	$618,708	$636,589	$655,051				
2	NON-GOVT GROSS PATIENT REVENUE	460,092	496,773	511,130	525,954				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	1,033,115	1,115,481	1,147,719	1,181,005				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	264,784	285,894	294,156	302,688				
5	NET BAD DEBTS	27,263	29,436	30,287	31,166				
6	FREE CARE	6,705	7,240	7,449	7,665				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	33,968	36,676	37,736	38,831				
8	NON-GOVT CONTRACTUAL ALLOWANCES	49,838	53,811	55,367	56,972				
9	UCP & TAX ADJUSTMENTS TO PAYMENTS								
10	OTHER ALLOWANCES	26,800	28,937	29,773	30,636				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	110,606	119,424	122,876	126,439				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	375,390	405,318	417,032	429,127				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	657,725	710,163	730,687	751,878				
14	INPATIENT GROSS REVENUE	778,452	840,515	864,806	889,887				
15	OUTPATIENT GROSS REVENUE	257,192	274,966	282,913	291,118				
16	OTHER OPERATING REVENUE	43,594	9,514	9,514	9,514				
17	REVENUE FROM OPERATIONS	701,319	719,677	740,201	761,392				
18	NON-PHYSICIAN SALARIES	295,268	303,536	312,035	320,772				
19	PHYSICIAN SALARIES	29,325	30,146	30,990	31,858				
20	FRINGE BENEFITS - NON PHYSICIAN	68,378	70,908	73,957	77,137				
21	FRINGE BENEFITS - PHYSICIAN	6,321	6,555	6,837	7,131				
22	OTHER: SUPPLY & DRUGS	97,942	99,754	102,348	105,009				
23	OTHER THAN SUPPLY & DRUGS	103,563	107,188	111,208	115,378				
24	PHYSICIAN FEES	52,781	54,364	56,049	57,787				
25	MALPRACTICE	11,013	11,387	11,786	12,199				
26	LEASES - ANNUAL	4,937	5,105	5,284	5,469				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	4,937	5,105	5,284	5,469				
29	DEPARTMENTAL DEPRECIATION	24,216	24,216	24,216	24,216				
30	PLANT DEPRECIATION	17,649	17,649	17,649	17,649				
31	**TOTAL DEPRECIATION (29 + 30)**	41,865	41,865	41,865	41,865				
32	INTEREST	16,032	16,032	16,032	16,032				
33	EXPENSE RECOVERY (Enter as negative)	(35,664)	(36,663)	(37,690)	(38,745)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	691,761	710,177	730,701	751,892				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	9,558	9,500	9,500	9,500				
36	NON-OPERATING REVENUE	13,102	13,102	13,102	13,102				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$22,660	$22,602	$22,602	$22,602				
38	FULL TIME EQUIVALENTS	7,636.6	7,636.6	7,636.6	7,636.6				
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REQUESTED FACILITY (DEPARTMENT) WITH THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO.
CON PROJECT Affiliation with Greenwich Health Care Services, Inc.
APPLICANT Yale-New Haven Health Services Corporation
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$664,329	$715,005	$744,194	$771,346				
2	NON-GOVT GROSS PATIENT REVENUE	544,560	586,356	611,538	634,782				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	1,208,889	1,301,361	1,355,732	1,406,128				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	315,703	341,436	360,956	378,115				
5	NET BAD DEBTS	30,134	32,923	34,700	36,497				
6	FREE CARE	10,141	11,334	12,542	13,734				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	40,275	44,257	47,242	50,231				
8	NON-GOVT CONTRACTUAL ALLOWANCES	58,660	63,731	67,156	70,521				
9	UCP & TAX ADJUSTMENTS TO PAYMENTS	5,852	6,083	6,676	7,079				
10	OTHER ALLOWANCES	22,045	29,886	30,837	31,789				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	126,832	143,957	151,911	159,620				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	442,535	485,393	512,867	537,735				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	766,354	815,968	842,865	868,393				
14	INPATIENT GROSS REVENUE	880,302	945,685	980,945	1,013,895				
15	OUTPATIENT GROSS REVENUE	331,116	355,676	374,787	392,232				
16	OTHER OPERATING REVENUE	$43,452	$10,333	$10,364	$10,395				
17	REVENUE FROM OPERATIONS	809,806	826,301	853,229	878,788				
18	NON-PHYSICIAN SALARIES	339,978	349,312	359,051	369,061				
19	PHYSICIAN SALARIES	33,899	34,844	35,814	36,813				
20	FRINGE BENEFITS - NON PHYSICIAN	78,584	81,454	84,894	88,479				
21	FRINGE BENEFITS - PHYSICIAN	7,366	7,639	7,961	8,296				
22	OTHER: SUPPLY & DRUGS	110,252	112,310	115,155	118,072				
23	OTHER THAN SUPPLY & DRUGS	123,566	127,672	132,196	136,878				
24	PHYSICIAN FEES	54,288	55,915	57,645	59,429				
25	MALPRACTICE	12,054	12,449	12,869	13,304				
26	LEASES - ANNUAL	5,473	5,652	5,842	6,038				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	5,473	5,652	5,842	6,038				
29	DEPARTMENTAL DEPRECIATION	27,740	28,626	31,018	30,688				
30	PLANT DEPRECIATION	22,830	21,969	23,389	23,021				
31	**TOTAL DEPRECIATION (29 + 30)**	50,570	50,595	54,407	53,709				
32	INTEREST	16,039	16,039	17,888	19,743				
33	EXPENSE RECOVERY (Enter as negative)	(38,714)	(39,774)	(40,863)	(41,981)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	793,355	814,107	842,859	867,841				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	16,451	12,194	10,370	10,947				
36	NON-OPERATING REVENUE	19,060	19,119	19,179	19,240				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$35,511	$31,313	$29,549	$30,187				
38	FULL TIME EQUIVALENTS	8,582.0	8,583.0	8,583.0	8,583.0				
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REQUESTED FACILITY (DEPARTMENT) INCREMENTAL
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO.
CON PROJECT Affiliation with Greenwich Health Care Services, Inc.
APPLICANT Yale-New Haven Health Services Corporation
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$91,306	$96,297	$107,605	$116,295				
2	NON-GOVT GROSS PATIENT REVENUE	84,468	89,583	100,408	108,828				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	175,774	185,880	208,013	225,123				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	50,919	55,542	66,800	75,427				
5	NET BAD DEBTS	2,671	3,487	4,413	5,331				
6	FREE CARE	3,436	4,094	5,093	6,069				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	6,307	7,581	9,506	11,400				
8	NON-GOVT CONTRACTUAL ALLOWANCES	8,822	9,920	11,789	13,549				
9	UCP & TAX ADJUSTMENTS TO PAYMENTS	5,852	6,083	6,676	7,079				
10	OTHER ALLOWANCES	(4,755)	949	1,064	1,153				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	16,226	24,533	29,035	33,181				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	67,145	80,075	95,835	108,608				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	108,629	105,805	112,178	116,515				
14	INPATIENT GROSS REVENUE	101,850	105,170	116,139	124,008				
15	OUTPATIENT GROSS REVENUE	73,924	80,710	91,874	101,114				
16	OTHER OPERATING REVENUE	(142)	819	850	881				
17	REVENUE FROM OPERATIONS	108,487	106,624	113,028	117,396				
18	NON-PHYSICIAN SALARIES	44,710	45,776	47,016	48,289				
19	PHYSICIAN SALARIES	4,574	4,698	4,824	4,955				
20	FRINGE BENEFITS - NON PHYSICIAN	10,206	10,546	10,937	11,342				
21	FRINGE BENEFITS - PHYSICIAN	1,045	1,084	1,124	1,165				
22	OTHER: SUPPLY & DRUGS	12,310	12,556	12,807	13,063				
23	OTHER THAN SUPPLY & DRUGS	20,003	20,484	20,988	21,500				
24	PHYSICIAN FEES	1,507	1,551	1,596	1,642				
25	MALPRACTICE	1,041	1,062	1,083	1,105				
26	LEASES - ANNUAL	536	547	558	569				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	536	547	558	569				
29	DEPARTMENTAL DEPRECIATION	3,524	4,410	6,802	6,472				
30	PLANT DEPRECIATION	5,181	4,320	5,740	5,372				
31	**TOTAL DEPRECIATION (29 + 30)**	8,705	8,730	12,542	11,844				
32	INTEREST	7	7	1,856	3,711				
33	EXPENSE RECOVERY (Enter as negative)	(3,050)	(3,111)	(3,173)	(3,236)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	101,594	103,930	112,158	115,949				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	6,893	2,694	870	1,447				
36	NON-OPERATING REVENUE	5,958	6,017	6,077	6,138				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$12,851	$8,711	$6,947	$7,585				
38	FULL TIME EQUIVALENTS	945.4	946.4	946.4	946.4				
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REQUESTED FACILITY (DEPARTMENT) WITHOUT THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO.
CON PROJECT Affiliation with Yale-New Haven Health Services Corporation
APPLICANT Greenwich Health Care Services, Inc.
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$91,306	$96,297	$107,605	$116,295				
2	NON-GOVT GROSS PATIENT REVENUE	84,468	89,583	100,408	108,828				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	175,774	185,880	208,013	225,123				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	50,919	55,542	66,800	75,427				
5	NET BAD DEBTS	2,871	3,487	4,413	5,331				
6	FREE CARE	3,436	4,094	5,093	6,069				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	6,307	7,581	9,506	11,400				
8	NON-GOVT CONTRACTUAL ALLOWANCES	8,822	9,920	11,789	13,549				
9	UCP & TAX ADJUSTMENTS TO PAYMENTS	5,852	6,083	6,676	7,079				
10	OTHER ALLOWANCES	(4,755)	949	1,064	1,153				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	16,226	24,533	29,035	33,181				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	67,145	80,075	95,835	108,608				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	108,629	105,805	112,178	116,515				
14	INPATIENT GROSS REVENUE	101,850	105,170	116,139	124,008				
15	OUTPATIENT GROSS REVENUE	73,924	80,710	91,874	101,114				
16	OTHER OPERATING REVENUE	(142)	819	850	881				
17	REVENUE FROM OPERATIONS	108,487	106,624	113,028	117,396				
18	NON-PHYSICIAN SALARIES	44,710	45,776	47,016	48,289				
19	PHYSICIAN SALARIES	4,574	4,698	4,824	4,955				
20	FRINGE BENEFITS - NON PHYSICIAN	10,206	10,546	10,937	11,342				
21	FRINGE BENEFITS - PHYSICIAN	1,045	1,084	1,124	1,165				
22	OTHER: SUPPLY & DRUGS	12,310	12,556	12,807	13,063				
23	OTHER THAN SUPPLY & DRUGS	20,003	20,484	20,988	21,500				
24	PHYSICIAN FEES	1,507	1,551	1,596	1,642				
25	MALPRACTICE	1,041	1,062	1,083	1,105				
26	LEASES - ANNUAL	536	547	558	569				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	536	547	558	569				
29	DEPARTMENTAL DEPRECIATION	3,524	4,410	6,802	6,472				
30	PLANT DEPRECIATION	5,181	4,320	5,740	5,372				
31	**TOTAL DEPRECIATION (29 + 30)**	8,705	8,730	12,542	11,844				
32	INTEREST	7	7	1,856	3,711				
33	EXPENSE RECOVERY (Enter as negative)	(3,050)	(3,111)	(3,173)	(3,236)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	101,594	103,930	112,158	115,949				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	6,893	2,694	870	1,447				
36	NON-OPERATING REVENUE	5,958	6,017	6,077	6,138				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$12,851	$8,711	$6,947	$7,585				
38	FULL TIME EQUIVALENTS	945.4	946.4	946.4	946.4				
39									
40									
41									
42									
43									

REQUESTED FACILITY (DEPARTMENT) WITH THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO.
CON PROJECT Affiliation with Yale-New Haven Health Services Corporation
APPLICANT Greenwich Health Care Services, Inc.
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$91,306	$96,297	$107,605	$116,295				
2	NON-GOVT GROSS PATIENT REVENUE	84,468	89,583	100,408	108,828				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	175,774	185,880	208,013	225,123				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	50,919	55,542	66,800	75,427				
5	NET BAD DEBTS	2,871	3,487	4,413	5,331				
6	FREE CARE	3,436	4,094	5,093	6,069				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	6,307	7,581	9,506	11,400				
8	NON-GOVT CONTRACTUAL ALLOWANCES	8,822	9,920	11,789	13,549				
9	UCP & TAX ADJUSTMENTS TO PAYMENTS	5,852	6,083	6,676	7,079				
10	OTHER ALLOWANCES	(4,755)	949	1,064	1,153				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	16,226	24,533	29,035	33,181				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	67,145	80,075	95,835	108,608				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	108,629	105,805	112,178	116,515				
14	INPATIENT GROSS REVENUE	101,850	105,170	116,139	124,008				
15	OUTPATIENT GROSS REVENUE	73,924	80,710	91,874	101,114				
16	OTHER OPERATING REVENUE	(142)	819	850	881				
17	REVENUE FROM OPERATIONS	108,487	106,624	113,028	117,396				
18	NON-PHYSICIAN SALARIES	44,710	45,776	47,016	48,289				
19	PHYSICIAN SALARIES	4,574	4,698	4,824	4,955				
20	FRINGE BENEFITS - NON PHYSICIAN	10,206	10,546	10,937	11,342				
21	FRINGE BENEFITS - PHYSICIAN	1,045	1,084	1,124	1,165				
22	OTHER: SUPPLY & DRUGS	12,310	12,556	12,807	13,063				
23	OTHER THAN SUPPLY & DRUGS	20,003	20,484	20,988	21,500				
24	PHYSICIAN FEES	1,507	1,551	1,596	1,642				
25	MALPRACTICE	1,041	1,062	1,083	1,105				
26	LEASES - ANNUAL	536	547	558	569				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	536	547	558	569				
29	DEPARTMENTAL DEPRECIATION	3,524	4,410	6,802	6,472				
30	PLANT DEPRECIATION	5,181	4,320	5,740	5,372				
31	**TOTAL DEPRECIATION (29 + 30)**	8,705	8,730	12,542	11,844				
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33	EXPENSE RECOVERY (Enter as negative)	(3,050)	(3,111)	(3,173)	(3,236)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	101,594	103,930	112,158	115,949				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	6,893	2,694	870	1,447				
36	NON-OPERATING REVENUE	5,958	6,017	6,077	6,138				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$12,851	$8,711	$6,947	$7,585				
38	FULL TIME EQUIVALENTS	945.4	946.4	946.4	946.4				
39									
40									
41									
42									
43									

REQUESTED FACILITY (DEPARTMENT) INCREMENTAL
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO.
CON PROJECT Affiliation with Yale-New Haven Health Services Corporation
APPLICANT Greenwich Health Care Services, Inc.
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE								
2	NON-GOVT GROSS PATIENT REVENUE								
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**								
4	GOVT DEDUCTIONS FROM GROSS REVENUE								
5	NET BAD DEBTS								
6	FREE CARE								
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**								
8	NON-GOVT CONTRACTUAL ALLOWANCES								
9	UCP & TAX ADJUSTMENTS TO PAYMENTS								
10	OTHER ALLOWANCES								
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**								
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**								
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**								
14	INPATIENT GROSS REVENUE								
15	OUTPATIENT GROSS REVENUE								
16	OTHER OPERATING REVENUE								
17	REVENUE FROM OPERATIONS								
18	NON-PHYSICIAN SALARIES								
19	PHYSICIAN SALARIES								
20	FRINGE BENEFITS - NON PHYSICIAN								
21	FRINGE BENEFITS - PHYSICIAN								
22	OTHER: SUPPLY & DRUGS								
23	OTHER THAN SUPPLY & DRUGS								
24	PHYSICIAN FEES								
25	MALPRACTICE								
26	LEASES - ANNUAL								
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28	**TOTAL LEASES (26 + 27)**								
29	DEPARTMENTAL DEPRECIATION								
30	PLANT DEPRECIATION								
31	**TOTAL DEPRECIATION (29 + 30)**								
32	INTEREST								
33	EXPENSE RECOVERY (Enter as negative)								
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**								
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)								
36	NON-OPERATING REVENUE								
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**								
38	FULL TIME EQUIVALENTS								
39									
40									
41									
42									
43									

Appendix D

Hospital Licensing Survey

- Yale-New Haven Hospital
- Bridgeport Hospital
- The Greenwich Hospital Association

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

December 30, 1996

Joeph A. Zaccagnino, Administrator
Yale-New Haven Hospital
20 York Street
New Haven, CT 06504

Dear Administrator:

Unannounced visits were made to Yale-New Haven Hospital on November 6, 7, 8 and 12, 1996 by a representative of the Division of Health Systems Regulation for the purpose of conducting complaint investigations.

Attached are the violations of the State of Connecticut Public Health Code and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by January 14, 1997 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

a. Measures to prevent the reoccurrence of the identified violation, (e.g:., policy/procedure, inservice program, repairs, etc.).

b. Date corrective measure will be effected.

c. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Janet M. McKiernan, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JAN 2 1997

JMM/KWB/mh

cc: Edwin C. Cadman, MD
Diana Weaver, RN, DON
Joseph A. Zaccagnino, President

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191

FACILITY: Yale New Haven Hospital

DATE(S) OF VISIT: November 6, 7, 8 and 12, 1996

THE FOLLOWING VIOLATIONS OF THE STATE OF CONNECTICUT PUBLIC HEALTH CODE AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Patient #4, a 29 year old female, presented on 4/20/96 to the Emergency Room with exacerbation of back pain relating to a known herniated disc. Surgery had already been scheduled for 5/15/96. The patient was examined by the Emergency Room physician, a neurosurgical resident and an orthopedic surgeon. The patient identified she had increased problems with incontinence. Exam revealed decreased right lower extremity motor ability, but it was not determined if it was related to the disc or to her pain. A repeat CT scan compared with previous films showed no significant change. Nursing progress notes reflected the patient was medicated for pain at 2:45 AM, 4:30 AM, 5:45 AM and 11:10 AM. There was no corresponding physician's order for the first dose of Toradol given at 11:10 AM.

The above is a violation of the State of Connecticut Public Health Code Section 19-13-D3 (d) Medical Records (3).

2. Patient #1, a twenty-five year old profoundly mentally retarded patient, was sent to the hospital for assessment of possible gastrointestinal bleeding. Evaluation in the Emergency Room revealed gastric tube site irritation, but no gastrointestinal bleeding. Significant findings included tachycardia of a rate of 154-175 and an oxygen saturation of 88% on room air. The patient was afebrile. The Emergency Room record lacked documentation that information was forwarded back to the receiving facility identifying clinical findings, recommended interventions (including referral to Endocrine Clinic) to provide for the continuity of care of the patient.

The above is a violation of the State of Connecticut Public Health Code Section 19a-504c Discharge Planning (e).

Yale New Haven Hospital
1826
20 York Street, New Haven, CT 06504

January 17, 1997

Janet McKiernan, RN
State of Connecticut
Department of Public Health
410 Capitol Avenue - MS #12HFA
P.O. Box 340308
Hartford, CT 06134

Dear Ms. McKiernan:

I am writing in response to your letter of January 6, 1997 in which you set forth violations related to visits made on November 6, 7, 8 and 12, 1996. I will respond to the allegations as they are set forth in the letter. Thank you for the grant of additional time to reply.

1. Patient #4, a 29 year old female, presented on 4/20/96 to the Emergency Room with exacerbation of back pain relating to a known herniated disc. Surgery had already been scheduled for 5/15/96. The patient was examined by the Emergency Room physician, a neurosurgical resident and an orthopedic surgeon. The patient identified she had increased problems with incontinence. Exam revealed decreased right lower extremity motor ability, but it was not determined if it was related to her pain. A repeat CT scan compared with previous films showed no significant change. Nursing progress notes reflected the patient was medicated for pain at 2:45 AM, 4:30 AM, 5:45 AM and 11:10 AM. There was no corresponding physician's order for the first dose of Toradol given at 11:10 AM.

The above is a violation of the State of Connecticut Public Health Code Section 19-13-D3 (d) Medical Records (3).

Response: The Hospital acknowledges that there was no written order for the first dose of Toradol administered, which was apparently given pursuant to an unsigned verbal order and not properly recorded as such by the nurse who administered the medication. As its Plan of Correction, the Hospital agrees to review with nursing and physician staff in the Emergency Department the current policy for the use and documentation of verbal orders. This will be accomplished by the Co-Director of the Emergency Department within the next two weeks. In addition, the Emergency Service Co-Director will oversee an audit of 10 charts per week for the period

commencing on or about February 1 and ending on or about April 1, 1997 to determine compliance with the verbal order policy. Notable levels of non-compliance will be addressed through retraining and counseling.

2. Patient #1, a twenty-five year old profoundly mentally retarded patient, was sent to the hospital for assessment of possible gastrointestinal bleeding. Evaluation in the Emergency Room revealed gastric tube site irritation, but no gastrointestinal bleeding. Significant findings included tachycardia of a rate of 154-175 and an oxygen saturation of 88% on room air. The patient was afebrile. The Emergency Room record lacked documentation that information was forwarded back to the receiving facility identifying clinical findings, recommended interventions (including referral to Endocrine Clinic) to provide for the continuity of care of the patient.

The above is a violation of the State of Connecticut Public Health Code Section 19a-504c Discharge Planning (e).

Response: The Hospital acknowledges that its record failed to document what information was provided to the receiving facility. It should be noted that discharging a patient to a long term care facility is unusual enough in the Pediatric Emergency Department that it is less familiar to the staff there than at other places in the Hospital. As the Hospital's Plan of Correction, the Co-Director of the Emergency Service will review with all relevant Pediatric Emergency Department staff the discharge procedures for a patient being discharged to a long-term care facility). This review will take place within the next month. Though not directly related to this Plan of Correction, the Hospital wishes to inform the Department of its intent to charter a new Quality Improvement team to review issues surrounding discharge planning for the entire Emergency Department. It is likely that the work of this new team will be performed over the period of the next year.

Thank you for this opportunity to respond to the alleged violations. Please feel free to call should you have further questions.

Very truly yours,

Stuart G. Warner
Assistant Counsel

cc: Marna P. Borgstrom
Diana Weaver, RN, DNS
Edwin C. Cadman, MD
Beth Esposito, RN

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

000209

April 14, 1994

Robert J. Trefry
President and Chief Executive Officer
Bridgeport Hospital
267 Grant Street
Post Office Box 5000
Bridgeport, Connecticut 06610

Dear Mr. Trefry:

An unannounced visit was made to Bridgeport Hospital on March 16, 1994 by representatives of the Hospital and Medical Care Division and the Monitoring and Radiation Division of the Department of Environmental Protection for the purpose of conducting a licensure inspection.

A focused review of the following services was undertaken:

Nursing - Evaluation of nursing process and infection control procedures.
Medical Staff - Control of privileges and quality assurance.
Dietary Services - Therapeutic clinical services.
Social Services - Discharge planning.
Physical Plant - Physical environment and fire safety.
Radiology - Evaluation of equipment and quality control.

The following violations of the State of Connecticut Public Health Code were observed during the course of the inspection.

1. The Clean Utility Rooms, located on the fifth floor through the tenth floor of the West Tower were not provided with doors to separate the rooms from the corridor.

The above is a violation of the State of Connecticut Public Health Code, Section 19-13-D3 (a) Physical Plant (2).

2. In twelve (12) of seventeen (17) nursing care plans reviewed, the plan failed to reflect the actual problems/needs of the patient as evidenced by:
   a. In five (5) of ten (10) medical records reviewed, care plans lacked individualization.
   b. Three (3) nursing assessments identified patient educational needs not addressed on the care plan.

2. c. Three (3) care plans identified assessment of patient pain every three hours. The interventions were not documented as identified on the plan.
   d. One (1) patient with newly diagnosed cancer lacked the psychosocial needs of the patient identified on the plan of care.

3. Four (4) of ten (10) medical records reviewed contained physician notes and orders that were illegible.

4. Two (2) of ten (10) medical records contained physician orders that were nonspecific.

5. The facility failed to weigh one (1) of four (4) patients at nutritional risk both upon admission; and also following a recommendation of the registered dietitian.

6. Two (2) of three (3) records in which patients were documented as having received prn (as necessary) medications, the response to the medication was not identified.

The above, 2 through 6, are violations of the State of Connecticut Public Health Code, Section 19-13-D3 (d) Medical Records (3).

7. Five (5) of ten (10) records of patients transferred to skilled nursing facilities failed to include the signature of the patient or family member or representative on the patient discharge plan.

The above is a violation of the Regulations of Connecticut State Agencies, Section 19a-504c-1 Discharge Planning (f) and the State of Connecticut Public Health Code, Section 19-13-D3 (d) Medical Records (3).

8. The hospital's Department of Obstetrics and Gynecology lacked a written standard for, and two (2) of ten (10) VIP (voluntary interruption of pregnancy) records lacked evidence of, the provision of postoperative counseling including family planning to the patient.

The above is a violation of the State of Connecticut Public Health Code, Section 19-13-D54 Regulations on Abortions (d)(10) and Section 19-13-D3 (d) Medical Records (3).

9. Surfaces and countertops (along with various pieces of equipment) in the Emergency Department contained a visible accumulation of dust.

10. The pediatric scale in the "Emergease" area of the Emergency Department contained a visible accumulation of dust.

11. Supplies were stored uncovered on carts in the Plaster Room suite.

000211

12. Supplies and equipment were stored uncovered in the Clean Utility Room on Tower 7 which lacked doors and was therefore open to the hallways.

13. The pediatric warming unit housed in the Emergency Department lacked evidence of current biomedical inspection (last review date 2/15/93).

14. The Endoscopy suite lacked adequate space to prevent cross-contamination of equipment, equipment processing and equipment storage. The suite, additionally, lacked adequate patient processing.

15. The area identified in the preoperative laboratory of "Surgease" allowed for cross-contamination of personnel and patient medical records.

The above, 9 through 15, are violations of the State of Connecticut Public Health Code, Section 19-13-D3 (i) General (7) and (l) Infection Control (4).

Please respond by April 28, 1994 with a plan of correction for these violations.

You may wish to dispute the violations stated above and you may be provided with an opportunity to be heard. If these violations are not responded to by the date requested, or if a request for a meeting is not made within that time period, the violations shall be deemed admitted.

If there are any questions please do not hesitate to contact this office.

Sincerely,

Rita E. Grygus

Rita E. Grygus, R.N., M.S.N.
Medical Facilities Consultation Supervisor
Hospital and Medical Care Division

REG:KWB:jp

#0855J

STATE OF CONNECTICUT

000212

DEPARTMENT OF PUBLIC HEALTH

Greenwich Hospital
Administration Department

JAN 27 1997

Received

January 23, 1997

Certified Mail No. - Z 175 349 142

Frank Corvino, Administrator
Greenwich Hospital
5 Perryridge Road
Greenwich, CT. 06830

Dear Mr. Corvino:

An unannounced visits wasc made to Greenwich Hospital on December 13, 1996 by a representative of the Division of Health Systems Regulation for the purpose of investigating an incident with an additional telephone interview conducted on December 20, 1996.

Attached are the violations of the State of Connecticut Public Health Code and/or General Statutes of Connecticut which were noted during the course of the visit.

Section 4-182 (c) of the General Statutes of Connecticut, as amended, requires that you be given the opportunity to show compliance with all lawful requirements for the retention of your license.

In accordance with this Statutory requirement, an office conference has been scheduled for February 7, 1997 at 9:30 a.m. in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Hartford, Connecticut.

The purpose of this meeting is to provide you with an opportunity to discuss the violations contained in this letter and to show that further action by this Department should not be instituted.

You may wish to be accompanied by your attorney. It is not mandatory that you attend this meeting, however, if you do not attend we will have no recourse but to institute further proceedings.

Please prepare a written plan of correction for the above mentioned violations to be presented at this conference.

Address each violation with a prospective plan of correction which includes the following components:

a. Measures to prevent the reoccurrence of the identified violation, (e.g., policy/procedure, inservice programs, repairs, etc.).
b. Date corrective measure will be effected.
c. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Rita L. Grygus

Rita L. Grygus, R.N., M.S.N.
Medical Facilities Consultation Supervisor
Division of Health Systems Regulation
[illegible]
REG:CCG:jod

Phone: 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

THE FOLLOWING VIOLATIONS OF THE STATE OF CONNECTICUT PUBLIC HEALTH CODE AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. The hospital failed to have a completed history and physical recorded by the physician within twenty-four hours of admission. Based on medical record review the findings include:
   a. Three of the five medical records lacked a history and physical, (e.g., Patient's #1, #2 and #3).
2. Through medical record review, policy review and staff interview it was determined that the hospital staff failed to accurately assess skin integrity on admission for five patient's reviewed. Facility policy for wound care states an initial assessment is to include stage, size and description with reassessment of skin integrity every twenty-four hours for potential complications. The findings include:
   a. Patient #1's initial nursing assessment lacked size and description.
   b. Patient #2's initial nursing assessment lacked size of the decubiti.
   c. Patient #3's initial nursing assessment lacked sizing of the lesions.
   d. Patient #4's initial nursing assessment lacked identification of all areas of skin breakdown except for one. The patient had four other areas of breakdown undocumented.
   e. Patient #5's initial nursing assessment lacked any assessment of scale to determine risk for pressure sore; fall risk assessment; neurological assessment and pain/comfort scale.
3. The hospital failed to develop a patient care plan to include the problem of skin integrity for four of the five patient's reviewed. The findings based on medical record review include:
   a. Patient #1's patient care plan of 12/6/96 lacked the problem of skin integrity, goal and/or interventions.
   b. Patient #2's patient care plan of 12/3/96 identified tissue perfusion but lacked identifying a pressure sore, goal and/or interventions.
   c. Patient #3's patient care plan of 12/2/96 lacked goals and interventions.
   d. Patient #4's patient care plan of 11/21/96 lacked the problem of skin integrity, goals and interventions.
4. The hospital staff failed to document accurately in the progress notes of four medical records information on skin integrity and/or pressure sores. Based on medical record review, observation and staff interview the findings include:
   a. Patient #1's progress notes lacked any documentation of the sacral decubitus. Observation of the patient on 12/13/96 identified a dry and intact Duoderm dressing

THE FOLLOWING VIOLATIONS OF THE STATE OF CONNECTICUT PUBLIC HEALTH CODE AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

over the sacrum, two reddened pressure areas were observed on the left ankle and heel, no protective devices were observed between the legs and on the feet.

b. Patient #2's progress notes lacked documentation of decubiti. Observation of Patient #2 on 12/13/96 identified two dime sized openings on the right and left buttock and one 1 inch by 2 inch right lower buttock all Stage II.

c. Patient #3's progress notes lacked description of old' and new lesions. Observation on 12/13/96 identified three new open areas on the right leg.

d. Patient #4's progress notes inconsistently documented some areas which received treatment. Observation on 12/13/96 identified a Stage II sacral decubiti without the benefit of a dressing. A gauze dressing on the inner aspect of the left foot appeared dirty with old dried blood. All observations were confirmed by the nurse manager.

The above are violations of the State of Connecticut Public Health Code Section 19-13-D3 (d) Medical Records (3).

Rita E. Grygus
Medical Facilities Consultation Supervisor
Division of Health Systems Regulation
State of Connecticut Department of Health
410 Capitol Avenue - MS # 12 HRS
P.O. Box 340308
Hartford, Connecticut 06134

Dear Ms. Grygus:

As you are aware, a representative of the Division of Health Systems Regulation made an unannounced visit to Greenwich Hospital on December 13, 1997. We received a report of the State's findings on January 27,1997 and subsequently met with you to discuss the violations. At our meeting I agreed to send you a report regarding the issues in June after the Wound Care Team had reported to the Quality Council.

I have enclosed the following for your review:

With regard to issue #1:

The Utilization Review Department continues to notify the Health Information Management Department of any record that does not have a history or physical dictated within 24 hours. The Health Information Management Committee contacts the physician. During the months of April and May only four phone calls had to be made. In all instances the chart was then dictated within 24 hours, except for one which was dictated within 48 hours. We will continue to address this with the medical staff until there is 100% compliance.

With regard to issue #2 and #3:

The Wound Care Team presentation to the Quality Council (Attachment B). In summary, it includes a prevalence study, assessment of documentation patterns, assessment of product usage, and policies and procedures. The team recommendations and status of the action taken is reported on the last five pages of the presentation. The last page of these five is the monitoring plan. (The prevalence study indicated 5 Level I, 6 Level 2, and 1 not documented.)

The "Management of Skin Integrity" (purple binder) is a resource manual on every unit. It includes in the front pocket several tools that have been developed to aid in the documentation of skin integrity. The items included are: a one time use disposable ruler which describes the stages on the front and the wound assessment on the reverse side; a page of skin integrity skin care plans, which come in sticker form, to attach to the chart; and the care plan that has been piloted on ICU which includes the same information. The sticker is an interim step until the piloted care plan is implemented on all units and the care plan is an interim step until the computer documentation system is implemented. The clinical documentation system is anticipated to be operational in November, at that point there should be no lack of documentation because the

system will not allow you to move forward if you have not completed the assessment. Also, included is a yellow laminated reference tool which is on every unit.

The monitoring of skin integrity is an ongoing process on the units. The initial assessment component for skin integrity continues to improve. Documentation of ongoing assessments, nursing care provided, and patient response are addressed close to 100% of the time for patients with issues related to skin integrity. The Documentation Committee is developing a less cumbersome tool to promote the constant updating of the plan of care when new problems occur.

With regard to issue #4:

The Health Information Management Department will conduct quarterly reports on wound care documentation. The first quarter report indicated all records included wound care documentation which was appropriate for the cases reviewed. All records included wound care documentation in the progress notes as well as in other reports including consults, and summaries.

Please contact me if you would like me to provide you with any further information at (203) 863-3337.

Sincerely,

Gail E. Doria
Director Quality Management

Greenwich Hospital Response to
Violations of State of Connecticut Public Health Code

1. **The hospital failed to have a completed history and physical recorded by the physician within twenty-four (24) hours of admission. Based on medical record review, the findings include:**

a) Three of five records lacked a history and physical

The three records noted that lacked a completed history and physical were the responsibility of a single physician. We believe this to be an anomoly with respect to the Hospital's recordkeeping practices. Attached for your review are the historical delinquency rates for history and physical reports (see Attachment I). To help insure that history and physical reports are recorded by physicians within 24 hours of admission, the attached policy has been put into effect as of 1/28/97 (see Attachment II). Sharon Bollerman, Director of Health Information Management, will monitor compliance with this policy. In addition, the responsible physician will be monitored for completeness of record on a concurrent basis for a six month period of time by the Utilization/Quality Management staff. Gail Cucurullo, Director of Quality Management, will report any findings to the Chief of Medicine and to the Executive Committee of the Medical Staff. The initial findings will be presented at the February 24, 1997 Executive Committee meeting.

2. **Through medical record review, policy review and staff interview, it was determined that the hospital staff failed to accurately assess skin integrity on admission for five patient's reviewed. Facility policy for wound care states an initial assessment is to include stage, size, description with reassessment of skin integrity every twenty-four hours for potential complications. The findings include:**

a) **Patient #1's initial nursing assessment lacked size and description.**
b) **Patient #2's initial nursing assessment lacked size of the decubiti.**
c) **Patient #3's initial nursing assessment lacked sizing of the lesions.**
d) **Patient #4's initial nursing assessment lacked identification of all areas of skin breakdown except for one. The patient had four other areas of breakdown undocumented.**
e) **Patient #5's initial nursing assessment lacked any assessment of scale to determine risk of pressure sore, fall risk assessment, neurological assessment and pain/comfort scale.**

2a. A 92 year old female admitted 12/6/96 with increasing dyspnea, cough, and orthopnea. She had a 20 year history of COPD, was diagnosed with pneumonia (aspergillus on culture) and CHF. Her respiratory status was of major concern. The nurse's initial assessment described skin condition (see attached page A2), although the size was not noted. Flow sheet indicates skin dry from 12/7-12/10 , advancing to normal for 12/11 through 12/15/96 (see A3 - A4). Issue of skin breakdown apparently resolved within 24 hours. Patient's skin condition documented on a 12/6 home care visit to be 0.5cm. X 0.1cm. On admission, the patient was on a pressure guard bed. Acuity sheet documents assistive repositioning on every shift from admission to discharge except for the evening shifts of 12/06 and 12/13. Extensive nurses notes with emphasis on respiratory status, patient expired on 12/15 secondary to pneumonia and severe COPD and Bronchiectasis.

2b. An 88 year old male admitted from a nursing home on 12/4/96, obtunded and in a septic state requiring intensive antibiotic treatment. On admission, patient's diagnosis included polymicrobial sepsis with sacral cellulitis, decubitus and urinary tract infection, prognosis guarded. Temperature on admission was 102 - 102.6 degrees. Description and stage of decubitus was noted on initial admission assessment, (B3) although size was not noted. Patient was on a pressure guard bed. He returned to the nursing home on 1/2/97 after resolution of his sepsis, hypovolemia, and dehydration. His skin integrity improved, but continued to be a problem secondary to incontinence of stool and urine. An indwelling foley catheter was used to assist with maintenance of skin care.

2c. An 89 year old female with history of recurrent CVA's, chronic renal failure, ASHD, NIDDM, and dementia was admitted from a subacute facility with CHF and blisters in varying stages of development over arms, legs and trunk, which were diagnosed as pemphigus. Initial assessment notes area of involvement and description, as appropriate for this diagnosis (see attached C2 - C3). Initial Dermatology consult on 12/2 documents extent of skin condition (C4). Dermatologist continues to document no new lesions from 12/6/96 through to 1/2/97 where he documents "no new lesions old ones are completely

2c. healed" (C6-C19). Patient was on a specialty bed. Patient expired on 1/26/96 related to pneumonia as a consequence of recurrent CVA's.

2d. An 85 year old male was admitted on 11/20/96 with hypothermia (temperature 93.8) and rhambdomyolysis. The patient was found in a stairwell in his home, which had been condemned. On admission, patient's diagnoses included rhambdomyolysis, pneumonia, dehydration and hypoglycemia (blood glucose was 55). On 12/13/96, the patient started choking during breakfast, Heimlich maneuver was performed. The patient was suctioned, O2 sats were at 60% on 3L oxygen, subsequently O2 sats were back to 95% after further suctioning. Patient expired on 12/17/96 from respiratory distress secondary to pneumonia. The initial admission assessment lacks all documentation of skin breakdown; however, all areas are documented in 11/20/96 nursing notes (see attached D1), although not sized or staged. Patient was on a pressure guard bed.

2e. A 90 year old female was admitted from a nursing home on 12/5/96 with shortness of breath secondary to pneumonia and unresponsive to p.o. antibiotics. The patient's condition improved and she was discharged back to the nursing home on 12/13/96. Although the initial nursing assessment form lacks documentation, as noted above, the initial patient care record and flow sheet documents skin is normal and mobility requirements. Patient was on a Pressure guard bed. Nurses notes document assistance with all activities of daily living. The primary emphasis is on patient's respiratory status (see attached E1 - E3).

To help insure the issues noted above do not recur, the following steps have been taken:

1. Unit Manager on 4 South informed staff of preliminary State findings during staff meetings held on December 16, 1996 and January 15, 1997. Reinforcement of policy standards regarding Initial Admission Assessment and Care Planning was carried out. Included in the education plan was problem identification, follow through of assessment, interventions, and outcomes, as well as documentation requirements (see Attachment IIIa, and IIIb).

2. Preliminary State findings were presented at Patient Care Advisory Committee on January 15, 1996.

3. A Multidisciplinary Continuous Quality Improvement team has been launched to improve documentation in assessment and intervention as related to skin integrity (see attached charge and composition, Attachment IV). Team will report results at Quality Council meeting on June 3, 1997. Gail Cucurullo, Director of Quality Management, will be kept apprised of team's status on a regular basis. Preliminary State findings were presented to Quality Council on February 4, 1997.

4. A Quality Assessment tool has been developed to monitor compliance with policy and procedures related to skin and wound management. The monitoring tool includes

4. documentation on Initial Admission Assessment, Care Plan and Reassessment (see Attachment V). Initial collection of data has already been instituted. Initial report will be sent to Gail Cucurullo, Director of Quality Management on March 1, 1997. Subsequent reports will be compiled and sent as indicated.

5. The role of the Geriatric Clinical Specialist has been expanded to include assisting with education and monitoring of patients with skin integrity issues.

6. Unit Managers will consult with Geriatric Nurse Specialist to assist with ongoing education and monitoring as patients are identified in multidisciplinary team rounds. Each unit will meet on a schedule consistent with patient specialty needs.

3. **The hospital failed to develop a patient care plan to include the problem of skin integrity for four of the five patient's reviewed. The findings based on medical record review include:**
   a) **Patient #1's patient care plan of 12/6/96 lacked the problem of skin integrity, goal and/or interventions.**
   b) **Patient #2's patient care plan of 12/3/96 identified tissue perfusion, but lacked identifying a pressure sore, goal and/or interventions.**
   c) **Patient #3's patient care plan of 12/2 lacked goals and interventions.**
   d) **Patient #4's patient care plan of 11/21/96 lacked the problem of skin integrity, goals and interventions.**

3a) As noted in 2a above, the emphasis was on patient's respiratory status. Initial and subsequent flow sheets and patient record indicate status of skin. Documentation of interventions for skin care were not specifically documented in a narrative form, but were indicated on the patient care record (see attached A5 - A7). Patient was on a pressure guard bed.

3b) Although patient care plan of 12/3 did not specifically delineate goals and interventions for skin integrity, since the emphasis was related to septic condition, the nurses notes on 12/3 clearly indicate interventions and identification of skin condition. A culture was taken, lotrimin applied, patient turned and positioned (see attached B6). Patient Care Record also notes interventions (see attached B7 - B11). Patient was on a pressure guard bed.

3c) Plan on initial assessment does not document intervention to be taken, although notation is made to assess and monitor condition (see attached C17 - C18). Patient was on a specialty bed.

3d) Care plan notes to assess skin breakdown and goal to return to optimal health (see attachment D2). Flow sheet and patient care record identify skin breakdown and requirements for hygiene and mobility. Interventions are not noted in the plan, but nurses notes on day of admission document orders received for skin care (D1). Medication Kardex notes interventions taken; however, nurses notes inconsistently document interventions taken in a narrative format. Patient was on a pressure guard bed.

To help insure the above noted issues do not recur please refer to action plan as noted above under item 2.

4. **The hospital failed to document accurately in the progress notes of four medical records, information on skin integrity and/or pressure sores. Based on medical record review, observation and staff interview, the findings include:**

   a) **Patient #1's progress note lacks any documentation of sacral decubitus. Observation of patient on 12/13/96 identified a dry and intact Duoderm dressing over the sacrum, two reddened pressure areas were observed on the left ankle and heel, no protective devices were observed between the legs and on the feet.**

   b) **Patient #2's progress note lacks documentation of decubiti. Observation of patient on 12/13/96 identified two dime sized openings on the right and left buttock and one 1 inch by 2 inch right lower buttock all Stage II.**

   c) **Patient #3's progress note lacked description of old and new lesions. Observation on 12/13/96 identified three new open areas on the right leg.**

   d) **Patient #4's progress notes inconsistently documented some areas which received treatment. Observation on 12/13/96 identified a Stage II sacral decubiti without benefit of a dressing. A gauze dressing on the inner aspect of the left foot appeared dirty with old dry blood. All observations were confirmed by the nurse manager.**

4a) As noted above, progress notes lacked documentation of 0.5cm X 0.1cm decubiti which was resolved within 24 hours, the emphasis was given to patient's respiratory status. Duoderm on sacrum as a precautionary skin barrier; there was no skin breakdown at this time. Patient was on a pressure guard bed.

4b) Area of sacral breakdown is noted regularly throughout the primary physician's progress notes, as well as those of the Infectious Disease Specialist (see attached B12 - B15).

4c) As noted in 2c above, progress notes consistently document status of lesions, noting on 12/6 no new lesions and on 1/2/97 old ones fully healed (see attached C4 - C16).

4d) On 12/13/97 the patient experienced an episode of desaturation secondary to respiratory distress as noted in 2d above. Focus was on respiratory status with observation, continual periodic suctioning, O2, etc. The skin barrier had been removed in the morning during routine care prior to the acute episode. Supply had been exhausted and reordered that morning as explained to the surveyor at the time. Physician's notes regularly document wound condition, but not consistently. As noted, emphasis was on dehydration, hypothermia, rhamdomyolysis and respiratory state. Dressing on ankle abrasion was not routinely documented in notes. Patient had been out of bed with attempted ambulation as noted in nurses notes on 12/12/96, this may have contributed to the visual appearance of the dressing.

To help insure the above issues do not recur, see plan outlined under item 2 above. In addition, the Department of Health findings have been reviewed with the Hospital's Vice President for Medical Services, Dr. A. Michael Marino, who will present the State findings at the Medical Staff

meeting in February. In addition, the Health Information Department will conduct a study of documentation in progress notes as related to wound care. The study will be reported at the April meeting of the Health Information Management committee. Further action will be taken at that time, if indicated.

YALE NEW HAVEN HEALTH

October 9, 1997

Mr. Harold M. Oberg
Principal Health Care Analyst
State of Connecticut
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Re: Certificate of Need Application, Docket Number 97-559
Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

Dear Mr. Oberg:

Please find attached an original and three (3) copies of the responses to the September 18, 1997 completeness questions regarding the Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc. Certificate of Need application. I hope that the following information will clarify any remaining issues regarding this application and bring it to completion.

Please contact me if you have any further inquiries.

Sincerely,

Caroline R. Piselli
Director, Planning & Marketing

Attachment

cc: Jeanette C. Schreiber, Esq.
Andrew E. Schultz, Esq.

789 Howard Avenue
New Haven, CT 06519

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
AND
GREENWICH HEALTH CARE SERVICES, INC.

CERTIFICATE OF NEED APPLICATION

CORPORATE AFFILIATION OF
YALE-NEW HAVEN HEALTH SERVICES CORPORATION
AND GREENWICH HEALTH CARE SERVICES, INC.

DN 97-546

RESPONSES TO 9/18/97 COMPLETENESS QUESTIONS

GENERAL INFORMATION

Question # 1b, Page 13

1. **As requested, please provide a completed Acute Care Hospital Affidavit for each of the following:**

   a. **Yale-New Haven Hospital**

   b. **Bridgeport Hospital**

   c. **Greenwich Hospital Association**

   Acute Care Hospital Affidavits are presented in Appendix A.

Question # 2, Page 13

2. **The Applicants have stated that "This affiliation will enhance the ability of both the regional and local networks to continue their missions centered around serving the health care needs and promoting the health status of people in their communities, within a continually changing health care environment." What mechanisms are planned by the Applicants which would enable network leadership to be responsive to the questions and concerns of the service area population regarding the CON proposal?**

   As described in the response to Question 14, page 14 in the CON application, the community has been involved through representatives on the parent companies' and hospitals' boards and through community meetings as described in the response to Question 10. Additionally there have been radio call-in shows, extensive news stories in local and regional papers, conversations and meetings with elected officials and a news conference and a press release announcing the affiliation. Prior to the public announcement many community representatives, including political and civic leaders, hospital auxiliarians, volunteers and donors, other local providers and payers, were informed about the proposed affiliation via letters, facsimile, telephone and distribution of the *Focus* magazine as described in the response to Question 10. The Applicants have received no letters of support or opposition to date and do not expect to receive any concerns from either service area. Any concerns that may be received will be addressed fully and in the appropriate forum.

Question # 2, Page 14 and Article VI of the System Affiliation Agreement ("Agreement")

3. **The Applicants have stated that "The endowment will, at all times, be dedicated to use for the benefit of Greenwich Hospital, its affiliates and the Greenwich community." Section 6.4 of the Agreement describes uses of income and principal from the fund. In this paragraph, there is no reference to restrictions as to the use of funds for the GHCS network only. In addition, any reference to the handling of restricted principal according to the wishes of the donor appears to be absent.**

The Agreement requires the principal of the endowment and any income earned be used exclusively for the benefit of the GHCS network in a manner consistent with any restrictions imposed by the donors. Please note section 6.4.1 states that income will be distributed to GHCS or Greenwich Hospital to be used in accordance with their respective missions. Since all income is distributed to GHCS or GH, the income must be used for the GHCS network only. Further, Section 6.4.2 requires that distributions of principal be made only with the approval of the Boards of the Foundation and GHCS and that the use of the distributed funds must not be inconsistent with the mission of the Foundation or any donor restrictions. As stated in Section 6.1, the mission of the Foundation is to hold, manage and distribute these funds for the benefit of the GHCS network, exclusively.

a. **Please explain and document how fund utilization in general will be managed and restricted to use for the only.**

As specified in Section 6.1, the activities of the Foundation will be limited by its mission, which is to hold, manage and distribute the funds for the exclusive benefit of the GHCS network.

b. **Please explain and document how donor restricted funds will be handled and managed according to donor wishes.**

As specified in Section 6.3, the endowment is being transferred "to the Foundation to be held, managed and distributed in accordance with the mission of the Foundation... and with any and all restrictions placed on such funds by the donor thereof or by law."

Question # 3, Pages 15 through 19

4. **The Applicants' affiliates include the following "For Profit" entities: YNHH-MSO, Inc., York Enterprises, Medical Center Realty, Inc., Medical Center Pharmacy & Home Care, Inc., Harbor Health Plan, Inc., Century Collections Agency, NovaMed, Greenwich Health Services, Inc. and Future Care, Inc. Public Act 97-188 defines a non-profit hospital to include any entity affiliated with such a hospital. Therefore please provide a copy of a legal opinion stating how and whether or not Public Act 97-188 applies to this CON proposal.**

   A copy of a legal opinion stating that Public Act 97-188 does not apply to this proposal is presented in Appendix B.

5. **Please describe the functions of YNHH-MSO, Inc.**

   YNHH-MSO, Inc. operates two lines of business. The first provides non-clinical management and support services to physician practices. The second provides non-clinical managed care contracting support services to members of the YNHH System and other contracting organizations.

Question # 3, Page 19

6. **The Applicants stated that in the short term, there are no plans to consolidate services, therefor no short-term cost savings are anticipated. What long term cost savings excluding computer services are being planned or considered involving the consolidation of any functions or services between YNHHSC and GHCS?**

   At the present time, plans to consolidate any functions or services between YNHHSC and GHCS have not progressed beyond preliminary conceptual discussions.

Question # 3, Page 19 and Article II, Paragraph 2.1.2 of the Agreement

7. **Within Article II, Paragraph 2.1.2, the parties state, "Provide *centralized managed care services* by the System and develop the System's *managed care arrangements* to increase the number of *managed care patients* served by the System, and enhance each System Member's ability to seek and accept regional, statewide, and state/federal government *managed care contracts* for enrolled populations."**

a. Please describe the aforementioned *centralized managed care services*.

"Centralized managed care services" refers to the use of certain individuals within the System who have substantial managed care experience to handle contracting activities for all members of the YNHH System. In this manner, managed care contract negotiation will be "centralized" so that obligations of System members under managed care contracts will be similar and therefore easier to administer.

b. Describe what the Applicants mean by the term, *managed care arrangements.*

The term *"managed care arrangements"* refers generally to the multitude of contractual relationships being offered by HMOs and other payors.

c. Please describe how the Applicants would increase the number of managed care patients through managed care arrangements.

By centralizing managed care services, YNHHSC hopes to speed the process of negotiating and entering into managed care contracts to facilitate the provision of services to enrollees in managed care plans. Use of experienced personnel across the YNHH System should serve the managed care companies and their enrollees more effectively and efficiently. This will enable members of the YNHH System to attract new contracts and increase enrollment under existing contracts, thereby increasing the number of managed care patients served.

d. Describe the program that the applicants intend to implement which would enhance each member's ability to seek and accept managed care contracts.

As noted in paragraphs a through c above, YNHHSC plans to utilize managed care experts available within the YNHH System to improve the process by which all members interact with managed care companies, thus enhancing each member's ability to seek and accept managed care contracts.

e. Do the Applicants intend to allow indemnity and other non-managed care contracts to lapse under the described plan? Please explain.

The Applicants do not intend to allow indemnity and other non-managed care contracts to lapse. YNHHSC intends to continue to support traditional insurance arrangements including indemnity plans and otherwise.

Question # 7, Page 21 and Section 5 of the Agreement

8. **The Applicants stated that GHCS will appoint three members to the Board of Directors of YNHHSC. The Agreement states "YNHHS will use its best efforts to assure that the YNHHS Board of Directors reflects, to the extent reasonably possible, the geographic diversity of the service area of the System." Please explain why GHCS network service area representation on the Board of Directors of YNHHSC is not guaranteed in the agreement.**

GHCS network service area representation on the YNHHSC Board of Directors is guaranteed by the Agreement. The Chairman of the GHCS Board is an ex officio member of the YNHHSC Board (Section 5.2). Thus, there will always be GHCS representation on the YNHHSC Board. The YNHHSC Board, with the inclusion of GHCS representation, reflects the service area of theYNHH System.

9. **Please explain why there is no specific reference in the Agreement regarding the "geographic diversity" of the members of the Board of Directors of GHCS.**

There is no need for a specific reference regarding the geographic diversity of the members of the GHCS Board. The GHCS Board nominates its own successors and thereby can reflect the geographic representation that is appropriate for the GHCS network.

LICENSURE AND COMPLEMENT CHANGES:

Question # 14, Page 24

10. **The Applicants have described efforts to inform the public of the proposed affiliation through community participation involving board representation as well as through efforts which utilize local media sources and direct mailings.**

    a. **Describe mechanisms in place in the GHCS network service area which provide feedback from the community at large concerning the CON proposal.**

There are a number of mechanisms in place that have provided, and will continue to provide, feedback from the Greenwich community-at-large concerning the CON proposal. Most significantly, Greenwich Hospital continues to schedule community meetings, at which members of the senior administrative staff, including Greenwich Hospital's President, update the community on affiliation activities, and encourage feedback through a question and answer session at each presentation.

Greenwich Hospital also is continuing its media relations program, which includes appearances by its President on radio call-in programs on WGCH, the local Greenwich station, and meetings with the editorial staff of the local newspaper, *Greenwich Time*. Greenwich Hospital engages in a direct mailing campaign, including the distribution of its *Focus* magazine to more than 60,000 homes, which has covered the affiliation topic in some detail, and will continue to do so.

b. **Please provide any letters of support or opposition which the Applicants have received regarding the proposed affiliation.**

The Applicants have not received any letters of support or opposition to the affiliation at this time.

Question # 21, Pages 26 and 27 and Appendix C Beginning on Page 198

11. **Please provide a summary of revenue, expense and volume statistics for the current fiscal year, plus fiscal years 1998, 1999 and 2000 with the CON proposal, without the CON proposal and incrementally due to the CON proposal for each of the following:**

a. **Yale-New Haven Hospital**

b. **Bridgeport Hospital**

c. **Greenwich Hospital Association**

Please refer to Appendix C.

The Agreement, Page 92

12. **In the conclusion of the WITNESS on Page 1 of the Agreement, the Applicants state, "NOW, THEREFORE, in consideration of the foregoing and the mutual agreements and covenants hereinafter set forth and for other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:" The Applicants should define the term "other valuable consideration" as it is used in the agreement and should indicate where it is identified in the Agreement.**

The quoted reference is legal term of art used frequently in legal documents. As such it is not defined or otherwise identified in the Agreement.

OTHER REVIEW CRITERIA

Question # 23, Page 27 and Section 7 of the Agreement

13. **The Applicants stated that the proposed affiliation will allow for coordination of operations through senior management committees to address clinical and non-clinical issues and thereby increase efficiency.**

    a. **Describe some of the mechanisms that are currently in place in the existing YNHHSC network, that have proved sufficient to achieve the goal of efficiency, that might be adapted for the proposed affiliation.**

    Each vertical network, including affiliated organizations, benefits from the voluntary sharing of expertise and clinical and non-clinical best practices with all other vertical networks in the YNHH System. The YNHHSC senior operating group is the primary forum where clinical and non-clinical best practices information and ideas are exchanged. The senior operating group also identifies appropriate organizational resources required for evaluation of potential projects.

    Recently, YNHHSC received CON approval for the development and implementation of an integrated information system. The goal of this project is to enable all YNHHSC affiliates to communicate electronically and to standardize information and systems wherever possible.

b. The Agreement states that YNHHS shall be consulted in the recruitment and selection of Chiefs of Service or other comparable positions. Please identify who holds the final approval responsibility for appointment of these positions.

Final responsibility for the appointment of Chiefs of Service is held by the vertical network Board of Trustees/Directors.

APPENDIX A

ACUTE CARE HOSPITAL AFFIDAVITS

- Yale-New Haven Hospital
- Bridgeport Hospital
- Greenwich Hospital Association

ACUTE CARE HOSPITAL AFFIDAVIT

APPLICANT: Yale-New Haven Health Services Corporation

PROJECT TITLE: Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

I, H. Bart Price (Name), Executive Vice President, Finance and Chief Financial Officer (Position - CEO or CFO) of Yale-New Haven Hospital, being duly sworn, depose and state that the information submitted in this Certificate of Need Application entitled "Corporate Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc." is accurate and correct to the best of my knowledge and with regard to future Budget adjustments* related to this CON application do hereby affirm:

Initial only one of the two following statements:

___ The Hospital projects that the implementation of this Certificate of Need proposal will require a budget adjustment* for any fiscal year; therefore, the Hospital acknowledges that the Commission's ninety-day application review period does not apply pursuant to Section 19a-154 and/or Section 19a-155 of the Connecticut General Statutes as amended by Sections 3 and 4, respectively, of Public Act 93-229. If subsequent to this filing and prior to the issuance of a decision on the Certificate of Need Application, the Hospital projects that the implementation of this proposal will not require a budget adjustment, then the Hospital acknowledges that upon the Commission's Receipt of this revised projection by the Hospital, the ninety-day application review period will commence.

or

✔ The Hospital projects that the implementation of this Certificate of Need proposal will not require a budget adjustment* for any fiscal year; therefore, the Commission's ninety-day application review period does apply pursuant to Section 19a-154 and/or Section 19a-155 of the Connecticut General Statutes as amended by Sections 3 and 4, respectively, of Public Act 93-229. If subsequent to this filing and prior to the issuance of a decision on the Certificate of Need Application, the Hospital projects that the implementation of this proposal will require a budget adjustment, then the Hospital acknowledges that upon the Commission's Receipt of this revised projection by the Hospital, the ninety-day application review period shall not apply.

Signature

Subscribed and sworn to before me on October 6, 1997.
Date

Notary Public/Commissioner of Superior Court

Notes: * Budget Adjustment shall be defined as any change in the authorized net revenue, expenses, operating gain, discharges or equivalent discharges to implement this Certificate of Need proposal.

IMPROPER COMPLETION OF THIS AFFIDAVIT OR MODIFICATION OF THE LANGUAGE INCLUDED HEREIN MAY RESULT IN THE DETERMINATION OF THE COMMISSION THAT THE APPLICATION IS INCOMPLETE.

ACUTE CARE HOSPITAL AFFIDAVIT

APPLICANT: Yale-New Haven Health Services Corporation
Corporate Affiliation of Yale-New Haven Health Services
PROJECT TITLE: Corporation and Greenwich Health Care Services, Inc.

I, Richard J. Morris, Chief Financial Officer
Name Position - CEO or CFO
of Bridgeport Hospital, being duly sworn, depose and state that the information submitted in this Certificate of Need Application entitled "Corporate Affiliation of YNHHSC and GHCS" is accurate and correct to the best of my knowledge and with regard to future Budget adjustments* related to this CON application do hereby affirm:

Initial only one of the two following statements:

___ The Hospital projects that the implementation of this Certificate of Need proposal will require a budget adjustment* for any fiscal year; therefore, the Hospital acknowledges that the Commission's ninety-day application review period does not apply pursuant to Section 19a-154 and/or Section 19a-155 of the Connecticut General Statutes as amended by Sections 3 and 4, respectively, of Public Act 93-229. If subsequent to this filing and prior to the issuance of a decision on the Certificate of Need Application, the Hospital projects that the implementation of this proposal will not require a budget adjustment, then the Hospital acknowledges that upon the Commission's Receipt of this revised projection by the Hospital, the ninety-day application review period will commence.

or

✓ The Hospital projects that the implementation of this Certificate of Need proposal will not require a budget adjustment* for any fiscal year; therefore, the Commission's ninety-day application review period does apply pursuant to Section 19a-154 and/or Section 19a-155 of the Connecticut General Statutes as amended by Sections 3 and 4, respectively, of Public Act 93-229. If subsequent to this filing and prior to the issuance of a decision on the Certificate of Need Application, the Hospital projects that the implementation of this proposal will require a budget adjustment, then the Hospital acknowledges that upon the Commission's Receipt of this revised projection by the Hospital, the ninety-day application review period shall not apply.

Richard J. Morris
Signature

Subscribed and sworn to before me on September 30, 1997, a Notary Public in and for the County
Date

of Fairfield and State of Connecticut.

Notary Public/~~Commissioner of Superior Court~~
Tammie E. Kristman My Commission Expires: June 30, 2002

Notes: * Budget Adjustment shall be defined as any change in the authorized net revenue, expenses, operating gain, discharges or equivalent discharges to implement this Certificate of Need proposal.

IMPROPER COMPLETION OF THIS AFFIDAVIT OR MODIFICATION OF THE LANGUAGE INCLUDED HEREIN MAY RESULT IN THE DETERMINATION OF THE COMMISSION THAT THE APPLICATION IS INCOMPLETE.

ac-affid

ACUTE CARE HOSPITAL AFFIDAVIT

APPLICANT: Greenwich Health Care Services, Inc.

PROJECT TITLE: Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc.

I, Eugene J. Colucci (Name), Vice President, Finance and Chief Financial Officer (Position - CEO or CFO) of Greenwich Hospital Association, being duly sworn, depose and state that the information submitted in this Certificate of Need Application entitled "Affiliation of Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc." is accurate and correct to the best of my knowledge and with regard to future Budget adjustments* related to this CON application do hereby affirm:

Initial only one of the two following statements:

___ The Hospital projects that the implementation of this Certificate of Need proposal will require a budget adjustment* for any fiscal year; therefore, the Hospital acknowledges that the Commission's ninety-day application review period does not apply pursuant to Section 19a-154 and/or Section 19a-155 of the Connecticut General Statutes as amended by Sections 3 and 4, respectively, of Public Act 93-229. If subsequent to this filing and prior to the issuance of a decision on the Certificate of Need Application, the Hospital projects that the implementation of this proposal will not require a budget adjustment, then the Hospital acknowledges that upon the Commission's Receipt of this revised projection by the Hospital, the ninety-day application review period will commence.

or

✓ The Hospital projects that the implementation of this Certificate of Need proposal will not require a budget adjustment* for any fiscal year; therefore, the Commission's ninety-day application review period does apply pursuant to Section 19a-154 and/or Section 19a-155 of the Connecticut General Statutes as amended by Sections 3 and 4, respectively, of Public Act 93-229. If subsequent to this filing and prior to the issuance of a decision on the Certificate of Need Application, the Hospital projects that the implementation of this proposal will require a budget adjustment, then the Hospital acknowledges that upon the Commission's Receipt of this revised projection by the Hospital, the ninety-day application review period shall not apply.

Signature

Subscribed and sworn to before me on October 6, 1997.
Date

Ellen Helgesen
Notary Public/Commissioner of Superior Court

ELLEN M. HELGESEN
NOTARY PUBLIC
MY COMMISSION EXPIRES FEB. 28, 2001

Notes: * Budget Adjustment shall be defined as any change in the authorized net revenue, expenses, operating gain, discharges or equivalent discharges to implement this Certificate of Need proposal.

IMPROPER COMPLETION OF THIS AFFIDAVIT OR MODIFICATION OF THE LANGUAGE INCLUDED HEREIN MAY RESULT IN THE DETERMINATION OF THE COMMISSION THAT THE APPLICATION IS INCOMPLETE.

APPENDIX B

LEGAL OPINION

Wiggin & Dana

Counsellors at Law

Offices in
New Haven,
Hartford and
Stamford

One Century Tower
P.O. Box 1832
New Haven, Connecticut
06508-1832
Telephone 203.498.4400
Telefax: 203.782.2889

Mark R. Kravitz
203.498.4323

October 2, 1997

Ms. Gayle L. Capozzalo
Executive Vice President
Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Re: Response to completeness questions for certificate of need application; applicability of Public Act 97-188

Dear Ms. Capozzalo:

As you know, in the September 18, 1997 letter from the Office of Health Care Access containing completeness questions for the certificate of need application filed in connection with the affiliation between Yale-New Haven Health Services Corporation ("YNHHSC") and Greenwich Health Care Services, Inc. ("GHCS"), a question was raised concerning Connecticut Public Act 97-188. Question number 4 asks that a copy of a legal opinion be provided stating how and whether or not Public Act No. 97-188 applies to the CON proposal.

Public Act No. 97-188 is entitled "An Act Requiring Advance Review And Approval Of The Sale Of Nonprofit Health Care Facilities To For-Profit Entities." This Act provides that no nonprofit hospital (nor the holding company, subsidiary or other affiliate of a nonprofit hospital) shall enter into an agreement to transfer a material amount of its assets or operations or a change in control of operations to a corporation or other entity that is organized or operated for profit without first notifying and, as necessary, obtaining approval from the Commissioner of Health Care Access and the Attorney General.

In the present transaction, GHCS, which is the parent company of a nonprofit hospital, will transfer a substantial amount of control of governance to YNHHSC. YNHHSC is a non-stock, non-profit, federally tax-exempt corporation and thus is not organized or operated for profit. Therefore, Public Act No. 97-188 does not apply to the proposed corporate affiliation of YNHHSC and GHCS.

Yours very truly,

Jeanette C. Schreiber

JCS:rc

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APPENDIX C

REVENUE AND EXPENSE

- Yale-New Haven Hospital
- Bridgeport Hospital
- Greenwich Hospital Association

ATTACHMENT B

REQUESTED FACILITY (DEPARTMENT) WITHOUT THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

CON DOCKET NO. 97-546
CON PROJECT Corporate Affiliation of Yale-New Haven Health Services Corp. & Greenwich Health Care Services, Inc.
APPLICANT Greenwich Hospital Association
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$91,306	$96,297	$107,605	$116,295				
2	NON-GOVT GROSS PATIENT REVENUE	84,468	89,583	100,408	108,828				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	175,774	185,880	208,013	225,123				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	50,919	55,542	66,800	75,427				
5	NET BAD DEBTS	2,871	3,487	4,413	5,331				
6	FREE CARE	3,436	4,094	5,093	6,068				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	6,307	7,581	9,506	11,399				
8	NON-GOVT CONTRACTUAL ALLOWANCES	8,822	9,920	11,789	13,549				
9	UCP & TAX ADJUSTMENTS TO PAYMENTS	5,852	6,083	6,676	7,079				
10	OTHER ALLOWANCES	(4,755)	949	1,064	1,153				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	16,226	24,533	29,035	33,180				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	67,145	80,075	95,835	108,607				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	108,629	105,805	112,178	116,516				
14	INPATIENT GROSS REVENUE	101,850	105,170	116,139	124,008				
15	OUTPATIENT GROSS REVENUE	73,924	80,710	91,874	101,114				
16	OTHER OPERATING REVENUE	(937)	410	420	430				
17	REVENUE FROM OPERATIONS	107,692	106,215	112,598	116,946				
18	NON-PHYSICIAN SALARIES	44,349	45,546	46,776	48,039				
19	PHYSICIAN SALARIES	4,574	4,698	4,824	4,955				
20	FRINGE BENEFITS - NON PHYSICIAN	10,131	10,508	10,895	11,298				
21	FRINGE BENEFITS - PHYSICIAN	1,045	1,084	1,124	1,165				
22	OTHER: SUPPLY & DRUGS	12,310	12,556	12,807	13,063				
23	OTHER THAN SUPPLY & DRUGS	19,795	20,190	20,594	21,006				
24	PHYSICIAN FEES	1,507	1,551	1,596	1,642				
25	MALPRACTICE	1,041	1,061	1,083	1,105				
26	LEASES - ANNUAL	536	547	558	569				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	536	547	558	569				
29	DEPARTMENTAL DEPRECIATION	3,524	4,410	6,802	6,472				
30	PLANT DEPRECIATION	4,698	3,814	5,234	4,866				
31	**TOTAL DEPRECIATION (29 + 30)**	8,222	8,224	12,036	11,338				
32	INTEREST	7	7	1,856	3,711				
33	EXPENSE RECOVERY (Enter as negative)	(3,050)	(3,111)	(3,173)	(3,236)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	100,467	102,861	110,976	114,655				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	7,225	3,354	1,622	2,291				
36	NON-OPERATING REVENUE	5,958	6,017	6,077	6,138				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$13,183	$9,371	$7,699	$8,429				
38	FULL TIME EQUIVALENTS	935.1	935.1	935.1	935.1				
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REQUESTED FACILITY (DEPARTMENT) WITH THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO. 97-546
CON PROJECT Corporate Affiliation of Yale-New Haven Health Services Corp. & Greenwich Health Care Services, Inc.
APPLICANT Greenwich Hospital Association
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

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10	OTHER ALLOWANCES	(4,755)	949	1,064	1,153				
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16	OTHER OPERATING REVENUE	($937)	$410	$420	$430				
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24	PHYSICIAN FEES	1,507	1,551	1,596	1,642				
25	MALPRACTICE	1,041	1,061	1,083	1,105				
26	LEASES - ANNUAL	536	547	558	569				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	536	547	558	569				
29	DEPARTMENTAL DEPRECIATION	3,524	4,410	6,802	6,472				
30	PLANT DEPRECIATION	4,698	3,814	5,234	4,866				
31	**TOTAL DEPRECIATION (29 + 30)**	8,222	8,224	12,036	11,338				
32	INTEREST	7	7	1,856	3,711				
33	EXPENSE RECOVERY (Enter as negative)	(3,050)	(3,111)	(3,173)	(3,236)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	100,467	102,861	110,976	114,655				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	7,225	3,354	1,622	2,291				
36	NON-OPERATING REVENUE	5,958	6,017	6,077	6,138				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$13,183	$9,371	$7,699	$8,429				
38	FULL TIME EQUIVALENTS	935.1	935.1	935.1	935.1				
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APPLICANT Greenwich Hospital Association
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

REQUESTED FACILITY (DEPARTMENT) INCREMENTAL
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

($000's Omitted - Excluding Statistics)

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		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE								
2	NON-GOVT GROSS PATIENT REVENUE								
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**								
4	GOVT DEDUCTIONS FROM GROSS REVENUE								
5	NET BAD DEBTS								
6	FREE CARE								
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**								
8	NON-GOVT CONTRACTUAL ALLOWANCES								
9	UCP & TAX ADJUSTMENTS TO PAYMENTS								
10	OTHER ALLOWANCES								
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24	PHYSICIAN FEES								
25	MALPRACTICE								
26	LEASES - ANNUAL								
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**								
29	DEPARTMENTAL DEPRECIATION								
30	PLANT DEPRECIATION								
31	**TOTAL DEPRECIATION (29 + 30)**								
32	INTEREST								
33	EXPENSE RECOVERY (Enter as negative)								
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**								
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)								
36	NON-OPERATING REVENUE								
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**								
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($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$374,333	$380,095	$389,689	$399,931				
2	NON-GOVT GROSS PATIENT REVENUE	315,629	320,487	328,577	337,212				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	689,962	700,582	718,266	737,143				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	191,817	194,769	199,686	204,934				
5	NET BAD DEBTS	19,459	19,758	20,258	20,790				
6	FREE CARE	5,105	5,184	5,314	5,454				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	24,564	24,942	25,572	26,244				
8	NON-GOVT CONTRACTUAL ALLOWANCES	41,701	42,343	43,411	44,552				
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES								
10	OTHER ALLOWANCES								
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	66,265	67,285	68,983	70,796				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	258,082	262,054	268,669	275,730				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	431,880	438,528	449,597	461,413				
14	INPATIENT GROSS REVENUE	571,497	580,294	594,941	610,577				
15	OUTPATIENT GROSS REVENUE	118,465	120,288	123,325	126,566				
16	OTHER OPERATING REVENUE	470	470	470	470				
17	REVENUE FROM OPERATIONS	432,350	438,998	450,067	461,883				
18	NON-PHYSICIAN SALARIES	192,987	195,110	200,183	206,389				
19	PHYSICIAN SALARIES	13,729	14,237	14,764	15,355				
20	FRINGE BENEFITS - NON PHYSICIAN	45,159	44,933	46,640	48,086				
21	FRINGE BENEFITS - PHYSICIAN	3,213	3,335	3,458	3,593				
22	OTHER: SUPPLY & DRUGS	70,452	72,072	73,730	74,762				
23	OTHER THAN SUPPLY & DRUGS	57,466	58,385	58,910	59,853				
24	PHYSICIAN FEES	34,566	35,257	35,962	36,681				
25	MALPRACTICE	8,419	8,646	8,879	9,128				
26	LEASES - ANNUAL	2,567	2,665	2,766	2,821				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	2,567	2,665	2,766	2,821				
29	DEPARTMENTAL DEPRECIATION	12,450	13,110	13,910	14,842				
30	PLANT DEPRECIATION	13,063	13,755	14,594	15,572				
31	**TOTAL DEPRECIATION (29 + 30)**	25,513	26,865	28,504	30,414				
32	INTEREST	8,826	11,130	11,143	11,139				
33	EXPENSE RECOVERY (Enter as negative)	(35,007)	(35,847)	(36,958)	(38,252)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	427,890	436,788	447,981	459,969				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	4,460	2,210	2,086	1,914				
36	NON-OPERATING REVENUE	9,560	9,560	9,560	9,560				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$14,020	$11,770	$11,646	$11,474				
38	FULL TIME EQUIVALENTS	5,025.7	5,025.7	5,025.7	5,025.7				
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ATTACHMENT B

REQUESTED FACILITY (DEPARTMENT) WITH THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

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APPLICANT Bridgeport Hospital
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$172,671	$181,305	$190,370	$199,889				
2	NON-GOVT GROSS PATIENT REVENUE	105,436	110,707	116,242	122,054				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	278,107	292,012	306,612	321,943				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	66,254	72,228	78,384	85,849				
5	NET BAD DEBTS	6,700	7,000	7,200	7,400				
6	FREE CARE	1,600	1,600	1,800	2,000				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	8,300	8,600	9,000	9,400				
8	NON-GOVT CONTRACTUAL ALLOWANCES	3,662	4,428	5,821	6,721				
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES	21,491	22,141	22,684	23,284				
10	OTHER ALLOWANCES	4,000	4,500	5,000	6,000				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	37,453	39,669	42,505	45,405				
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	103,707	111,897	120,889	131,254				
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	174,400	180,115	185,723	190,689				
14	INPATIENT GROSS REVENUE	206,955	217,302	228,167	239,575				
15	OUTPATIENT GROSS REVENUE	71,152	74,710	78,445	82,368				
16	OTHER OPERATING REVENUE	4,000	4,000	4,000	4,000				
17	REVENUE FROM OPERATIONS	178,400	184,115	189,723	194,689				
18	NON-PHYSICIAN SALARIES	69,758	70,517	72,356	74,618				
19	PHYSICIAN SALARIES	5,645	5,855	6,071	6,311				
20	FRINGE BENEFITS - NON PHYSICIAN	16,812	16,734	17,362	17,905				
21	FRINGE BENEFITS - PHYSICIAN	1,355	1,406	1,458	1,515				
22	OTHER: SUPPLY & DRUGS	20,615	21,090	21,575	21,670				
23	OTHER THAN SUPPLY & DRUGS	39,260	39,885	40,254	40,890				
24	PHYSICIAN FEES	7,137	7,280	7,425	7,575				
25	MALPRACTICE	1,517	1,558	1,600	1,645				
26	LEASES - ANNUAL	2,370	2,460	2,553	2,805				
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**	2,370	2,460	2,553	2,805				
29	DEPARTMENTAL DEPRECIATION	6,680	7,033	7,465	7,965				
30	PLANT DEPRECIATION	4,586	6,042	7,475	7,705				
31	**TOTAL DEPRECIATION (29 + 30)**	11,266	13,075	14,940	15,670				
32	INTEREST	4,850	6,134	6,016	5,898				
33	EXPENSE RECOVERY (Enter as negative)	(4,759)	(4,700)	(4,700)	(4,700)				
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	175,826	181,294	186,910	191,802				
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	2,574	2,821	2,813	2,887				
36	NON-OPERATING REVENUE	360	360	360	360				
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$2,934	$3,181	$3,173	$3,247				
38	FULL TIME EQUIVALENTS	1,718.0	1,688.4	1,673.4	1,668.4				
39									
40									
41									
42									
43									

REQUESTED FACILITY (DEPARTMENT) WITH THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO. 97-546
CON PROJECT Corporate Affiliation of Yale-New Haven Health Services Corp. & Greenwich Health Care Services, Inc.
APPLICANT Bridgeport Hospital
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5)	(6)	(7)	(8)
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE	$172,671	$181,305	$190,370	$199,889				
2	NON-GOVT GROSS PATIENT REVENUE	105,436	110,707	116,242	122,054				
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	278,107	292,012	306,612	321,943				
4	GOVT DEDUCTIONS FROM GROSS REVENUE	66,254	72,228	78,384	85,849				
5	NET BAD DEBTS	6,700	7,000	7,200	7,400				
6	FREE CARE	1,600	1,600	1,800	2,000				
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	8,300	8,600	9,000	9,400				
8	NON-GOVT CONTRACTUAL ALLOWANCES	3,662	4,428	5,821	6,721				
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES	21,491	22,141	22,684	23,284				
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11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	37,453	39,669	42,505	45,405				
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39									
40									
41									
42									
43									

REQUESTED FACILITY (DEPARTMENT) INCREMENTAL
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

ATTACHMENT B

CON DOCKET NO. 97-546
CON PROJECT Corporate Affiliation of Yale-New Haven Health Services Corp. & Greenwich Health Care Services, Inc.
APPLICANT Bridgeport Hospital
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000's Omitted - Excluding Statistics)

LINE	LINE DEFINITION	(1) CURRENT YEAR 1997 BUDGET	(2) CYR + 1 1998 12 MONTHS	(3) CYR + 2 1999 12 MONTHS	(4) CYR + 3 2000 12 MONTHS	(5) CURRENT YEAR BUDGET	(6) CYR + 1 12 MONTHS	(7) CYR + 2 12 MONTHS	(8) CYR + 3 12 MONTHS
		TOTAL FACILITY							
1	GOVERNMENT GROSS PATIENT REVENUE								
2	NON-GOVT GROSS PATIENT REVENUE								
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**								
4	GOVT DEDUCTIONS FROM GROSS REVENUE								
5	NET BAD DEBTS								
6	FREE CARE								
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**								
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25	MALPRACTICE								
26	LEASES - ANNUAL								
27	LEASES - MULTIYEAR								
28	**TOTAL LEASES (26 + 27)**								
29	DEPARTMENTAL DEPRECIATION								
30	PLANT DEPRECIATION								
31	**TOTAL DEPRECIATION (29 + 30)**								
32	INTEREST								
33	EXPENSE RECOVERY (Enter as negative)								
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**								
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)								
36	NON-OPERATING REVENUE								
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**								
38	FULL TIME EQUIVALENTS								
39									
40									
41									
42									
43									

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

RAYMOND J. GORMAN
COMMISSIONER

June 7, 1999

Jeanette C. Schreiber
Wiggin & Dana
One Century Tower
P.O. Box 1832
New Haven, CT 06508-1832

Re: Certificate of Need Modification, Docket Number 99-537R
Yale-New New Haven Health Services Corporation and
Greenwich Health Care Services, Inc.
Modification of Docket Number 97-559

Dear Ms. Schreiber:

On December 17, 1997, the Office of Health Care Access ("OHCA") granted a Certificate of Need ("CON") under Docket Number 97-559, to Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc. ("Applicants"). The CON authorized the corporate affiliation of Yale-New Haven Health Services Corporation, the parent corporation of Yale-New Haven Hospital, and Greenwich Health Care Services, Inc., the parent corporation of The Greenwich Hospital Association.

Stipulation # 5 in the Agreed Settlement under Docket Number 97-559 states the following:

"5. OHCA and the Applicants agree that a plan for the attainment of cost savings, which reflects any specific incremental operating expense reductions anticipated to result from actions emerging from the corporate affiliation approved herein, will be filed with OHCA by December 31, 1998. This filing will include a completed **Attachment II** for Yale-New Haven Hospital and The Greenwich Hospital Association individually, and the assumptions related to these operating expense reductions. In addition, OHCA and the Applicants further agree that within sixty (60) days subsequent to the end of each fiscal year for the first three full fiscal years following the corporate affiliation, a fully completed **Attachment II** will be filed for Yale-New Haven Hospital and Bridgeport Hospital and The

Greenwich Hospital Association individually, reflecting a total of all actual cost savings for the completed fiscal year facilitated by the corporate affiliation."

On May 4, 1999, Yale-New Haven Health Services Corporation and Greenwich Health Care Services, Inc. filed a request under Docket Number 99-537R, seeking modification to eliminate paragraph 5 from the Agreed Settlement. This modification is requested because the information is reported in a format that does not provide useful information to OHCA.

OHCA has reviewed the request for a modification to the Order issued under Docket Number 97-559. The provisions of Section 19a-638, C.G.S., as well as the principles and guidelines set forth in Section 19a-637, C.G.S. were fully considered by OHCA in its review.

OHCA hereby approves the Applicants' modification request. Stipulation # 5 is vacated. All other conditions contained in the June 16, 1996, OHCA order issued under Docket Number 97-559, not amended by this modification remain in effect.

Sincerely,

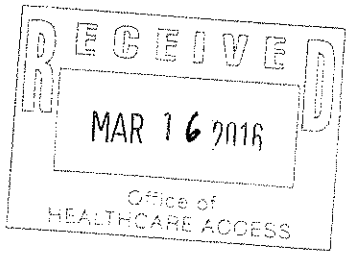
Raymond J. Gorman
Commissioner

Cc: Rose McLellan, Processing Technician, DHSR, DPH

RJG:sce

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610



February 28, 1996

Commissioner William Diamond
Chairman
Commission on Hospitals and Health Care
1049 Asylum Avenue
Hartford, CT 06105-2431

Dear Commissioner Diamond:

Enclosed for review by the Office of Health Care Access is an original and five copies of the Certificate of Need application for the proposed affiliation between Yale-New Haven Health Services Corporation and Southern Connecticut Health System. This affiliation will have no substantial impact on delivery of systems, operations, nor capital expenditures and will not impact rates.

If you have any further question or concerns, please contact Caroline Piselli at 785-2609. We look forward to working with you and your staff on this CON.

Sincerely,

Frant Tiedemann
Senior Vice President
System Development
Yale-New Haven Health Services Corp.

Clayton Medeiros
Senior Vice President
Planning & Marketing
Southern Connecticut Health System

FT/CM:jl

cc: Jeanette C. Schreiber, Esq., Wiggin & Dana (Attorney to YNHHSC)
Collin P. Baron, Esq., Pullman & Comley (Attorney to SCHS)

LET-1

leaders, hospital auxiliaries, volunteers and donors, other local providers and payers, were informed about the proposed affiliation via letters, phone call or facsimile.

Clinical Services

15. ***Please provide a chart depicting all changes to services provided on each campus of the two Hospitals as of the date of affiliation, compared to the current status and location of these services. For each service, the Hospitals must indicate the following.***

    a. ***Relocations***
    b. ***Terminations***
    c. ***Additions***
    d. ***Duplications***
    e. ***Anticipated scheduling for future changes.***

    No changes to services provided at YNHH or BH are planned as a result of the proposed affiliation.

16. ***In the same format as Question #15 above, please list those programs and services of the two Hospitals and all affiliates which have yet to be integrated and include a projected timetable for their eventual integration.***

    There are no plans to integrate clinical programs and services. Each affiliate will continue to function independently.

17 ***Please provide the same information requested in Question #16 above, for all non-health care related services, functions and programs of the two Applicants and their corporate affiliates.***

    There are no plans in place to integrate non-health care related services. However, in the future, opportunities may be explored for potential cost savings in areas such as selected business services, purchasing, insurance and information systems.

Financial Information

18. ***Provide an itemized list of all capital expenditures associated with the proposed merger.***

Not applicable. There are no capital expenditures associated with this proposed affiliation.

19. ***How will the proposed capital expenditures be financed? Identify the sources of funding of any equity contribution (fund raising, funded depreciation, etc.) and debt financing (tax-exempt bonds, conventional bank financing, etc.). Provide evidence of the financial feasibility of the proposed merger and the interest of any lenders for the debt financing specified above.***

Not applicable. There are no capital expenditures associated with this proposed affiliation. Therefore, financing is not required.

20. ***Please describe the current financial condition of each corporate parent and the anticipated effect of the proposed merger. Specifically address the impact of the combined level of uncompensated care on the proposed merged entity.***

Not applicable. The current sound financial conditions of each corporate parent will continue following the affiliation. Likewise, the level of uncompensated care of YNHH and BH will continue following the affiliation. YNHH and BH both exhibit strength in their successful marketing of CHEFA bonds. Financial performance resulting from improved managed care contracting is difficult to accurately quantify, and therefore is not included.

21. ***Provide a summary of projections of revenue, expense and volume statistics for the current fiscal year, plus fiscal years 1996, 1997 and 1998 for each Hospital with the merger proposal, without the merger proposal, and incrementally due to the merger proposal (See Attachment 3.)***

This is an affiliation, not a merger. The financial projections for YNHH or BH either alone or as affiliated are the same. The requested projections are provided in Appendix II.

22. ***Discuss the impact of the proposed merger and the rates and financial condition of each Hospital including the continuing ability of each Hospital to operate effectively and efficiently, and to meet its financial obligations consistent with principles of sound financial management.***

This proposal involves an affiliation between the two parent companies, YNHHSC and SCHS, which will maintain the current sound financial conditions of both hospitals and their ability to operate effectively and efficiently. The proposed affiliation will not impact the published rates or financial condition of either hospital. Both hospitals have recently undergone redesign and reengineering initiatives to ensure cost effective delivery of care, and subsequently have implemented ongoing Continuous Quality Improvement (CQI) processes.

23. ***Discuss the proposed merger's contribution to the cost effectiveness of health care delivery in the region (including any reduction in FTE's, economies of scale, improvements in productivity and cost containment, reduction in licensed beds/excess capacity, and the integration of non-clinical services such as accounting, laundry, purchasing, etc.). This discussion should include the degree to which the proposed merger is likely to achieve appropriate health service area objectives at the most reasonable financial cost.***

The proposed affiliation will contribute to the cost effectiveness of health care delivery in the region as follows:

- Coordinate operations through senior management committees to address clinical and non-clinical issues and thereby increase efficiencies.
- Improve the quality and cost-effective care of both institutions by sharing clinical and non-clinical best practices between the two hospitals.
- Continue to deliver healthcare services in a cost effective manner.

24. ***Please list and describe all cost savings expected due to the proposed merger.***

Please refer to question # 23.

25. ***Please provide a copy of any consultant's report received by the Applicants' relating to an operational efficiency analysis of the proposed merger.***

Not applicable. Operational efficiency analysis was not performed.

26. ***Please comment on the needs of the public that currently are not being met and describe how the proposed merger would help to meet such needs.***

YNHHSC and SCHS are committed to identifying, targeting and serving their respective communities' healthcare needs. The proposed relationship between YNHHSC and SCHS is intended to respond to the needs of the public for improved access to cost effective/coordinated healthcare services. This need has been expressed through the public's move to managed care benefit plans and structures. Communications about the features and benefits of the proposed system will assist the community in making informed choices about hospital provider groups and payor plans. In addition, the integrated system which delivers a high-quality continuum of care will be available to a broader geographic area including people in all socioeconomic classes with a wide range of health care needs. The intent of the affiliation is to utilize the combined system's expertise in delivering primary through quaternary healthcare services to improve the health status of participating segments of the communities served.

27. ***Discuss how the proposed merger will serve the public interest.***

The proposed affiliation will serve the public interest by addressing the following constituents:

- The patients by providing access to a patient-focused continuum of integrated healthcare services and clinical centers of excellence of high quality through convenient local access points.

- The community by building a community health resource dedicated to improving the health status of the population served.

- The community in the initiation, development, maintenance and oversight of educational programs for health professionals and the public across the system by ensuring a stable base of qualified professionals and improved health.

- The community in the initiation, development and maintenance of programs of scientific research related to the care of the sick and injured.

- The consumers/employers by enabling long-term partnerships that bring the critical resources of care under one umbrella to manage various aspects of health while providing high quality, cost effective, convenient services to employees and other beneficiaries.

28. ***Discuss how the proposed merger will affect the quality of health care delivery in the combined Hospitals' service area. Please provide copies of each Hospital's most recent Department of Public Health and Addiction Services licensing survey.***

One of the key goals of the affiliation is to maintain quality. This will occur through the sharing of system-wide clinical best practices.

Please refer to Appendix III for the Hospital Licensing Surveys for YNHH and BH.

29. ***Discuss how the proposed merger will contribute to an improvement in access to health care services in the combined Hospitals' service area.***

The proposed affiliation is designed to enable two local delivery systems to remain competitive in a changing marketplace by improving access to care and enhancing quality of care. Both hospitals individually will continue to provide comprehensive healthcare services to their respective service areas. Together, as a part of a system, YNHH and BH will be able to improve access to care by expanding:

- the overall geographic area for care and referrals
- the array of services available for people in the communities served by both hospitals
- the level of shared resources and expertise between affiliates
- options for patients covered by managed care contracts.

30. ***Describe the relationship of the proposed merger to the most recent State Health Plan.***

The proposed affiliation between YNHHSC and SCHS supports the following policies contained in the Connecticut State Health Plan:

Policy AIC-II

Access to high quality patient care along with cost effectiveness should remain an important consideration.

As stated above, a primary goal of the proposed affiliation is to improve community access to the system. The expanded geographic area for care and referrals should make the proposed system accessible to more covered lives. Ongoing efforts to improve the quality, cost effectiveness and the array of needed health care services in their communities represent primary goals for YNHH, BH and the proposed affiliation system.

Policy AIC-IV

> The SHCC supports the Certificate of Need Program in Connecticut in order to assure access to needed services while avoiding unnecessary capital expenditure.

The improved access to quality health care, described above, can be achieved through the proposed affiliation without any capital expenditure (please refer to the responses to questions 18 and 19).

31. ***Describe the relationship of the proposed merger to each Hospital's long range plan.***

Both YNHH and BH have similar missions and share the primary mission of improving the health of the populations served.

The mission of YNHHSC is to benefit, uphold and promote the welfare, programs and activities of YNHH and other affiliates and to benefit the communities served by the system. The SCHS vision is to be a regional, economically viable, integrated healthcare delivery system which excels on the basis of cost effectiveness, customer satisfaction, documentable quality and compassion.

The proposed YNHHSC/SCHS affiliation allows both organizations to establish a delivery system that offers broad, geographic coverage. This relationship is anticipated to strengthen the individual providers and enhance managed care contracting and patient preference.

Long range plans recognize that the organization and financing of healthcare has changed. In order to carry out the missions, the institutions must become increasingly efficient and proactively enhance quality, improve access and control costs of care. The proposed affiliation will support these activities to further the institutions' missions and long range plans.

32. ***Please provide a copy of the long range plan for the proposed merged entity. If a long range plan for the proposed merged entity has not been completed, please indicate the date on which this plan is expected to be completed.***

Not applicable. This is not a merger.

33. ***In what way will the proposed merger affect the interests of consumers and payers of health care services based on the merger proposal's contribution to quality. Accessibility and cost effectiveness?***

Please refer to the answers to questions #26 and #27.

34. ***Discuss whether the proposed merger will result in the elimination of any unnecessary duplication of services.***

Not applicable. There are no unnecessary duplications due to the distinct nature of the markets served independently by SCHS and YNHHSC.

35. ***In what way will the proposed merger affect the technical, financial and managerial efficiency and expertise of the staff at each Hospital?***

As the combined system begins to operate, system members, including affiliated organizations, will benefit from the voluntary sharing of expertise and non-clinical best practices. In addition, as discussed before, it is expected that there are certain areas in which efficiency and efficacy can be enhanced as a result of this shared knowledge.

36. ***Describe any applied research or educational programs that would be developed or affected as a result of the proposed merger.***

The only changes currently planned are the integration of the general surgery residency program and the initiation of a combined program in Emergency Medicine. Specific aspects of the relationship are cited in the System Affiliation Agreement by and between YNHHSC and SCHS. Shared information between the two institutions, facilitated by the affiliation, will inevitably enhance both provider education and

research endeavors. The combined impact of this information transfer will be to improve the quality of care delivered at YNHH and BH as described in the answer to question #28. Future clinical trials and educational programs could be co-developed and made accessible to providers at both hospitals.

37 ***Describe how the proposed merger would impact the patient-physician mix of each Hospital.***

The proposed affiliation will not affect the current patient-physician mix at either facility.

38. ***Describe any improvements in productivity and cost containment each Hospital would make as a result of the proposed merger.***

Please refer to the answers to questions #22 and #23.

LIST OF EXHIBITS

A Current Structure of Yale-New Haven Health Services Corp. and Affiliated Companies

B Current Structure Southern Connecticut Health System, Inc. and Affiliated Companies

C Proposed Post-Affiliation Structure, Yale-New Haven Health Services Corp.

D Amended and Restated Pre-Affiliation Corporate Bylaws -- Southern Connecticut Health System, Inc. and Affiliated Companies

- Southern Connecticut Health System, Inc.
- Bridgeport Hospital Foundation, Inc.
- Bridgeport Hospital
- Rehabilitation Center of Fairfield County, Inc.
- Nova Med
- SCHS Properties, Inc.

E Amended and Restated Post-Affiliaton Corporate Bylaws -- Yale-New Haven Health Service Corp.

F Post-Affiliation Certificate of Incorporation -- Yale-New Haven Health Services Corp.

G Proposed Board of Directors of Yale-New Haven Health Services Corp. following affiliation

H The System Affiliation Agreement

I Resolutions of Yale-New Haven Health Services Corp. Board of Directors (approving proposed affiliation)

J Resolutions of Southern Connecticut Health System, Inc. Board of Directors (approving proposed affiliation)

K Licensed Bed Configuration -- Yale-New Haven Hospital and Bridgeport Hospital

- Pre-Affiliation
- Post-Affiliation

L Legal Opinion Regarding Tax Exempt Status of Yale-New Haven Health Services Corp.

1. Yale-New Haven Health Services Corp.
2. Southern Connecticut Health System, Inc.

EXHIBIT A

Current Structure of Yale-New Haven Health Services Corp. and Affiliated Companies

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
PRE-AFFILIATION

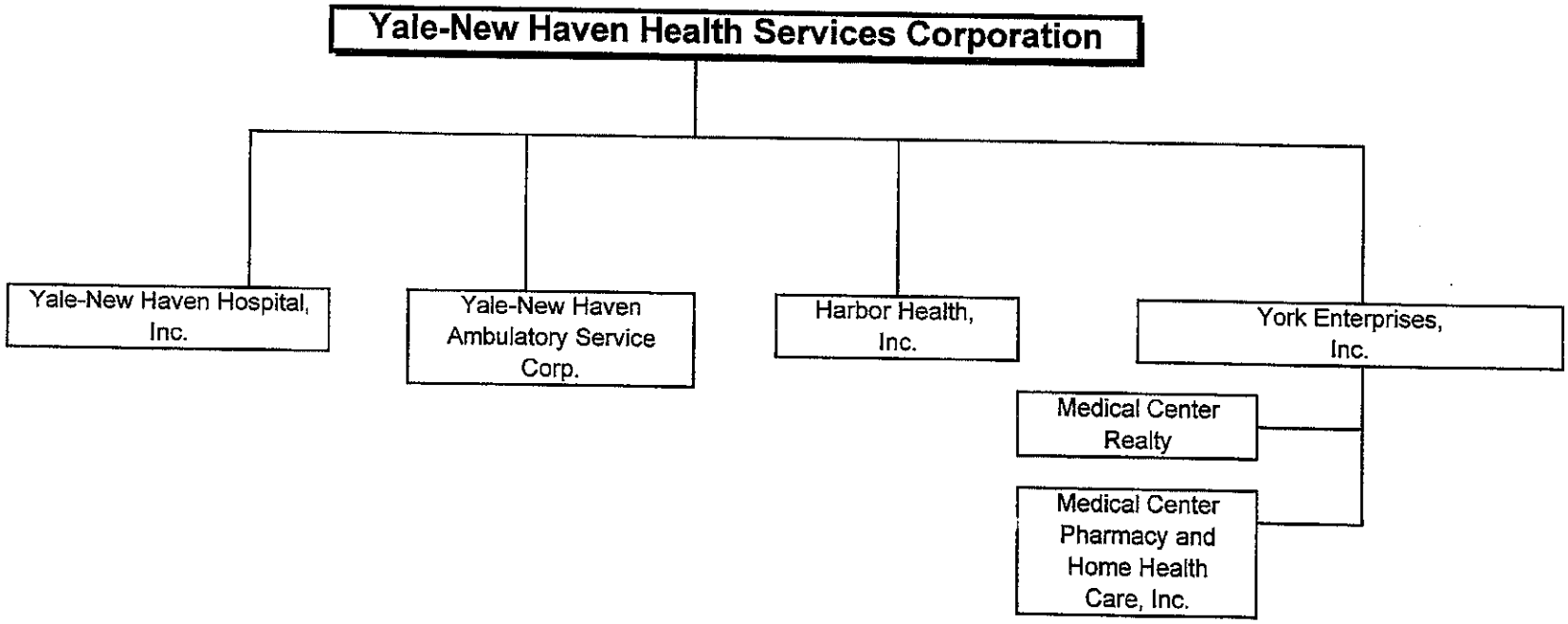


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EXHIBIT B

Current Structure of Southern Connecticut Health System, Inc. and Affiliated Companies

SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.
PRE-AFFILIATION

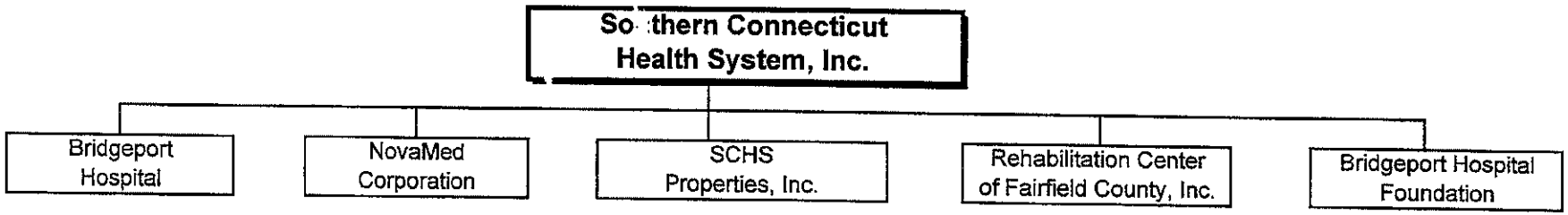

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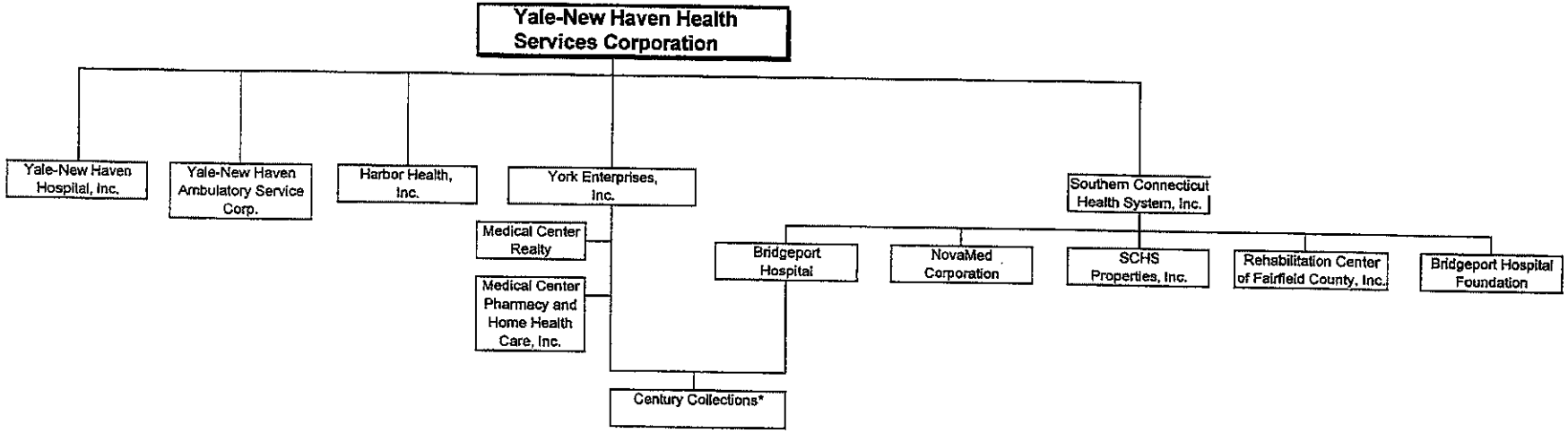
EXHIBIT C

Proposed Post-Affiliation Structure, YNHHS Corp.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
POST-AFFILIATION



* Note: Each of NovaMed and York hold approximately 30% of the stock of Century Collection. Following the affiliation, a majority of the stock of Century will be controlled by members of the YNHHSC System.

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EXHIBIT D

Amended and Restated Pre-Affiliation Corporate Bylaws -- SCHS, Inc. and Affiliated Companies

– Southern Connecticut Health System, Inc.
– Bridgeport Hospital Foundation, Inc.
– Bridgeport Hospital
– Rehabilitation Center of Fairfield County, Inc.
– Nova Med
– SCHS Properties, Inc.

BYLAWS

OF

SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.

TABLE OF CONTENTS

BYLAWS OF
SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.
(THE "CORPORATION")

ARTICLE I

OFFICES

Section 1.1 - Principal Office. The principal office of the Corporation shall be at such place in the United States as the Board of Directors shall from time to time designate.

Section 1.2 - Additional Offices. The Corporation may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Corporation may require.

ARTICLE II

BOARD OF DIRECTORS

Section 2.1 - General Powers. The activities, property and affairs of the Corporation shall be managed by the Board of Directors, which shall exercise all of the powers of the Corporation under the Connecticut Nonstock Corporation Act, the Certificate of Incorporation, and these Bylaws as each may be amended from time to time.

Section 2.2 - Number of Directors and Qualification. The Board of Directors shall consist of not less than ten and not more than twenty persons, which number shall be fixed from time to time by the Board of Directors. At each annual meeting of the Board of Directors, the directors shall be elected by the then Board of Directors to take office immediately following such annual meeting. The Board of Directors shall be elected from among members of the Bridgeport Hospital Board of Directors elected at its last prior annual meeting.

A person who is an ex-officio director with vote of the Bridgeport Hospital Board of Directors and who is elected to the Board of Directors shall be an ex-officio director with vote of the Board of Directors and shall be considered a director for all purposes of these Bylaws except he shall not be subject to the age or term of office provisions.

The Board of Directors also may elect non-voting directors. Non-voting directors shall receive notice of, and shall be entitled to attend and speak at, meetings of the Board of Directors, and shall be eligible to serve as voting members of committees. Such non-voting directors shall be subject to the age and term of office provisions of these Bylaws, but shall not count toward quorum requirements, shall not have voting rights, shall not be considered in calculating the number of directorships and shall not be considered directors for any other purpose under these Bylaws.

Except as otherwise provided in this Section 2.2, a director who has attained age 70 shall be ineligible to continue to serve as a director after the annual meeting of the Board of Directors next following the date the director attains age 70.

Section 2.3 - Terms of Directors. Directors shall hold office for a term of four years or until their successor has been elected and qualified, except that a director may be elected for a term of less than four years as provided in Section 2.12 or if the Board of Directors deems it necessary to serve the objective that the terms of office of approximately one-fourth of all directors shall expire at each annual meeting. A director shall cease to be in office upon his death, resignation or removal. At each annual meeting, the Board of Directors shall elect directors to succeed the directors whose terms are then expiring and to fill any new directorships fixed by the Board of Directors. Such directors shall take office immediately following such annual meeting. No director shall serve more than two successive terms of three or more years. Not included in this limitation shall be a term of less than three years due to effectuating staggered terms or due to a director completing a term due to the death, removal or resignation of another director. Also not included in this limitation shall be any term served prior to March 30, 1995. A director who has served two successive terms of three or more years may again serve as a director following the expiration of a period of not less than one year during which time such individual does not serve as a director.

Directors ex-officio shall hold office for a term of one year or until their successors are elected and qualified or until they no longer are serving in the positions that entitle such persons to such ex-officio directorships.

Non-voting directors shall be elected for a term of four years or until their successors are elected and qualified and shall be subject to the terms of office provisions described in these Bylaws.

Section 2.4 - Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall elect the officers, directors, non-voting directors and Board of Associates of the Corporation and shall transact such other business relating to the affairs of the Corporation as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 2.5 - Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the Chief Executive Officer, or upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of

Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 2.6 - Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 2.7 - Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 2.8 - Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 2.9 - Participation by Conference. A director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 2.10 - Resignation of Directors. Any director and any non-voting director may resign at any time by giving written notice to the Board of Directors or to the Chairman, the President or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 2.11 - Removal of Directors. Any director and any non-voting director may be removed from office with or without cause at any time, regardless of the term for which such director may have been elected, by the affirmative vote of a majority of all of the directors in office at that time at any regular, annual, or special meeting.

Section 2.12 - Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the remaining directors, though less than a quorum, by the concurring vote of a majority of such remaining directors at any meeting of the Board of Directors, may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect directors to serve until the next annual meeting. Any director so elected must be a member of the Board of Directors of Bridgeport Hospital.

ARTICLE III

COMMITTEES

Section 3.1 - Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Development Committee, Director Affairs Committee, Finance Committee, Investment Committee, and Management Affairs Committee.

Section 3.2 - Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors, the Board of Associates or others by the Chairman of the Board of Directors. The Chairman of the Board of Directors may increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 3.3 - Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 3.4 - Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

Section 3.5 - Audit Committee. The Audit Committee shall cause an annual audit to be made of the books, accounts and records of the Corporation by certified public accountants under the supervision of the Audit Committee. The Audit Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 3.6 - Development Committee. The Development Committee shall recommend policies and procedures for the development, growth, and management of the endowment funds of the Corporation and shall consider funding requests from affiliates. The Development Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 3.7 - Director Affairs Committee. The Director Affairs Committee shall develop criteria for membership on the Board of Directors and its committees and shall consider the eligibility requirements and qualification specified in these Bylaws, as well as the interest and participation in Corporation matters of the individuals under consideration. It shall nominate for election members of the Board of Directors and Board of Associates and shall assist in the selection of individuals for committee assignments. The Director Affairs Committee also shall review the performance of directors and recommend amendments to the Corporation's bylaws and shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 3.8 - Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Corporation and shall monitor and oversee the financial performance of the Corporation. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 3.9 - Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Corporation and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the Corporation. The Investment Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide. The Chief Executive Officer and the Treasurer shall be members of the Investment Committee.

Section 3.10 - Management Affairs Committee. The Management Affairs Committee shall establish performance goals for the Chief Executive Officer and shall conduct annual evaluations of his performance. It shall also review and recommend to the Board of Directors human resource, fringe benefit, and compensation policies and monitor compliance therewith and shall act in an advisory capacity to the Chief Executive Officer. The Management Affairs Committee also shall perform such other functions as a duly adopted resolution of the Board of Director may provide.

ARTICLE IV

OFFICERS

Section 4.1 - Principal and Subordinate Officers. The principal officers of the Corporation shall be Chairman of the Board, Vice Chairmen of the Board, Chief Executive Officer, President, Secretary, and Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the Chief Executive Officer or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more offices may be held by the same person provided that the same individual shall not simultaneously occupy the offices of (i) Chief Executive Officer or President and (ii) Secretary. The Chairman of the Board and Vice Chairmen shall be selected from among members of the Board of Directors.

Section 4.2 - General Authority and Duties. All officers and agents of the Corporation shall have such authority and perform such duties in the management of the Corporation as may be provided in these Bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 4.3 - Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the Board of Directors at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the Chief Executive Officer or any other principal officer to whom the Chairman of the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal, whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights. An individual may not serve in the office of Chairman of Vice Chairman for more than four consecutive one year terms. Not included in this limitation shall be any term served prior to March 30, 1995 or any partial term served to fill a vacancy.

Section 4.4 - Removal. Any officer or agent may be removed by the Board of Directors whenever in their judgment the best interests of the Corporation will be served by so doing. Any officer or agent may also be removed by the Chief Executive Officer, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 4.5 - Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 4.6 - Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 4.7 - Chairman of the Board. The Chairman of the Board shall preside at the annual meeting of the Corporation and at all meetings of the Board of Directors, shall appoint members of all committees and the chairmen thereof, and shall perform such duties as the Board of Directors may from time to time assign to the Chairman of the Board and such other duties as are usual to this office.

Section 4.8 - Vice Chairmen of the Board. The Vice Chairmen of the Board shall perform the duties of the Chairman of the Board in the event of the Chairman's absence or disability and shall assist the Chairman of the Board in such duties as the Chairman of the Board may from time to time assign to the Vice Chairmen of the Board.

Section 4.9 - Chief Executive Officer. The Chief Executive Officer of the Corporation shall be the President, unless otherwise designated by the Board of Directors. The Chief Executive Officer shall exercise general supervision of the business and affairs of the Corporation and over its officers and employees and shall be responsible for seeing that the resolutions and actions of the Board of Directors are carried into effect, and for reporting to the Board of Directors on the conduct and management of the affairs of the Corporation. The Chief Executive Officer shall have the authority to appoint and remove employees of the Corporation, including management level officers, and may delegate to such officers and employees such authority as he deems appropriate provided, however, he shall be responsible for their actions.

Section 4.10 - President. The President shall have such duties and responsibilities as are assigned to him by the Chief Executive Officer and shall report and be responsible to the Chief Executive Officer.

Section 4.11 - Treasurer. The Treasurer shall have supervision over the receipt and custody of the Corporation's funds, and shall cause to be kept correct and complete books and records of account, including full and accurate accounts of receipts and disbursements in books belonging to the Corporation, and in general shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer. The Treasurer shall render to the Chairman of the Board, the Chief Executive Officer and the Board of Directors promptly upon its completion an annual report of the financial condition and operation of the Corporation prepared and certified by the independent certified auditors appointed by the Board of Directors.

Section 4.12 - Secretary. The Secretary shall keep minutes of the proceedings of the Board of Directors shall give or cause to be given all notices in accordance with the provisions of these Bylaws or as required by law; and shall be custodian of the corporate records and of the seal of the Corporation. The Secretary also shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer.

ARTICLE V

BOARD OF ASSOCIATES

Section 5.1 - Qualifications and Responsibilities. The Board of Associates shall be comprised of individuals who have given special service to the Corporation or its affiliates or who are otherwise deemed by the Board of Directors worthy and deserving to serve as members of the Board of Associates. The Board of Associates shall advise the Board of Directors and management on the activities, property and affairs of the Corporation. The Board of Associates shall be elected annually for four year terms by the Board of Directors at its annual meeting unless the Board of Directors deems it appropriate to serve the objective that the terms of approximately one-fourth of

all Associates shall expire at each annual meeting. There shall be no limit on the number of members of the Board of Associates or on their term of service but it is intended that the Board of Associates shall be comprised of individuals who have the experience, knowledge, and interest to provide the Corporation and its Board of Directors and management with advice and counsel. Members of the Board of Associates may be appointed by the Chairman of the Board to serve on committees of the Board of Directors.

Section 5.2 - Honorary Associates. The Board of Directors may elect for one year terms individuals chosen in recognition of their personal or professional achievements outside the Corporation and its affiliates, particularly as they relate to accomplishments in the general field of health, to the status of Honorary Associates. Past service on the Board of Directors shall not be a requirement. Honorary Associates shall receive notice and may attend all meetings of the Board of Associates, and may serve as voting members on committees of the Board of Directors.

Section 5.3 - Meetings. Meetings of the Board of Associates shall be held on the call of the Board of Directors or the Chairman of the Board who shall preside at all meetings. Meetings may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of meeting. There shall be two days written notice of all meetings.

ARTICLE VI

INDEMNIFICATION OF CORPORATION DIRECTORS, BOARD OF ASSOCIATES, OFFICERS, EMPLOYEES AND AGENTS

Section 6.1 - Rights of Indemnification. Directors, Board of Associates, officers, employees, and agents shall have the rights of indemnification provided by Section 33-454a of the Connecticut General Statutes.

Section 6.2 - Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-454a of the Connecticut General Statutes, incurred in defending a proceeding, may be paid by the Corporation in advance of the final disposition of such proceeding when authorized by the Board of Directors upon agreement, by or on behalf of the individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Corporation as authorized under the Bylaws.

ARTICLE VII

MISCELLANEOUS PROVISIONS

Section 7.1 - **Amendment.** These Bylaws may be amended or repealed, and new Bylaws may be adopted, at any regular, annual or special meeting of the Board of Directors by the affirmative vote of a majority of all directors. Any notice of a meeting of the Board of Directors at which these Bylaws are to be amended or repealed, or new Bylaws are to be adopted, shall be given at least two days prior to such meeting and shall include notice of such proposed action.

Section 7.2 - Fiscal Year. The fiscal year of the Corporation shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 7.3 - Seal. The seal of the Corporation shall be circular in form and shall bear the name of the Corporation and shall be in such form as the Board of Directors may determine.

Section 7.4 - Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board of Directors shall specify from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures.

Section 7.5 - Execution of Deeds and Contracts. Subject to the general directions of the Board of Directors, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the Chief Executive Offic[illegible] or such other officer as may be specified by the Board of Directors or authorized by the Chief Executive Officer and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to such instruments.

Section 7.6 - Conflict of Interest. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Corporation, the provisions of Section 33-457 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the legal effect of such contract or transaction.

Section 7.7 - Connecticut General Statutes. Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

Section 7.8 - Pronouns. References herein to the masculine shall include references to the feminine, references to the singular shall include references to the plural and references to the plural shall include references to the singular, where the context of the language involved so permits or requires.

BYLAWS

OF

BRIDGEPORT HOSPITAL FOUNDATION, INC.

TABLE OF CONTENTS

BYLAWS

OF

BRIDGEPORT HOSPITAL FOUNDATION, INC.

(The "Foundation")

ARTICLE I

OFFICES

Section 1.1 Principal Office. The principal office of the Foundation shall be at such place in the United States as the Board of Directors shall from time to time designate.

Section 1.2 Additional Offices. The Foundation may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Foundation may require.

ARTICLE II

MEMBERSHIP

Section 2.1 Sole Member. The Foundation shall have but one member, Southern Connecticut Health System, Inc., which shall have the right to elect the Board of Directors of the Foundation in accordance with these Bylaws, and shall have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock nonprofit corporation and not conferred thereby or by the Certificate of Incorporation or Bylaws upon the Board of Directors of the Foundation.

Section 2.2 Specific Rights, Powers and Privileges. In addition to such other rights, powers and privileges as it may have by law, Southern Connecticut Health System, Inc., as the Foundation's sole member, shall have the following rights, powers and privileges:

A. To approve the long range development plans, annual operating and capital budgets, and plans that materially affect the growth, operations and development of the Foundation.

B. To approve the Foundation's business plan, its annual budget for fund raising programs and the conduct of all special giving programs.

C. To elect and remove the members of the Board of Directors and non-voting directors in accordance with the provision of these Bylaws.

D. To elect and remove the officers of the Foundation in accordance with the provision of these Bylaws.

E. To vote upon all matters on which members are entitled to vote under the Nonstock Corporation Act of the State of Connecticut.

F. To act on any other matters on which action by members is required or permitted by these Bylaws.

Section 2.3 Meetings of the Member. The annual meeting of the member shall be held on such day and at such time and place as may be designated by the Board of Directors or the Chairman of the Board of Directors for the purposes set forth in Sections 2.1 and 2.2 herein and for the transaction of any other business as may properly come before such meeting. Regular meetings of the member shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the member may be called at any time by the Board of Directors, the Chairman of the Board of Directors, the Chief Executive Officer or the member. Each such request for a special meeting shall state the purposes for which the requested meeting is to be called. The member shall cast one vote on each matter submitted to a vote at each regular, annual and special meeting. Except as otherwise provided, any action required to be, or which may be, taken at any regular, annual or special meeting of the member may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the member.

Section 2.4 Notice of Meeting. A notice of each meeting of the member shall be given in writing to the member not less than seven days or more than fifty days before the date of the meeting. Each notice shall state the place, day and hour of the meeting. The general purpose for which a special meeting is called shall be stated in the notice thereof, and no other business shall be transacted at the meeting.

Section 2.5 Waiver of Notice. Notice of any meeting of the member may be waived in writing by the member.

ARTICLE III

BOARD OF DIRECTORS

Section 3.1 General Powers. Subject to the rights, powers and privileges accorded to the member by law, the Certificate of Incorporation or these Bylaws, the activities, property and affairs of the Foundation shall be managed by the Board of Directors, which shall exercise all of the powers and responsibilities conferred upon the Board of Directors by the Connecticut

Nonstock Corporation Act, the Certificate of Incorporation and these Bylaws as each may be amended from time to time.

Section 3.2 Number of Directors and Qualification. The Board of Directors shall consist of not less than ten and not more than twenty persons, which number shall be fixed from time to time by the member. At each annual meeting of the member, the directors shall be elected by the member to take office immediately following such annual meeting.

A person who is an ex-officio director with vote of the Bridgeport Hospital Board of Directors and who is elected to the Board of Directors shall be an ex-officio director with vote of the Board of Directors and shall be considered a director for all purposes of these Bylaws except he shall not be subject to the age or term of office provisions.

The member also may elect non-voting directors. Non-voting directors shall receive notice of, and shall be entitled to attend and speak at, meetings of the Board of Directors and shall be eligible to serve as voting members of committees. Such non-voting directors shall be subject to the age and term of office provisions of these Bylaws, but shall not count toward quorum requirements, shall not have voting rights, shall not be considered in calculating the number of directorships and shall not be considered directors for any other purpose under these Bylaws.

Except as otherwise provided in this Section 3.2, a director who has attained age 70 shall be ineligible to continue to serve as a director after the annual meeting of the Board of Directors next following the date the director attains age 70.

Section 3.3 Terms of Directors. Directors shall hold office for a term of four years or until their successor has been elected and qualified, except that a director may be elected for a term of less than four years as provided in Section 3.12 or if the member deems it necessary to serve the objective that the terms of office of approximately one-fourth of all directors shall expire at each annual meeting. A director shall cease to be in office upon his death, resignation or removal. At each annual meeting, the member shall elect directors to succeed the directors whose terms are then expiring and to fill any new directorships fixed by the member. Such directors shall take office immediately following such annual meeting. No director shall serve more than two successive terms of three or more years. Not included in this limitation shall be a term of less than three years due to effectuating staggered terms or due to a director completing a term due to the death, removal or resignation of another director. Also not included in this limitation shall be any term served prior to March 30, 1995. A director who has served two successive terms of three or more years may again serve as a director following the expiration of a period of not less than one year during which time such individual does not serve as a director.

Directors ex-officio shall hold office for a term of one year or until their successors are elected and qualified or until they no longer are serving in the positions that entitle such persons to such ex-officio directorships.

Non-voting directors shall be elected for a term of four years or until their successors are elected and qualified and shall be subject to the terms of office provisions described in these Bylaws.

Section 3.4 Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall transact such business relating to the affairs of the Foundation as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 3.5 Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the Chief Executive Officer, or upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 3.6 Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 3.7 Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 3.8 Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Foundation, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 3.9 Participation by Conference. A director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 3.10 Resignation of Directors. Any director and any non-voting director may resign at any time by giving written notice to the Board of Directors, the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the

notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 3.11 Removal of Directors. Any director and any non-voting director may be removed from office, with or without cause, at any time, regardless of the term for which such director may have been elected, by the member at any regular, annual or special meeting.

Section 3.12 Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the member may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect director to serve until the next annual meeting.

ARTICLE IV

COMMITTEES

Section 4.1 Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Foundation. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Development Committee, Director Affairs Committee, Finance Committee, Investment Committee, and Management Affairs Committee.

Section 4.2 Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors or others by the Chairman of the Board of Directors. The Chairman of the Board of Directors may increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 4.3 Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 4.4 Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

Section 4.5 Audit Committee. The Audit Committee shall cause an annual audit to be made of the books, accounts and records of the Foundation by certified public accountants under the supervision of the Audit Committee. The Audit Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 4.6 Development Committee. The Development Committee shall recommend policies and procedures for the development, growth, and management of the endowment funds of the Foundation and shall consider funding requests from affiliates. The Development Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 4.7 Director Affairs Committee. The Director Affairs Committee shall develop criteria for membership on the Board of Directors and its committees and shall consider the eligibility requirements and qualification specified in these Bylaws, as well as the interest and participation in Foundation matters of the individuals under consideration. It shall nominate for election members of the Board of Directors and shall assist in the selection of individuals for committee assignments. The Director Affairs Committee also shall review the performance of directors and recommend amendments to the Foundation's Bylaws and shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 4.8 Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Foundation and shall monitor and oversee the financial performance of the Foundation. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 4.9 Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Foundation and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the Foundation. The Investment Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide. The Chief Executive Officer and the Treasurer shall be members of the Investment Committee.

Section 4.10 Management Affairs Committee. The Management Affairs Committee shall establish performance goals for the Chief Executive Officer and President and shall conduct annual evaluations of their performance. It shall also review and recommend to the Board of Directors human resource, fringe benefit, and compensation policies and shall monitor compliance therewith and shall act in an advisory capacity to the Chief Executive Officer. The Management Affairs Committee also shall perform such other functions as a duly adopted resolution of the Board of Director may provide.

ARTICLE V

OFFICERS

Section 5.1 Principal and Subordinate Officers. The principal officers of the Foundation shall be Chairman of the Board, Vice Chairmen of the Board, Chief Executive Officer, President, Secretary, and Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the Chief Executive Officer or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more offices may be held by the same person provided that the same individual shall not simultaneously occupy the offices of (i) Chief Executive Officer or President and (ii) Secretary. The Chairman of the Board and Vice Chairmen shall be selected from among members of the Board of Directors.

Section 5.2 General Authority and Duties. All officers and agents of the Foundation shall have such authority and perform such duties in the management of the Foundation as may be provided in these bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 5.3 Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the member at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the Chief Executive Officer or any other principal officer to whom the Chairman of the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal, whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights. An individual may not serve in the office of Chairman of Vice Chairman for more than four consecutive one year terms. Not included in this limitation shall be any term served prior to March 30, 1995 or any partial term served to fill a vacancy.

Section 5.4 Removal. Any officer or agent may be removed by the member whenever in its judgment the best interests of the Foundation will be served by so doing. Any subordinate officer or agent may also be removed by the Chief Executive Officer, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 5.5 Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 5.6 Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 5.7 Chairman of the Board. The Chairman of the Board shall preside at the annual meeting of the Foundation and at all meetings of the Board of Directors, shall appoint members of all committees and the chairmen thereof, and shall perform such duties as the Board of Directors may from time to time assign to the Chairman of the Board and such other duties as are usual to this office.

Section 5.8 Vice Chairmen of the Board. The Vice Chairmen of the Board shall perform the duties of the Chairman of the Board in the event of the Chairman's absence or disability and shall assist the Chairman of the Board in such duties as the Chairman of the Board may from time to time assign to the Vice Chairmen of the Board.

Section 5.9 Chief Executive Officer. The Chief Executive Officer shall be responsible for seeing that the resolutions and actions of the Board of Directors are carried into effect, and for reporting to the Board of Directors on the conduct and management of the affairs of the Foundation.

Section 5.10 President. The President shall exercise general supervision of the business and affairs of the Corporation and over its officers and employees. The President shall have the authority to appoint and remove employees of the Corporation, including management level officers, and may delegate to such officers and employees such authority as he deems appropriate provided, however, he shall be responsible for their actions. The President also shall have such duties and responsibilities as are assigned to him by the Chief Executive Officer and shall report and be responsible to the Chief Executive Officer.

Section 5.11 Treasurer. The Treasurer shall have supervision over the receipt and custody of the Foundation's funds, and shall cause to be kept correct and complete books and records of account, including full and accurate accounts of receipts and disbursements in books belonging to the Foundation, and in general shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer. The Treasurer shall render to the Chairman of the Board, the Chief Executive Officer and the Board of Directors promptly upon its completion an annual report of the financial condition and operation of the Foundation prepared and certified by the independent certified auditors appointed by the Board of Directors.

Section 5.12 Secretary. The Secretary shall keep minutes of the proceedings of the Board of Directors shall give or cause to be given all notices in accordance with the provisions of these Bylaws or as required by law; and shall be custodian of the corporate records and of the seal of the Foundation. The Secretary also shall perform all duties incident to the office of

Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer.

ARTICLE VI

INDEMNIFICATION OF FOUNDATION DIRECTORS, OFFICERS, EMPLOYEES AND AGENTS

Section 6.1 Rights of Indemnification. Directors, officers, employees, and agents shall have the rights of indemnification provided by Section 33-454a of the Connecticut General Statutes.

Section 6.2 Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-454a of the Connecticut General Statutes, incurred in defending a proceeding, may be paid by the Foundation in advance of the final disposition of such proceeding when authorized by the Board of Directors upon agreement, by or on behalf of the individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Foundation as authorized under the Bylaws.

ARTICLE VII

MISCELLANEOUS PROVISIONS

Section 7.1 Amendment. These Bylaws may be amended or repealed, and new Bylaws may be adopted, at any regular, annual or special meeting of the member. Any notice of a meeting of the member at which these Bylaws are to be amended or repealed, or new Bylaws are to be adopted, shall be given in writing not less than seven days or more than fifty days prior to such meeting and shall include notice of such proposed action.

Section 7.2 Fiscal Year. The fiscal year of the Foundation shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 7.3 Seal. The seal of the Foundation shall be circular in form and shall bear the name of the Foundation and shall be in such form as the Board of Directors may determine.

Section 7.4 Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the Chief Executive Officer, President or such officer or officers of the Foundation as the Board of Directors shall specify from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures.

Section 7.5 Execution of Deeds and Contracts. Subject always to the specific directions of the Board of Directors, all deeds and mortgages made by the Foundation and all other written contracts, agreements and undertakings to which the Foundation shall be a party shall be executed in its name by the Chief Executive Officer, President or such other officer as may be specified by the Board of Directors or authorized by the Chief Executive Officer or President and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to such instruments.

Section 7.6 Conflict of Interest. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Foundation, the provisions of Section 33-457 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the legal effect of such contract or transaction.

Section 7.7 Connecticut General Statutes. Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

Section 7.8 Pronouns. References herein to the masculine shall include references to the feminine, references to the singular shall include references to the plural and references to the plural shall include references to the singular, where the context of the language involved so permits or requires.

BYLAWS

OF

BRIDGEPORT HOSPITAL

TABLE OF CONTENTS

ARTICLE V

ARTICLE VI

ARTICLE VII

BYLAWS
OF
BRIDGEPORT HOSPITAL
(THE "HOSPITAL")

ARTICLE I

PURPOSE

Section 1.1 Objectives. The objectives and purposes for which the Hospital exists are as follows:

A. To establish, maintain and carry on a general hospital in Bridgeport Connecticut, to provide diagnosis and treatment for all persons who shall apply therefore without regard to sex, race, religious creed, color or national origin and without discrimination, in violation of applicable law, in the selection of employees, volunteers, students and medical staff.

B. To promote and carry on any educational activities relating to health care to the sick and injured and the promotion of health, which in the opinion of the Board of Directors, may be justified by the facilities, personnel or funds that are, or can be made, available.

C. To promote and carry on scientific research related to the care of the sick and injured insofar as, in the opinion of the Board of Directors, such research can be carried on in, or in connection with, the Hospital.

D. To participate, insofar as circumstances warrant, in any activity designed and carried on to promote the general health of the community.

E. To do all such other things necessary, suitable and proper for the accomplishment of any of the purposes of the Hospital or attainment of any of the objectives of the Hospital herein mentioned either alone or in association with other individuals, corporations, partnerships or other entities, and in general, to do and perform such acts and transact such business in connection with the purposes and objectives of the Hospital not inconsistent with law, including but not limited to the following:

1. to acquire, lease, hold, manage, sell, mortgage, and otherwise dispose of such real or personal property as may be convenient or necessary to carry out the purposes herein mentioned.

2. to borrow money and to issue bonds, debentures, notes and other evidences of indebtedness and obligations and to mortgage, pledge and otherwise charge any or all of the Hospital's properties and assets to secure the payment thereof.

3. to solicit, receive and expend donations, bequests and/or legacies for any purposes or objectives of the Hospital.

4. to make gifts of real and personal property to corporations, trusts, funds, foundations, and other entities organized and operated exclusively for charitable, scientific or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholders or individuals and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation.

Section 1.2 Limitations. The Hospital is organized exclusively for charitable, health care, and scientific purposes as a non-profit organization.

ARTICLE II

OFFICES

Section 2.1 Principal Office. The principal office of the Hospital shall be at such place in Bridgeport, Connecticut as the Board of Directors shall from time to time designate.

Section 2.2 Additional Offices. The Hospital may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Hospital may require.

ARTICLE III

MEMBERSHIP

Section 3.1 Sole Member. The Hospital shall have but one member, Southern Connecticut Health System, Inc., which shall have only the rights, powers and privileges provided in these Bylaws. Subject to the rights, powers and privileges accorded to Southern Connecticut

Health System, Inc. under these Bylaws, the Hospital shall be governed by its Board of Directors which shall elect the persons to serve on such Board of Directors.

Section 3.2 **Rights, Powers and Privileges.** Southern Connecticut Health System, Inc., as the Hospital's sole member, shall have the following rights, powers and privileges:

A. To approve the annual operating and capital budgets, programs and expenditures requiring Certificate of Need approval by appropriate governmental bodies, and plans that materially affect the growth, operation and development of the Hospital.

B. To vote upon all matters, other than the election of the Board of Directors, on which members are entitled to vote under the Nonstock Corporation Act of the State of Connecticut.

C. To elect and remove the officers of the Hospital in accordance with the provision of these Bylaws.

D. To act on any other matters on which action by members is required or permitted by these Bylaws.

Section 3.3 Meetings of the Member. The annual meeting of the member shall be held on such day and at such time and place as may be designated by the Board of Directors or the Chairman of the Board of Directors for the purposes set forth in Section 3.2 herein and for the transaction of any other business as may properly come before such meeting. Regular meetings of the member shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the member may be called at any time by the Board of Directors, the Chairman of the Board of Directors, the President or the member. Each such request for a special meeting shall state the purposes for which the requested meeting is to be called. The member shall cast one vote on each matter submitted to a vote at each regular, annual and special meeting. Except as otherwise provided, any action required to be, or which may be, taken at any regular, annual or special meeting of the member may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the member.

Section 3.4 Notice of Meeting. A notice of each meeting of the member shall be given in writing to the member not less than seven days or more than fifty days before the date of the meeting. Each notice shall state the place, day and hour of the meeting. The general purpose for which a special meeting is called shall be stated in the notice thereof, and no other business shall be transacted at the meeting.

Section 3.5 Waiver of Notice. Notice of any meeting of the member may be waived in writing by the member.

ARTICLE IV

BOARD OF DIRECTORS

Section 4.1 General Powers. Subject to the rights, powers and privileges accorded to the member under these Bylaws, the activities, property and affairs of the Hospital shall be managed by the Board of Directors, which shall exercise all of the powers of the Corporation under the Connecticut Nonstock Corporation Act, the Charter, and the Bylaws as each may be amended from time to time.

Section 4.2 Number of Directors and Qualifications. The Board of Directors shall consist of not less than ten nor more than twenty persons which number shall be fixed from time to time by the Board of Directors. At each annual meeting of the Board of Directors, the directors shall be elected by the then Board of Directors to take office immediately following such annual meeting. The President of Bridgeport Hospital shall be an ex-officio director with vote.

The Board of Directors shall elect voting physician directors from among physicians nominated by the Bridgeport Hospital medical staff. If the President of the Bridgeport Hospital Medical Staff is elected to this category, he shall serve ex-officio. The Board of Directors shall elect that number of voting physician directors equal to one less than twenty percent of the number of directorships; a number consistent with legal requirements. In the event of a change in such legal requirements, these Bylaws shall be amended to comport with such requirements.

The Board of Directors shall also elect four non-voting physician directors from among physicians nominated by the Bridgeport Hospital medical staff. If the President of the Bridgeport Hospital Medical Staff is elected to this category, he shall serve ex-officio.

Non-voting physician directors (except the President of the Bridgeport Hospital Medical Staff if so elected.) shall receive notice of, and have the right to attend and speak at, meetings of the Board of Directors, and serve on committees as voting members. Such non-voting physician directors shall be subject to the age and term of office provisions of these Bylaws, but shall not count toward quorum requirements, shall not have voting rights, shall not be considered in calculating the number of directorships, and shall not be considered directors for any other purpose.

The Bridgeport Hospital medical staff shall nominate no fewer than two physicians for each position being considered by the Board of Directors for election of a voting physician director and as a non-voting physician director. In any case, the President of the Bridgeport Hospital Medical Staff shall be nominated by the medical staff and shall be elected by the Board of Directors to serve ex-officio as provided above.

An ex-officio director with vote and an ex-officio voting physician director shall be considered a director for all purposes of these Bylaws except he shall not be subject to the age or term of office provisions.

Except as otherwise provided in this Section 4.2, a director or a non-voting physician director who has attained age 70 shall be ineligible to continue to serve as a director or a non-voting physician director after the annual meeting of the Board of Directors next following the date such person attains age 70.

Section 4.3 Terms of Directors. Directors shall hold office for a term of four years or until their successors have been elected and qualified, except that a director may be elected for a term of less than four years as provided in Section 4.12 or if the Board of Directors deems it necessary to serve the objective that the terms of office of approximately one-fourth of all directors shall expire at each annual meeting. A director shall cease to be in office upon his death, resignation or removal. At each annual meeting, the Board of Directors shall elect directors to succeed the directors whose terms are then expiring and to fill any new directorships fixed by the Board of Directors. Such directors shall take office immediately following such annual meeting. No director shall serve more than two successive terms of three or more years. Not included in this limitation shall be a term of less than three years due to effectuating staggered terms or due to a director completing a term due to the death, removal or resignation of another director. Also not included in this limitation shall be any term served prior to March 30, 1995. A director who has served two successive terms of three or more years may again serve as a director following the expiration of a period of not less than one year during which time such individual does not serve as a director.

The President of Bridgeport Hospital and the President of the Bridgeport Hospital Medical Staff shall hold office for a term of one year or until their successors are elected and qualified or until they no longer are serving in the position that entitles them to such ex-officio directorship.

Non-voting physician directors (except the President of the Bridgeport Hospital Medical Staff if so elected) shall be elected for a term of four years or until their successors are elected and qualified and shall be subject to the term of office provisions described in these Bylaws.

Section 4.4 Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall elect directors and non-voting physician directors of the Hospital and shall transact such other business relating to the affairs of the Hospital as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 4.5 Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the President, or

upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 4.6 Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 4.7 Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 4.8 Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Hospital, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 4.9 Participation by Conference . A director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 4.10 Resignation of Directors. Any director and any non-voting physician director may resign at any time by giving written notice to the Board of Directors or to the Chairman, the President or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 4.11 Removal of Directors. Any director and any non-voting physician director may be removed from office with or without cause at any time, regardless of the term for which such director may have been elected, by the affirmative vote of a majority of all of the directors in office at that time at any regular, annual or special meeting.

Section 4.12 Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the remaining directors, though less than a quorum, by the concurring vote of a majority of such remaining directors at any meeting of the Board of Directors, may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect directors to serve until the next annual meeting.

In case the vacancy is one of the directorships or one of the non-voting physician directorships designated for a physician, the vacancy shall be filled with a physician nominated by the Bridgeport Hospital medical staff, and the medical staff shall nominate no fewer than two physicians for each vacancy.

ARTICLE V

COMMITTEES

Section 5.1 Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Hospital. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Development Committee, Director Affairs Committee, Finance Committee, Investment Committee, Management Affairs Committee, and Professional and Quality Review Committee. The Board of Directors shall perform all of the duties of the Executive Committee set forth in the Bridgeport Hospital Medical Staff Bylaws.

Section 5.2 Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors or others by the Chairman of the Board of Directors. The Chairman of the Board of Directors may increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 5.3 Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 5.4 Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

Section 5.5 Audit Committee. The Audit Committee shall cause an annual audit to be made of the books, accounts and records of the Hospital by certified public accountants under the supervision of the Audit Committee. The Audit Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.6 Development Committee. The Development Committee shall recommend policies and procedures for the development, growth, and management of the endowment funds of the Hospital and shall consider funding requests from affiliates. The Development Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.7 Director Affairs Committee. The Director Affairs Committee shall develop criteria for membership on the Board of Directors and its committees and shall consider the eligibility requirements and qualification specified in these Bylaws, as well as the interest and participation in Hospital matters of the individuals under consideration. It shall nominate for election members of the Board of Directors and shall assist in the selection of individuals for committee assignments. The Director Affairs Committee also shall review the performance of directors and recommend amendments to the Hospital's and Auxiliary's bylaws and shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.8 Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Hospital and shall monitor and oversee the financial performance of the Hospital. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.9 Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Hospital and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the Hospital. The Investment Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide. The Chief Executive Officer and the Treasurer shall be members of the Investment Committee.

Section 5.10 Management Affairs Committee. The Management Affairs Committee shall establish performance goals for the President and shall conduct annual evaluations of his performance. It shall also review and recommend to the Board of Directors human resource, fringe benefit, and compensation policies and monitor compliance therewith and shall act in an advisory capacity to the President. The Management Affairs Committee also shall perform such other functions as a duly adopted resolution of the Board of Director may provide.

Section 5.11 Professional and Quality Review Committee. The Professional and Quality Review Committee shall perform all of the duties of the Professional Committee and the Joint Conference Committee as set forth in the Bridgeport Hospital Medical Staff Bylaws including meeting with members of the Medical Staff to resolve conflicts with the Medical Staff regarding appointments, reappointments and privileges. It also shall review recommendations from the Medical Staff and make recommendations to the Board of Directors concerning Medical Staff appointments and reappointments and the assignment, withdrawal, denial or curtailment of privileges. It shall compile and review information relating to the care and treatment of patients for the purposes of establishing mechanisms and policies for evaluating and improving quality of

health care and reducing morbidity and mortality, performance improvement and risk management functions related to patient care and safety. The Professional and Quality Review Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

ARTICLE VI

OFFICERS

Section 6.1 Principal and Subordinate Officers. The principal officers of the Hospital shall be Chairman of the Board, Vice Chairmen of the Board, President, Secretary, and Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the President or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more offices may be held by the same person provided that the same individual shall not simultaneously occupy the offices of (i) Chief Executive Officer or President and (ii) Secretary. The Chairman of the Board and Vice Chairmen shall be selected from among members of the Board of Directors.

Section 6.2 General Authority and Duties. All officers and agents of the Hospital shall have such authority and perform such duties in the management of the Hospital as may be provided in these Bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 6.3 Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the member at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the President or any other principal officer to whom the Chairman of the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal, whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights. An individual may not serve in the office of Chairman or Vice Chairman for more than four consecutive one year terms. Not included in this limitation shall be any term served prior to March 30, 1995, or any partial term served to fill a vacancy.

Section 6.4 Removal. Any officer or agent may be removed by the member whenever in its judgment the best interests of the Hospital will be served by so doing. Any subordinate officer or agent may also be removed by the President, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 6.5 Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the President or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 6.6 Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 6.7 Chairman of the Board. The Chairman of the Board shall preside at the annual meeting of the Hospital and at all meetings of the Board of Directors, shall appoint members of all committees and the chairmen thereof, and shall perform such duties as the Board of Directors may from time to time assign to the Chairman of the Board and such other duties as are usual to this office.

Section 6.8 Vice Chairmen of the Board. The Vice Chairmen of the Board shall perform the duties of the Chairman of the Board in the event of the Chairman's absence or disability and shall assist the Chairman of the Board in such duties as the Chairman of the Board may from time to time assign to the Vice Chairmen of the Board.

Section 6.9 President. The President shall be the Chief Executive Officer of the Hospital and the official representative of the Board of Directors in the management of the Hospital. The President shall exercise general supervision of the business and affairs of the Hospital and over its officers and its employees and shall be responsible for seeing that the resolutions and actions of the Board of Directors are carried into effect, and for reporting to the Board of Directors on the conduct and management of the affairs of the Hospital. The President shall be responsible for insuring Hospital compliance with the Bylaws, rules, regulations, and policies of the Hospital, compliance with all applicable laws and regulations, and prompt action on reports and recommendations from authorized planning, regulatory, and inspecting agencies. The President shall be responsible for establishing internal controls to safeguard physical, financial, information and human resources. The President also shall have the authority to appoint and remove employees of the Hospital, including management level officers, and may delegate to any such officers and employees such authority as he deems appropriate, provided however, he shall be responsible for their actions.

Section 6.10 Treasurer. The Treasurer shall have supervision over the receipt and custody of the Hospital's funds, and shall cause to be kept correct and complete books and records of account, including full and accurate accounts of receipts and disbursements in books belonging to the Hospital, and in general shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the President. The Treasurer shall render to the Chairman of the Board, the President and the Board of Directors promptly upon its completion an annual report of the

financial condition and operation of the Hospital prepared and certified by the independent certified auditors appointed by the Board of Directors.

Section 6.11 Secretary. The Secretary shall keep minutes of the proceedings of the Board of Directors, shall give or cause to be given all notices in accordance with the provisions of these Bylaws or as required by law, and shall be custodian of the corporate records and of the seal of the Hospital. The Secretary shall also perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the President.

ARTICLE VII

PROFESSIONAL STAFF

Section 7.1 Establishment of Medical Staff. The Board of Directors hereby establishes and sets forth the organizational structure of the Bridgeport Hospital Medical Staff and its relationship to the Board of Directors and to Hospital administration, and also establishes an Allied Health Professional Staff.

For the purposes of these Bylaws, the term "Medical Staff" shall have the meaning set forth in the Bridgeport Hospital Medical Staff Bylaws which are incorporated herein by reference.

In the event of any conflict between the provisions of these Bylaws and the Medical Staff Bylaws and Rules and Regulations, the provisions of these Bylaws shall supersede any conflicting provisions of the Medical Staff Bylaws and Medical Staff Rules and Regulations; provided, however, that every effort shall be made to interpret these Bylaws and the Medical Staff Bylaws and the Medical Staff Rules and Regulations as being consistent with one another.

Section 7.2 Requirements and Responsibility for Appointment, Reappointment. Granting or Curtailment of Privileges. The Board of Directors, through the Professional and Quality Review Committee, shall require that the Medical Staff be organized into a responsible administrative unit, and that it adopt and periodically review such Bylaws, Rules and Regulations and policies, subject to Section 7.3 for governance of its members' practice in the Hospital as the Board of Directors determines to be of the greatest benefit to the care of patients of the Hospital and as is consistent with Hospital policy, the requirements of the Joint Commission on Accreditation of Healthcare Organizations and applicable requirements of law.

The Board of Directors, through the Professional and Quality Review Committee, shall hold the Medical Staff responsible for making recommendations to the Board of Directors concerning initial staff appointments, reappointments, terminations of appointments, and the granting, termination, curtailment or revision of clinical privileges, and for the submission of regular reports on the review processes carried out by the Medical Staff in accordance with the

requirements of the Medical Staff Bylaws. The Board of Directors shall act on such recommendations within a reasonable time as specified in the Medical Staff Bylaws. In considering recommendations for appointment and privileges, the Board of Directors shall consider the resources of the Hospital.

Any differences between the Medical Staff and the Board of Directors in recommendations concerning Medical Staff appointments, reappointments, terminations of appointments, and the granting, curtailment, revision, or termination of clinical privileges shall be reviewed within a reasonable period of time by the Professional and Quality Review Committee in accordance with the provisions of the Medical Staff Bylaws.

Section 7.3 Medical Staff Bylaws, and Rules and Regulations. Bylaws, Rules and Regulations for the Medical Staff shall set forth its organization and governance including the following: mechanisms for appointment, reappointment, and termination of appointment; mechanisms for the granting, termination, curtailment and revision of clinical privileges; mechanisms for liaison between the Board of Directors and the Medical Staff; and the quality assurance, peer review and other responsibilities of the Medical Staff as required by the Joint Commission on Accreditation of Healthcare Organizations and applicable law.

The Medical Staff Bylaws, Rules and Regulations shall be adopted as provided in the Medical Staff Bylaws. The authority to adopt or amend the Medical Staff Bylaws and Rules and Regulations shall be vested in the Board of Directors, and shall not require recommendation or ratification by the Medical Staff.

Section 7.4 Admission of Patients. Only members of the Medical Staff in good standing and who hold appropriate admitting privileges can admit patients to the Hospital. Physician and dentist members of the Medical Staff, as provided in the Medical Staff Bylaws and Rules and Regulations and as authorized by law, shall be responsible for the medical aspects of patients' care and shall practice only within the scope of their clinical privileges as granted by the Board of Directors. The quality of care provided by these physicians and dentists to patients of the Hospital shall be reviewed as part of the Hospital's quality assurance program.

Section 7.5 Communication with the Board of Directors and Hospital Administration. As provided in these Bylaws and the Medical Staff Bylaws, there shall be effective and systematic liaison and communication between the Board of Directors, the Medical Staff, and Hospital administration. The Professional and Quality Review Committee has been established to further this purpose and shall meet with Members of the Medical Staff to resolve any conflicts between the Hospital and the Medical Staff regarding appointments, reappointments and privileges. In addition, the Medical Staff shall have the right of representation (through attendance and voice at meetings of the Board of Directors), by the President of the Bridgeport Hospital Medical Staff serving on the Board of Directors either as an ex-officio director with vote or as an ex-officio non-voting physician director and as otherwise provided in these Bylaws.

Section 7.6 Medical Staff Recommendations. The Medical Staff, as provided in the Medical Staff Bylaws, shall make recommendations to the Board of Directors for its approval which shall include recommendations pertaining to the following:

1. The structure of the Medical Staff;
2. The mechanism used to review credentials and to delineate individual clinical privileges;
3. Individual Medical Staff membership;
4. Specific delineated clinical privileges for each individual exercising such privileges;
5. The organization of the quality assurance and performance improvement activities of the Medical Staff as well as the mechanisms used to conduct, evaluate, and revise such activities;
6. The mechanism by which membership on the Medical Staff and clinical privileges may be suspended, curtailed or terminated; and
7. The mechanism for a fair hearing plan.

Section 7.7 Termination of Physicians in Medical/Administrative Positions. Physicians or dentists holding Hospital administrative appointments and appointment to the Medical Staff shall be entitled to continue their Medical Staff membership notwithstanding the termination of their Hospital administrative appointment (1) unless their Medical Staff membership is revoked, suspended, not renewed, or lapses in accordance with the Medical Staff Bylaws or Rules and Regulations; (2) unless otherwise provided by agreement with the physician or dentist or his practice group; or (3) unless otherwise provided pursuant to decisions by the Hospital terminating or otherwise affecting their administrative appointment and clinical privileges.

Section 7.8 Allied Health Professional Staff. The Allied Health Professional Staff shall be organized and function as provided in the Medical Staff Bylaws. For purposes of these Bylaws, the term "Allied Health Professional Staff" shall have the meaning set forth in the Medical Staff Bylaws.

ARTICLE VIII

INDEMNIFICATION OF HOSPITAL MEMBER, DIRECTORS, OFFICERS, EMPLOYEES AND AGENTS

Section 8.1 Rights of Indemnification. Member, directors, officers, employees, and agents shall have the rights of indemnification provided by Sec. 33-454a of the Connecticut General Statutes.

Section 8.2 Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-454a of the Connecticut General Statutes, incurred in defending a proceeding, may be paid by the Hospital in advance of the final disposition of such proceeding

when authorized by the Board of Directors upon agreement, by or on behalf of the individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Hospital.

ARTICLE IX

THE BRIDGEPORT HOSPITAL AUXILIARY, INC.

Section 9.1 Purpose. A Bridgeport Hospital Auxiliary may be organized to further the purposes and interests of the Hospital.

Section 9.2 Adoption of Bylaws. The Auxiliary shall have the authority, subject to the review and approval of the Board of Directors, to adopt and amend Auxiliary Bylaws which shall state its purpose, duties, and organization.

ARTICLE X

MISCELLANEOUS PROVISIONS

Section 10.1 Amendment of Bylaws. These Bylaws may be amended or repealed, and new Bylaws may be adopted, at any regular, annual or special meeting of the Board of Directors by the affirmative vote of a majority of all directors. Any notice of a meeting of the Board of Directors at which these Bylaws are to be amended or repealed, or new Bylaws are to be adopted, shall be given at least two days prior to such meeting and shall include notice of such proposed action. Notwithstanding the foregoing, the provisions of Article III of these Bylaws may be amended or repealed only with the additional approval of the member.

Section 10.2 Corporate Seal. The Corporate seal shall be an appropriate seal as adopted by the Board of Directors.

Section 10.3 Fiscal Year. The fiscal year of the Hospital shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 10.4 Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Hospital as the Board of Directors shall specify from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures.

Section 10.5 Execution of Deeds and Contracts. Subject to the general directions of the Board of Directors, all deeds and mortgages made by the Hospital and all other written contracts,

agreements and undertakings to which the Hospital shall be a party shall be executed in its name by the President or such other officer as may be specified by the Board of Directors or authorized by the President and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to such instruments.

Section 10.6 Conflict of Interest. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Hospital, the provisions of Section 33-457 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the legal effect of such contract or transaction.

Section 10.7 Pronouns. References herein to the masculine shall include references to the feminine, references to the singular shall include references to the plural and references to the plural shall include references to the singular, where the context of the language involved so permits or requires.

Section 10.8 Connecticut General Statutes. Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

BYLAWS
OF
REHABILITATION CENTER OF FAIRFIELD COUNTY, INC.

(The "Center")

ARTICLE I

PURPOSES

Section 1.1 Objectives. The objectives and purposes for which the Center exists are as follows:

A. To promote and carry out a program for the medical care, social education, vocational training and the rendering of other assistance to disabled and handicapped people regardless of age and regardless of the cause of the handicap.

B. To provide for its regional citizens opportunities to achieve health, productivity and self esteem when they are challenged by injury or illness.

C. To promote and carry on any educational activities relating to the medical care to, and rehabilitation of, the sick and injured and the promotion of health which, in the opinion of the Board of Directors, may be justified by the facilities, personnel or funds that are, or can be made, available

D. To promote and carry on scientific research related to the care and rehabilitation of the sick and injured insofar as, in the opinion of the Board of Directors, such research can be carried on in, or in connection with, the Center.

E. To participate, insofar as circumstances warrant, in any activity designed and carried on to promote the general health of the community.

F. To do all such other things necessary, suitable and proper for the accomplishment of any of the purposes of the Center or attainment of any of the objectives of the Center herein mentioned either alone or in association with other individuals, corporations, partnerships or other entities, and in general, to do and perform such acts and transact such business in connection with the purposes and objectives of the Center not inconsistent with law, including but not limited to the following:

1. to acquire, lease, hold, manage, sell, mortgage and otherwise dispose of such real or personal property as may be convenient or necessary to carry out the purposes herein mentioned.

2. to borrow money and to issue bonds, debentures, notes and other evidences of indebtedness and obligations and to mortgage, pledge and otherwise charge any or all of its properties and assets to secure the payment thereof.

3. to solicit, receive and expend donations, bequests and/or legacies for any purposes or objectives of the Center.

4. to make gifts of real and personal property to corporations, trusts, funds, foundations, or other entities organized and operated exclusively for charitable, scientific or educational purposes, no part of the net earnings of which inures to the benefit of any private shareholders or individuals and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation.

Section 1.2 Limitations. The Center is organized exclusively for charitable, health care, educational, and scientific purposes as a non-profit organization.

ARTICLE II

OFFICES

Section 2.1 Principal Office. The principal office of the Center shall be at such place in the United States as the Board of Directors shall from time to time designate.

Section 2.2 Additional Offices. The Center may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Corporation may require.

ARTICLE III

MEMBERSHIP

Section 3.1 Sole Member. The Center shall have but one member, Southern Connecticut Health System, Inc., which shall have the right to elect the Board of Directors of the Center in accordance with these Bylaws, and shall have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock nonprofit corporation and not conferred thereby or by the Articles of Association or Bylaws upon the Board of Directors of the Center.

Section 3.2 Rights, Powers and Privileges. In addition to such other rights, powers and privileges as it may have by law, the Center's sole member shall have the following rights, powers and privileges:

A. To approve the long range development plans, annual operating and capital budgets, programs and expenditures requiring Certificate of Need approval by appropriate governmental bodies, and plans that materially affect the growth, operations and development of the Center.

B. To elect and remove members of the Board of Directors of the Center and non-voting directors in accordance with the provisions of these Bylaws.

C. To elect and remove any officer of the Center in accordance with the provisions of these Bylaws.

D. To vote upon all matters on which members are entitled to vote under the Nonstock Corporation Act of the State of Connecticut.

E. To act on any other matters on which action by the member is provided for in these Bylaws.

Section 3.3 Meetings of the Member. The annual meeting of the member shall be held on such day and at such time and place as may be designated by the Board of Directors or the Chairman of the Board of Directors for the purposes set forth in Sections 3.1 and 3.2 herein and for the transaction of any other business as may properly come before such meeting. Regular meetings of the member shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the member may be called at any time by the Board of Directors, the Chairman of the Board of Directors, the Chief Executive Officer or the member. Each such request for a special meeting shall state the purposes for which the requested meeting is to be called. The member shall cast one vote on each matter submitted to a vote at each regular, annual and special meeting. Except as otherwise provided, any action required to be, or which may be, taken at any regular, annual or special meeting of the member may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the member.

Section 3.4 Notice of Meeting. A notice of each meeting of the member shall be given in writing to the member not less than seven days or more than fifty days before the date of the meeting. Each notice shall state the place, day and hour of the meeting. The general purpose for which a special meeting is called shall be stated in the notice thereof, and no other business shall be transacted at the meeting.

Section 3.5 Waiver of Notice. Notice of any meeting of the member may be waived in writing by the member.

ARTICLE IV

BOARD OF DIRECTORS

Section 4.1 General Powers. Subject to the rights, powers and privileges accorded to the member by law, the Articles of Association or these Bylaws, the activities, property and affairs of the Center shall be managed by the Board of Directors, which shall exercise all of the powers and responsibilities conferred upon the Board of Directors by the Connecticut Nonstock Corporation Act, the Articles of Association and these Bylaws as each may be amended from time to time.

Section 4.2 Number of Directors and Qualification. The Board of Directors shall consist of not less than ten and not more than twenty persons, which number shall be fixed from time to time by the member. At each annual meeting of the member, the directors shall be elected by the member to take office immediately following such annual meeting.

A person who is an ex-officio director with vote of the Bridgeport Hospital Board of Directors and who is elected to the Board of Directors shall be an ex-officio director with vote of the Board of Directors and shall be considered a director for all purposes of these Bylaws except he shall not be subject to the age or term of office provisions.

The member also may elect non-voting directors. Non-voting directors shall receive notice of, and shall be entitled to attend and speak at, meetings of the Board of Directors and shall be eligible to serve as voting members of committees. Such non-voting directors shall be subject to the age and term of office provisions of these Bylaws, but shall not count toward quorum requirements, shall not have voting rights, shall not be considered in calculating the number of directorships and shall not be considered directors for any other purpose under these Bylaws.

Except as otherwise provided in this Section 4.2, a director who has attained age 70 shall be ineligible to continue to serve as a director after the annual meeting of the Board of Directors next following the date the director attains age 70.

Section 4.3 Terms of Directors. Directors shall hold office for a term of four years or until their successor has been elected and qualified, except that a director may be elected for a term of less than four years as provided in Section 4.12 or if the member deems it necessary to serve the objective that the terms of office of approximately one-fourth of all directors shall expire at each annual meeting. A director shall cease to be in office upon his death, resignation or removal. At each annual meeting, the member shall elect directors to succeed the directors whose terms are then expiring and to fill any new directorships fixed by the member. Such directors shall take office immediately following such annual meeting. No director shall serve more than two successive terms of three or more years. Not included in this limitation shall be a term of less

than three years due to effectuating staggered terms or due to a director completing a term due to the death, removal or resignation of another director. Also not included in this limitation shall be any term served prior to March 30, 1995. A director who has served two successive terms of three or more years may again serve as a director following the expiration of a period of not less than one year during which time such individual does not serve as a director.

Directors ex-officio shall hold office for a term of one year or until their successors are elected and qualified or until they no longer are serving in the positions that entitle such persons to such ex-officio directorships.

Non-voting directors shall be elected for a term of four years or until their successors are elected and qualified and shall be subject to the terms of office provisions described in these Bylaws.

Section 4.4 Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall elect the subordinate officers, of the Center and shall transact such other business relating to the affairs of the Center as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 4.5 Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the Chief Executive Officer, or upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 4.6 Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 4.7 Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 4.8 Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Center, the action shall be as valid as

though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 4.9 Participation by Conference. A director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 4.10 Resignation of Directors. Any director and any non-voting director may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 4.11 Removal of Directors. Any director and any non-voting director may be removed from office, with or without cause, at any time, regardless of the term for which such director may have been elected, by the member at any regular, annual or special meeting.

Section 4.12 Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the member may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect directors to serve until the next annual meeting.

ARTICLE V

COMMITTEES

Section 5.1 Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Center. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Development Committee, Director Affairs Committee, Finance Committee, Investment Committee, and Management Affairs Committee.

Section 5.2 Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors or others by the Chairman of the Board of Directors. The Chairman of the Board of Directors may increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 5.3 Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 5.4 Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

Section 5.5 Audit Committee. The Audit Committee shall cause an annual audit to be made of the books, accounts and records of the Center by certified public accountants under the supervision of the Audit Committee. The Audit Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.6 Development Committee. The Development Committee shall recommend policies and procedures for the development, growth, and management of the endowment funds of the Center and shall consider funding requests from affiliates. The Development Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.7 Director Affairs Committee. The Director Affairs Committee shall develop criteria for membership on the Board of Directors and its committees and shall consider the eligibility requirements and qualification specified in these Bylaws, as well as the interest and participation in Center matters of the individuals under consideration. It shall nominate for election members of the Board of Directors and shall assist in the selection of individuals for committee assignments. The Director Affairs Committee also shall review the performance of directors and recommend amendments to the Center's and Auxiliary's Bylaws and shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.8 Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Center and shall monitor and oversee the financial performance of the Center. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 5.9 Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Center and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the Center. The Investment Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide. The Chief Executive Officer and the Treasurer shall be members of the Investment Committee.

Section 5.10 Management Affairs Committee. The Management Affairs Committee shall establish performance goals for the Chief Executive Officer and President and shall conduct annual evaluations of their performance. It shall also review and recommend to the Board of Directors human resource, fringe benefit, and compensation policies and monitor compliance therewith and shall act in an advisory capacity to the Chief Executive Officer. The Management Affairs Committee also shall perform such other functions as a duly adopted resolution of the Board of Director may provide.

Section 5.11 Professional and Quality Review Committee. The Professional and Quality Review Committee shall compile and review information relating to the care and treatment of patients for the purposes of establishing mechanisms and policies for evaluating and improving quality of health care and reducing morbidity and mortality, performance improvement and risk management functions related to patient care and safety. The Professional and Quality Review Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

ARTICLE VI

OFFICERS

Section 6.1 Principal and Subordinate Officers. The principal officers of the Center shall be Chairman of the Board, Vice Chairmen of the Board, Chief Executive Officer, President, Secretary, and Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the Chief Executive Officer or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more offices may be held by the same person provided that the same individual shall not simultaneously occupy the offices of (i) Chief Executive Officer or President and (ii) Secretary. The Chairman of the Board and Vice Chairmen shall be selected from among members of the Board of Directors.

Section 6.2 General Authority and Duties. All officers and agents of the Center shall have such authority and perform such duties in the management of the Center as may be provided in these bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 6.3 Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the member at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the Chief Executive Officer or any other principal officer to whom the Chairman of the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal,

whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights. An individual may not serve in the office of Chairman of Vice Chairman for more than four consecutive one year terms. Not included in this limitation shall be any term served prior to March 30, 1995 or any partial term served to fill a vacancy.

Section 6.4 Removal. Any officer or agent may be removed by the member whenever in its judgment the best interests of the Center will be served by so doing. Any subordinate officer or agent may also be removed by the Chief Executive Officer, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 6.5 Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 6.6 Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 6.7 Chairman of the Board. The Chairman of the Board shall preside at the annual meeting of the Center and at all meetings of the Board of Directors, shall appoint members of all committees and the chairmen thereof, and shall perform such duties as the Board of Directors may from time to time assign to the Chairman of the Board and such other duties as are usual to this office.

Section 6.8 Vice Chairmen of the Board. The Vice Chairmen of the Board shall perform the duties of the Chairman of the Board in the event of the Chairman's absence or disability and shall assist the Chairman of the Board in such duties as the Chairman of the Board may from time to time assign to the Vice Chairmen of the Board.

Section 6.9 Chief Executive Officer. The Chief Executive Officer shall be responsible for seeing that the resolutions and actions of the Board of Directors are carried into effect, and for reporting to the Board of Directors on the conduct and management of the affairs of the Center.

Section 6.10 President. The President shall exercise general supervision of the business and affairs of the Center and over its officers and employees. The President shall have the authority to appoint and remove employees of the Center, including management level officers, and may delegate to such officers and employees such authority as he deems appropriate provided, however, he shall be responsible for their actions. The President shall have such additional duties and responsibilities as are assigned to him by the Chief Executive Officer.

Section 6.11 Treasurer. The Treasurer shall have supervision over the receipt and custody of the Center's funds, and shall cause to be kept correct and complete books and records of account, including full and accurate accounts of receipts and disbursements in books belonging to the Center, and in general shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer. The Treasurer shall render to the Chairman of the Board, the Chief Executive Officer and the Board of Directors promptly upon its completion an annual report of the financial condition and operation of the Center prepared and certified by the independent certified auditors appointed by the Board of Directors.

Section 6.12 Secretary. The Secretary shall keep minutes of the proceedings of the Board of Directors shall give or cause to be given all notices in accordance with the provisions of these Bylaws or as required by law; and shall be custodian of the corporate records and of the seal of the Center. The Secretary also shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the Chief Executive Officer.

ARTICLE VII

INDEMNIFICATION OF CENTER DIRECTORS, CORPORATORS, OFFICERS, EMPLOYEES AND AGENTS

Section 7.1 Rights of Indemnification. Directors, officers, employees, and agents shall have the rights of indemnification provided by Section 33-454a of the Connecticut General Statutes.

Section 7.2 Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-454a of the Connecticut General Statutes, incurred in defending a proceedings, may be paid by the Center in advance of the final disposition of such proceeding when authorized by the Board of Directors upon agreement, by or on behalf of the individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Center as authorized under the Bylaws.

ARTICLE VIII

THE AUXILIARY OF THE REHABILITATION CENTER OF FAIRFIELD COUNTY

Section 8.1 Purpose. The purposes of the Auxiliary shall be to promote the objectives of the Center and support its activities throughout the community. The Auxiliary shall not act contrary to the policies set forth by the Center's Board of Directors.

Section 8.2 **Operation of Auxiliary**. The Auxiliary shall have the right pursuant to its Constitution and Bylaws, to elect its officers, maintain its own bank accounts and collect membership dues.

Section 8.3 **Adoption and Amendment of Constitution or Bylaws**. The Auxiliary shall have the authority, subject to the review and approval of the Center's Board of Directors, to adopt and amend their Constitution and Bylaws.

ARTICLE IX

MISCELLANEOUS PROVISIONS

Section 9.1 **Amendment**. These Bylaws may be amended or repealed, and new Bylaws may be adopted, at any regular, annual or special meeting of the member. Any notice of a meeting of the member at which these Bylaws are to be amended or repealed, or new Bylaws are to be adopted, shall be given in writing not less than seven days or more than fifty days prior to such meeting and shall include notice of such proposed action..

Section 9.2 **Fiscal Year**. The fiscal year of the Center shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 9.3 **Seal**. The seal of the Center shall be circular in form and shall bear the name of the Corporation and shall be in such form as the Board of Directors may determine.

Section 9.4 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President, Chief Executive Officer, or such officer or officers of the Center as the Board of Directors shall specify from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures.

Section 9.5 **Execution of Deeds and Contracts**. Subject to the general directions of the Board of Directors, all deeds and mortgages made by the Center and all other written contracts, agreements and undertakings to which the Center shall be a party shall be executed in its name by the Chief Executive Officer, President or such other officer as may be specified by the Board of Directors or authorized by the Chief Executive Officer or President and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to such instruments.

Section 9.6 **Conflict of Interest**. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Corporation, the provisions of Section 33-457 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the legal effect of such contract or transaction.

Section 9.7 **Connecticut General Statutes.** Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

Section 9.8 **Pronouns.** References herein to the masculine shall include references to the feminine, references to the singular shall include references to the plural and references to the plural shall include references to the singular, where the context of the language involved so permits or requires.

BYLAWS

OF

NOVAMED CORPORATION

TABLE OF CONTENTS

BYLAWS
OF
NOVAMED CORPORATION

(The "Corporation")

ARTICLE I

OFFICES

Section 1.1 Principal Office. The principal office of the Corporation shall be at such place in the United States as the Board of Directors shall from time to time designate.

Section 1.2 Additional Offices. The Corporation may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Corporation may require.

ARTICLE II

MEETINGS OF SHAREHOLDERS

Section 2.1 Place of Meetings. All meetings of the shareholders shall be held either at the principal office or place of business of the Corporation, or at such other place within or without the United States as from time to time may be designated by the Board of Directors.

Section 2.2 Annual Meetings. The annual meetings of shareholders shall be held on such day (other than a legal holiday) in each calendar year and at such time and place as may be designated by the Board of Directors or the President, for the election of directors and for the transaction of such other business as may properly come before such meeting.

Section 2.3 Special Meetings. Special meetings of the shareholders may be called at any time by the Board of Directors, the Chairman of the Board of Directors, or the President, and shall be called by the President or the Secretary upon the written request of a majority of the directors then in office or upon the written request of one or more shareholders holding in the aggregate at least 10% of the total number of shares outstanding and entitled to vote. Each such request shall state the purposes for which the requested meeting is to be called.

Section 2.4 Notice of Annual or Special Meeting. A notice setting forth the day, hour and place of each annual or special meeting of shareholders shall be mailed, postage prepaid, to each shareholder of record, at his last known post office address as the same appears on the stock records of the Corporation, or such notice shall be left with each such shareholder at his residence or usual place of business, not less than seven nor more than fifty days before such annual or

special meeting. In the case of a special meeting, the notice shall also state the general purpose or purposes thereof.

Section 2.5 Waiver of Notice. Notice of any shareholders' meeting may be waived in writing by any shareholder either before or after the time stated therein for convening the meeting and, if any person present in person or by proxy at a shareholders' meeting does not protest the lack of proper notice prior to or at the commencement of the meeting, such person shall be deemed to have waived notice of such meeting.

Section 2.6 Quorum The holders of a majority of the issued and outstanding stock entitled to vote, present either in person or by proxy, shall constitute a quorum for the transaction of business at any meeting of the shareholders. The shareholders present at a validly called and convened meeting at which a quorum is present may continue to transact business notwithstanding the withdrawal of persons holding enough shares to leave less than a quorum

Section 2.7 Adjournment of Shareholders' Meeting. If a quorum is not present at any meeting of the shareholders, the holders of a majority of the voting power of the shares entitled to vote who are present, in person or by proxy, may adjourn the meeting to such future time as shall be agreed upon by them and announced at the meeting, and no notice of such adjournment need be given to the shareholders not present or represented at the meeting unless the adjournment is for more than 30 days or, if after the adjournment, a new record date is fixed for the adjourned meeting; in either of the latter two events, a notice of the adjourned meeting shall be given to each shareholder of record entitled to vote at the meeting.

Section 2.8 Proxies. At all meetings of the shareholders, any shareholder entitled to vote may vote either in person or by written proxy signed by such shareholder or by his duly authorized attorney-in-fact or other legal representative.

Section 2.9 Number of Votes of Each Shareholder. Each outstanding share, regardless of class, shall be entitled to one vote on each matter submitted to a vote at a meeting of shareholders unless, and except to the extent that, voting rights of shares of any class are increased, limited or denied by the Corporation's Certificate of Incorporation.

Section 2.10 Voting. In voting on any question on which a vote by ballot is required by law or is demanded by any shareholder, the voting shall be by ballot; on all other questions it may be by voice vote.

Section 2.11 Consent of Shareholders in Lieu of Meeting. Except as otherwise provided in the Certificate of Incorporation of the Corporation, any action required to be, or which may be, taken at any annual or special meeting of the shareholders of the Corporation may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the holders (or their duly authorized attorneys or other legal

representatives) of all of the validly issued and outstanding shares of common stock which would be entitled to vote upon such action at such meeting.

ARTICLE III

BOARD OF DIRECTORS

Section 3.1 General Powers. The activities, properties and affairs of the Corporation shall be managed by its Board of Directors, which shall exercise all of the responsibilities conferred upon the Board of Directors by the Connecticut Stock Corporation Act, the Certificate of Incorporation and these Bylaws, as each may be amended from time to time.

Section 3.2 Number, Election and Term of Office. The property, business and affairs of the Corporation shall be managed by a Board of Directors consisting of not less than three nor more than eight, which number may be fixed, changed and reestablished from time to time by the shareholders entitled to elect the Board of Directors. Included in this number shall be the President of the Corporation, the Chief Executive Officer of Southern Connecticut Health System, Inc., the Chief Financial Officer of Southern Connecticut Health System, Inc., and the General Counsel of Southern Connecticut Health System, Inc. Each such person shall be a director ex-officio with vote, whose presence shall count in determining whether a quorum is present but who shall not be subject to the age provisions of these Bylaws. Directors shall be elected by the shareholders at the annual meeting or at any special meeting called for the election of directors, and it shall not be a qualification of office that the directors be shareholders of the Corporation or residents of any of the United States. Each director shall hold office for a term of one year or until his successor has been elected and qualified except that a director shall cease to be in office upon his death, resignation or removal. A director ex-officio shall cease to be in office as a director upon his resignation or removal from the office that entitles him to serve as a director ex-officio or his removal pursuant to Section 3.14. Except as otherwise provided herein, directors who have attained age 70 shall not be eligible to continue to serve as directors beyond the annual meeting of the shareholders following the director's 70th birthday.

Section 3.3 Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall elect the subordinate officers of the Corporation and shall transact such other business relating to the affairs of the Corporation as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 3.4 Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the Chief

Executive Officer, or upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 3.5 Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 3.6 Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 3.7 Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 3.8 Participation by Conference. A director may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment enabling all directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

Section 3.9 Resignation of Directors. Any director may resign at any time by giving written notice to the Board of Directors or to the Chairman, the Chief Executive Officer or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 3.10 Removal of Directors. Any director may be removed from office, with or without cause, at any time, regardless of the term for which such director may have been elected, by the shareholders at any regular, annual or special meeting.

Section 3.11 Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the shareholders may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect director to serve until the next annual meeting.

ARTICLE IV

COMMITTEES

Section 4.1 Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Finance Committee and Investment Committee.

Section 4.2 Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors or others, by the Chairman of the Board of Directors. The Chairman of the Board of Directors may increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 4.3 Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 4.4 Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

Section 4.5 Audit Committee. The Audit Committee shall cause an annual audit to be made of the books, accounts and records of the Corporation by certified public accountants under the supervision of the Audit Committee. The Audit Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 4.6 Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Corporation and shall monitor and oversee the financial performance of the Corporation. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide

Section 4.7 Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Corporation and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the

Corporation. The Investment Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

ARTICLE V

OFFICERS

Section 5.1 Principal and Subordinate Officers. The principal officers shall consist of the Chairman of the Board, the President, the Secretary and the Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the Chairman of the Board, the President or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more principal offices may be held by the same person, and any one or more subordinate offices may be held by any principal or subordinate officer; provided that the same individual shall not simultaneously occupy the offices of both President and Secretary.

Section 5.2 General Authority and Duties. All officers and agents of the Corporation shall have such authority and perform such duties in the management of the Corporation as may be provided in these Bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 5.3 Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the shareholders at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the Chairman or President or any other principal officer to whom the Chairman of the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal, whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights

Section 5.4 Removal. Any officer or agent may be removed by the shareholders whenever in their judgment the best interests of the Corporation will be served by so doing. Any subordinate officer or agent may also be removed by the President, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 5.5 Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the President or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 5.6 Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 5.7 Chairman of the Board. The Chairman of the Board, who shall be the Chief Executive Officer of Southern Connecticut Health System, Inc. and a director ex-officio, shall preside at all meetings of the Board of Directors, if present, and shall, in general, perform all duties incident to the office of Chairman of the Board and such other duties as may be assigned to him by the Board of Directors.

Section 5.8 President. The President, who need not be chosen from among the directors but who shall become a director ex-officio when chosen for office, shall have active executive management of the operations of the Corporation, subject, however, to the control of the Board of Directors and to the restrictions or limitations imposed by any applicable rules, regulations or contractual provisions. The President shall report to the Chairman of the Board. In the absence of the Chairman of the Board, the President shall preside at meetings of the Board of Directors.

Section 5.9 Secretary. The Secretary shall keep or cause to be kept in books provided for that purpose the minutes of the meetings of the shareholders and of the Board of Directors; shall see that all notices are duly given in accordance with the provisions of these Bylaws and as required by law; shall be custodian of the records and of the seal of the Corporation and shall see that the seal is affixed to all documents, the execution of which on behalf of the Corporation under its seal is duly authorized; and, in general, shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board or the President.

Section 5.10 Treasurer. The Treasurer shall be the chief financial officer; shall have charge and custody of, and be responsible for, all funds and deposit all such funds in the name of the Corporation in such banks, trust companies, or other depositaries as shall be selected by the Board of Directors; shall receive and give receipts for monies due and payable to the Corporation from any source whatsoever; and, in general, shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the President. The Treasurer shall render to the Chairman of the Board, the President, and the Board of Directors, whenever the same shall be required, an account of all his transactions as Treasurer and of the financial condition of the Corporation. He shall, if required so to do by the Board of Directors, give the Corporation a bond in such amount and with such surety or sureties as may be ordered by the Board of Directors for the faithful performance of the duties of his office and for the restoration to the Corporation, in case of his death, resignation, retirement, or removal from office, of all books, papers, vouchers, money, and other property of whatever kind in his possession or under his control belonging to the Corporation.

ARTICLE VI

ISSUE AND TRANSFER OF CAPITAL STOCK

Section 6.1 Certificates. Certificates of capital stock and other documentary evidences of equity securities shall be in the form authorized or adopted by the Board of Directors and shall be consecutively numbered. Each certificate shall set forth upon its face as at the time of issue: the name of the Corporation; a statement that the Corporation is organized under the laws of the State of Connecticut; the name of the person to whom issued; the number, class and designation of series, if any, of shares or units represented thereby; and the par value of each such share. Each certificate shall be signed by the President and by the Secretary or the Treasurer, and shall be sealed with the seal of the Corporation or a facsimile thereof; provided that the certificate shall also contain such other recitals as may from time to time be required by law. The signatures of any officers upon a certificate may be facsimiles if the certificate is countersigned by a transfer agent, or registered by a registrar, other than the Corporation itself or an employee of the Corporation. In case any officer who has signed or whose facsimile signature has been placed upon a certificate shall have ceased to be such officer before such certificate is issued, it may be issued by the Corporation with the same effect as if he were such officer at the date of its issue.

Whenever the Corporation shall be authorized to issue more than one class of stock or more than one series of any class of stock, the certificates representing shares of any such class or series shall set forth thereon the statements prescribed by the law of Connecticut. Any restrictions on the transfer or registration of transfer of any shares of stock or any class or series shall be noted conspicuously on the certificate representing such shares

Section 6.2 Transfer. The capital stock or other equity securities of the Corporation shall be transferred only upon the books of the Corporation either by the shareholder in person or by power of attorney executed by him for that purpose upon the surrender for cancellation of the old stock certificate. Prior to due presentment for registration of transfer of a certificate, the Corporation may treat the registered owner of such certificate as the person exclusively entitled to vote, receive notifications and distributions, and otherwise to exercise all the rights and powers of the shares represented by such certificate.

Section 6.3 Lost Certificates. The Corporation may issue a new certificate of stock in place of any certificate theretofore issued by it, alleged to have been lost, stolen or destroyed, and the Board of Directors may require the owner of any lost, stolen or destroyed certificate, or his legal representative, to give the Corporation a bond sufficient to indemnify the Corporation against any claim that may be made against it on account of the alleged loss, theft or destruction of any such certificate or the issuance of any such new certificate.

ARTICLE VII

SPECIAL CORPORATE ACTS

Section 7.1 Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange, and orders for the payment of money shall be signed by the Chairman of the Board or the President or such officer or officers of the Corporation as the Board shall determine from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures

Section 7.2 Execution of Deeds, Contracts, etc. Subject to the general directions of the Board of Directors, all deeds and mortgages made by the Corporation and all other written contracts, agreements, and undertakings to which the Corporation shall be a party shall be executed in its name by the Chairman of the Board or the President or such other officer as may be specified by the Board of Directors or authorized by the Chairman of the Board or President and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to the instruments.

Section 7.3 Endorsement of Stock Certificates. Subject to the general directions of the Board of Directors, any share or shares of stock issued by any corporation and owned by the Corporation (including reacquired shares of stock of the Corporation) may, for sale or transfer, be endorsed in the name of the Corporation by the Chairman of the Board or the President and his signature shall be attested to by the Secretary who shall affix the corporate seal.

Section 7.4 Voting of Shares Owned by Corporation. Subject to the general directions of the Board of Directors, any share or shares of stock issued by any other corporation and owned or controlled by the Corporation may be voted at any shareholders' meeting of the other corporation by the Chairman of the Board or the President of the Corporation. Whenever, in the judgment of the Chairman of the Board or the President it is desirable for the Corporation to execute a proxy or give a shareholders' consent in respect to any share or shares of stock issued by any other corporation and owned or controlled by the Corporation, the proxy or consent shall be executed in the name of the Corporation by the Chairman of the Board or the President without necessity of any authorization by the Board of Directors. Any person or persons designated in the manner above stated as the proxy or proxies of the Corporation shall have full right, power, and authority to vote the share or shares of stock issued by the other corporation.

ARTICLE VIII

INDEMNIFICATION OF CORPORATION DIRECTORS, OFFICERS, EMPLOYEES, SHAREHOLDERS AND AGENTS

Section 8.1 Rights of Indemnification. Shareholders, directors, officers, employees, and agents shall have the rights of indemnification provided by Sec. 33-320a of the Connecticut General Statutes.

Section 8.2 Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-320a of the Connecticut General Statutes, incurred in defending a proceeding, may be paid by the Corporation in advance of the final disposition of such proceeding when authorized by the Board of Directors upon agreement, by or on behalf of the individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Corporation as authorized under these Bylaws.

ARTICLE IX

AMENDMENTS AND MISCELLANEOUS

Section 9.1 Amendment. The shareholders shall have the power to make, amend and repeal these Bylaws, in whole or in part, by the affirmative vote of the holders of a majority of the capital stock of the Corporation outstanding and entitled to vote in the election of directors of the Corporation. Any such vote of shareholders making, amending or repealing the Bylaws may be had at any annual or special meeting of shareholders, provided that notice of the intention or proposal to make, amend or repeal the Bylaws at such meeting previously shall have been given to the shareholders entitled to vote thereon.

Section 9.2 Fiscal Year. The fiscal year of the Corporation shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 9.3 Seal. The seal of the Corporation shall have inscribed thereon the name of the Corporation, the word "Seal" and the word "Connecticut", and shall be maintained in the custody of the Secretary.

Section 9.4 Conflicts of Interest. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Corporation, the provisions of Section 33-323 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the enforceability of such contract or transaction.

Section 9.5 Pronouns. References herein to the masculine shall include reference to the feminine, reference to the singular shall include references to the plural and references to the plural shall include the singular, where the context of the language involved so permits or requires.

Section 9.6 Connecticut General Statutes. Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

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BYLAWS

OF

SCHS PROPERTIES, INC.

TABLE OF CONTENTS

BYLAWS

OF

SCHS PROPERTIES, INC.

(The "Corporation")

ARTICLE I

OFFICES

Section 1.1 Principal Office. The principal office of the Corporation shall be at such place in the United States as the Board of Directors shall from time to time designate.

Section 1.2 Additional Offices. The Corporation may have such additional offices, either within or without the United States, as the Board of Directors may from time to time designate or the business of the Corporation may require.

ARTICLE II

MEMBERSHIP

Section 2.1 Sole Member. The Corporation shall have but one member, Southern Connecticut Health System, Inc., which shall have the right to elect the Board of Directors of the Corporation in accordance with these Bylaws, and shall have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock nonprofit corporation and not conferred thereby or by the Certificate of Incorporation or Bylaws upon the Board of Directors of the Corporation.

Section 2.2 Specific Rights, Powers and Privileges. In addition to such other rights, powers and privileges as it may have by law, the member shall have the following rights, powers and privileges:

A. To elect the Board of Directors of the Corporation in accordance with the provisions of these Bylaws;

B. To remove any director of the Board of Director's at any time in accordance with the provisions of these Bylaws;

C. To elect and remove at any time any officer of the Corporation in accordance with the provisions of these Bylaws;

D. To vote upon all matters on which members are entitled to vote under the Nonstock Corporation Act of the State of Connecticut;

E. To act on any other matters on which action by members is required or permitted by these Bylaws;

F. To approve the Corporation's business plan, annual operating and capital budgets, and plans that materially affect the growth, operation and development of the Corporation.

Section 2.3 Meetings of the Member. The annual meeting of the member shall be held on such day and at such time and place as may be designated by the Board of Directors or the Chairman of the Board of Directors for the purposes set forth in Sections 2.1 and 2.2 herein and for the transaction of any other business as may properly come before such meeting. Regular meetings of the member shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the member may be called at any time by the Board of Directors, the Chairman of the Board of Directors, the Chief Executive Officer or the member. Each such request for a special meeting shall state the purposes for which the requested meeting is to be called. The member shall cast one vote on each matter submitted to a vote at each regular, annual and special meeting. Except as otherwise provided, any action required to be, or which may be, taken at any regular, annual or special meeting of the member may be taken without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken, shall be signed by the member.

Section 2.4 Notice of Meeting. A notice of each meeting of the member shall be given in writing to the member not less than seven days or more than fifty days before the date of the meeting. Each notice shall state the place, day and hour of the meeting. The general purpose for which a special meeting is called shall be stated in the notice thereof, and no other business shall be transacted at the meeting.

Section 2.5 Waiver of Notice. Notice of any meeting of the member may be waived in writing by the member.

ARTICLE III

BOARD OF DIRECTORS

Section 3.1 General Powers. Subject to the rights, powers and privileges accorded to the Corporation's sole member by law, the Certificate of Incorporation or these Bylaws, the activities, properties and affairs of the Corporation shall be managed by its Board of Directors, which shall exercise all of the responsibilities conferred upon the Board of Directors by the

Connecticut Nonstock Corporation Act, the Certificate of Incorporation and these Bylaws, as each may be amended from time to time.

Section 3.2 Number, Election and Term of Office. The property, business and affairs of the Corporation shall be managed by a Board of Directors consisting of not less than three nor more than eight, which number may be fixed, changed and reestablished from time to time by the member. Included in this number shall be the President of the Corporation, the Chief Executive Officer of Southern Connecticut Health System, Inc., the Chief Financial Officer of Southern Connecticut Health System, Inc., and the General Counsel of Southern Connecticut Health System, Inc. Each such person shall be a director ex-officio with vote, whose presence shall count in determining whether a quorum is present but who shall not be subject to the age provisions of these Bylaws. Directors shall be elected by the member at the annual meeting or at any special meeting called for the election of directors, and it shall not be a qualification of office that the directors be residents of any of the United States. Each director shall hold office for a term of one year or until his successor has been elected and qualified except that a director shall cease to be in office upon his death, resignation or removal. A director ex-officio shall cease to be in office as a director upon his resignation or removal from the office that entitles him to serve as a director ex-officio or his removal pursuant to Section 3.14. Except as otherwise provided herein, directors who have attained age 70 shall not be eligible to continue to serve as directors beyond the annual meeting of the member following the director's 70th birthday.

Section 3.3 Annual Meeting. The annual meeting of the Board of Directors shall be held each year on such date, at such time, and at such place as the Board of Directors may determine. At such meeting, the Board of Directors shall elect the subordinate officers of the Corporation and shall transact such other business relating to the affairs of the Corporation as may come before the meeting. No notice need be given of an annual meeting of the Board of Directors. There shall be no voting by proxy.

Section 3.4 Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chairman, the Chief Executive Officer, or upon the written request of a majority of the directors then in office. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Except as otherwise provided in these Bylaws, two days' written or oral notice shall be given of each special meeting of the Board of Directors. No notice need be given of a regular meeting of the Board of Directors. Neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need by specified in any notice or waiver of notice of such meeting unless otherwise required by law or specified herein. There shall be no voting by proxy.

Section 3.5 Quorum. A majority of the directors shall constitute a quorum at all meetings of the Board of Directors.

Section 3.6 Vote Required for Action. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 3.7 Action Without Meeting. If all the directors severally or collectively consent in writing to any action taken or to be taken by the Corporation, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

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Section 3.10 Removal of Directors. Any director may be removed from office, with or without cause, at any time, regardless of the term for which such director may have been elected, by the member at any regular, annual or special meeting.

Section 3.11 Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation, or removal of any director, the member may fill such vacancy for the remaining term of such directorship or, for any new or unoccupied directorships, may elect director to serve until the next annual meeting.

ARTICLE IV

COMMITTEES

Section 4.1 Establishment of Committees. The Board of Directors may, from time to time, establish such committees of the Board of Directors with such responsibilities as the Board of Directors shall determine. All committees shall act in an advisory capacity only and shall have no power or authority to bind the Corporation. Committees of the Board of Directors shall be standing and special. The standing committees shall include the Audit Committee, Finance Committee and Investment Committee.

Section 4.2 Appointment of Members. Except as otherwise provided in these Bylaws, all committee chairmen and committee members shall be appointed from among the directors or others, by the Chairman of the Board of Directors. The Chairman of the Board of Directors may increase or decrease the number of members on a committee, may fill vacancies on a committee and may remove, with or without cause, any chairman or member of a committee.

Section 4.3 Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business at all meetings of the committee. The act of a majority of the members of any committee present at a meeting at which a quorum is present shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

Section 4.4 Meetings of Committees. Except as otherwise provided in these Bylaws, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board of Directors upon request.

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Section 4.6 Finance Committee. The Finance Committee shall review and recommend to the Board of Directors annual operating and capital budgets for the Corporation and shall monitor and oversee the financial performance of the Corporation. The Finance Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

Section 4.7 Investment Committee. The Investment Committee shall recommend policies and procedures for the investment of all funds of the Corporation and shall monitor and evaluate the performance of any investment managers charged with the investment of funds of the Corporation. The Investment Committee shall perform such other functions as a duly adopted resolution of the Board of Directors may provide.

ARTICLE V

OFFICERS

Section 5.1 Principal and Subordinate Officers. The principal officers shall consist of the Chairman of the Board, the President, the Secretary and the Treasurer. The subordinate officers shall consist of such other officers, assistant officers and agents as may be deemed necessary and as are elected or appointed by the Board of Directors, the Chairman of the Board, the President or as may be chosen in such other manner as may be prescribed or permitted by these Bylaws. Any two or more principal offices may be held by the same person, and any one

or more subordinate offices may be held by any principal or subordinate officer; provided that the same individual shall not simultaneously occupy the offices of both President and Secretary.

Section 5.2 General Authority and Duties. All officers and agents of the Corporation shall have such authority and perform such duties in the management of the Corporation as may be provided in these Bylaws or as may be determined by resolution of the Board of Directors not inconsistent with these Bylaws.

Section 5.3 Election, Term of Office, and Qualifications. The principal officers shall be chosen annually by the member at its annual meeting or as soon thereafter as conveniently possible. Subordinate officers may be elected or appointed by the Board of Directors or may be appointed by the Chairman or President or any other principal officer to whom the Chairman of the Board of Directors shall delegate the authority of appointment. Each officer shall hold office until his successor is chosen and qualified, or until his death, his resignation, or his removal, whichever event shall first occur. Election or appointment of an officer or agent shall not of itself create any contractual rights

Section 5.4 Removal. Any officer or agent may be removed by the member whenever in its judgment the best interests of the Corporation will be served by so doing. Any subordinate officer or agent may also be removed by the President, or by any other principal officer having authority to designate or appoint the officer or agent to be removed, with or without cause. Any removal shall be without prejudice to the contract rights, if any, of the person so removed.

Section 5.5 Resignations. Any officer or agent may resign at any time by giving written notice to the Board of Directors or to the Chairman, the President or the Secretary. The resignation shall take effect at the time specified in the notice and, unless otherwise specified in it, acceptance of the resignation shall not be necessary to make it effective.

Section 5.6 Vacancies. Any vacancy in any office occurring by reason of death, resignation, removal, or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these Bylaws for election or appointment to the office.

Section 5.7 Chairman of the Board. The Chairman of the Board, who shall be the Chief Executive Officer of Southern Connecticut Health System, Inc. and a director ex-officio, shall preside at all meetings of the Board of Directors, if present, and shall, in general, perform all duties incident to the office of Chairman of the Board and such other duties as may be assigned to him by the Board of Directors.

Section 5.8 President. The President, who need not be chosen from among the directors but who shall become a director ex-officio when chosen for office, shall have active executive management of the operations of the Corporation, subject, however, to the control of the Board of Directors and to the restrictions or limitations imposed by any applicable rules, regulations or contractual provisions. The President shall report to the Chairman of the Board.

In the absence of the Chairman of the Board, the President shall preside at meetings of the Board of Directors.

Section 5.9 Secretary. The Secretary shall keep or cause to be kept in books provided for that purpose the minutes of the meetings of the shareholders and of the Board of Directors; shall see that all notices are duly given in accordance with the provisions of these Bylaws and as required by law; shall be custodian of the records and of the seal of the Corporation and shall see that the seal is affixed to all documents, the execution of which on behalf of the Corporation under its seal is duly authorized; and, in general, shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board or the President.

Section 5.10 Treasurer. The Treasurer shall be the chief financial officer; shall have charge and custody of, and be responsible for, all funds and deposit all such funds in the name of the Corporation in such banks, trust companies, or other depositaries as shall be selected by the Board of Directors; shall receive and give receipts for monies due and payable to the Corporation from any source whatsoever; and, in general, shall perform all the duties incident to the office of Treasurer and such other duties as may be assigned to him by the Board of Directors, the Chairman of the Board of Directors, or the President. The Treasurer shall render to the Chairman of the Board, the President, and the Board of Directors, whenever the same shall be required, an account of all his transactions as Treasurer and of the financial condition of the Corporation. He shall, if required so to do by the Board of Directors, give the Corporation a bond in such amount and with such surety or sureties as may be ordered by the Board of Directors for the faithful performance of the duties of his office and for the restoration to the Corporation, in case of his death, resignation, retirement, or removal from office, of all books, papers, vouchers, money, and other property of whatever kind in his possession or under his control belonging to the Corporation.

ARTICLE VI

INDEMNIFICATION OF CORPORATION DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS

Section 6.1 Rights of Indemnification. Directors, officers, employees, and agents shall have the rights of indemnification provided by Sec. 33-454a of the Connecticut General Statutes.

Section 6.2 Payment of Expenses in Advance. Expenses which may be indemnifiable under the provisions of Section 33-454a of the Connecticut General Statutes, incurred in defending a proceeding, may be paid by the Corporation in advance of the final disposition of such proceeding when authorized by the Board of Directors upon agreement, by or on behalf of the

individual entitled to be indemnified, to repay such amount if he is later found not entitled to be indemnified by the Corporation as authorized under these Bylaws.

ARTICLE VII

MISCELLANEOUS PROVISIONS

Section 7.1 Amendment. These Bylaws may be amended or repealed, and new Bylaws may be adopted, at any regular, annual or special meeting of the member. Any notice of a meeting of the member at which these Bylaws are to be amended or repealed, or new Bylaws are to be adopted, shall be given in writing not less than seven days or more than fifty days prior to such meeting and shall include notice of such proposed action.

Section 7.2 Fiscal Year. The fiscal year of the Corporation shall end on September 30 in each year unless the Board of Directors shall determine otherwise.

Section 7.3 Seal. The seal of the Corporation shall be circular in form and shall bear the name of the Corporation and shall be in such form as the Board of Directors may determine.

Section 7.4 Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the Chairman of the Board of Directors or the President or such officer or officers of the Corporation as the Board of Directors shall specify from time to time. The Board of Directors may authorize the use of facsimile signatures of any officer or employee in lieu of manual signatures.

Section 7.5 Execution of Deeds and Contracts. Subject to the general directions of the Board of Directors, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the Chairman of the Board of Directors or the President or such other officer as may be specified by the Board of Directors or authorized by the Chairman of the Board of Directors or President and, when requested, the Secretary shall attest to such signatures and affix the corporate seal to such instruments.

Section 7.6 Conflict of Interest. If any director or member of a director's immediate family has an interest in any contract or transaction involving the Corporation, the provisions of Section 33-457 of the Connecticut General Statutes shall determine the obligation of a director to disclose such interest to the Board of Directors and the legal effect of such contract or transaction.

Section 7.7 Connecticut General Statutes. Any reference herein to a section of the Connecticut General Statutes shall include reference to any amendment of such section or any successor statute.

Section 7.8 Pronouns. References herein to the masculine shall include references to the feminine, references to the singular shall include references to the plural and references to the plural shall include references to the singular, where the context of the language involved so permits or requires.

EXHIBIT E

Amended and Restated Post-Affiliation Corporate Bylaws -- Yale-New Haven Health Services Corp.

BYLAWS
OF
YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(Revised January , 1996)

ARTICLE I

Directors

Section 1.01. General Powers. The activities, property and affairs of the corporation shall be managed by the Board of Directors, which shall exercise all of the responsibilities conferred upon the Board of Directors by these Bylaws and by law. Directors shall serve without compensation for their services as Directors, but may be reimbursed by the corporation for their reasonable expenses and disbursements on behalf of the corporation.

Section 1.02. Number of Directors and Further Qualifications. The Board of Directors shall consist of fifteen (15) directorships, subject to reduction pursuant to Section 1.02.C, and shall be composed of two designations of directorships, Ex Officio Directors and Elected Directors, as follows:

A. Ex Officio Directors. The following persons shall, by virtue of their offices, be Directors of the corporation during their tenure in such offices, and shall be designated Ex Officio Directors: (i) the Chair of the Board of Trustees of Yale-New Haven Hospital, Inc. ("YNHH"); (ii) the President of Yale University; (iii) the Chief Executive Officer of the

corporation; and (iv) the Chair of the Board of Directors of Southern Connecticut Health System, Inc. ("SCHS") who shall at all times be a member of the Board of Directors of Bridgeport Hospital. Ex Officio Directors shall be counted in determining a quorum and shall have full voting rights.

B. Elected Directors. The remaining directorships shall be Elected Directors. Elected Directors shall be elected by ballot at each annual meeting of the Board of Directors for terms of three years, or for such shorter terms as may be prescribed by the Nominating Committee (if there be one) or the Board of Directors in order to comply with these Bylaws. The Nominating Committee (if there be one) or the Board of Directors shall exercise its responsibilities to nominate persons for election as Elected Directors and to prescribe the terms of such persons in such a way that there will at all times be included among the Elected Directors, the following:

(i) six persons (at least one of whom shall, when nominated, be a trustee of YNHH) whose names have been submitted for nomination by the Chair of the Board of Trustees of YNHH;

(ii) three persons (at least one of whom shall, when nominated, be a trustee of YNHH) whose names shall have been submitted for nomination by the President of Yale University, provided that (x) no more than two Directors nominated in accordance with this clause shall be employees of Yale University and (y) if any Directors nominated in accordance with this clause are employees of Yale University, then such Directors shall hold an officer position at Yale University throughout the term of such person's service as a Director; and

(iii) subject to Section 1.02C hereof, two persons (both of whom shall be, when nominated, members of the Board of Directors of SCHS) whose names have been submitted to the Nominating Committee (if there be one) or to the Board of Directors for nomination by the Chair of the Board of Directors of SCHS.

The Nominating Committee (if there be one) or the Board of Directors shall exercise its responsibilities to nominate and encourage the nomination of persons for election as Elected Directors and to prescribe the terms of such persons in such a way that the Elected Directors, when considered as a body, shall to the extent reasonably possible reflect the geographic diversity of the area served by the corporation.

C. Expiration of Certain Directorships. The terms of the Directors specified in Section 1.02.B(iii), and the directorships they hold, shall expire as follows:

> (i) one Director, and the directorship held by such Director, shall expire on the date two (2) years after the date of that Director's election; and
> (ii) one Director, and the directorship held by such Director, shall expire on the date one (1) year after the closing date described in Section 6.4 of the Affiliation Agreement between the corporation and SCHS, dated January 19, 1996, as such Agreement may be hereinafter amended.

Section 1.03. Terms of Directors. Subject to the provisions of Section 1.02C, the Board of Directors may prescribe terms of office of one, two or three years for Elected Directors, with the objective that the terms of office of approximately one-third of all of the Elected Directors shall expire at each subsequent annual meeting. At each such annual meeting, the Board of Directors shall elect Directors to succeed the Elected Directors whose terms are then expiring. No person shall be elected an Elected Director for a term beginning after the date of his seventy-second birthday. An Elected Director who has served three successive three-year terms shall not be eligible for re-election until one year has elapsed, except that such

Director may serve a fourth successive term if also elected, at the beginning of the fourth term, as an officer of the corporation as defined in Section 3.01 herein.

Section 1.04. Resignation of Directors. The written resignation of a Director shall be effective upon the date stated in such written resignation or, if no date is so stated or the Board of Directors so determines, immediately upon receipt of the resignation by the corporation. Acceptance of the resignation shall not be necessary to make it effective.

Section 1.05. Removal of Elected Directors. Any Elected Director may be removed from office with or without cause at any time, regardless of the term for which such Director may have been elected, by the affirmative vote of two-thirds of all of the Directors in office at that time, provided the Directors specified in Section 1.02.B(iii) may be removed without cause only with the consent of the Board of Directors of SCHS.

Section 1.06. Vacancies. In case of any vacancy in the Board of Directors by reason of the death, resignation or removal of any Elected Director, the institution (be it YNHH, Yale University or SCHS) that submitted the name of such person for nomination as a Director shall submit the name of a replacement nominee in a manner that complies with Section 1.02, and the remaining Directors, though less than a quorum, by the concurring vote of a majority of such remaining Directors, shall fill such vacancy until the next annual meeting of the Directors with the person whose name is so submitted.

Section 1.07. Organization Meeting. The organization meeting of the Board of Directors shall be held each year at such time and place as the Board of Directors may determine. At such meeting the Board of Directors shall elect the officers of the corporation and shall transact such other business relating to the affairs of the corporation as may come before the meeting.

Section 1.08. Regular and Special Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors shall from time to time determine. Special meetings of the Board of Directors may be called at any time by the Chief Executive Officer and shall be called by him upon the written request of any three of the Directors. Meetings of the Board of Directors may be held within or without the State of Connecticut and shall be held at such place as shall be designated in the notice of the meeting. Not less than seven days' notice by mail, telephone, telegraph, facsimile or e-mail shall be given of each regular meeting of the Board of Directors, except in the case of regular meetings held in accordance with an approved schedule. Except as otherwise provided in these Bylaws, not less than three days' notice by mail, telephone, telegraph, facsimile or e-mail shall be given of each special meeting of the Board of Directors. A majority of the Directors shall constitute a quorum at all meetings of the Board.

Section 1.09. Vote Required for Action.

The act of a majority of the Directors present at a meeting at which a quorum is present at the time of the act shall be the

act of the Board of Directors, unless the act of a greater number is required by these Bylaws or by law.

Section 1.10. Action Without Meeting. If all the Directors severally or collectively consent in writing to any action taken or to be taken by the corporation, the action shall be as valid as though it had been authorized at a meeting of the Board of Directors, and such written consent or consents shall be filed in the corporate minute book.

Section 1.11. Participation by Conference Telephone. A Director may participate in a meeting of the Board of Director's by means of a conference telephone or similar communications equipment enabling all Directors participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

ARTICLE II

Committees

Section 2.01. Standing Committees. If so determined by affirmative action of the Board of Directors, there shall be a Nominating Committee and a Finance and Audit Committee, and such other standing committees as the Board of Directors shall from time to time determine. Standing committees shall be chaired by a member of the Board of Directors. Except for Ex Officio members of a committee, the Board of Directors shall appoint the members of each committee, which may include individuals who are not Directors. Each committee shall serve at the pleasure of the Board of Directors. Each committee shall have such authority and

shall perform such duties as the Board of Directors shall from time to time determine, including but not limited to those duties enumerated below.

A. Nominating Committee. The Nominating Committee (if there be one) shall have not fewer than five nor more than seven members of whom the following shall be Ex Officio members: (i) the Chair of the Board of Trustees of YNHH; (ii) the President of Yale University; (iii) the Chief Executive Officer of the corporation; and (iv) the Chair of the Board of Directors of SCHS. Ex Officio members shall be counted in determining a quorum and shall have full voting rights. All other members of the Nominating Committee shall be named subject to the consent of the Chair of the Board of Directors of YNHH, and at least one of the non-Ex Officio members of the Nominating Committee shall be a Director of YNHH. The Chairman of the Board shall appoint the chairperson of the Nominating Committee. Reasonable notice of the date, time, and place of each meeting shall be given by mail, phone, or otherwise. The Nominating Committee (if there be one) shall nominate candidates for election at the annual meeting as Elected Directors and to fill vacancies in any such positions.

B. Finance and Audit Committee. The responsibilities of the Finance and Audit Committee (if there be one) shall include fact-finding for the Board on matters relating to the financial administration of the corporation and its affiliates, examination and analysis of financial reports of

the corporation and its affiliates and preparation of annual operating and capital budgets for presentation to the Board that takes into account the financial plans for the corporation and its affiliates. The Board of Directors shall appoint the chairperson of the Finance and Audit Committee.

Section 2.02. Other Committees. The Board of Directors may constitute and appoint from among its number or others such other committees with such powers and authority as the Board of Directors shall determine.

Section 2.03. Quorum; Vote Required for Action. A majority of the members of any committee shall constitute a quorum for the transaction of business. The act of a majority of the members of any committee present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board of Directors or by law.

ARTICLE III

Officers

Section 3.01. Number and Title. The officers of the corporation shall be a President and Chief Executive Officer, a Secretary, a Treasurer, and such Vice Presidents and other officers as the Board of Directors may from time to time deem necessary; and a Chairman and Vice Chairman, if the Board of Directors so determines.

Section 3.02. Election, Term of Office and Vacancies. The officers of the corporation, except for those officers who shall be paid employees of the corporation, shall be elected annually by the Board of Directors, and shall hold office until the next annual meeting or until others shall have been chosen in their stead. Vacancies or new offices may be filled at any meeting of the Board of Directors. Employees of the corporation who are designated as officers shall be appointed by the Board of Directors and shall hold office at the pleasure of the Board of Directors.

Section 3.03. Duties and Powers. The duties of the officers shall be as follows:

A. Chairman: The Chairman, if one there be, shall preside at all meetings of the Board of Directors and shall perform such duties as the Board of Directors may from time to time assign to the Chairman and such other duties as are usual to this office.

B. Vice Chairman: The Board of Directors may designate a Vice Chairman who shall exercise the powers and duties of the Chairman when the Chair is absent or disabled.

C. President and Chief Executive Officer: The President and Chief Executive Officer shall be the chief executive officer of the corporation. The President and Chief Executive Officer shall be delegated the responsibility for the overall conduct and management of the corporation's affairs and shall be given the authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board of Directors. The President and Chief Executive Officer shall be ex

officio a voting member of all committees, and shall act as the duly authorized representative of the corporation in all matters in which the Board of Directors has not formally delegated some other person so to act. In the absence of the Chairman and Vice Chairman, or if there be no Chairman or Vice Chairman, the President and Chief Executive Officer shall preside at all meetings of the Board of Directors. The President and Chief Executive Officer shall also serve, so long as he is appointed by the Board of Trustees of YNHH, as Chief Executive Officer of YNHH.

D. Treasurer: The Treasurer shall have supervision over the receipt and custody of the corporation's funds, and shall cause to be kept correct and complete books and records of account, including full and accurate accounts of receipts and disbursements in books belonging to the corporation, and in general shall perform such duties as the Board of Directors may from time to time assign to the Treasurer. The Treasurer, if required by the Board of Directors, shall give the corporation a bond in a sum and with one or more sureties satisfactory to the Board of Directors, for the faithful performance of his duties and for the delivery to the corporation, in case of his death, resignation, retirement or removal from office, of all books, papers and other property of whatever kind in his possession or under his control belonging to or pertaining to the affairs of the corporation.

E. Secretary: The Secretary shall keep minutes of the proceedings of the Board of Directors; shall give, or cause to be

given, all notices in accordance with the provisions of these Bylaws or as required by law; and shall be custodian of the corporate records and of the seal of the corporation. The Secretary shall keep at the principal office of the corporation in the State of Connecticut, a record of the Directors of the corporation, giving the names and addresses of all such Directors, and in general shall perform such duties as the Board of Directors may from time to time assign to the Secretary.

Section 3.04. Removal. The Board of Directors may remove any elected or appointed officer of the corporation from office with or without cause at any time, regardless of the term for which any elected officer may have been elected, subject to the terms of any existing employment contract with any such officer.

ARTICLE IV

Related Corporations

Section 4.01. Policy as to Business Activities. The corporation is nonprofit and shall not engage directly in activities for profit. It may, however, from time to time organize and control, through stock ownership or otherwise, one or more corporations organized and operated for profit. In considering the appropriateness of organizing or controlling corporations organized and operated for profit, the corporation shall give principal consideration to corporations engaged in activities which relate to health care or which directly or indirectly support, advance or contribute to the purposes and objectives of the corporation and YNHH and Bridgeport Hospital.

The Board of Directors shall establish guidelines, consistent with the provisions of this Section, for consideration of activities which might suitably be developed through for-profit corporations controlled by the corporation.

Section 4.02. Names of Controlled Corporations. The corporation shall not use the words "Yale-New Haven" or the word "Yale" in the name of any corporation organized and operated for profit, nor shall it permit any such corporation to utilize such words in the conduct of its business.

ARTICLE V

Amendments and Miscellaneous

Section 5.01. Amendment by Directors. The Board of Directors shall have power to alter, amend or repeal these Bylaws at any regular or special meeting of the Board by the affirmative vote of a majority of all of the Directors, provided notice of the proposed alteration, amendment or repeal shall have been given in the notice of the meeting, and provided further that any amendment to reduce or alter the number, conditions of office, or terms of Directors that are either (x) required to be trustees of YNHH or (y) whose names have been submitted for nomination by the Chair of the Board of Trustees of YNHH, shall be subject to approval by at least a majority of the seven Directors which include the Chair of the YNHH Board and the six Directors who were nominated by the Chair of the YNHH Board.

Section 5.02. Principal Office. The principal office of the corporation shall be located in New Haven, Connecticut. The

corporation may have other offices within or without the State of Connecticut as the Board of Directors may from time to time determine.

Section 5.03. Seal. The seal of the corporation shall be in such form as the Board of Directors may determine.

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EXHIBIT F

Post-Affiliation Certificate of Incorporation -- Yale-New Haven Health Services Corp.

CERTIFICATE OF INCORPORATION

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

The undersigned incorporators hereby form a corporation under the Nonstock Corporation Act of the State of Connecticut:

1. The name of the corporation is YALE-NEW HAVEN HEALTH SERVICES CORPORATION.

2. The nature of the activities to be conducted, or the purposes to be promoted or carried out by the corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1954 (the "Code"), as the same may be amended from time to time, and shall include the following:

A. To benefit, carry out the purposes of, and uphold, promote and further the welfare, programs and activities of Yale-New Haven Hospital, of New Haven, Connecticut ("YNHH").

B. To benefit, carry out the purposes of, and uphold, promote and further the welfare, programs and activities of Bridgeport Hospital, of Bridgeport, Connecticut ("BH");

C. To collaborate with YNHH and BH, with Yale University and with other hospitals and health care institutions and organizations in the initiation, development and maintenance of programs directed toward improving the efficiency and reducing the cost of health care services while maintaining a high quality of such care;

D. To collaborate with Yale University and with other colleges and schools in the initiation, development and maintenance of educational programs for health professionals and for the public, including programs of medical and nursing education, continuing education, graduate medical education and community health education;

E. To collaborate with YNHH and BH, with Yale University and with other hospitals, health care institutions, colleges and schools in the initiation, development and maintenance of programs of scientific research related to the care of the sick and injured;

F. To initiate, develop, operate and maintain, in collaboration with YNHH and BH and with other hospitals and health care institutions and organizations, programs for the delivery of health care services through one or more separate corporations;

G. To acquire, improve, hold and lease any real or personal property useful to the accomplishment of the purposes of this corporation;

H. To receive and accept public and private gifts, trusts, donations, grants, loans and other sources of funding to promote the purposes of this corporation; and generally to do and perform such other acts and to exercise such other powers as may be authorized or permitted under the laws of the State of Connecticut to promote and attain the purposes set forth herein;

I. To engage in any lawful act or activity for which a corporation may be organized under the Nonstock Corporation Act of the State of Connecticut in furtherance of the foregoing.

3. The corporation is nonprofit and shall not have or issue shares of stock or pay dividends.

4. The corporation shall have no Members, and the corporation shall be operated under the management of the Board of Directors.

5. The Board of Directors shall be composed of two designations of directorships, Elected Directors and Ex Officio Directors, with the directors to be selected as provided in the Bylaws. Ex-officio Directors may be counted in determining a quorum and have the right to vote as shall be provided in the Bylaws.

6. No part of the net earnings of the corporation shall inure to the benefit of or be distributable to the corporation's directors, officers or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Paragraph 2 hereof. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal Income Tax under Section 501(c)(3) of the Code or (b) by a corporation,

contributions to which are deductible under Section 170(c)(2) of the Code.

7. Upon any dissolution or termination of the existence of the corporation, all of its property and assets shall, after payment of the lawful debts of the corporation and the expenses of its dissolution or termination, be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to Yale-New Haven Hospital, Inc. and Bridgeport Hospital, provided they shall then qualify as exempt organizations under Section 501(c)(3) of the Code, in such proportions as the Board of Directors may deem appropriate consistent with the relative financial and other contributions of each to the corporation, and to such other charitable, scientific or educational organizations qualified as exempt organizations under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Directors may determine.

8. References to sections of the Code shall be deemed references to the Internal Revenue Code of 1986, as the same may be amended from time to time, and to the corresponding provisions of any future United States Internal Revenue Law.

Adopted: December 12, 1983
Filed: December 14, 1983
Amended: January __, 1996

EXHIBIT G

Proposed Board of Directors of YNHHSC following affiliation

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
(YNHHSC)

Directors

Name	Representation
Michael Flynn	Southern Connecticut Health Systems
Robert Haversat	Yale-New Haven Health Services Corporation
Richard M. Hoyt	Southern Connecticut Health Systems
Richard Levin	Yale University
F. Patrick McFadden, Jr.	Yale-New Haven Health Services Corporation
Julia McNamara	Yale-New Haven Health Services Corporation
Daniel J. Miglio	Yale-New Haven Health Services Corporation
Walter Monteith, Jr.	Yale-New Haven Health Services Corporation
Joseph Mullinix	Yale University
Alison Richard	Yale University
James G. Woods	Southern Connecticut Health Systems
Joseph A. Zaccagnino	Yale-New Haven Health Services Corporation
(Vacancy)	
(Vacancy)	
(Vacancy)	

Exhibit H

EXHIBIT H

The System Affiliation Agreement

CONFIDENTIAL

SYSTEM AFFILIATION AGREEMENT

BY AND BETWEEN

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

AND

SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.

January 19, 1996

TABLE OF CONTENTS

SYSTEM AFFILIATION AGREEMENT

THIS SYSTEM AFFILIATION AGREEMENT is made and entered as of January 19, 1996, by and between **YALE-NEW HAVEN HEALTH SERVICES CORPORATION**, a Connecticut non-stock corporation having its principal office at 789 Howard Avenue, New Haven, Connecticut 06504, and **SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.**, a Connecticut non-stock corporation having its principal office at 267 Grant Street, P.O. Box 5000, Bridgeport, Connecticut 06610-0120.

W I T N E S S E T H:

WHEREAS, the health care industry is being substantially affected by significant changes in federal and state government regulatory and reimbursement programs, rapid technological developments, shifts in demographics and demand, greatly expanding use of managed care and an increased need for capital, all of which have encouraged health care providers to affiliate by creating health care systems to share resources and provide additional, integrated, and cost-effective services and facilities to the communities they serve;

WHEREAS, the parties have analyzed the regional health care marketplace and the costs and benefits to the organizations and the communities they serve of various potential models of integration and affiliation;

WHEREAS, the parties deem it to be consistent with and in furtherance of their respective charitable purposes and in the best interests of their communities and constituencies to become permanently affiliated;

WHEREAS, the parties desire to foster both an academically-oriented medical care delivery system and a primary care-based, integrated, regional delivery system to enhance their excellence in quality patient care, education and research; their ability to maintain qualified, diverse medical staffs; and their ability to serve their respective communities while competing in an increasingly competitive health care environment;

WHEREAS, a permanent affiliation between the parties will provide coordination of the provision of patient care services, which should reduce duplication of resources, increase efficiencies and decrease costs to health care consumers; provide additional patient access to specialized services; improve strategic planning within geographic areas; and enhance other clinical, medical educational, clinical research, marketing, planning, finance, human resources, information systems and management services and expertise;

WHEREAS, the parties have determined that a permanent affiliation can best be developed and implemented through the planning and coordination efforts of Yale-New Haven Health Services Corporation, which shall become the sole member of Southern Connecticut Health System, Inc.;

WHEREAS, the parties intend Yale-New Haven Health Services Corporation to direct and implement the System's activities and to have various leadership responsibilities and powers with respect to Southern Connecticut Health System, Inc., as more fully set forth in this Agreement, while allowing the parties and their affiliates, to a significant and meaningful extent, to retain their unique traditions, constituencies, and philanthropic support; and

WHEREAS, each party considers it in its best interest to enter into a permanent affiliation on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements and covenants hereinafter set forth and for other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I

DEFINITIONS

In addition to the words and terms defined elsewhere in this Agreement, the following words and terms shall have the following meanings:

1.1 "Act" shall mean The Connecticut Non-Stock Corporations Act, as amended, Chapter 600 of the Conn. Gen. Stat., or successor provisions.

1.2 "Affiliate" shall mean, with respect to any Entity, any other Entity which at the time Affiliate status is being determined is directly or indirectly Controlling or Controlled by or under direct or indirect common Control with such Entity. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject Entity, or (b) direct or cause the direction of the subject Entity's operations or management, whether the foregoing power(s) exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

1.3 "Agreement" shall mean this System Affiliation Agreement.

1.4 "CEO" shall mean the YNHHS President and Chief Executive Officer.

1.5 "Closing Date" shall mean the date five business days after the last of conditions in Article XIV has been satisfied to the reasonable satisfaction of the parties, or waived by the parties in writing, but not later than September 30, 1996, unless such date is extended by written agreement of the parties.

1.6 "Code" shall mean the Internal Revenue Code of 1986, as amended, and any corresponding provision of any future United States Internal Revenue law.

1.7 "Corporate Documents" shall mean, as the context requires, the Certificate of Incorporation or similar charter document, Bylaws and other agreements that address the powers and governance of a corporation.

1.8 "Effective Date" shall mean the date on which the last of the conditions specified in Article XIV hereof shall have been satisfied.

1.9 "Entity" shall mean a corporation, association, partnership, trust, limited liability company, organization, business or any other entity.

1.10 "Fiscal Year" shall mean the year ending September 30.

1.11 "Goals and Objectives" shall mean the goals and objectives for the System, as set forth in Section 2.2.

1.12 "Local Network" shall mean, respectively, the SCHS Network or the YNHH Network; and "Local Networks" shall mean the SCHS Network and the YNHH Network collectively.

1.13 "Managed C e Contract" shall mean any agreement between a provider and any payor, or any intermediary organization acting on behalf of either itself or a payor, to provide covered health care services, whether on an indemnity basis, or under an arrangement in which there are incentives to utilize the contracting provider for covered services, or on any other basis.

1.14 "Major Programmatic Changes" shall mean the creation of any major new health care service, the establishment of any new location for the delivery of health care services outside of the then existing primary service area of the affected Entity, the addition or deletion of a major clinical program, the substantial alteration of a health care facility or clinic and other major modifications of services, programs or facilities.

1.15 "Primary Service Area" shall mean as to YNHHS the cities and towns listed in **Exhibit A**, and as to SCHS shall mean the cities and towns listed on **Exhibit B**.

1.16 "SCHS" shall mean Southern Connecticut Health System, Inc.

1.17 "SCHS Network" (sometimes referred to as the "member(s) of the SCHS Network") shall mean SCHS and all then existing SCHS Affiliates; provided that none of YNHHS or any of its Affiliates shall be included in the definition of the SCHS Network.

1.18 "System" shall mean YNHHS and all the System Members acting in concert pursuant to this Agreement and such other agreements as may be entered into by YNHHS with any additional System Member, it being acknowledged that when acting as a part of the System YNHHS is acting in its capacity as the sole member of YNHH, and in its capacity as sole member of SCHS, and in its capacity as the institution directed and empowered to manage the System and to exercise the rights and privileges granted to it in this Agreement.

1.19 "System Member" shall mean each Local Network and each Entity that hereafter (a) affiliates with YNHHS such that YNHHS exercises Control over such Entity, or (b) merges into or consolidates with YNHHS or any Entity that is part of either Local Network or any Entity that hereafter becomes an Affiliate of YNHHS.

1.20 "YNHH" shall mean Yale-New Haven Hospital.

1.21 "YNHH Network" (sometimes referred to as "member(s) of the YNHH Network") shall mean YNHH and all then existing YNHH Affiliates, provided that YNHHS shall not be included in the definition of YNHH Network, and provided further that none of SCHS or any of its Affiliates shall be included in the definition of the YNHH Network.

1.22 "YNHHS" shall mean Yale-New Haven Health Services Corporation.

1.23 "YSM" shall mean Yale University, a Connecticut specially chartered corporation, acting through its School of Medicine.

ARTICLE II

STRUCTURAL CONSIDERATIONS AND GOALS AND OBJECTIVES

Section 2.1 Underlying Structural Considerations. One of the most significant considerations in achieving successful system integration and accomplishing effectively the Goals and Objectives is the commitment of the Local Networks to provide YNHHS with sufficient authority over the Local Networks to operate a successful, integrated System. This delegation of authority is intended to be accomplished, however, while addressing adequately the need of each Local Network to maintain the ability to respond to the needs of its community while acknowledging the contributions of its constituencies.

The following summarizes the basic principles upon which the parties are entering into this Agreement:

2.1.1 Local Networks. Each of the Local Networks serves unique constituencies. Consistent with the need to achieve the Goals and Objectives, the Local Networks will be responsive to their communities and their base of philanthropic support, and function and be recognized as integral components of an integrated, regional primary and tertiary health care delivery system of national stature and reputation in areas of patient care and health professional education.

2.1.2 Governing Boards. Each of the Local Networks provides a consistently high quality of care and is well regarded in its community. The Local Networks have attained such status through the dedication and efforts of individuals who are experienced in health care matters and who are concerned about the future of health care in their respective communities. Given this commonality of interests of the Local Networks' governing boards, YNHHS recognizes that, consistent with the need to achieve the Goals and Objectives, there will be substantial local responsibility for the delivery of health care services.

2.1.3 Medical Staff. A primary reason for developing the System is to maintain and expand the level of excellence in health care that exists in each region served by the Local Networks. This commitment to a consistently high quality of care will require the support of each Local Network's medical staff. The parties recognize the importance of and vital roles played by both full-time physicians and private medical practitioners to the success of the System and to the quality of care, level of research, and medical education programs that the Local Networks provide. Each Local Network shall make its own decisions concerning the granting and renewal of medical staff membership and the granting and renewal of medical staff privileges. All such decisions shall be consistent with the requirements of this Agreement, including the Goals and Objectives.

2.1.4 Management and Financial Operations. The System's management and financial operations will evolve to permit each Local Network to enjoy the benefits of integration in order to permit the development and ultimate delivery of health care services by the Local Networks on an integrated, non-duplicative, cost-effective basis.

2.1.5 University Affiliated System. The parties' commitment to provide a consistently high quality of care is paralleled by their individual, historical commitments to health professional education. The Local Networks desire their respective medical education and research programs be coordinated by YNHHS, including coordination of the affiliation agreements between YSM and each Local Network.

Section 2.2 System Goals and Objectives. The Goals and Objectives for the System are as follows:

2.2.1 Create an integrated, regional health care delivery system composed of local, vertically integrated networks that provides high quality, cost-effective health services and that successfully operates in a managed care marketplace;

2.2.2 Affiliate with additional local networks;

2.2.3 Implement a managed care contracting and product structure to increase the number of managed care patients served by the System, and enhance each System Member's ability to seek and accept regional, statewide, and state/federal government managed care contracts for enrolled populations;

2.2.4 Assist each System Member to develop and work effectively with local and regional physician organizations, physician-hospital organizations, management service organizations and primary care organizations; including doing so with existing organizations of those types;

2.2.5 Establish insurance plans to meet community and market needs;

2.2.6 Provide leadership in the development of improved health care delivery, health professional education, and research programs;

2.2.7 Actively support healthcare in Connecticut by working with local communities and providers to maintain appropriate access to care;

2.2.8 Maximize operating efficiencies and reduce capital costs of System Members by sharing technology, services, management and programs, where appropriate;

2.2.9 Ensure the long-term financial viability of YNHHS and each System Member by assisting System Members in providing quality health care in Connecticut and throughout the Northeast;

2.2.10 Provide coordination for clinical services, medical, nursing, and other health professional education, research, fund raising, finance, strategic planning, marketing, human resources, information systems and such other administrative and management activities important to System Members as YNHHS and each System Member shall identify in order to enhance quality, reduce duplication of resources, increase efficiencies, maintain and improve the System Members' financial condition, and decrease costs to health care consumers;

2.2.11 Recognize the importance of physicians to the success of the System and assist System Members to maintain active and productive medical staffs;

2.2.12 Establish centralized managed care participation by the System and develop and administer the System's managed care products;

2.2.13 Strengthen and develop each System Member's position as a referral institution in its market;

2.2.14 Develop information collection and management capabilities to improve the quality and cost-effectiveness of health care delivery and to foster medical research and education;

2.2.15 Achieve such other objectives as necessary or appropriate to the successful implementation and operation of the System in as prompt, efficient and effective a manner as possible; and

2.2.16 Achieve such other objectives as YNHHS, with Local Network input, shall establish as necessary or appropriate to the successful implementation and operation of the System.

ARTICLE III

SYSTEM STRUCTURE AND FORMATION

Section 3.1 Required SCHS Action. In accordance with the Act, and effective on or before the Closing Date, SCHS will amend its Certificate of Incorporation and Bylaws in a manner acceptable to YNHHS and to SCHS to reflect the agreements and commitments made in this Agreement. In addition SCHS shall cause its Affiliates to amend their Corporate Documents (if necessary) to conform to this Agreement on or before the Closing Date.

Section 3.2 Required YNHHS Action. In accordance with the Act, and effective on or before the Closing Date, YNHHS will amend its Certificate of Incorporation and Bylaws in a manner acceptable to YNHHS and to SCHS to reflect the agreements and commitments made in this Agreement.

ARTICLE IV

THE ROLES OF YNHHS AND OF THE SCHS NETWORK IN THE SYSTEM

Section 4.1 YNHHS' Role. YNHHS' role in the System is to lead a statewide healthcare delivery and financing system dedicated to providing high quality, cost-effective services to the communities it serves. The specific actions to be undertaken by YNHHS in fulfilling this role include:

(a) Develop, manage, coordinate and lead the System;

(b) Develop strategies by which the System can achieve the Goals and Objectives, including developing System-wide strategic plans, operating budgets and capital budgets in a timely manner;

(c) Organize and coordinate the provision of services of all System Members to ensure that the System provides high quality, cost-effective and coordinated health care services in a manner that balances each System Member's needs with System-wide strategies;

(d) Through the sponsorship of System insurance plans, manage the financing of healthcare delivery to ensure that health care dollars are used to improve the health status of the populations served; including providing leadership in the promotion of community wellness, health education and accessible preventive health services;

(e) Enhance collaboration among the Local Networks, YSM and other health-care institutions, colleges and schools in the initiation, development, maintenance and oversight of (i) educational programs for health professionals and the public, and (ii) programs of scientific research related to the care of the sick and injured, in each case of consistently high quality;

(f) Develop System-wide resources for use by the System and the Local Networks to provide the full continuum of care to the populations served;

(g) Develop System-wide Managed Care Contracts, within the specifications and conditions of the contracting authority granted by each Local Network and affiliated physician organization(s);

(h) In coordination with the hospitals associated with each System Member, develop primary care networks that will be linked to the local integrated networks through one or more management services organizations or other appropriate mechanisms;

(i) Establish and coordinate management objectives, incentives and performance measures for the System, and coordinate such for all System Members;

(j) Provide guidance and support for local strategic plans, local network operating and capital budgets, day-to-day management functions, the development and implementation of managed care strategies, and local and regional clinical management initiatives; and

(k) Strengthen local network medical education programs.

Section 4.2 Role of the SCHS Network. The role of the SCHS Network in the System includes accomplishing the following specific actions in a manner that is consistent with the Goals and Objectives:

(a) Develop, manage and coordinate a local, vertically integrated network (including physicians, ambulatory and extended care services) in conjunction with the Bridgeport Hospital medical staff and YNHHS;

(b) Provide high quality, cost-effective services to the local community and to patients referred to it for clinical services, including tertiary care;

(c) Develop, maintain and nurture key local community relationships, and to this end work with other local community organizations in the coordination and provision of health services;

(d) Collaborate through YNHHS with YSM and other healthcare institutions, colleges and schools in the initiation, development and maintenance of (i) graduate physician medical education programs, (ii) educational programs for other health professionals and the public, and (iii) sites for scientific research related to the care of the sick and injured, in each case of consistently high quality;

(e) Disseminate through YNHHS information developed by the SCHS Network as appropriate for System-wide functions and System oversight of Local Network operations; this may include information as to: financial, human resources, information systems, government relations, community and public relations, planning and marketing, managed care, purchasing, business and new product development and legal;

(f) Develop and maintain medical staff relationships;

(g) Coordinate clinical program development with YNHHS;

(h) Maintain day-to-day management functions with oversight and, if necessary, assistance from YNHHS, subject to rights granted to YNHHS to approve certain actions as specified in this Agreement; and

(i) Develop and maintain relationships with local physician organizations and/or physician-hospital organizations.

ARTICLE V

GOVERNANCE OF SCHS

The following sets forth certain rights granted to YNHHS and the CEO in connection with the governance of SCHS and the SCHS Network. The substance of this Article V has been, or shall be in accordance with Section 3.1, incorporated into the Corporate Documents of SCHS and any conflict between the terms of this Article V and the SCHS Corporate Documents shall be determined by reference to such Corporate Documents.

Section 5.1 SCHS Network Governance. SCHS covenants that it shall from and after the Closing Date (a) maintain, and cause all members of the SCHS Network to maintain, the present size, structure and overlap of the governing body of each such member, (b) cause the Boards of SCHS and each of the SCHS Affiliates to be composed of the same persons, (except for the Boards of NovaMed Corporation, SCHS Properties, Inc. and any Affiliates approved as provided in Section 8.11 hereof if at the time of approval a different Board structure is consented to by YNHHS), (c) not amend, modify, alter or rescind, or permit any member of the SCHS Network to amend, modify, alter or rescind, in any material respect, any of the Corporate Documents relating to SCHS or to that member, and (d) not adopt, or permit any member of the SCHS Network to adopt, any resolution, rule, regulation or procedure that would affect the covenants in clauses (a), (b) and (c) of this paragraph.

Section 5.2 Election of SCHS Directors. The SCHS Board shall nominate persons to serve as SCHS directors as vacancies occur on the SCHS Board in the ordinary course due to expiration of term, death, voluntary resignation or removal pursuant to Section 5.3 below or as otherwise provided in the SCHS Bylaws. All persons nominated by the SCHS Board shall have the background and experience appropriate to that position. No person shall be elected a director of SCHS unless such person's election is approved by the YNHHS Board of Directors, except as provided below. For each such vacancy, the SCHS Board shall nominate one (1) person. If the YNHHS Board fails to approve such nominee, then: (a) the SCHS Board will promptly nominate two other individuals to that Board position; (b) the YNHHS Board may approve either of such nominees in which case the nominee so approved shall be promptly elected by the SCHS Board as an SCHS director, or the YNHHS Board may reject both of such nominees in which case the SCHS Board shall promptly nominate two other individuals to that Board position; (c) the YNHHS Board may approve either of such additional nominees in which case the nominee so approved shall be promptly elected by the SCHS Board as a director; and (d) the YNHHS Board may reject both of such additional nominees in which case the choice of which of any of the foregoing proposed persons to name as an SCHS director shall be made by the Chairman of the Board of SCHS after consultation with the CEO and the Chairman of the Board of YNHHS. Until a new

director of SCHS is elected in accordance with this section, the director previously holding the seat as to which an election is occurring (unless such director shall have been removed) shall, if willing and able to do so, continue to hold that position.

Section 5.3 Removal of SCHS Directors. The Board of Directors of YNHHS may remove any SCHS director: (a) for an act or omission that constitutes a breach of fiduciary duty by such director under applicable law; or (b) if such director voted in favor of a resolution approved by the SCHS Board, and as a consequence of the actions taken or not taken as a result of the implementation of such resolution SCHS or an Affiliate of SCHS (i) violates a law, rule or regulation to the material detriment of SCHS or any such Affiliate, or (ii) takes any action specifically prohibited by this Agreement or fails to take any action specifically required by this Agreement. Any SCHS director may be removed pursuant to this Section only by the affirmative vote of three-fourths (3/4) of the Directors of YNHHS then in office. No SCHS director removed in accordance with this Section shall hold or be nominated or proposed for any directorship or position of similar responsibility in any member of the SCHS Network, and SCHS shall cause any such director to be promptly removed from any such positions.

Section 5.4 Senior Executive Officer. The CEO shall appoint SCHS' President and Chief Executive Officer in consultation with and with the consent of the SCHS Board. The CEO shall periodically evaluate the SCHS President and Chief Executive Officer, and in connection therewith shall determine the terms and conditions of that person's employment and compensation, provided the CEO shall consult with the Chairman of the SCHS Board, and if the SCHS Chairman so requests, then with the SCHS Board or an appropriate Committee thereof prior to taking any action as to any such evaluation or as to the terms of such person's employment. The CEO shall have the sole right, if the CEO deems it appropriate, to remove the SCHS President and Chief Executive Officer, provided the CEO shall consult with the SCHS Board prior to taking any such action.

Section 5.5 YNHHS Board Designee to SCHS. YNHHS shall have the right at all times to have one person designated by it serve as a director of SCHS. Such person shall be designated by the CEO. SCHS shall promptly cause any such designee to be elected as a director of SCHS and each of its Affiliates to enjoy all rights and privileges enjoyed by the directors of SCHS and each of its Affiliates. YNHHS shall have the sole right to remove its designee from the SCHS Board and the boards of its Affiliates. If SCHS has an active executive committee, or any committee that has been delegated all or most of the Board's power to act, the YNHHS designee shall serve on that committee.

ARTICLE VI

GOVERNANCE OF YNHHS

The following sets forth certain aspects of the governance structure for YNHHS. The substance of this Article VI has been, or shall be in accordance with Section 3.2, incorporated into the Corporate Documents of YNHHS and any conflict between the terms of this Agreement and the YNHHS Corporate Documents shall be determined by reference to such Corporate Documents.

Section 6.1 YNHHS Governance. YNHHS covenants that it shall from and after the Closing Date (a) maintain the total size of its Board of Directors (including Ex Officio Directors) at 15 members, subject to reduction as provided in Section 6.4 and subject to increase as provided in agreements entered into in connection with the addition of new System Members to the System, (b) not amend, modify, alter or rescind in any material respect any of the Corporate Documents relating to YNHHS so as to deprive the SCHS Network of the benefits of this Agreement, and (c) not adopt any resolution, rule, regulation or procedure that would affect the covenants in clauses (a) and (b) of this paragraph.

Section 6.2 Ex Officio Directors. The persons holding the following offices from time to time shall, by virtue of their offices, be Directors of YNHHS during their tenure in such offices, and shall be designated Ex Officio Directors: (i) the Chairman of the Board of Trustees of Yale-New Haven Hospital, Inc.; (ii) the President of Yale University; (iii) the President and Chief Executive Officer of YNHHS; and (iv) the Chairman of the Board of Directors of SCHS. Ex Officio Directors shall be counted in determining a quorum and shall have full voting rights.

Section 6.3 Elected Directors. The directors of YNHHS who are not otherwise ex-officio directors shall include the two persons (both of whom shall, when nominated, be directors of SCHS) whose names are submitted for nomination by SCHS and listed on Schedule 6.3 ("SCHS Directors"). If not previously accomplished, at the first meeting of the YNHHS Directors following the Closing Date, the Board of Directors shall elect as Directors those persons set forth on Schedule 6.3. The terms of the SCHS Directors shall expire as set forth in Section 6.4 below. In addition, the directors of YNHHS who are not ex-officio directors shall include (unless otherwise agreed by YNHHS and Yale University) three persons (at least one of whom shall, when nominated, be a trustee of Yale-New Haven Hospital) whose names shall have been submitted for nomination by the President of Yale University, provided that (x) no more than two directors nominated in this manner shall be employees of Yale University and (y) if any directors nominated in this manner are employees of Yale University, then such directors shall hold one of the officer positions of Yale University throughout the term of such person's service as a director.

Section 6.4 Terms of SCHS Directors. As designated by SCHS in Schedule 6.3, the term of one SCHS Director shall expire two years following his election. The other SCHS Director's term shall expire one year after the closing date of the next transaction by which a hospital, with total annual expenses equal to or greater than Seventy Million Dollars ($70,000,000) as reported in the 1995/1996 AHA Guide, or any of its Affiliates becomes a System Member with the right to cause the election or designation of one or more persons to the YNHHS Board. Upon the expiration of an SCHS Director's term, such SCHS Director's directorship shall be eliminated and the number of directors shall be reduced accordingly. Prior to such expiration, SCHS and YNHHS may mutually agree to remove such director without cause, and in any event SCHS shall have the right to fill any vacancy arising in any directorship as to which it has the right to nominate a director.

Section 6.5 Geographic Diversity. YNHHS will use its best efforts to assure that the YNHHS Board of Directors reflects, to the extent reasonably possible, the geographic diversity of the service area of the System.

Section 6.6 YNHHS Nominating Process. The Chairman of SCHS, in his or her capacity as an ex-officio director of YNHHS, shall be involved in whatever process the YNHHS Board employs for selecting nominees to the YNHHS Board, whether as a member of any nominating committee that may exist at any time, or through consultation with the CEO, the Chairman of YNHH and the President of Yale University, or in such other way as permits the SCHS Chairman to participate in a meaningful way in that process.

ARTICLE VII

POWERS RESERVED TO THE SCHS NETWORK

Notwithstanding anything else contained in Article VIII hereof or in any other section of this Agreement, the members of the SCHS Network shall have the following rights:

Section 7.1 Enforcement of this Agreement. Notwithstanding anything else contained herein, the SCHS Board of Directors shall have the right to take such actions as it deems necessary to enforce the commitments made to SCHS and the members of the SCHS Network in this Agreement by YNHHS.

Section 7.2 Medical Staff. Each member of the SCHS Network that has a medical staff shall maintain its own medical staff bylaws and credentialling procedures, and its own medical staff rules and regulations. Each such member of the SCHS Network shall make its own decisions concerning the granting and renewal of medical

staff membership and the granting and renewal of medical staff privileges. All such decisions shall be consistent with the requirements of this Agreement, including the Goals and Objectives.

Section 7.3 Initiate Programmatic Changes. A Major Programmatic Change affecting a member of the SCHS Network shall be initiated solely through SCHS' inclusion of such Change in a Local Plan (as defined in Section 8.2), subject to YNHHS' right to approve any such Major Programmatic Change as provided in Section 8.6. Only SCHS may initiate a change as to the services, programs or facilities of the members of the SCHS Network, and SCHS may only do so through the Local Plans.

Section 7.4 Utilization Review and Quality Assurance and Improvement. Each member of the SCHS Network shall be responsible for utilization review activities within its facility and shall be responsible for related quality assurance and improvement activities, provided all such activities shall be conducted in a manner consistent with all Managed Care Contracts applicable to the members of the SCHS Network and in a manner so as to assure the provision of quality, cost-effective services.

Section 7.5 Medical Education. Each member of the SCHS Network shall be responsible for overseeing its medical education program and house staff (if any), and (subject to Section 8.7.2) shall be responsible for determining and revising from time to time all aspects of its graduate medical education programs.

Section 7.6 Endowments and Fund-Raising. Each member of the SCHS Network shall be responsible for and have full authority, control and ownership of its own endowment funds. New endowments may be created by any member of the SCHS Network with monies derived from gifts, bequests, fund-raising activities, and other such endowment sources. Each member of the SCHS Network shall be responsible for its own fund-raising, but shall coordinate all such efforts with YNHHS.

ARTICLE VIII

ALLOCATION OF RIGHTS AND RESPONSIBILITIES

Certain of the rights and responsibilities of SCHS and of YNHHS in connection with their affiliation are set forth in this Article VIII. Each party agrees and covenants with the other that it will fulfill its responsibilities as set forth herein, and that in exercising its rights set forth herein it will do so using its reasonable judgment taking into account the Goals and Objectives.

Section 8.1 System Planning and Implementation. YNHHS shall establish the System's mission and to that end shall plan and organize the System's provision of

clinical services, clinical research, and support systems on an integrated and cost-effective basis. The planning, organization and implementation of all such activities shall be consistent with the Goals and Objectives.

Section 8.2 **Local Planning.** SCHS shall prepare or cause to be prepared each year a strategic plan and related capital and operating budgets (collectively, the "Local Plans") for the SCHS Network as a whole and separately for each member of the SCHS Network. The Local Plans shall be consistent with the Goals and Objectives, and shall be prepared annually in a format acceptable to YNHHS and at the same time that YNHHS prepares its annual strategic plan and budgets. YNHHS shall review and approve the Local Plans, and neither SCHS nor any member of the SCHS Network shall implement any portion of the Local Plans unless and until approved by YNHHS. YNHHS agrees to act promptly to review the Local Plans and not to unreasonably withhold or delay approval of the Local Plans. On the Closing Date, or as otherwise agreed by the parties, SCHS shall prepare and deliver to YNHHS transition Local Plans for the period from the Closing Date through the end of SCHS' 1996 fiscal year, and such transition Local Plans shall be subject to review and approval by YNHHS as and to the extent provided in this Section 8.2.

As to each organization in which SCHS or any member of the SCHS Network participates through an equity interest or by Board representation, the annual capital and operating budgets for that organization, and its strategic plans, shall be reviewed by SCHS with YNHHS prior to the adoption or approval of such budgets and plans so that YNHHS has a reasonable opportunity to comment on such budgets and plans.

Section 8.3 **Implementation of Local Plans.** Once the Local Plans have been approved by YNHHS, SCHS shall use its best efforts to cause the Local Plans to be implemented in accordance with their terms, and shall not modify the Local Plans in any material respect, or deviate therefrom in any material respect, without the prior written approval of YNHHS, which approval shall not be unreasonably withheld or delayed.

Section 8.4 **Incurrence of Debt.** Neither SCHS nor any member of the SCHS Network shall incur any "debt" or enter into any line of credit except as specifically contemplated by the Local Plans or unless such debt or line of credit is otherwise approved by YNHHS. In addition to utilizing any line of credit approved by YNHHS, any SCHS Network member may incur short-term debt in any fiscal year in addition to any approved lines of credit without approval of YNHHS and without such debt being specifically contemplated by the Local Plans, provided the amount of that debt does not exceed two percent of such member's budgeted expenses for such fiscal year and provided further that any such borrowing is approved by the SCHS Board prior to the borrowing being made. For purposes of this paragraph, "debt" shall include (a) the guaranty of a financial obligation of a third party (other than the guaranty on behalf of another SCHS Network member where the guaranty is of an amount permitted to be incurred pursuant to this Section 8.4); (b) all obligations for money borrowed, except for

money borrowed from another member of the SCHS Network for purposes consistent with the Local Plans; and (c) capital leases for the acquisition of equipment or real estate, except a capital lease entered into in any fiscal year as to which total payments under the lease will not exceed $75,000 over the term of the lease, provided the total payments under all such capital leases entered into in any year (measured over the terms of those leases) shall not exceed $150,000 (and all such capital leases shall be a part of the Local Plans (as defined in Section 8.2) in subsequent years.)

Section 8.5 Transfer of Assets. SCHS agrees that neither it nor any member of the SCHS Network shall sell, assign, encumber, lease, or otherwise transfer any assets (other than immaterial assets transferred in the ordinary course) except (a) as specifically provided for in the Local Plans approved by YNHHS, (b) as otherwise approved by YNHHS, or (c) to another SCHS Network member consistent with the Local Plans.

Section 8.6 Major Programmatic Changes. Without limiting the scope and effect of Section 8.2 or Section 7.3, YNHHS shall have the right to approve any decision by SCHS or any other member of the SCHS Network with respect to Major Programmatic Changes. SCHS agrees that neither it nor any member of the SCHS Network shall commence a Major Programmatic Change without the prior approval of YNHHS.

Section 8.7 Relationships with Teaching Institutions.

8.7.1 General. After the Closing Date, YNHHS shall have the right to participate in negotiations involving, and the right to approve, any new undergraduate or graduate medical education relationship or agreement entered into by SCHS or any other member of the SCHS Network, including renewals or any material amendments of agreements as to graduate or undergraduate medical education in effect prior to the Closing Date.

8.7.2 Medical Education. YNHHS shall use its best efforts to assist SCHS in attaining high quality residents and will encourage as appropriate the integration of the SCHS graduate medical education programs with the YNHH graduate medical education programs (subject to Residency Review Commission approvals). If integration of such programs is not accomplished, YNHHS shall use its best efforts to support the continuation of separate graduate medical education programs at Bridgeport Hospital and at YNHH.

YNHHS will use its best efforts to encourage the integration where appropriate of SCHS fellowships with YSM fellowship training programs and to encourage appropriate recognition of SCHS medical staff members engaged in YSM affiliated training at Bridgeport Hospital.

Changes to the scope of graduate medical education programs at SCHS, and any revisions thereto contemplated by Section 7.5 hereof, will be subject to the approval of SCHS and YNHHS.

Section 8.8 Mergers, Consolidations, and Dissolutions. Except with the prior consent of YNHHS, neither SCHS nor any other member of the SCHS Network shall enter into discussions or negotiations with any Entity, or solicit any such discussions or negotiations, or solicit any offer from any Entity, in respect of, nor shall SCHS or any member of the SCHS Network conclude: (a) the sale by SCHS or any such member of all or a substantial part of its assets, (b) any merger or a consolidation involving SCHS or any such member, or (c) any contract to manage or administer SCHS, any such member or a substantial part of the business of SCHS or any such member. Except with the prior consent of YNHHS, neither SCHS nor any member of the SCHS Network shall liquidate or dissolve or file for bankruptcy or similar protection.

Section 8.9 Managed Care Relationships. YNHHS has the exclusive right to negotiate with third party payors and commit on behalf of SCHS and the other members of the SCHS Network all terms and conditions of all new or renewed Managed Care Contracts, the grant of such rights to be subject to the following agreements:

(a) YNHHS shall price competitively in SCHS' Primary Service Area within parameters established in SCHS' Local Plans (as defined in Section 8.2);

(b) SCHS and all members of the SCHS Network shall provide for all YNHHS sponsored products their best competitive pricing based on comparable products;

(c) Whenever commercially reasonable, YNHHS shall not offer to (i) any future System Member of which YNHHS is sole member or (ii) any Affiliate of that future System Member, the authority to exclude that System Member's or that Affiliate's competitors from participating in YNHHS sponsored products; the foregoing agreement on the part of YNHHS shall not apply to any product as to which YNHHS or a YNHHS Affiliate does not have the ability to itself control how and to whom that product will be offered;

(d) Whenever commercially reasonable, YNHHS shall seek exclusive contracts for SCHS and all members of the SCHS Network in SCHS' Primary Service Area; and

(e) YNHHS shall include all services of members of the SCHS Network available at the time of contracting in all YNHHS Managed Care Contract proposals.

YNHHS and SCHS senior management will each be actively involved in developing YNHHS' managed care policies for the System and in developing the provider network for the Managed Care Contracts offered by the System.

SCHS shall operate, and cause the members of the SCHS Network to operate, within the managed care policies established by the System.

SCHS agrees that it shall, and shall cause the other members of the SCHS Network to, execute such attorney-in-fact or other agreements as YNHHS shall reasonably request to give effect to the provisions of this paragraph.

SCHS shall use its best efforts to obtain in a timely manner for YNHHS contracting authority, within specified terms and conditions, from local physician-hospital organizations in which Bridgeport Hospital participates and/or such organization's related professional corporation; and as necessary to effectively market competitive managed care products in the SCHS Network's market area, SCHS shall use its best efforts to obtain in a timely manner in cooperation with YNHHS such contracting authority, or such contractual alternative as may be reasonable in the circumstances, from local physicians and physician organizations.

Section 8.10 **Local Network Development**. SCHS shall use its best efforts to develop a local integrated network as part of the strategy contemplated by the Local Plans.

Section 8.11 **Affiliations, Systems, and Alliances**. Neither SCHS nor any other member of the SCHS Network currently participates directly or indirectly in any affiliation, network, system or alliance of health care providers for the provision of health care services except as shown on Schedules 8.11 A and B. Neither SCHS nor any other member of the SCHS Network shall (a) create or acquire any Affiliate, or (b) except as set forth in Schedule 8.11 B, participate directly or indirectly in any affiliation, network, system, or alliance of health care providers for the provision of health care services in which SCHS or any member of the SCHS Network does not now participate, in either case without the prior approval of YNHHS. Nothing contained herein shall prevent or restrict SCHS or any member of the SCHS Network from participating in any affiliation, network, system or alliance of health care providers listed on Schedule 8.11 A or any arrangements similar to those listed on Schedule 8.11 A.

Section 8.12 **System Name; Entity Name**. The name of the System shall be Yale-New Haven Health Services Corporation, provided, however, the System may operate under the trade name Yale-New Haven Health System. Prior to the Closing, should another name for the System be selected by YNHHS, that will only be done with the concurrence of SCHS. Neither SCHS nor any other member of the SCHS Network shall change its name or adopt a trade name without the prior written consent of YNHHS.

Section 8.13 Selection of Chiefs. YNHHS shall use its best efforts to assist Bridgeport Hospital in the recruitment and selection of Chiefs of Service in the event that such support is not available through Bridgeport Hospital's affiliation with YSM.

Section 8.14 Advertising, Marketing and Promotional Activities. YNHHS shall, in consultation with SCHS, develop general policies to coordinate the System's and the System Members' advertising, marketing and promotional efforts.

Section 8.15 Compliance with Laws, etc. SCHS shall comply, and shall cause each member of the SCHS Network to comply, with all laws, rules and regulations applicable to its business and shall obtain and preserve all licenses and accreditations necessary or useful to the conduct of the business.

ARTICLE IX

YNHHS MANAGEMENT AND OPERATIONS

Section 9.1 General. YNHHS shall be responsible for establishing the critical balance of local autonomy for the System Members while still achieving System integration. For that reason, and because it is imperative to the accomplishment of the Goals and Objectives, System operations will be guided by policies established by the Board of Directors of YNHHS and with such policies implemented by the management of YNHHS under the general guidelines set forth in this Article.

Section 9.2 YNHHS Management. The responsibilities of certain principal officers of YNHHS shall be substantially as follows:

9.2.1 CEO. The CEO will manage the relationship between YNHHS and the System Members so as to achieve the Goals and Objectives. The CEO will be responsible for implementing programs that are consistent with the Goals and Objectives and with the strategies and policies established by YNHHS.

9.2.2 SCHS President. The SCHS President and Chief Executive Officer will report directly to the CEO and to the SCHS Board and will be elected as a Senior Vice President of YNHHS, and as such shall fully participate as a member of the YNHHS senior management group in the development of YNHHS's strategy, policies and plans.

9.2.3 Other SCHS Officers. The Chief Financial Officer of SCHS, the officer responsible for SCHS' planning and marketing functions, the officer in charge of SCHS' human resources function, and such other officers of SCHS as the Chief Executive Officer of YNHHS shall from time to time designate, shall become members of the YNHHS management team and be employed by YNHHS, provided, if the CEO

designates any such other officer of SCHS, that officer shall be offered employment with compensation equivalent to his then existing compensation, and YNHHS shall do so in a manner that does not cause a breach of any contract then existing with any such officer. Notwithstanding the fact that these officers will be employed by YNHHS, each of them shall report directly to the President and Chief Executive Officer of SCHS. Each of these officers will have an indirect reporting relationship to the YNHHS counterpart for the relevant functional area. The Chief Medical Officer of SCHS will participate fully with other members of the YNHHS management team if not employed by YNHHS. The CEO shall determine the future configuration of the YNHHS staff.

Section 9.3 Committee Structure. An important interface between YNHHS and SCHS will be through YNHHS management committees. These committees will include the participation of key SCHS personnel to ensure SCHS involvement in YNHHS planning and operations. The CEO shall establish such committees as may be necessary or desirable from time to time and appoint appropriate individuals.

ARTICLE X

EXCLUSIVE ALLIANCE

SCHS, including Bridgeport Hospital and its controlled subsidiaries, shall be the exclusive hospital member or hospital affiliate of the System with a principal service area of which Bridgeport, Connecticut is the major component.

ARTICLE XI

REPRESENTATIONS AND WARRANTIES

YNHHS hereby represents and warrants to SCHS, and SCHS hereby represents and warrants to YNHHS, that the statements set forth in this Article are true and correct as of date hereof, and will be true and correct on the Effective Date and the Closing Date, as to it.

Section 11.1 Authority to Enter into Agreement; Enforceability. It has full corporate power and authority to enter into and to carry out the terms and provisions of this Agreement, and the transactions contemplated hereby, without obtaining the approval or consent of any other party or authority (other than any regulatory approvals required under Connecticut law and other than the expiration of any applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. §§ 7A et seq. which period shall have expired on or prior to the Closing Date); all corporate proceedings have been taken and all corporate authorizations have been

obtained by such party and its Affiliates which are necessary to authorize the execution and delivery of this Agreement; and this Agreement is a legal, valid and binding obligation of such party enforceable in accordance with its terms.

Section 11.2 Organization and Standing. It and each of its Affiliates is a corporation duly organized, validly existing and in good standing under the laws of the State of Connecticut. Each such corporation has all requisite corporate power and authority to own, lease, and operate its properties and to carry on its business as it is now being conducted. Complete and correct copies of the Certificate of Incorporation and Bylaws of each party and its Affiliates, as amended to date, have been delivered to the other party.

Section 11.3 Financial Statements. It has provided the other party with the audited balance sheets and income statements of such party and its Affiliates for the most recent three (3) Fiscal Years for which audited statements are available, together with the most recent unaudited balance sheet and income statement of such party. The foregoing financial statements (a) are in accordance with the books and records of such party and its Affiliates, and (b) fairly present the financial condition and results of operations for such party and its Affiliates as of the dates and for the periods indicated in accordance with generally accepted accounting principles applied on a consistent basis, except as may be noted therein. Each party and its Affiliates have no material liabilities or obligations, whether contingent or absolute, direct or indirect, or matured or unmatured, which are not shown or provided for in the most recent of such financial statements or which have not otherwise been disclosed to the other parties.

Section 11.4 Litigation. Except as otherwise disclosed in writing in Schedule 11.4, each party represents and warrants that there are no suits, actions, or legal, administrative, arbitration or other proceedings or governmental investigations pending, filed, or initiated by, or to the best of its knowledge, threatened against or directly involving the party or any of its Affiliates that may materially and adversely affect the operations, financial status or tax-exempt status of such party or its Affiliates or their ability to perform hereunder.

Section 11.5 Compliance with Laws and Other Instruments. To the best of its knowledge, the business and operations of each party and its Affiliates have been and are being conducted in substantial accordance with all applicable laws, ordinances, and rules and regulations of all authorities, the violation of which, individually or in the aggregate, would materially and adversely affect the business or operations of that party or its Affiliates. Except for laws and regulations that commonly apply to health care institutions in Connecticut, and matters, if any, reflected in the financial statements referred to in Section 11.3, each party and its Affiliates are not subject to any restriction of any kind or character which may materially and adversely affect their business or operations. Neither the execution and delivery of this Agreement, nor the consummation of the affiliation contemplated hereby, will conflict with, result in a violation or breach of

any term or provision of, or constitute a default under the Corporate Documents of each party or its Affiliates, or any statute, order, judgment, writ, injunction, decree, license, permit, rule or regulation of any court or any governmental or regulatory body, or any indenture, mortgage, lease, contract, agreement, instrument, commitment or other arrangement to which any party or any of its Affiliates is a party or by which it is or may be bound, which conflict, violation, breach or default would materially and adversely affect the operations of the party or any of its Affiliates.

Section 11.6 Insurance. Each party and its Affiliates have continuously maintained and currently maintain fire, casualty, liability, professional liability and all other insurance (including self-insurance) coverages necessary in their respective businesses and operations. Such insurance policies or programs cover the property, business, and operations of such party and its Affiliates in amounts and against losses and risks such as are generally maintained for comparably situated businesses.

Section 11.7 Material Misstatements or Omissions. No representation or warranty by a party contained in this Agreement or in any certificate or Schedule furnished to the other parties under this Agreement contains any untrue statement of a material fact or omits to state a material fact necessary to make the statements and facts contained therein not materially misleading. Each party and its Affiliates have no "material agreements" other than those that such party and its Affiliates have provided in response to the other party's due diligence investigation which preceded execution of this Agreement.

ARTICLE XII

COVENANTS

From and after the date hereof and through the Closing Date, each party hereby agrees to keep, perform, and fully discharge the following covenants and agreements.

Section 12.1 Interim Conduct of Business. Each party shall use its best efforts and shall cause its Affiliates to use their best efforts to (a) preserve, protect and maintain the businesses, properties and assets of the party and its Affiliates; (b) operate the businesses of the party and its Affiliates as a going concern consistent with prior practices and in the ordinary course of business except that YNHHS shall continue to pursue System development; (c) preserve the goodwill of all individuals having business or other relations with it or them, including physicians, employees, patients, customers and suppliers; (d) prepare all documents called for by this Agreement and required to facilitate the consummation of the transactions contemplated herein; and (e) enter into no new undergraduate or graduate medical education affiliation with any university, medical school, or teaching institution other than YSM. Each party shall provide the other parties promptly with interim financial statements and any material management

reports of the party and its Affiliates as and when they become available. Each Local Network shall make, and shall cause its Affiliates to make, no material changes in its or their Corporate Documents, except for changes expressly authorized by this Agreement.

Section 12.2 Preserve Accuracy of Representations and Warranties. Each party shall take, and shall cause its Affiliates to take, no action that would render any representation and/or warranty contained in Article XI of this Agreement inaccurate as of the Closing Date. Each party shall promptly notify the other party of any lawsuits, claims, administrative actions, investigations, or other proceedings asserted or commenced against the party or any of its Affiliates, or its or their officers, directors, or members involving in any material way the businesses, properties, assets or tax-exempt status of the party or its Affiliates. Each party shall promptly notify the other party in writing of any facts or circumstances which come to the party's attention and which the party reasonably believes causes, or through the passage of time may cause, any of the representations and warranties as to it or its Affiliates contained in Article XI to be false or inaccurate.

Section 12.3 Access to Information. Each party shall give, and shall cause its Affiliates to give, to the other party and to appropriate representatives of each (defined for purposes of this paragraph as a party's directors, officers, employees, agents, or advisors) access, during normal business hours, to such properties, books, records, contracts and other documents pertaining to the businesses, properties and assets of the party and its Affiliates, as may be reasonably requested and appropriate in order for each party to perform its obligations hereunder. Officers and employees of a party and its Affiliates shall be available on a regular and frequent basis to confer with appropriate representatives of the other party to report material operational matters and the general status of ongoing operations. Each party shall cooperate in keeping the other party fully informed and shall promptly provide notice to the other party of any unexpected emergency or other unanticipated adverse change in the business or prospects of the party and its Affiliates.

Section 12.4 Maintain Books and Accounting Practices. Each party shall maintain, and cause its Affiliates to maintain, its and their books of account in the usual, regular and ordinary manner in accordance with generally accepted accounting principles consistently applied and shall make no change in any of their accounting methods or practices without the prior written approval of the other party.

ARTICLE XIII

INDEMNIFICATION

Section 13.1 Indemnification. Each party agrees to indemnify and hold the other party and its Affiliates and their respective directors and officers (collectively a "Section

13.1 indemnified party") forever harmless from and against any and all liabilities, demands, claims, actions, or causes of action, assessments, judgments, losses, costs, damages or expenses, including reasonable attorneys' fees, sustained or incurred by a Section 13.1 indemnified party and not otherwise reimbursed by insurance (other than self-insurance) resulting from or arising out of or by virtue of any false or incomplete representation or warranty made herein by such party or any of its Affiliates or non-compliance with or breach by such party or any of its Affiliates of any of the covenants, commitments or obligations of this Agreement to be performed by such party or any of its Affiliates.

The right to indemnification set forth in this Section 13.1 shall survive termination of this Agreement, except that such right shall expire two (2) years after the Closing Date with respect to any false or incomplete representation or warranty.

Section 13.2 Indemnification Notice. In the event that any claim is asserted against a Section 13.1 indemnified party as to which such party is entitled to indemnification hereunder, such party (the "indemnified party") shall promptly after learning of such claim notify the party obligated to indemnify it (the "indemnifying party") thereof in writing; provided, however, that the failure of the indemnified party to give prompt notice of such claim shall not relieve the obligation of the indemnified party with respect to such claim. Except to the extent otherwise provided by the terms of applicable insurance policies (other than self-insurance), the indemnifying party shall have the right, upon written notice to the indemnified party within ten (10) days after receipt from the indemnified party of notice of such claim, to conduct at its expense the defense against such claim in its own name, or, if the indemnifying party shall fail to give such notice, it shall be deemed to have elected not to conduct the defense of the subject claim, and in such event the indemnified party shall have the right to conduct such defense and to compromise and settle the claim without prior consent of the indemnifying party. In the event that the indemnifying party elects to conduct the defense of the subject claim, the indemnified party will cooperate with and make available to the indemnifying party such assistance and materials as may be reasonably requested by it, all at the expense of the indemnifying party, and the indemnified party shall have the right at its expense to participate in the defense, provided that the indemnified party shall have the right to compromise and settle the claim only with the prior written consent of the indemnifying party, unless otherwise provided by the terms of applicable insurance policies (other than self-insurance).

ARTICLE XIV

CONDITIONS PRECEDENT

Section 14.1 List of Conditions Precedent. The obligations of each party to effect the transactions contemplated hereby are subject to the satisfaction of each of the following conditions:

14.1.1 Each and every representation and warranty by the other party contained in this Agreement or in any certificate, Exhibit or Schedule furnished to the other party pursuant hereto shall be true and complete in all material respects on and as of the Closing Date as though made on such date.

14.1.2 The other party shall have performed and complied with all covenants and conditions required by this Agreement to be performed or complied with by it prior to or on the Closing Date.

14.1.3 The party shall have received a certificate of a duly authorized officer of the other party, dated as of the Closing Date, certifying (a) that there have been no material adverse changes in the other party's business or operations prior to the Closing Date, and (b) that the representations and warranties of the other party and its Affiliates contained in Article XI are true and complete on and as of the Closing Date in all material respects as if made on and as of such date.

14.1.4 No suit or action by any party or any investigation, inquiry, or proceeding by any governmental authority, or any legal or administrative proceeding shall have been instituted or threatened on or before the Closing Date which: (a) questions the validity or legality of this Agreement or any transaction contemplated hereby, or (b) seeks to enjoin any transaction contemplated hereby, or (c) seeks material damages on account of the consummation of any transaction contemplated hereby.

14.1.5 No change shall have occurred or have been announced or proposed prior to the Closing Date in the laws, rules, regulations, or policies of any governmental authority which might reasonably be expected to materially and adversely affect the consummation of this transaction.

14.1.6 Opinions of counsel for each party shall have been delivered to the other party in form and content reasonably satisfactory to the other party.

14.1.7 The party shall have received certified resolutions of the governing body of the other party, dated prior to the Closing Date, evidencing authorization to adopt the changes to the party's Corporate Documents required hereby.

14.1.8 Any applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, 15 U.S.C. §§ 7A et seq., shall have expired, and no judicial action or other proceeding shall have been instituted by any governmental authority or agency, or by any other person before any court or governmental authority or agency which challenges or seeks to restrain or prohibit the performance of this Agreement.

14.1.9 The parties shall have obtained all governmental consents and regulatory approvals required for the consummation of the transaction contemplated by this Agreement.

14.1.10 Each party shall have completed its respective due diligence investigation of the other party.

14.1.11 The parties shall have agreed upon a corporate name for SCHS and for Bridgeport Hospital and for the other members of the SCHS Network that is satisfactory to both parties.

Section 14.2 Failure to Fulfill Conditions Precedent; Waiver. In the event that any of the conditions set forth in Section 14.1 or elsewhere in this Agreement has not been fulfilled as of the appropriate dates, a party may, at its option, provided it has not been the cause of the nonfulfillment or has not contributed thereto, by written notice to the other party, terminate its obligations hereunder (other than its obligations described in Article XIII), and thereupon this Agreement shall be of no further force or effect. By proceeding on the Closing Date, each party shall be conclusively deemed to have accepted or waived fulfillment of all such conditions, unless otherwise provided in a writing executed by both parties at such time. In the event the Closing has not occurred on or before September 30, 1996, then this Agreement shall terminate and be of no further force and effect, unless otherwise provided in a writing executed by both parties.

ARTICLE XV

REIMBURSEMENT AND FEES

In consideration for the services to be performed by YNHHS on behalf of the SCHS Network as the institution responsible for developing and leading the System following the Closing Date, SCHS agrees that it will pay to YNHHS: (a) the full cost of compensation and any contractual obligations of those SCHS employees who become employed by YNHHS pursuant to Sections 9.2.2 and 9.2.3 hereof, and (b) a percentage of the annual operating expenses of the SCHS Network as reflected in the SCHS Network Local Plans, but not more than one percent (1%) of such expenses. SCHS shall pay the full amount required by clause (a) above on a monthly basis. SCHS shall pay the amount required by clause (b) above by paying monthly one-twelfth of the

applicable percentage of the actual operating expenses of the SCHS Network over the preceding twelve month period. On or before ninety (90) days after the end of each fiscal year, the parties shall (if necessary) calculate any adjustment required to be made to the clause (b) payment based upon actual operating expenses for the SCHS Network in the preceding fiscal year. YNHHS may request additional economic support, either through a higher percentage of annual expenses or a request for a capital contribution, to achieve the Goals and Objectives. SCHS shall consider such request and if the SCHS Board determines such to be in SCHS' and the System's best interests, taking into account the payments being made to YNHHS by other System Members, SCHS shall increase the percentage of expenses paid to the YNHHS.

ARTICLE XVI

TERM

The term of this Agreement is perpetual unless terminated by a written agreement executed by both parties or as otherwise specifically provided herein.

ARTICLE XVII

MISCELLANEOUS

Section 17.1 Strict Compliance. No failure by any party to insist upon the strict performance of any covenant, agreement, term or condition of this Agreement shall constitute a waiver of any such breach of such covenant, agreement, term or condition. No waiver of any breach shall affect or alter this Agreement, but each and every covenant, agreement, term and condition of this Agreement shall continue in full force and effect.

Section 17.2 Notices. All notices, requests, approvals, demands and other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given and to be effective when delivered personally (including delivery by express or courier services) or, if mailed, three (3) business days after being deposited in the United States mail as registered or certified matter, postage prepaid, return receipt requested, addressed to parties at the addresses set forth in Schedule 17.2 or to such other address as either party may designate by notice to the other parties.

Section 17.3 Amendments. Except as provided herein, neither this Agreement nor any term or provision hereof may be changed, waived, discharged or terminated except by the written agreement of the parties.

Section 17.4 Captions. The captions to this Agreement are for convenience of reference only and in no way define, limit or describe the scope or intent of this Agreement or any part hereof, nor in any way affect this Agreement or any part hereof.

Section 17.5 Assignment. This Agreement shall be assignable by a party only upon the prior written consent of the other party.

Section 17.6 Controlling Law. This Agreement shall be construed, and the rights and liabilities of the parties hereto determined, in accordance with the internal laws of the State of Connecticut; provided, however, that the conflicts of law principles of the State of Connecticut shall not apply to the extent that they would operate to apply the laws of another state.

Section 17.7 Severability. If any provision of this Agreement shall for any reason be held to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof, and this Agreement shall be construed as if such invalid or unenforceable provision were omitted.

Section 17.8 Confidentiality. Each party agrees to not provide a copy of this Agreement or any portion hereof to any person not a party hereto, and to not discuss the contents hereof, or the negotiations or discussions with respect hereto, with any person not a party hereto, other than with that party's legal counsel, auditors and other professional advisors, and except as required by applicable law, provided the parties shall consult as to the need for and timing of the disclosure of this Agreement to any governmental authority. Notwithstanding the foregoing, to coordinate the efforts and improve the position of YNHHS in attracting new System Members the CEO may disclose such information concerning this Agreement as he considers necessary to insure the success of the System.

Section 17.9 Successors and Assigns. This Agreement shall inure to the benefit of and be binding upon the parties hereof, and their respective successors and permitted assigns.

Section 17.10 Expenses. Each party agrees to pay its own expenses incurred in connection with the creation of the System and the transactions contemplated hereby.

Section 17.11 Remedies. In addition to other remedies available at law or provided for herein, the parties shall be entitled to restraint by injunction of the violation, or attempted or threatened violation, of any condition or provision of this Agreement, or to a decree specifically compelling performance of any such condition or provision.

Section 17.12 Entire Agreement. This Agreement, including any Exhibits or Schedules attached hereto, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof.

Section 17.13 Cross References. Unless otherwise stated, all references to Exhibits and Schedules in the text of this Agreement are to other Exhibits and Schedules of this Agreement.

Section 17.14 Execution in Counterparts. This Agreement may be executed in two (2) or more counterparts, each of which shall be an original, but all of which taken together shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement on the day and year first written above.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____
F. Patrick McFadden
Chairman of the Board of Directors

By: _____
Joseph A. Zaccagnino
President and Chief Executive Officer

SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.

By: _____
Michael H. Flynn
Chairman of the Board of Directors

By: _____
Robert J. Trefry
President and Chief Executive Officer

SYSTEM AFFILIATION AGREEMENT

EXHIBIT A

YNHHS PRIMARY SERVICE AREA

1. Ansonia
2. Beacon Falls
3. Branford
4. Cheshire
5. Clinton
6. Deep River/Killingworth
7. Derby
8. East Haven
9. Essex
10. Guilford
11. Hamden
12. Madison
13. Meriden
14. Milford
15. New Haven
16. North Branford
17. North Haven
18. Old Saybrook
19. Orange
20. Seymour/Oxford
21. Shelton
22. Wallingford
23. Westbrook
24. West Haven
25. Woodbridge/Bethany

SYSTEM AFFILIATION AGREEMENT

EXHIBIT B

SCHS PRIMARY SERVICE AREA

1. Bridgeport
2. Easton
3. Fairfield
4. Milford
5. Monroe
6. Shelton
7. Stratford
8. Trumbull

SYSTEM AFFILIATION AGREEMENT

SCHEDULE 6.3

SCHS DIRECTORS TO BE ELECTED AS YNHHS DIRECTORS

James G. Woods - term expires two years after his election to the YNHHS Board of Directors

Richard M. Hoyt - term expires one year after a hospital becomes a System Member as described in Section 6.4 of this Agreement

SYSTEM AFFILIATION AGREEMENT

SCHEDULE 8.11-A

1. Agreements for training of health care providers other than medical residents and fellows (nurses, CRNAs, health aides, physician assistants, dietetic technicians, respiratory therapists, ultrasound technologists, medical technologists, radiologic technologists, physical therapists, occupational therapists, etc.).

2. Agreements with physicians and physician practice groups for provision of services (radiology, pathology, anesthesiology, dialysis, resident training sites, rehab, etc.) in connection with services provided by a member of the SCHS Network.

3. Patient transfer agreements.

4 Pending Title 19 Agreements.

5. Agreements for provision of Home Care and Hospice services (VNS, United Home Care, etc.) offered in connection with the services provided by a member of the SCHS Network.

6. Agreements to provide patient services that are provided by a member of the SCHS Network to other health care facilities.

SYSTEM AFFILIATION AGREEMENT

SCHEDULE 8.11-B

1. Southern Connecticut Health Network, Inc.
2. Joint Hospital Planning Council of Bridgeport, Inc.
3. Health Connecticut, LLC
4. Mill Hill Medical Consultants, Inc.
5. Park City Primary Care Center, Inc. including operation thereof and provisions of services thereto.
6. Health Direct, Inc.
7. St. Vincent's Medical Center, Inc. - Neonatal and Antenatal Services Agreement.
8. Bridgeport Health Network, Inc.
9. Chartwell Southern New England
10. Connecticut Rehabilitation Network, LLC

SYSTEM AFFILIATION AGREEMENT

SCHEDULE 11.4

MATERIAL ADVERSE LITIGATION

YNHHS:

None

SCHS:

None

EXHIBIT I

Resolutions of Yale-New Haven Health Services Corp. Board of Directors (approving proposed affiliation)

YALE-NEW HAVEN HEALTH SERVICES CORPORATION, INC.

I certify that the following is a true and exact copy of a resolution passed by the Board of Directors of Yale-New Haven Health Services Corporation, Inc. on January 19, 1996, and that said resolution continues in full force and effect as of the date of this certification:

FURTHER RESOLVED, that the Corporation enter into the System Affiliation Agreement with SCHS, substantially in the form presented at this meeting, with such changes as may be deemed necessary, appropriate or desirable by any of the Officers in his or her discretion, and that the Officers be, and each of them hereby is, authorized to execute and deliver, for and on behalf of the Corporation, the System Affiliation Agreement and such other documents, certificates, applications, filings and agreements with private or public entities or agencies as the Officers, in their sole discretion, deem necessary, appropriate or advisable to effect the transactions contemplated by the System Affiliation Agreement, including without limitation filings pursuant to the Hart-Scott-Rodino Antitrust Improvements Act, applications for Certificates of Need from the Connecticut Office of Health Care Access, and requests for private letter rulings or determination letters from the Internal Revenue Service, the execution and delivery thereof by such Officer or Officers to be conclusive evidence of authorization and approval hereunder.

Marna P. Borgstrom
Secretary
Yale-New Haven Health Services Corporation, Inc.

DATED: February 9, 1996

YNHHSC.res

EXHIBIT J

Resolutions of Southern Connecticut Health System, Inc. Board of Directors (approving proposed affiliation)

CERTIFICATION OF
SECRETARY

I, Sandra Jarva Weiss, Secretary of Southern Connecticut Health System, Inc., a corporation organized and existing under the laws of the State of Connecticut (the Corporation), do hereby certify that a meeting of the Board of Directors of the Corporation duly held on the 18th day of January, 1996, at which a quorum was present and acting throughout, the following resolutions were adopted and are now in full force and effect:

WHEREAS, the Board of Directors has considered the implications of the proposed affiliation with Yale-New Haven Health Services Corporation and finds the affiliation to be in the best interests of the Corporation, its affiliates and the communities and constituencies that they serve; and

WHEREAS, the Board of Directors has considered the legal and financial due diligence materials and presentations that describe the material legal and financial status of Yale-New Haven Health Services Corporation and its affiliates, and

WHEREAS, the Board of Directors has reviewed all of the material terms and conditions of the System Affiliation Agreement between Yale-New Haven Health Services Corporation and the Corporation.

NOW, THEREFORE, be it

RESOLVED, that the President and Chief Executive Officer and Chairman of the Corporation are hereby authorized to execute on behalf of the Corporation the System Affiliation Agreement with Yale-New Haven Health Services Corporation presented and reviewed at this meeting subject to such modifications as the President and Chief Executive Officer and Chairman deem necessary and appropriate; and it is further

RESOLVED, that the President and Chief Executive Officer and Chairman of the Corporation are authorized to execute on behalf of the Corporation the "Business Plan for Southern Connecticut Health System and Affiliates" ("Business Plan") presented and reviewed at this meeting subject to such modifications as the President and Chief Executive Officer and Chairman deem necessary and appropriate; and it is further

RESOLVED, that the Corporation will work cooperatively with Yale-New Haven Health Services Corporation and will use all commercially reasonable efforts to accomplish the Business Plan within the parameters of the proposed Business Plan budget and accepts the level of financial commitment outlined in the proposed budget as necessary to accomplish the Business Plan; and it is further

RESOLVED, that the President and Chief Executive Officer and Chairman of the Corporation are hereby authorized to execute on behalf of the Corporation all such other contracts, documents and agreements as they deem necessary and appropriate to effectuate proper execution and effect of the System Affiliation Agreement and the Business Plan for the Corporation and its affiliates and to make such filings with regulatory authorities as is necessary to effectuate the affiliation between the Corporation and Yale-New Haven Health Services Corporation

IN WITNESS WHEREOF, I have signed my name as Secretary and have caused the seal of the corporation to be placed this 20th day of February, 1996.

Sandra Jarvis Weiss
Secretary

EXHIBIT K

Pre- and Post-Affiliation Licensed Bed Configuration -- Yale-New Haven Hospital and Bridgeport Hospital

Exhibit K

LICENSED BED CONFIGURATION

PRE-AFFILIATION

	YNHH	BH
General Hospital Beds	808	395
Bassinets	92	30
TOTAL	900	425

Exhibit K

LICENSED BED CONFIGURATION

POST-AFFILIATION

	YNHH	BH
General Hospital Beds	808	395
Bassinets	92	30
TOTAL	900	425

EXHIBIT L.1

Legal Opinion Regarding Tax Exempt Status

Yale-New Haven Health Services Corp.

Wiggin & Dana

Counsellors at Law

Offices in New Haven and Hartford

One Century Tower
New Haven, Connecticut
06508-1832
Telephone 203.498.4400
Telefax 203.782.2889

Melinda A. Epstein
203.498.4326

February 23, 1996

Mr. Joseph A. Zaccagnino
President & Chief Executive Officer
Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Dear Mr. Zaccagnino:

I am writing about the federal tax exemption status of Yale New Haven Health Services Corporation ("YNHHSC") and its related entities currently exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code ("the Code"). You have asked for an opinion concerning the effect on their respective section 501(c)(3) exemptions of the affiliation between YNHHSC and Southern Connecticut Health Services, Inc. ("SCHS"), the parent corporation of Bridgeport Hospital ("BH") and other subsidiary corporations.

I understand the facts as follows. The proposed affiliation will be effected by having YNHHSC become the sole member of SCHS, which, along with BH and two other SCHS controlled corporations, is currently exempt from federal income taxation under section 501(c)(3) of the Code and not a private foundation. Other than the membership change for SCHS and certain other governance changes related to board composition and the broadening of YNHHSC's purpose to include serving as the parent organization of SCHS and its affiliates, no further significant governance, structural, or operating changes will occur as a result of the affiliation, and it will not alter YNHHSC's purposes of promoting health care in a charitable manner. You have represented that no activities forbidden to or improper for entities maintaining exemption under section 501(c)(3), including but not limited to private inurement, excessive private benefit, political activity, or excessive unrelated trade or business activity, will be conducted.

Under these circumstances, in my opinion the affiliation between YNHHSC and SCHS will not affect the tax status of YNHHSC and its affiliated entities currently exempt under section 501(c)(3). It is my further view that approval of the affiliation by the Internal Revenue Service ("IRS") is not required. The IRS must be notified of the affiliation

by both YNHHSC and SCHS and must also receive copies of the amended corporate documents. This notification should be made either when the next Form 990's are filed or prior to that time by letters to the District Director.

Very truly yours,

Melinda A. Agsten

MAA:lcj

F:\DATA\CLI\56\00010256\9\LTR0001_.MAA

EXHIBIT L.2

Legal Opinion Regarding Tax Exempt Status

Southern Connecticut Health System Inc.

PULLMAN & COMLEY, LLC

Attorneys At Law

Reply to Bridgeport
(203) 330-2219

February 22, 1996

Mr. Robert J. Trefry
President and Chief Executive Officer
Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

Re: Affiliation with Yale-New Haven Health Services Corporation

Dear Mr. Trefry:

You have requested our opinion as to whether the planned affiliation between Southern Connecticut Health System, Inc. ("SCHS") and Yale-New Haven Health Services Corporation ("YNHHS") would adversely affect the tax-exempt status of SCHS, Bridgeport Hospital, Bridgeport Hospital Foundation, Inc., Rehabilitation Center of Fairfield County, Inc. or SCHS Properties, Inc. SCHS Properties, Inc. is exempt from federal income taxation under Section 501(c)(2) of the Internal Revenue Code of 1986 ("Code") and each of the other aforementioned organizations is exempt from federal income taxation under Section 501(c)(3) of the Code.

SCHS has entered into a System Affiliation Agreement dated January 19, 1996, with YNHHS. The Affiliation Agreement provides, inter alia, that YNHHS shall become the sole member of SCHS. As the sole member of SCHS, YNHHS would have certain reserve powers that are detailed in the Affiliation Agreement. Among those powers are the following:

1. Approve SCHS strategic plans, operating budgets and capital budgets.
2. Approve SCHS incurrence of debt over an agreed upon amount.
3. Approve the appointment and removal of the President and Chief Executive Officer of SCHS.
4. Designate a member of the Board of Directors of SCHS.
5. Approve the election of members of the Board of Directors of SCHS.
6. Approve material changes to the Bylaws and Certificates of Incorporation of SCHS and its affiliates.
7. Approve any sale of assets, merger, consolidation or reorganization of SCHS and its affiliates.
8. Approve any major programmatic changes at SCHS and its affiliates.

The Bylaws and Certificate of Incorporation of SCHS and Bridgeport Hospital Foundation, Inc. and the Bylaws of Bridgeport Hospital and the Rehabilitation Center of Fairfield County, Inc. will be amended effective upon the closing date of the affiliation between SCHS and YNHHS to reflect the provisions of the Affiliation Agreement.

We understand that aside from the revisions to the Bylaws and the Certificates of Incorporation discussed above, no other changes in the corporate documents of SCHS or its affiliates will be made, that their charitable purposes will not change and their actual operation also will remain unchanged. We also understand that the various proscriptions set forth in Section 501(c)(3) of the Code shall continue to be followed by SCHS, Bridgeport Hospital, Bridgeport Hospital Foundation, Inc. and the Rehabilitation Center of Fairfield County, Inc.

Based upon the foregoing, it is our opinion that the affiliation between SCHS and YNHHS as contemplated under the Affiliation Agreement will not adversely affect the exemption from federal income taxation under Section 501(c)(3) of the Code now held by SCHS, Bridgeport Hospital, Bridgeport Hospital Foundation and the Rehabilitation Center of Fairfield County, Inc. or the exemption of SCHS Properties, Inc. under Section 501(c)(2) of the Code.

Very truly yours,

Collin P. Baron

CPB:dmb

cc: Sandra Jarva Weiss, Esq.

LIST OF APPENDICES

I LOI and Dated Ammendment

II Audited Financial Statements and other Financial Information

- Yale-New Haven Hospital
- Bridgeport Hospital

III Department of Public Health and Addiction Services License Survey

- Yale-New Haven Hospital
- Bridgeport Hospital

APPENDIX I

LOI and Dated Ammendment

Yale-New Haven Health Services Corp.
789 Howard Avenue
New Haven, CT 06504

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

November 1, 1995

Ms. Joan Symon
Assistant Director of Operations
Office of Health Care Access
1049 Asylum Avenue
Hartford, CT 06105

RE: Affiliation of Yale-New Haven Health Services Corporation and Southern Connecticut Health Systems, Inc.; Letter of Intent

Dear Ms. Symon:

We are writing to inform the Office of Health Care Access ("OHCA") of a proposed affiliation between Yale-New Haven Health Services Corporation ("YNHHSC," the parent corporation of Yale-New Haven Hospital) and Southern Connecticut Health System, Inc. ("SCHS, Inc." the parent corporation of Bridgeport Hospital). The affiliation is designed to establish a strategic alliance between the two systems, enabling these organizations to remain competitive in a changing marketplace by enhancing quality of care and controlling costs. As part of the affiliation, YNHHSC will become the parent corporation of SCHS, Inc. The governing boards and financial structures of each system will remain separate. The Medical Staff appointments and licensure of two hospitals will remain separate.

This proposed affiliation will not involve or result in the introduction of any new functions or services nor the expansion or termination of any functions or services at either hospital. There will be no capital expenditures associated with the affiliation. As such, we would like to explore as appropriate whether any approval of this affiliation by OHCA is required.

In the event it is determined that certificate-of-need approval is required, this letter is submitted as a letter of intent pursuant to section 19a-154 of the Connecticut General Statutes. The CON applicant would be Yale-New Haven Health Services Corporation, and, if requested by OHCA, Southern Connecticut Health System, Inc. as applicant. The CON application would seek approval as required for the affiliation described above. As noted, there would be no capital cost. The two hospitals would continue to be located at their present locations in New Haven and Bridgeport, Connecticut.

Please forward a copy of the appropriate CON application forms and requests for any additional information to Frank Tiedemann at Yale-New Haven Health Services Corporation. Also, since this affiliation will not affect in any substantive way the operation of either hospital, the applicants would greatly appreciate the assistance of OHCA in expediting any CON review process, including making a determination without holding a hearing.

Thank you for your consideration.

Sincerely,

Robert J. Trefry
President and Chief Executive Officer
Southern Connecticut Health System, Inc.

Frank Tiedemann
Senior Vice President, System Development
Yale-New Haven Health Services Corporation

RJT/FT:mrg

F5396

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

1049 Asylum Avenue
Hartford, CT 06105-2431
Phone: (860) 566-3880

November 7, 1995

Robert J. Trefry
President and CEO
Southern Connecticut Health Systems, Inc.
267 Grant Street
Bridgeport, CT 06610

Frank Tiedemann
Senior Vice President, System Development
Yale-New Haven Health Services Corp.
789 Howard Avenue
New Haven, CT 06504

Re: Application for Certificate of Need
Other Than Long Term Care - Affiliations/Mergers
LOI # 95-163

Dear Sirs:

Effective July 1, 1995, pursuant to Public Act ("P..A.") 95-257, the Office of Health Care Access ("OHCA") constitutes a successor agency to the Commission on Hospitals and Health Care ("Commission") and the Commission's regulations until amended, repealed or superseded pursuant to law shall remain in effect.

On November 1, 1995, the Office of Health Care Access ("OHCA") received your Letter of Intent ("LOI") dated November 1, 1995. Pursuant to Sections 19a-154 and 19a-155,of the Connecticut General Statutes ("C.G.S."), as amended, your LOI will be considered to be current from **November 1, 1995** to **March 1, 1996**, and will allow for filing of your Certificate of Need ("CON") between **January 30, 1996** and **March 1, 1996**. A complete current LOI must be on file with OHCA not less than 90 days before a Certificate of Need ("CON") application may be considered filed with OHCA. A current LOI is one not more than 120 days old.

OHCA is required pursuant to Sections 19a-153, 19a-154, and Section 19a-155, C.G.S., as amended, to take into consideration certain criteria in its review of CON applications. Please address the questions found in the enclosed CON application related to these criteria as they pertain to your proposal.

When responding to the questions, please repeat each question prior to the answer. If you indicate that the question is "not applicable," please provide an explanation and proper justification. The application should be paginated using consecutive numbering and page numbers should be referenced on a Table of Contents. An original and five (5) copies of the responses with all supporting documentation should be filed with OHCA in the format prescribed in Section 19a-160-27 of OHCA's Regulations and in the time frames described in Sections 19a-154 and 19a-155 C.G.S., as amended, as set forth on page 1 of this correspondence. All subsequent material filed with OHCA will be required in this format and an original and five (5) copies of all material is necessary.

As of January 1,1993, all Certificate of Need applications and requests to modify a Certificate of Need decision must include a filing fee per Section 19a-160-65b of the Regulations of Connecticut State Agencies. Please complete the attached Certificate of Need Filing Fee Computation Schedule and attach the proper fee in a certified check or cashier's check, made out to "Treasurer, State of Connecticut."

Prior to the submission of the application, please contact the Assistant Director of Operations to discuss your filing date and status of your Letter of Intent.

If you have any questions regarding this matter, please contact me at 566-3880.

Sincerely,

Joan K. Symon

Joan K. Symon
Assistant Director of Operations

W:\CHHC\FORMS\MRGRCON

Note: Please note that duplicate forms have been sent to each co-applicant for your convenience since some portions of the forms must be filled out by each, with only one filing fee being required.

APPENDIX II

Audited Financial Statements and other financial information

- Yale-New Haven Hospital
- Bridgeport Hospital

SUMMARY OF REVENUE, EXPENSE, AND VOLUM STATISTICS

CON DOCKET NO. LOI #95-163
CON PROJECT Yale/Bridgeport Affiliation
APPLICANT Yale-New Haven Hospital/Yale-New Haven Health Services Corp.
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000'S OMITTED)

UNF	LINE DEFINITION	(1) FISCAL 1995 ACTUAL	(2) FISCAL 1996 BUDGET	(3) FISCAL 1997 PROJECTED	(4) FISCAL 1998 PROJECTED
1	GOVERNMENT GROSS PATIENT REVENUE	$367,411	$373,886	$388,841	$404,395
2	NON-GOVT GROSS PATIENT REVENUE	307,966	315,252	327,862	340,976
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	675,377	689,138	716,703	745,371
4	GOVT DEDUCTIONS FROM GROSS REVENUE	192,493	199,126	212,091	225,075
5	NET BAD DEBTS	19,281	20,200	21,008	21,848
6	FREE CARE	5,085	5,300	5,512	5,732
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	24,366	25,500	26,520	27,580
8	NON-GOVT CONTRACTUAL ALLOWANCES	33,511	43,290	57,592	77,216
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES				
10	OTHER ALLOWANCES				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	57,877	68,790	84,112	104,796
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	250,370	267,916	296,203	329,871
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	425,007	421,222	420,500	415,500
14	INPATIENT GROSS REVENUE	561,480	570,814	593,646	617,392
15	OUTPATIENT GROSS REVENUE	113,897	118,324	123,057	127,979
16	OTHER OPERATING REVENUE	545	428	428	428
17	REVENUE FROM OPERATIONS	425,552	421,650	420,928	415,928
18	NON-PHYSICIAN SALARIES	179,670	187,804	187,358	185,116
19	PHYSICIAN SALARIES	12,720	12,821	12,790	12,638
20	FRINGE BENEFITS - NON PHYSICIAN	42,299	42,173	42,072	41,570
21	FRINGE BENEFITS - PHYSICIAN	2,995	2,879	2,872	2,838
22	OTHER: SUPPLY & DRUGS	70,051	73,635	73,459	72,582
23	OTHER THAN SUPPLY & DRUGS	63,054	56,545	56,410	55,736
24	PHYSICIAN FEES	30,958	31,585	31,510	31,133
25	MALPRACTICE	9,481	8,888	8,867	8,761
26	LEASES - ANNUAL	2,588	2,543	2,537	2,507
27	LEASES - MULTIYEAR				
28	**TOTAL LEASES (26 + 27)**	2,588	2,543	2,537	2,507
29	DEPARTMENTAL DEPRECIATION	12,719	11,773	11,745	11,605
30	PLANT DEPRECIATION	13,121	12,601	12,571	12,421
31	**TOTAL DEPRECIATION (29 + 30)**	25,840	24,374	24,316	24,026
32	INTEREST	10,796	10,861	10,835	10,706
33	EXPENSE RECOVERY (Enter as negative)	(32,806)	(34,608)	(34,526)	(34,113)
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25.28.31.33))**	417,646	419,500	418,500	413,500
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	7,906	2,150	2,428	2,428
36	NON-OPERATING REVENUE	9,951	6,563	6,563	6,563
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$17,857	$8,713	$8,991	$8,991
38	FULL TIME EQUIVALENTS	4,969.7	4,978.2	4,978.2	4,978.2
39	DISCHARGES	38,202	37,000	37,000	37,000
40	PATIENT DAYS	227,224	222,000	203,500	196,100
41	CASE MIX INDEX	1.2352	1.2259	1.2259	1.2259
42	OTHER STATISTIC (SPECIFY)				
43	RATE IMPACT				

SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

CON DOCKET NO. LOI #95-163
CON PROJECT Yale/Bridgeport Affiliation
APPLICANT Yale-New Haven Hospital/Yale-New Haven Health Services Corp.
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000'S OMITTED)

LINE	LINE DEFINITION	(1) FISCAL 1995 ACTUAL	(2) FISCAL 1996 BUDGET	(3) FISCAL 1997 PROJECTED	(4) FISCAL 1998 PROJECTED
1	GOVERNMENT GROSS PATIENT REVENUE	$0	$0	$0	$0
2	NON-GOVT GROSS PATIENT REVENUE	0	0	0	0
3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	0	0	0	0
4	GOVT DEDUCTIONS FROM GROSS REVENUE	0	0	0	0
5	NET BAD DEBTS	0	0	0	0
6	FREE CARE	0	0	0	0
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	0	0	0	0
8	NON-GOVT CONTRACTUAL ALLOWANCES	0	0	0	0
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES				
10	OTHER ALLOWANCES				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	0	0	0	0
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	0	0	0	0
13	**TOTAL PAYMENTS (NET REVENUE) (3-12)**	0	0	0	0
14	INPATIENT GROSS REVENUE	0	0	0	0
15	OUTPATIENT GROSS REVENUE	0	0	0	0
16	OTHER OPERATING REVENUE	0	0	0	0
17	REVENUE FROM OPERATIONS	0	0	0	0
18	NON-PHYSICIAN SALARIES	0	0	0	0
19	PHYSICIAN SALARIES	0	0	0	0
20	FRINGE BENEFITS - NON PHYSICIAN	0	0	0	0
21	FRINGE BENEFITS - PHYSICIAN	0	0	0	0
22	OTHER: SUPPLY & DRUGS	0	0	0	0
23	OTHER THAN SUPPLY & DRUGS	0	0	0	0
24	PHYSICIAN FEES	0	0	0	0
25	MALPRACTICE	0	0	0	0
26	LEASES - ANNUAL	0	0	0	0
27	LEASES - MULTIYEAR				
28	**TOTAL LEASES (26 + 27)**	0	0	0	0
29	DEPARTMENTAL DEPRECIATION	0	0	0	0
30	PLANT DEPRECIATION	0	0	0	0
31	**TOTAL DEPRECIATION (29 + 30)**	0	0	0	0
32	INTEREST	0	0	0	0
33	EXPENSE RECOVERY (Enter as negative)	0	0	0	0
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	0	0	0	0
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	0	0	0	0
36	NON-OPERATING REVENUE	0	0	0	0
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$0	$0	$0	$0
38	FULL TIME EQUIVALENTS	0.0	0.0	0.0	0.0
39	DISCHARGES	0	0	0	0
40	PATIENT DAYS	0	0	0	0
41	CASE MIX INDEX	0.0000	0.0000	0.0000	0.0000
42	OTHER STATISTIC (SPECIFY)				
43	RATE IMPACT				

SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

CON DOCKET NO. LOI #95-163
CON PROJECT Yale/Bridgeport Affiliation
APPLICANT Yale-New Haven Hospital/Yale-New Haven Health Services Corp.
SPECIFY TOTAL FACILITY OR DEPARTMENT: Total Facility

($000'S OMITTED)

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3	**TOTAL GROSS PATIENT REVENUE (1 + 2)**	675,377	689,138	716,703	745,371
4	GOVT DEDUCTIONS FROM GROSS REVENUE	192,493	199,126	212,091	225,075
5	NET BAD DEBTS	19,281	20,200	21,008	21,848
6	FREE CARE	5,085	5,300	5,512	5,732
7	**TOTAL UNCOMPENSATED CARE (5 + 6)**	24,366	25,500	26,520	27,580
8	NON-GOVT CONTRACTUAL ALLOWANCES	33,511	43,290	57,592	77,216
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES				
10	OTHER ALLOWANCES				
11	**TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)**	57,877	68,790	84,112	104,796
12	**TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)**	250,370	267,916	296,203	329,871
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16	OTHER OPERATING REVENUE	545	428	428	428
17	REVENUE FROM OPERATIONS	425,552	421,650	420,928	415,928
18	NON-PHYSICIAN SALARIES	179,670	187,804	187,358	185,116
19	PHYSICIAN SALARIES	12,720	12,821	12,790	12,638
20	FRINGE BENEFITS - NON PHYSICIAN	42,299	42,173	42,072	41,570
21	FRINGE BENEFITS - PHYSICIAN	2,995	2,879	2,872	2,838
22	OTHER: SUPPLY & DRUGS	70,051	73,635	73,459	72,582
23	OTHER THAN SUPPLY & DRUGS	63,054	56,545	56,410	55,736
24	PHYSICIAN FEES	30,958	31,585	31,510	31,133
25	MALPRACTICE	9,481	8,888	8,867	8,761
26	LEASES - ANNUAL	2,588	2,543	2,537	2,507
27	LEASES - MULTIYEAR				
28	**TOTAL LEASES (26 + 27)**	2,588	2,543	2,537	2,507
29	DEPARTMENTAL DEPRECIATION	12,719	11,773	11,745	11,605
30	PLANT DEPRECIATION	13,121	12,601	12,571	12,421
31	**TOTAL DEPRECIATION (29 + 30)**	25,840	24,374	24,316	24,026
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33	EXPENSE RECOVERY (Enter as negative)	(32,806)	(34,608)	(34,526)	(34,113)
34	**TOTAL NET OPERATING EXPENSES (SUM (18.25,28,31.33))**	417,646	419,500	418,500	413,500
35	GAIN/(LOSS) FROM OPERATIONS (17 - 34)	7,906	2,150	2,428	2,428
36	NON-OPERATING REVENUE	9,951	6,563	6,563	6,563
37	**REVENUE OVER/(UNDER) EXPENSES (35 + 36)**	$17,857	$8,713	$8,991	$8,991
38	FULL TIME EQUIVALENTS	4,969.7	4,978.2	4,978.2	4,978.2
39	DISCHARGES	38,202	37,000	37,000	37,000
40	PATIENT DAYS	227,224	222,000	203,500	196,100
41	CASE MIX INDEX	1.2352	1.2259	1.2259	1.2259
42	OTHER STATISTIC (SPECIFY)				
43	RATE IMPACT				

CON LOI # 95 - 163
CON PROJECT: BH/YALE AFFILIATION

BRIDGEPORT HOSPITAL
SUMMARY OF REVENUE AND EXPENSE AND VOLUME STATISTICS
WITHOUT THE PROJECT
(000'S)

	REVENUE	ACTUAL 1995	PROJECTED 1996	PROJECTED 1997	PROJECTED 1998
1	GOVERNMENT GROSS PATIENT REVENUE	$150,203	$133,784	$139,804	$146,095
2	NON-GOVT GROSS PATIENT REVENUE	90,568	102,664	$107,284	$112,112
3	TOTAL GROSS PATIENT REVENUE	240,771	236,448	247,088	258,207
4	GOVT DEDUCTIONS FROM GROSS REV	48,217	41,219	42,462	45,833
5	NET BAD DEBTS	8,129	6,168	6,413	6,746
6	FREE CARE	1,506	1,500	1,500	1,500
7	TOTAL UNCOMPENSATED CARE	9,635	7,668	7,913	8,246
8	NON-GOVT CONTRACTUAL ALLOWANCES	861	2,901	3,032	3,168
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES	10,052	16,175	16,903	17,664
10	OTHER ALLOWANCES	(46)	5,110	6,373	8,280
11	TOTAL NON-GOVT DEDUCTIONS FROM G.R.	20,502	31,854	34,220	37,358
12	TOTAL DEDUCTIONS FROM G.R.	68,719	73,073	76,682	83,191
13	TOTAL PAYMENTS (NET REVENUE)	172,052	163,375	170,406	175,016
14	INPATIENT GROSS REVENUE	174,989	168,502	176,085	184,008
15	OUTPATIENT GROSS REVENUE	65,782	67,946	71,004	74,199
16	OTHER OPERATING REVENUE	1,090	1,100	1,100	1,100
17	REVENUE FROM OPERATIONS	173,142	164,475	171,506	176,116
18	NON-PHYSICIAN SALARIES	74,487	66,211	68,363	70,585
19	PHYSICIAN SALARIES	5,664	5,877	6,068	6,265
20	FRINGE BENEFITS-NON PHYSICIAN	20,295	16,261	15,723	16,234
21	FRINGE BENEFITS-PHYSICIAN	1,303	1,352	1,396	1,441
22	OTHER:SUPPLY & DRUGS	21,905	21,431	22,245	23,091
23	OTHER THAN SUPPLY & DRUGS	25,866	27,015	29,042	29,364
24	PHYSICIAN FEES	6,076	6,420	6,664	6,917
25	MALPRACTICE	1,827	2,290	2,377	2,467
26	LEASES - ANNUAL	2,028	2,105	2,185	2,268
27	LEASES - MULTI-YEAR	0	0	0	0
28	TOTAL LEASES	2,028	2,105	2,185	2,268
29	DEPARTMENTAL DEPRECIATION	3,796	4,640	5,816	6,037
30	PLANT DEPRECIATION	5,693	6,960	7,224	7,499
31	TOTAL DEPRECIATION	9,489	11,600	13,041	13,536
32	INTEREST	3,681	4,418	4,824	4,245
33	EXPENSE RECOVERY	(3,198)	(2,900)	(2,900)	(2,900)
34	TOTAL NET OPERATING EXPENSES	169,423	162,080	169,028	173,514
35	GAIN (LOSS) FROM OPERATIONS	3,719	2,395	2,478	2,602
36	NON OPERATING REVENUE	204	200	200	200
37	REVENUE OVER/(UNDER) EXPENSES	$3,923	$2,595	$2,678	$2,802
38	FULL TIME EQUIVALENTS	2018.83	1629.98	1629.98	1629.98
39	DISCHARGES	19,254	18,396	18,396	18,396
40	PATIENT DAYS	101,912	91,108	91,108	91,108
41	CASE MIX	1.0948	1.2320	1.2320	1.2320
42	OTHER STATISTIC:				
43	ANNUAL RATE IMPACT				

CON LOI # 95 - 163
CON PROJECT: BH/YALE AFFILIATION

BRIDGEPORT HOSPITAL
SUMMARY OF REVENUE AND EXPENSE AND VOLUME STATISTICS
INCREMENTAL (DECREMENTAL)
(000'S)

	REVENUE	ACTUAL 1995	PROJECTED 1996	PROJECTED 1997	PROJECTED 1998
1	GOVERNMENT GROSS PATIENT REVENUE	$0	$0	$0	$0
2	NON-GOVT GROSS PATIENT REVENUE	0	0	0	0
3	TOTAL GROSS PATIENT REVENUE	0	0	0	0
4	GOVT DEDUCTIONS FROM GROSS REV	0	0	0	0
5	NET BAD DEBTS	0	0	0	0
6	FREE CARE	0	0	0	0
7	TOTAL UNCOMPENSATED CARE	0	0	0	0
8	NON-GOV'T CONTRACTUAL ALLOWANCES	0	0	0	0
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES	0	0	0	0
10	OTHER ALLOWANCES	0	0	0	0
11	TOTAL NON-GOVT DEDUCTIONS FROM G.R.	0	0	0	0
12	TOTAL DEDUCTIONS FROM G.R.	0	0	0	0
13	TOTAL PAYMENTS (NET REVENUE)	0	0	0	0
14	INPATIENT GROSS REVENUE	0	0	0	0
15	OUTPATIENT GROSS REVENUE	0	0	0	0
16	OTHER OPERATING REVENUE	0	0	0	0
17	REVENUE FROM OPERATIONS	0	0	0	0
18	NON-PHYSICIAN SALARIES	0	0	0	0
19	PHYSICIAN SALARIES	0	0	0	0
20	FRINGE BENEFITS-NON PHYSICIAN	0	0	0	0
21	FRINGE BENEFITS-PHYSICIAN	0	0	0	0
22	OTHER:SUPPLY & DRUGS	0	0	0	0
23	OTHER THAN SUPPLY & DRUGS	0	0	0	0
24	PHYSICIAN FEES	0	0	0	0
25	MALPRACTICE	0	0	0	0
26	LEASES	0	0	0	0
27	LEASES -MULTI-YEAR	0	0	0	0
28	TOTAL LEASES	0	0	0	0
29	DEPARTMENTAL DEPRECIATION	0	0	0	0
30	PLANT DEPRECIATION	0	0	0	0
31	TOTAL DEPRECIATION	0	0	0	0
32	INTEREST	0	0	0	0
33	EXPENSE RECOVERY	0	0	0	0
34	TOTAL NET OPERATING EXPENSES	0	0	0	0
35	GAIN (LOSS) FROM OPERATIONS	0	0	0	0
36	NON OPERATING REVENUE	0	0	0	0
37	REVENUE OVER/(UNDER) EXPENSES	$0	$0	$0	$0
38	FULL TIME EQUIVALENTS	0	0	0.00	0.00
39	DISCHARGES	0	0	0	0
40	PATIENT DAYS	0	0	0	0
41	CASE MIX	0.0000	0.0000	0.0000	0.0000
42	OTHER STATISTIC:				
43	ANNUAL RATE IMPACT				

CON LOI # 95 - 163
CON PROJECT: BH/YALE AFFILIATION

BRIDGEPORT HOSPITAL
SUMMARY OF REVENUE AND EXPENSE AND VOLUME STATISTICS
WITH THE PROJECT
(000'S)

	REVENUE	ACTUAL 1995	PROJECTED 1996	PROJECTED 1997	PROJECTED 1998
1	GOVERNMENT GROSS PATIENT REVENUE	$150,203	$133,784	$139,804	$146,095
2	NON-GOVT GROSS PATIENT REVENUE	$90,568	102,664	107,284	112,112
3	TOTAL GROSS PATIENT REVENUE	240,771	236,448	247,088	258,207
4	GOVT DEDUCTIONS FROM GROSS REV	$48,217	41,219	42,462	45,833
5	NET BAD DEBTS	$8,129	6,168	6,413	6,746
6	FREE CARE	$1,506	1,500	1,500	1,500
7	TOTAL UNCOMPENSATED CARE	9,635	7,668	7,913	8,246
8	NON-GOV'T CONTRACTUAL ALLOWANCES	$861	2,901	3,032	3,168
9	ALT. DELIVERY SYS. (HMO) ALLOWANCES	$10,052	16,175	16,903	17,664
10	OTHER ALLOWANCES	($46)	5,110	6,373	8,280
11	TOTAL NON-GOVT DEDUCTIONS FROM G.R.	20,502	31,854	34,220	37,358
12	TOTAL DEDUCTIONS FROM G.R.	68,719	73,073	76,682	83,191
13	TOTAL PAYMENTS (NET REVENUE)	172,052	163,375	170,406	175,016
14	INPATIENT GROSS REVENUE	174,989	168,502	176,085	184,008
15	OUTPATIENT GROSS REVENUE	65,782	67,946	71,004	74,199
16	OTHER OPERATING REVENUE	1,090	1,100	1,100	1,100
17	REVENUE FROM OPERATIONS	173,142	164,475	171,506	176,116
18	NON-PHYSICIAN SALARIES	74,487	66,211	68,363	70,585
19	PHYSICIAN SALARIES	5,664	5,877	6,068	6,265
20	FRINGE BENEFITS-NON PHYSICIAN	20,295	16,261	15,723	16,234
21	FRINGE BENEFITS-PHYSICIAN	1,303	1,352	1,396	1,441
22	OTHER:SUPPLY & DRUGS	21,905	21,431	22,245	23,091
23	OTHER THAN SUPPLY & DRUGS	25,866	27,015	29,042	29,364
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25	MALPRACTICE	1,827	2,290	2,377	2,467
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30	PLANT DEPRECIATION	5,693	6,960	7,224	7,499
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33	EXPENSE RECOVERY	(3,198)	(2,900)	(2,900)	(2,900)
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35	GAIN (LOSS) FROM OPERATIONS	3,719	2,395	2,478	2,602
36	NON OPERATING REVENUE	204	200	200	200
37	REVENUE OVER/(UNDER) EXPENSES	$3,923	$2,595	$2,678	$2,802
38	FULL TIME EQUIVALENTS	2018.83	1629.98	1629.98	1629.98
39	DISCHARGES	19,254	18,396	18,396	18,396
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41	CASE MIX	1.0948	1.2320	1.2320	1.2320
42	OTHER STATISTIC:				
43	ANNUAL RATE IMPACT				

APPENDIX III

Department of Public Health and Addiction Services License Survey

- Yale-New Haven Hospital
- Bridgeport Hospital

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0044

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Yale-New Haven Hospital, Inc. of New Haven, CT, d/b/a Yale-New Haven Hospital is hereby licensed to maintain and operate a General Hospital.

Yale-New Haven Hospital is located at 20 York Street, New Haven, CT with:
Julia McNamara as President of the Governing Board
Joseph A. Zaccagnino as Administrator,
Edwin C. Cadman, M.D. as Chief of Medical Staff,
Diana Weaver, D.N.S., R.N. as Director of Nursing Services.

The maximum number of beds shall not exceed at any time:

808 General Hospital beds,

92 Bassinets.

This license expires **September 30, 1997** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, October 1, 1995. RENEWAL
Satellites:
Weller Building

Stephen A. Harriman, Commissioner
Department of Public Health

STATE OF CONNECTICUT

Department of Public Health and Addiction Services

LICENSE

License No. 0040

General Hospital

In accordance with the provisions of the General Statutes of Connecticut Section 19a-490:

Bridgeport Hospital of Bridgeport, CT, d/b/a Bridgeport Hospital is hereby licensed to maintain and operate a General Hospital.

Bridgeport Hospital is located at 267 Grant Street, Bridgeport, CT with:
Robert J. Trefry as President of the Governing Board,
Robert J. Trefry as Administrator,
Mitchell Driesman, M.D. as Chief of Medical Staff,
Hope Juckel-Reagan, R.N. as Director of Nursing Services.

The maximum number of beds shall not exceed at any time:

581 General Hospital beds,

50 Bassinets.

This license expires March 31, 1996 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 1994.

*Decrease in services and beds Eff 5/10/95 - 81 Beds.

Satellites:
Trumbull/Monroe Satellite Center, 15 Corporate Drive
Psychiatric Day Hospital, 1046 Fairfield Avenue
Park City Hospital Site, 695 Park Avenue

Commissioner of Public Health and
Addiction Services

BRIDGEPORT HOSPITAL

Memo

TO: See *Distribution*

FROM: Sandra Jarva Weiss, Esq., General Counsel

DATE: July 21, 1995

SUBJECT: ***HOSPITAL LICENSE***

Attached please find a copy of the revised Bridgeport Hospital General Hospital License reflecting the reduction of 81 beds (40 Rehab beds and 41 Psychiatric Beds) as a result of the movement of these Park Avenue services back to Grant Street.

The Hospital will be requesting a further revision of the license, in compliance with the Master Facility Plan Agreed Settlement from 581 general hospital beds and 50 bassinets (totalling 631 beds) to 395 general hospital beds and 30 bassinets (totalling 425 beds).

However, the attached license will remain in effect until this next revision is made by the Department of Public Health and Addiction Services.

Sandra Jarva Weiss

Sandra Jarva Weiss, Esq.
General Council

SJW:tetk

Attachment

DISTRIBUTION

Robert J. Trefry, President and C.E.O.
Bruce M. McDonald, M.D., Sr. Vice President of Medical Affairs
Barbara Hughes, Vice President of Quality Management
Hope Juckel-Regan, Vice President of Patient Care Services
John S. LaBella, Vice President of Operations
Clayton Medeiros, Vice President of Planning and Marketing

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

November 10, 1994

Joseph A. Zaccagnino
President and Chief Executive Officer
Yale-New Haven Hospital
20 York Street
New Haven, Connecticut 06510-3203

Dear Mr. Zaccagnino:

Unannounced visits were made to Yale-New Haven Hospital on September 13, 1994 with subsequent visits on September 19 and 26, 1994 by representatives of the Hospital and Medical Care Division for the purpose of conducting a licensure inspection.

As requested by the facility, the individual recommendations of the inspection team members made at the time of the exit summary are noted as follows:

As requested by the facility, the individual recommendations of the inspection team members made at the time of the exit summary are noted as follows:

PHYSICAL PLANT/FIRE SAFETY

- The completion of work orders issued by the Engineering Department should be verified by a Department Supervisor. The Acute Dialysis Unit-Clean Utility Room was noted to have an unrepaired pipe leak above the ceiling located above clean supplies.

- The Engineering Department maintenance staff, which are assigned to specific areas of the hospital, should be provided with a list of critical and safety items that are monitored, e.g. safe storage of oxygen cylinders, repairs that are required, building and safety code violations, or where hospital systems are altered and used for other purposes.

- The Engineering Department should develop a Policy and Procedure requiring all out-of-hospital contractors/vendors to submit proposed installations for approval in writing. Upon completion of the installation, the Engineering Department would inspect to assure code compliance.

- Medical gas valves and valve boxes, located in high materials handling traffic areas should be protected against physical damage and/or tampering.

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MEDICAL STAFF BYLAWS AND QUALITY ASSURANCE

- Consideration should be given to modifying the temporary privileges section which is Article V, Section G on pages 23-24, as follows:
  a. The temporary privileges in paragraph 1 which may be renewed but shall not extend beyond the period of the pendency of the application should have a firm number affixed when these temporary privileges are given someone. By this I mean "period of pendency of application" is an open-ended period however short it may seem to be and it would make more sense and be more consistent with the rest of the bylaws and with bylaws around the state to assign a particular number of months like three or six months with one extension even for something like this which is envisioned to be a short period.
  b. The temporary privileges for a visiting physician or dentist may be given for a "specified limited time." Here too, there should be a number like six months with one extension rather than the open-ended adjective or adverb restricting the time period.
  c. The temporary privileges that may be summarily suspended by the joint action of a chief of staff and a chief or associate chief leads to the possibility that, in departments where there is only a chief and no associate chief, this summary suspension action may come down to a decision involving two people. It is a practice of the Division to discourage very strongly any summary action which is dependent upon an even number of people and therefore possible deadlock. I would recommend that for this temporary privileges summary suspension that any one of the following people be designated to exercise summary suspension of temporary privileges: chief or staff, chief, associate chief, etc. This presently is actually a more restrictive and cumbersome summary suspension clause than the summary suspension clause involving full privileges.

- As discussed with Attorney Cohn and Dr. Crede, the inconsistent use of practice parameters and volume figures for certain privileges be revisited. By this I mean the expectation that anyone who wishes to do a paracentesis should have done two per year for the two years since the last re-appointment does not make a lot of sense when no one who was requesting privileges to do pericardiocentesis is not asked what his or her particular volume vis-à-vis outcome is. This is to say nothing of the fact that none of these surgical subspecialties whether it's OB/Gyn or vascular surgery is asked such questions. I fully understand the reasoning behind the internal medicine volume questions (and the attempt to limit the number of practitioners requesting but not using certain privileges) but this may be a practice that could lead to more problems than Yale-New Haven Hospital wishes to encounter.

- Make it clear without going into peer review details the fact and the general nature of the incorporation of QA and QI data in the re-appointment process. Something a little more than a simple statement on the re-appointment sheet should be present.

NURSING

- Nursing's Quality Improvement Program for the Maternity Department has not been implemented since June 1994. Although the restructuring of the department is in process and a care coordinator role is evolving for the area which will impact on the QI Program, projects which have already been implemented need to go forward/concluded until such time as a new direction has been set.

- The facility should update its legent to include abbreviations used in current practice. All patient care units should be supplied with a copy.

- The facility should include training in basic arrhythmia monitoring for those nurses engaged in IV conscious sedation procedures.

DIETARY SERVICES

- Appropriate arrangements should be made with nursing and dietary services to ensure soiled meal trays are returned to the dietary department in a timely fashion, i.e. prior to service of the next meal.

- Nursing should obtain admission weights and follow weights when requested by the dietitian, in a timely manner.

- Consider implementation of a Hazard Analysis or "HACCP" program to identify and avoid potential problems in food handling which may result in outbreaks of food borne illness.

- Contact the local sanitarian to request a kitchen inspection for the year of 1994.

- Assess which nutritional risk categories would indicate testing of serum albumin in order to complete the nutritional assessment.
  Consider proposing that patients in these categories have standing orders which would allow albumins to be tested for patients in these specific nutritional risk categories.

GENERAL

- Increased surveillance of refrigerators for temperature and cleanliness. Four refrigerators on two units (C-T ICU, and 6-4) were maintained at temperatures of 40, 42, and 44 degrees. Refrigerators were observed cluttered with food and had ice buildup in the freezer.

- Secure oxygen tanks in all areas.

These recommendations are offered for internal consideration only. No response from the facility is anticipated. Should you have any questions please feel free to contact the individual consultant for additional clarification or assistance. On site consultative services are available from the Hospital and Medical Care Division upon written request.

On behalf of the inspection team, my thanks and appreciation for the cooperation and assistance of the hospital staff.

Sincerely,

Rita E. Grygus, R.N., M.S.N.
Medical Facilities Consultation Supervisor
Hospital and Medical Care Division

REG:jp

#1367J

STATE OF CONNECTICUT

000225

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

April 14, 1994

Robert J. Trefry
President and Chief Executive Officer
Bridgeport Hospital
267 Grant Street
Post Office Box 5000
Bridgeport, Connecticut 06610

Dear Mr. Trefry:

An unannounced visit was made to Bridgeport Hospital on March 16, 1994 by representatives of the Hospital and Medical Care Division and the Monitoring and Radiation Division of the Department of Environmental Protection for the purpose of conducting a licensure inspection.

A focused review of the following services was undertaken:

Nursing - Evaluation of nursing process and infection control procedures.
Medical Staff - Control of privileges and quality assurance.
Dietary Services - Therapeutic clinical services.
Social Services - Discharge planning.
Physical Plant - Physical environment and fire safety.
Radiology - Evaluation of equipment and quality control.

The following violations of the State of Connecticut Public Health Code were observed during the course of the inspection.

1. The Clean Utility Rooms, located on the fifth floor through the tenth floor of the West Tower were not provided with doors to separate the rooms from the corridor.

The above is a violation of the State of Connecticut Public Health Code, Section 19-13-D3 (a) Physical Plant (2).

2. In twelve (12) of seventeen (17) nursing care plans reviewed, the plan failed to reflect the actual problems/needs of the patient as evidenced by:
   a. In five (5) of ten (10) medical records reviewed, care plans lacked individualization.
   b. Three (3) nursing assessments identified patient educational needs not addressed on the care plan.

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2. c. Three (3) care plans identified assessment of patient pain every three hours. The interventions were not documented as identified on the plan.
   d. One (1) patient with newly diagnosed cancer lacked the psychosocial needs of the patient identified on the plan of care.

3. Four (4) of ten (10) medical records reviewed contained physician notes and orders that were illegible.

4. Two (2) of ten (10) medical records contained physician orders that were nonspecific.

5. The facility failed to weigh one (1) of four (4) patients at nutritional risk both upon admission; and also following a recommendation of the registered dietitian.

6. Two (2) of three (3) records in which patients were documented as having received prn (as necessary) medications, the response to the medication was not identified.

The above, 2 through 6, are violations of the State of Connecticut Public Health Code, Section 19-13-D3 (d) Medical Records (3).

7. Five (5) of ten (10) records of patients transferred to skilled nursing facilities failed to include the signature of the patient or family member or representative on the patient discharge plan.

The above is a violation of the Regulations of Connecticut State Agencies, Section 19a-504c-1 Discharge Planning (f) and the State of Connecticut Public Health Code, Section 19-13-D3 (d) Medical Records (3).

8. The hospital's Department of Obstetrics and Gynecology lacked a written standard for, and two (2) of ten (10) VIP (voluntary interruption of pregnancy) records lacked evidence of, the provision of postoperative counseling including family planning to the patient.

The above is a violation of the State of Connecticut Public Health Code, Section 19-13-D54 Regulations on Abortions (d)(10) and Section 19-13-D3 (d) Medical Records (3).

9. Surfaces and countertops (along with various pieces of equipment) in the Emergency Department contained a visible accumulation of dust.

10. The pediatric scale in the "Emergease" area of the Emergency Department contained a visible accumulation of dust.

11. Supplies were stored uncovered on carts in the Plaster Room suite.

12. Supplies and equipment were stored uncovered in the Clean Utility Room on Tower 7 which lacked doors and was therefore open to the hallways.

13. The pediatric warming unit housed in the Emergency Department lacked evidence of current biomedical inspection (last review date 2/15/93).

14. The Endoscopy suite lacked adequate space to prevent cross-contamination of equipment, equipment processing and equipment storage. The suite, additionally, lacked adequate patient processing.

15. The area identified in the preoperative laboratory of "Surgease" allowed for cross-contamination of personnel and patient medical records.

The above, 9 through 15, are violations of the State of Connecticut Public Health Code, Section 19-13-D3 (i) General (7) and (l) Infection Control (4).

Please respond by April 28, 1994 with a plan of correction for these violations.

You may wish to dispute the violations stated above and you may be provided with an opportunity to be heard. If these violations are not responded to by the date requested, or if a request for a meeting is not made within that time period, the violations shall be deemed admitted.

If there are any questions please do not hesitate to contact this office.

Sincerely,

Rita E. Grygus

Rita E. Grygus, R.N., M.S.N.
Medical Facilities Consultation Supervisor
Hospital and Medical Care Division

REG:KWB:jp

#0855J

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

May 31, 1996

Mr. Harold Oberg
Office of Health Care Access
410 Capitol Avenue, MS#13 HCA
P.O. Box 340308
Hartford, CT 06134

Re: Corporate Affiliation of YNHHSC and SCHS, DN 96-518

Dear Hal:

Thank you for updating me about your progress in evaluating the Yale-New Haven Health Services, Inc. (YNHHSC) and Southern Connecticut Health System (SCHS) affiliation CON. Per your telephone request on May 21, I am forwarding you the following information.

Clarification of page 17 of the CON application regarding the proposed effective date of the affiliation.

This will be amended to state that the proposed effective date of the affiliation be on or about June 14, 1996.

Clarification of p.21 of the CON application regarding the post-affiliation bylaws of SCHS and its affiliates and post-affiliation Certificates of Incorporation.

These are post-affiliation documents and will be provided upon receiving CON approval.

Please feel free to contact me with any further questions or concerns you may have.

Yours truly,

Caroline R. Piselli
Planning Consultant, YNHHSC

CRP:jl

cc: Jeanette C. Schreiber, Esq., Wiggin & Dana (Attorney to YNHHSC)
Collin P. Baron, Esq., Pullman & Comley (Attorney to SCHS)

LET-2

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06504

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

April 12, 1996

Mr. Harold M. Oberg
Health Care Financial and
Management Analyst Supervisor
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

Re: Certificate of Need Application, Docket Number 96-513
Corporate Affiliation of Yale-New Haven Health Services Corp.
and Southern Connecticut Health System, Inc.

Dear Mr. Oberg:

Enclosed are responses to the completeness questions for DN 96-513, Corporate Affiliation of Yale-New Haven Health Services Corp. (YNHHSC) and Southern Connecticut Health System, Inc. (SCHS) and three copies for your review.

We respectfully request that the remaining review process be expedited and concluded without a hearing, as is authorized pursuant to section 19a-154. The proposed affiliation does not involve any substantive change in the operations of either of the hospitals.

Thank you for your consideration and anticipated cooperation. We are available to answer any questions that you may wish to address to us.

Respectfully submitted,

Caroline Piselli
Planning Consultant
Yale-New Haven Health Services Corporation

CP:jl
Attachment

cc: Jeanette C. Schreiber, Esq., Wiggin & Dana (Attorney to YNHHSC)
Colon P. Baron, Esq., Pullman & Comley (Attorney to SCHS)
Mary Heffernan, SCHS

CHHC\HSC-SCHS\CON-DOC\LET-2a

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
AND
SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.

Completeness Questions

1. **The Applicants stated that in the short term, there are no plans to consolidate services; therefore no short-term cost savings are anticipated. Define in terms of months and/or years what the Applicants consider to be "the short-term".**

   There are no anticipated cost savings in the foreseeable future, i.e., in 3-5 years. As stated in the response to question #2, p.16 of the CON application, Yale-New Haven Health Services Corporation (YNHHSC) and Southern Connecticut Health System (SCHS) are pursuing a corporate affiliation to create an integrated regional healthcare system.

2. **Regarding the post-affiliation corporate structure, explain the function of Century Collections which is a part of the proposed corporate structure and why it will be linked to both YNHHSC and SCHS, Inc.**

   The stock of Century Collections is held by a number of shareholders including Nova Med (an SCHS affiliate) and York (a YNHHSC affiliate). Because the combined interests of Nova Med and York are greater than 50% of the total stock, Century Collections is shown as linked to both.

3. **Discuss any future plans the Applicants may have regarding joint purchases of medical equipment and unified patient information systems as a result of the proposed corporate affiliation.**

   Independently of the affiliation process, YNHHSC may seek to initiate certain market-driven programs to benefit the system. There are no plans regarding joint purchases of medical equipment and unified patient information systems as a result of the proposed corporate affiliation, but these may be areas for future discussion after the affiliation is complete.

4. **Discuss any future plans the Applicants may have regarding achieving cost savings in areas such as selected business services, purchasing and insurance as a result of the proposed corporate affiliation.**

   Currently, there are no plans to achieve cost savings in areas such as business services, purchasing and insurance as a result of the proposed corporate affiliation.

5. **Discuss the change currently planned which involves the integration of the general surgery residency program and the initiation of a combined program in Emergency Medicine as a result of the proposed corporate affiliation.**

   Discussions concerning the integration of the residency program in General Surgery between Bridgeport Hospital and Yale-New Haven Hospital began approximately five years ago. Discussions were coordinated by the Chairmen of the Department of Surgery at the School of Medicine, Dr. William Collins and his successor, Dr. Ronald Merrell, and the Chairman of the Department of Surgery at Bridgeport Hospital, Dr. John MacArthur. These discussions pre-dated and were independent of discussions regarding the corporate affiliation of Yale-New Haven Health Services Corporation and Southern Connecticut Health System. An application was forwarded to the Residency Review Committee in General Surgery in 1994 and approval was obtained from that body for integration of the residencies on 8/8/95.

   Similarly, discussions concerning the creation of an integrated residency program between Yale-New Haven Hospital and Bridgeport Hospital were initiated approximately 3 years ago. Neither hospital had a residency in Emergency Medicine, but both felt the need for a residency to train physicians in this specialty. An application was forwarded to the Residency Review Committee in Emergency Medicine and approval was obtained from that body on 10/30/95. Again, these discussions and planning were independent of the discussions concerning the corporate affiliation of Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc.

6. **Discuss how shared information between YNHHSC and SCHS, Inc., facilitated by the proposed corporate affiliation, will enhance both provider education and research endeavors.**

   YNHHSC and SCHS have collaborated on Yale School of Medicine practice issues prior to the affiliation and will continue to do so. The Definitive Agreement encourages the sharing of information. In the

spirit of true colleagiality, the communication of research findings across the system will provide health care professionals with a broader knowledge base and subsequently improve patient care on a continuous basis.

7. **Specify whether the Summaries of Revenue, Expense and Volume Statistics on pages 211, 212 and 213 are for Yale-New Haven Hospital or for Yale-New Haven Health Services Corp. These schedules should pertain only to Yale-New Haven Hospital.**

   The Summaries of Revenue, Expense and Volume Statistics on pp.211, 212, and 213 are for Yale-New Haven Hospital.

YALE NEW HAVEN HEALTH

December 29, 1998

Raymond J. Gorman
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134

Dear Commissioner Gorman:

Currently, the Planning and Finance departments of the Yale New Haven Health System are in the process of developing responses to Stipulation #5 for Docket #96-513 (Bridgeport Hospital Affiliation) and Docket # 97-559 (Greenwich Hospital Affiliation). Given a complicated year-end close and several other projects, we will need additional time to address this issue. We will be contacting your office by Friday, January 15, 1999, with additional information on this matter.

Sincerely,

Geoffrey T. Fromme
Planner

cc: Jeanette C. Schreiber, Esq.
H. Bart Price

789 Howard Avenue
New Haven, CT 06519

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

June 13, 1996

IN THE MATTER OF:

An Application Pursuant to Section 19a-154, C.G.S., as amended, by	Notice of Agreed Settlement Office of Health Care Access Docket Number: 96-513
Yale-New Haven Health Services Corp. **Southern Connecticut Health System, Inc.**	**Corporate Affiliation**

TO: Ms. Caroline R. Piselli
Planning Consultant
Yale-New Haven Health Services Corporation
789 Howard Street
New Haven, CT 06520

Dear Ms. Piselli:

This will serve as notice of the Agreed Settlement between Yale-New Haven Health Services Corporation, Southern Connecticut Health System, Inc. and the Office of Health Care Access in the above matter, as provided by Section 19a-154, C.G.S., as amended. On June 13, 1996, the Agreed Settlement was accepted as the finding and order of the Office of Health Care Access. A copy of the agreement is attached hereto for your information.

By Order of the
Office of Health Care Access

William H. Diamond
Acting Commissioner

cc: Mary Heffernan, Southern Connecticut Health System, Inc.

ww.100/cv96513

410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134
Telephone: (860) ~~509~~ 418 7001 • Fax: (860) ~~509~~ 418 7053

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF:

Yale-New Haven Health Services Corporation
789 Howard Street
New Haven, CT 06520

Docket Number: 96-513
June 13, 1996

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

AGREED SETTLEMENT

WHEREAS, pursuant to Public Act 95-257 and effective July 1, 1995, the Office of Health Care Access ("OHCA") constitutes a successor agency to the Commission on Hospitals and Health Care ("Commission"), and the Commission's Regulations unless amended, repealed or superseded pursuant to law will remain in effect; and

WHEREAS, Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. ("Applicants"), health care facilities and institutions as defined in Section 19a-145 of the Connecticut General Statutes ("C.G.S."), as amended, filed a Certificate of Need ("CON") application with OHCA on April 12, 1996 under Docket Number 96-513, pursuant to Section 19a-154, C.G.S., as amended; and

WHEREAS, the CON application was for the corporate affiliation of Yale-New Haven Health Services Corporation ("YNHHSC"), the parent corporation of Yale-New Haven Hospital doing business at 20 York Street in New Haven, and Southern Connecticut Health System, Inc. ("SCHS"), the parent corporation of Bridgeport Hospital doing business at 267 Grant Street in Bridgeport, with no associated capital expenditure; and

WHEREAS, the Applicants are proposing that YNHHSC, the parent company and sole member of Yale-New Haven Hospital, will also become the parent company and sole member of SCHS, which is and will remain the parent company and sole member of Bridgeport Hospital; and

WHEREAS, the Applicants stated that the proposed corporate affiliation of YNHHSC and SCHS, which is to be effective on or about June 14, 1996, will enhance each entity's patient care, community service, education and research missions, and that the proposed business concept for YNHHSC and SCHS incorporates a proactive approach to anticipate and meet the demands of the healthcare environment; and

WHEREAS, the Applicants stated that upon the effective date of the proposed affiliation of YNHHSC and SCHS, the combined system will be overseen by the YNHHSC Board of Directors, with boards remaining at each of its corporate affiliates which will have specific responsibilities and functions; and

WHEREAS, the Applicants stated that the governing boards, financial structures, medical staff appointments and hospital licensure for each health delivery system will remain separate and will not be impacted by the proposed corporate affiliation; and

WHEREAS, both YNHHSC and SCHS are non-stock corporations which are tax-exempt under Section 501(c)(3) of the Internal Revenue Service Code; and

WHEREAS, YNHHSC's corporate affiliates are Yale-New Haven Hospital, Yale-New Haven Ambulatory Services Corporation, Harbor Health Plan, Inc. and York Enterprises, Inc. (and its subsidiaries, Medical Center Realty, Inc. and Medical Center Pharmacy & Home Health Care, Inc.); and

WHEREAS, SCHS's corporate affiliates are Bridgeport Hospital, NovaMed Corporation, SCHS Properties, Inc., Rehabilitation Center of Fairfield County, Inc. and Bridgeport Hospital Foundation, Inc.; and

WHEREAS, the Applicants stated that upon the effective date of the proposed affiliation, the role and oversight authority of the YNHHSC Board of Directors over SCHS will be as follows:

1. Approve SCHS strategic plans, operating budgets and capital budgets.

2. Approve SCHS incurrence of debt over an agreed upon amount.

3. Designate a member of SCHS Board and approve/consult with respect to other SCHS Board appointments as further described in Article V, Section 5.2 of the System Affiliation Agreement.

4. Approve material changes to the bylaws or certificates of incorporation of SCHS or its affiliates.

5. Approve affiliations by SCHS or its affiliates with other healthcare providers.

6. Approve changes of name, sale of assets or the merger, consolidation or reorganization of SCHS or its affiliates.

7. Approve major programmatic changes by SCHS or its affiliates; and

WHEREAS, the Applicants stated that the licensure of beds and healthcare services at Yale-New Haven Hospital and Bridgeport Hospital will not be changed as a result of the proposed affiliation; and

WHEREAS, the Applicants stated that there are no current plans to integrate clinical programs or non-health care related services, and that the proposed affiliation will not affect the published rates or financial condition of either Yale-New Haven Hospital or Bridgeport Hospital; and

WHEREAS, the Applicants stated that there are no currently anticipated cost savings in the foreseeable future resulting from the proposed affiliation, and that in the future opportunities may be explored for potential cost savings in certain areas such as selected business services, purchasing, insurance and information systems; and

WHEREAS, pursuant to Section 19a-154, C.G.S., as amended, OHCA shall determine whether any additional function or service which a health care facility or institution intends to provide is justified; and

WHEREAS, Section 19a-153, C.G.S. sets forth the principles and guidelines to be considered by OHCA in its review of the CON application; and

WHEREAS, OHCA has reviewed the CON application pursuant to Section 19a-154, C.G.S., as amended, and has fully considered the principles and guidelines set forth in Section 19a-153, C.G.S. in its review; and

WHEREAS, the Applicants' proposal will not impede the Applicants' ability to meet the goals of the most recent State Health Plan that relate to health care services provided by the acute care system in Connecticut; and

WHEREAS, the Applicants' proposal demonstrates that the Applicants are committed to a long range planning process which will be facilitated by the proposed corporate affiliation; and

WHEREAS, the Applicants' proposal appears to be financially feasible and appears to have no adverse impact on the Applicants' financial condition; and

WHEREAS, the Applicants' proposal is not inconsistent with the interests of consumers of health care services and the payers for such services; and

WHEREAS, the Applicants' proposal will not impede the Applicants' continued ability to offer the health care services they currently provide in their region of the state, thereby maintaining the quality of health care delivery in the region; and

WHEREAS, the Applicants' proposal will not impede the Applicants' ability to maintain the current level of accessibility of health care delivery in the region; and

WHEREAS, the Applicants' proposal will not impede the Applicants' ability to continue to maintain the cost-effectiveness of health care delivery in the region; and

WHEREAS, the Applicants' proposal appears to demonstrate that the Applicants are technically, financially and managerially competent to provide efficient and adequate service to the public; and

WHEREAS, the Applicants' proposal does not include any proposed capital expenditure or incremental operating expenses; and

WHEREAS, the Applicants' proposal will not impact the Applicants' current utilization statistics, as there are no service relocations, additions or terminations planned to occur as a result of the proposed corporate affiliation; and

WHEREAS, the Applicants' proposal will not affect the teaching and research responsibilities of the Applicants but future collaboration between the Applicants in these areas may eventually be developed as a result of the proposed corporate affiliation; and

WHEREAS, the Applicants presented no evidence concerning the proportionate number of patients of different types and physicians of different types, that differentiates the Applicants from otherwise similar applicants; and

WHEREAS, the Applicants' proposal demonstrates that the Applicants have committed themselves to making voluntary efforts in improving productivity and containing costs; and

WHEREAS, the Applicants' stated that currently there are no plans to achieve operational cost savings as a result of the proposed corporate affiliation, and that in the future opportunities may be explored for potential cost savings in various areas of health care delivery system operations; and

WHEREAS, both OHCA and the Applicants wish to resolve their differences regarding this CON application.

NOW, THEREFORE, the Office of Health Care Access ("OHCA") and Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. ("Applicants"), hereby stipulate and agree to the terms of settlement with respect to the Applicants' request for a Certificate of Need ("CON") for the corporate affiliation of Yale-New Haven Health Services Corporation ("YNHHSC"), the parent corporation of Yale-New Haven Hospital doing business at 20 York Street in New Haven, and Southern Connecticut Health System, Inc. ("SCHS"), the parent corporation of Bridgeport Hospital doing business at 267 Grant Street in Bridgeport, with no associated capital expenditure, as follows:

1. The Applicants' request for a CON for the corporate affiliation of YNHHSC, the parent corporation of Yale-New Haven Hospital doing business at 20 York Street in New Haven, and SCHS, the parent corporation of Bridgeport Hospital doing business at 267 Grant Street in Bridgeport, with no associated capital expenditure, is hereby approved. The effective date of the approved corporate affiliation presented in **Attachment I**, will be on or about June 14, 1996.

2. OHCA and the Applicants agree that within sixty (60) days of the effective date of the approved corporate affiliation, the Applicants will submit to OHCA a copy of the final executed corporate affiliation documents, which will also include a copy of the final post-affiliation Certificates of Incorporation and bylaws of the Applicants and their affiliates.

3. OHCA and the Applicants agree that there is no capital expenditure associated with this CON project. In the event that the scope of project is changed or that the Applicants expect to incur capital expenditures, the Applicants shall file with OHCA a request for approval of the changed scope or capital expenditures prior to implementing such change in scope or incurring such capital expenditures.

4. For purposes of CON approval requirements, Yale-New Haven Hospital and Bridgeport Hospital will continue to be considered as two separate hospitals operating on two separate campuses, with any movement of beds and services from one hospital campus to the other hospital campus requiring CON approval. Pursuant to Section 19a-154, C.G.S., as amended, should Yale-New Haven Hospital and/or Bridgeport Hospital seek to add, consolidate or terminate services on either hospital campus and /or substantively reduce the services offered by either hospital, CON approval would be required for either hospital to so proceed. Nothing contained herein shall cause the Applicants to be exempt from compliance with federal and state antitrust laws, and such laws shall remain in full force and effect as to the Applicants as if no action had been taken by OHCA.

5. OHCA and the Applicants agree that a plan for the attainment of cost savings, which reflects any specific incremental operating expense reductions anticipated to result from actions emerging from the corporate affiliation approved herein, will be filed with OHCA by July 31, 1997. This filing will include a completed **Attachment II** for Yale-New Haven Hospital and Bridgeport Hospital individually, and the assumptions related to these operating expense reductions. In addition, OHCA and the Applicants further agree that within sixty (60) days subsequent to the end of each fiscal year for the first three full fiscal years following the corporate affiliation, a fully completed **Attachment II** will be filed for Yale-New Haven Hospital and Bridgeport Hospital individually, reflecting a total of all actual cost savings for the completed fiscal year facilitated by the corporate affiliation.

6. The Applicants shall obtain the further approval of the Department of Public Health and all other local, state and federal agencies governing the licensing of health care facilities, and the Applicants shall report to OHCA upon receiving such licensure approvals.

7. This CON authorization shall expire on June 13, 1997, unless the Applicants present evidence to OHCA that the corporate Affiliation has become effective by that date.

8. OHCA and the Applicants recognize and agree that Section 4-38d(b), C.G.S. shall apply to the terms of this Agreed Settlement.

9. OHCA and Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. agree that this represents a final agreement between OHCA and Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. with respect to this request. The signing of this Agreed Settlement resolves all objections, claims and disputes which may have been raised by the Applicants with regard to Docket Number 96-513.

10. This Agreed Settlement is an Order of the Office of Health Care Access with all the rights and obligations attendant thereto, and the Office of Health Care Access may enforce this Agreed Settlement pursuant to the provisions of Sections 19a-159 and 19a-167j of the Connecticut General Statutes at the Applicants' expense, if the Applicants fail to comply with its terms.

6/12/96
Date

Duly Authorized Agent for
Yale-New Haven Health Services
Corporation

6/12/96
Date

Duly Authorized Agent for
Southern Connecticut Health
System, Inc.

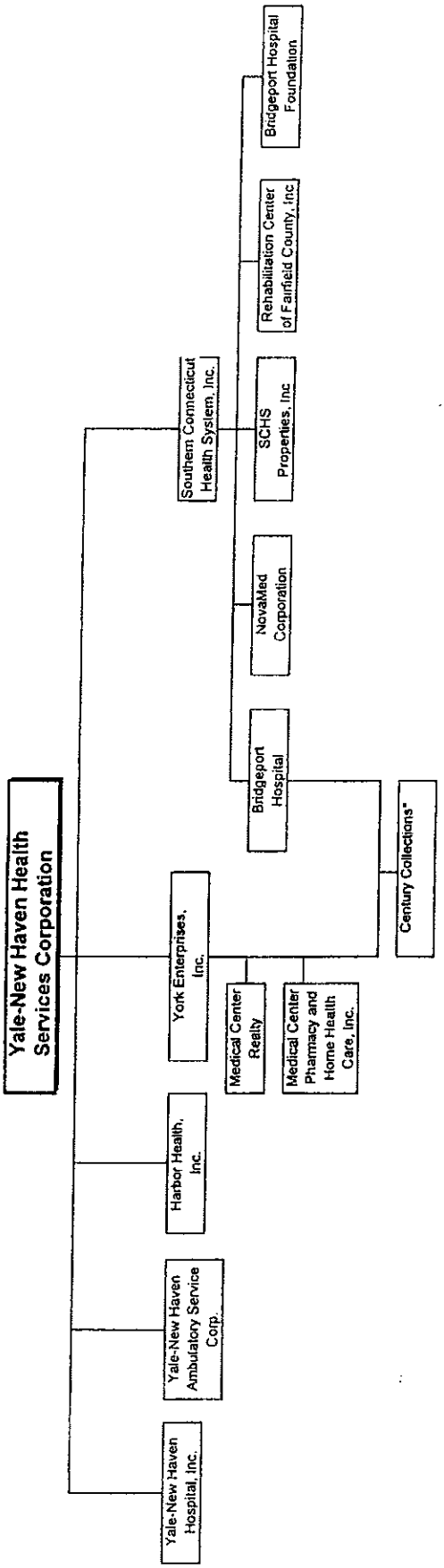
The above Agreed Settlement is hereby accepted and so ordered by the Office of Health Care Access on June 13, 1996.

6/13/96
Date

William H. Diamond
Acting Commissioner
Office of Health Care Access

WHD/HC/ww
WW#100
a:\as96513.doc

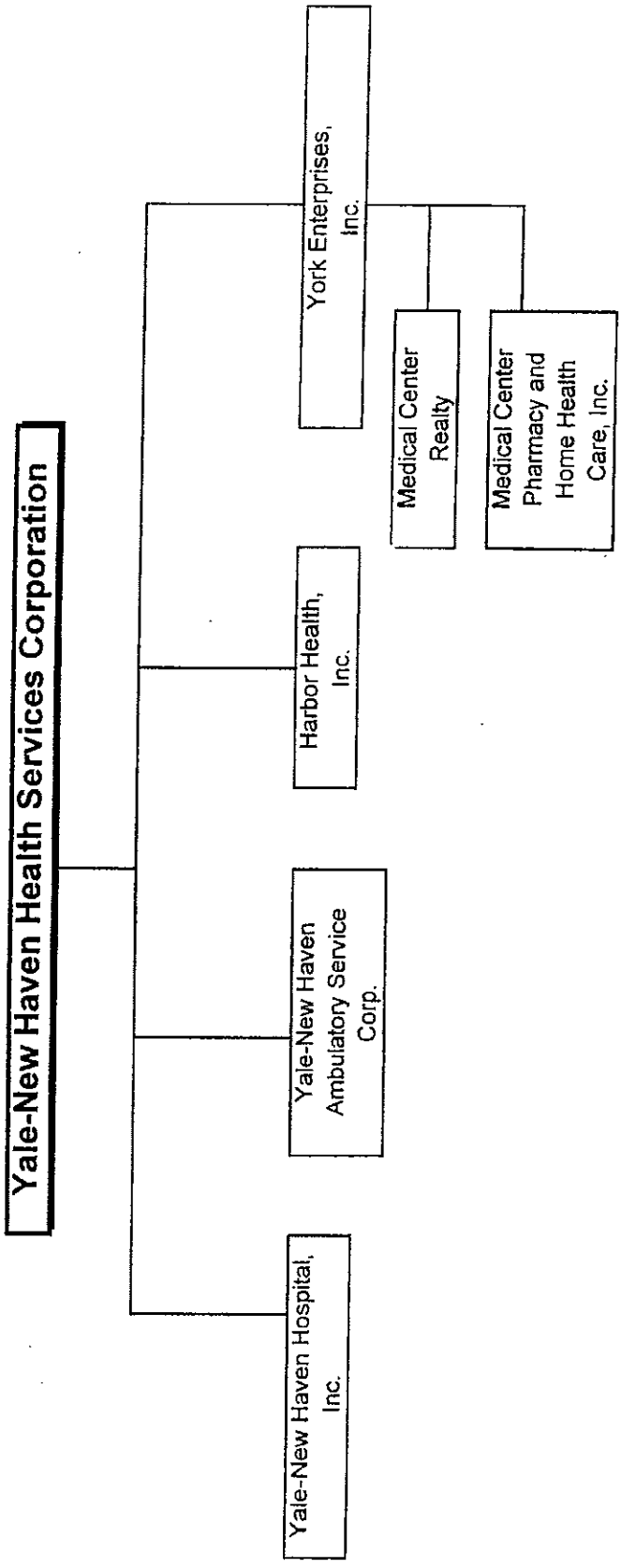
YALE-NEW HAVEN HEALTH SERVICES CORPORATION
POST-AFFILIATION



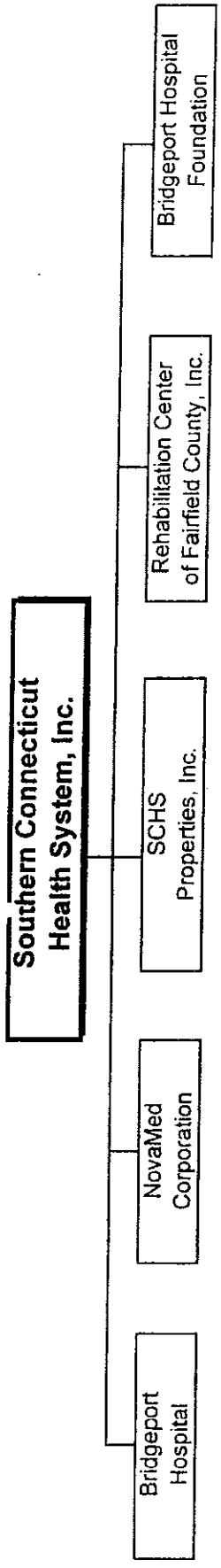
* Note: Each of NovaMed and York hold approximately 30% of the stock of Century Collection. Following the affiliation, a majority of the stock of Century will be controlled by members of the YNHHSC System.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

PRE-AFFILIATION



SOUTHERN CONNECTICUT HEALTH SYSTEM, INC.
PRE-AFFILIATION



CON [illegible]KET NO _____
CON [illegible]ECT _____
APPLICANT _____
SPECIFY TOTAL FACILITY OR DEPARTMENT: _____

REQUESTED FACILIT[illegible] [illegible]PARTMENT) WITH THE PROJECT
SUMMARY OF REVEN[illegible] [illegible]XPENSE, AND VOLUME STATISTICS

Attachment II

LINE	LINE DEFINITION	(1) CURRENT YEAR 199__ REQUESTED	(2) CYR + 1 199__ ___ MONTHS	(3) CYR + 2 199__ ___ MONTHS	(4) CYR + 3 199__ MONTHS	(5) CYR + 4 199__ MONTHS	(6) CYR + 5 199__ MONTHS
1	GOVERNMENT GROSS PATIENT REVENUE						
2	NON-GOVT GROSS PATIENT REVENUE						
3	TOTAL GROSS PATIENT REVENUE (1+2)						
4	GOVT DEDUCTIONS FROM GROSS REVENUE						
5	NET BAD DEBTS						
6	FREE CARE						
7	TOTAL UNCOMPENSATED CARE (5+6)						
8	NON-GOVT CONTRACTUAL ALLOWANCES						
9 *	ALT.DELIVERY SYS.(HMO) ALLOWANCES						
10	OTHER ALLOWANCES						
11	TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)						
12	TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)						
13	TOTAL PAYMENTS (NET REVENUE) (3-12)						
14 *	INPATIENT GROSS REVENUE						
15 *	OUTPATIENT GROSS REVENUE						
16	OTHER OPERATING REVENUE						
17	REVENUE FROM OPERATIONS						
18	NON-PHYSICIAN SALARIES						
19	PHYSICIAN SALARIES						
20	FRINGE BENEFITS-NON PHYSICIAN						
21	FRINGE BENEFITS-PHYSICIAN						
22	OTHER: SUPPLY & DRUGS						
23	OTHER THAN SUPPLY & DRUGS						
24	PHYSICIAN FEES						
25	MALPRACTICE						
26	LEASES - ANNUAL						
27	LEASES - MULTIYEAR						
28	TOTAL LEASES (26+27)						
29	DEPARTMENTAL DEPRECIATION						
30	PLANT DEPRECIATION						
31	TOTAL DEPRECIATION (29+30)						
32	INTEREST						
33	EXPENSE RECOVERY(ENTER AS NEGATIVE)						
34	TOTAL NET OPERATING EXPENSES (SUM(18..25,28,31..33))						
35	GAIN/(LOSS) FROM OPERATIONS (17-34)						
36	NON-OPERATING REVENUE						
37	REVENUE OVER/(UNDER) EXPENSES (35+36)						
38	FULL TIME EQUIVALENTS						
39	DISCHARGES						
40	PATIENT DAYS						
41 *	CASE MIX INDEX						
42 **	OTHER STATISTIC (SPECIFY)						
43	RATE IMPACT						

L:\LOTUS\HOSPDATA\BEDNEED\CONSUM1.WK1, April, 28, 1993, Page 1 of 1. * Applicable to acute care hospitals only. ** Other statistic required if departmental schedule

CON DOCKET NO. _____
CON PROJECT _____
APPLICANT _____
SPECIFY TOTAL FACILITY OR DEPARTMENT: _____

REQUESTED FACILITY (DEPARTMENT) WITHOUT THE PROJECT
SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

Attachment II

LINE	LINE DEFINITION	(1) CURRENT YEAR 199__ REQUESTED	(2) CYR + 1 199__ ___ MONTHS	(3) CYR + 2 199__ ___ MONTHS	(4) CYR + 3 199__ ___ MONTHS	(5) CYR + 4 199__ ___ MONTHS	(6) CYR + 5 199__ ___ MONTHS
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43	RATE IMPACT						

 * Applicable to acute care hospitals only. ** Other statistic required if department(s) scheduled.

COI ...KET NO. _____
CON...JECT _____
APPLICANT _____
SPECIFY TOTAL FACILITY OR DEPARTMENT: _____

REQUESTED FACILI...PARTMENT) INCREMENTAL

SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS

Attachment II

LINE	LINE DEFINITION	(1) CURRENT YEAR 199__ REQUESTED	(2) CYR + 1 199__ ___ MONTHS	(3) CYR + 2 199__ ___ MONTHS	(4) CYR + 3 199__ ___ MONTHS	(5) CYR + 4 199__ MONTHS	(6) CYR + 5 199__ MONTHS
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43	RATE IMPACT						

L:\LOTUS\HOSPDATA\BEDNEED\CONSUM3.WK1, April 26, 1993, Page 1 of 1. * Applicable to acute care hospitals only. ** Other statistic required if departmental schedule.

Yale-New Haven Health Services Corporation

789 Howard Avenue
New Haven, Connecticut 06504
203/785-5861 Fax 203/737-2904

I met [A2] any last measure to protect the DA from public arguing

August 29, 1996

Mr. Harold M. Oberg
Health Care Financial and
Management Analyst Supervisor
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
Hartford, CT 06134

RE: Certificate of Need Application, Docket #96-513
Corporate Affiliation of Yale-New Haven Health Serices Corp.
and Southern Connecticut Health System, Inc.

Dear Mr. Oberg:

The agreed settlement for the affiliation between Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. cites requirements for submission of documents. The following table provides a summary of information and documents enclosed.

Required by settlement; prepared by W&D

Agreed Settlement Paragraph	Enclosed Documents
2	Final post-affiliation Certificate of Incorporation and bylaws of applicants and affiliates
6	A letter from DPH stating that no further licensing approval is required in connection with the affiliation

Please feel free to contact me with any questions and/or concerns you may have.

Sincerely,

Caroline R. Piselli
Planning Consultant
Yale-New Haven Health Services Corporation

CRP:lbb
Enclosures
Corres-202

cc: Jeanette C. Schreiber, Esq.
Mary Heffernan

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

JOHN G. ROWLAND
GOVERNOR

RAYMOND J. GORMAN
COMMISSIONER

June 7, 1999

Jeanette C. Schreiber
Wiggin & Dana
One Century Tower
P.O. Box 1832
New Haven, CT 06508-1832

Re: Certificate of Need Modification, Docket Number 99-536R
Yale-New New Haven Health Services Corporation and
Southern Connecticut Health Systems, Inc.
Modification of Docket Number 96-513

Dear Ms. Schreiber:

On June 16, 1996, the Office of Health Care Access ("OHCA") granted a Certificate of Need ("CON") under Docket Number 96-513, to Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. ("Applicants"). The CON authorized the corporate affiliation of Yale-New Haven Health Services Corporation, the parent corporation of Yale-New Haven Hospital, and Southern Connecticut Health System, Inc., the parent corporation of Bridgeport Hospital.

Stipulation # 5 in the Agreed Settlement under Docket Number 96-513 states the following:

"5. OHCA and the Applicants agree that a plan for the attainment of cost savings, which reflects any specific incremental operating expense reductions anticipated to result from actions emerging from the corporate affiliation approved herein, will be filed with OHCA by July 31, 1997. This filing will include a completed **Attachment II** for Yale-New Haven Hospital and Bridgeport Hospital individually, and the assumptions related to these operating expense reductions. In addition, OHCA and the Applicants further agree that within sixty (60) days subsequent to the end of each fiscal year for the first three full fiscal years following the corporate affiliation, a fully completed **Attachment II** will be filed for Yale-New Haven Hospital and Bridgeport Hospital individually, reflecting a

total of all actual cost savings for the completed fiscal year facilitated by the corporate affiliation."

On May 4, 1999, Yale-New Haven Health Services Corporation and Southern Connecticut Health System, Inc. filed a request under Docket Number 99-536R, seeking modification to eliminate paragraph 5 from the Agreed Settlement. This modification is requested because the information is reported in a format that does not provide useful information to OHCA.

OHCA has reviewed the request for a modification to the Order issued under Docket Number 96-513. The provisions of Section 19a-638, C.G.S., as well as the principles and guidelines set forth in Section 19a-637, C.G.S. were fully considered by OHCA in its review.

OHCA hereby approves the Applicants' modification request. Stipulation # 5 is vacated. All other conditions contained in the June 16, 1996, OHCA order issued under Docket Number 96-513, not amended by this modification remain in effect.

Sincerely,

Raymond J. Gorman
Commissioner

Cc: Rose McLellan, Processing Technician, DHSR, DPH

RJG:sce

Yale New Haven Hospital
1826

Date: 2/23/96

To: JAZ, MPB, FT

PLEASE:

- ☐ Send copies to _____
- ☐ Forward to _____
- ☐ Return to this office
- ☐ See (phone) me re the attached
- ☐ Reply directly to _____
- ☐ Take suitable action

- ☐ As Requested
- ☐ Per our conversation
- ☐ For your files
- ☐ Retain or discard
- ☐ For your information
- ☐ For your reaction or recommendation
- ☐ For your approval

Remarks:

Enclosed is the final draft of the CON core application. Please carefully examine for accuracy the package of Exhibits and appendices which you received last Friday and notify the Planning Office by 10:30 a.m. Monday (2/26). If we do not hear from you, we will assume that you have no further comments or changes.

Caroline

From: Tel.

F. 1798 (Rev. 2/79)

Memorandum *Yale-New Haven Hospital*

To: Mert Gollaher, Esq., Terry Jones, Esq., Jeanette Schreiber

From: Caroline Piselli

Date: February 23, 1996

Subject: YNHHSC/SCHS CON Submission

Enclosed for you review is a final draft of the YNHHSC-SCHS Affiliation CON application questions and responses. Please provide your comments by Monday morning.

The package of exhibits and appendices had been previously provided to you on February 16. Since that time, the following changes/additions have been made to those attachments:

- Replacement of Bridgeport Hospital Foundation Pre-Affiliation Bylaws with clean copy;
- Removal of all drafts of Post-Affiliation Bylaws for SCHS, Inc. and its affiliates;
- Replacement of Post-Affiliation Bylaws for YNHHSC with final version;
- Removal of all Post-Affiliation Certificates of Incorporation for SCHS, Inc. and its affiliates;
- Addition of two Directors and representations of the proposed Post-Affiliation Board of Directors;
- Inclusion of the signed SCHS Board Resolution;
- Inclusion of legal opinion regarding continued tax-exempt status for both YNHHSC and SCHS;
- Inclusion of the most recent Department of Health and Addiction's Services licensing survey for YNHH and BH.

In addition, a copy of the legal opinion regarding continued tax-exempt status (Exhibit M.2) from Collin Baron, Esq. is included for your review.

OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED/MODIFICATION FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____ NEW CON: _____or Modification: _____ (Check one of the above) If new CON: Complete SECTION A If modification: Complete SECTION B	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (front desk) _____ _____ 2. Check rec'd (D.O. Sec.) _____ _____ 3. Check correct (A.D.O.) _____ _____ 4. Check logged (D.O. Sec.) _____ _____ 5. Check rec'd (Comr. Sec.) _____ _____ 6. Other: _____ _____ _____

SECTION A - NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail): _____19a-154. Additional function or service, Change of Ownership prior to licensure. _____19a-155.. Capital expenditure for major medical equipment exceeding $400,000 or other capital expenditure exceeding $1,000,000.	
2. Enter $1,000 on "total Fee Due" line (SECTION C) if application is required pursuant to Section 19a-154 only, otherwise go on to line 3 of this section.	
3. Section 19a-155 fee calculation (applicable if section 19a-155 is checked above **OR** if both 19a-154 and 19a-155 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment) _____ (To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied time .0005 and round to nearest dollar.) ($_____x.0005)	$ _____.00
c. Sum of base fee plus additional fee: (Lines A3a & A3b) _____	
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION C).	$ _____.00
SECTION B - REQUEST FOR MODIFICATION OF PRIOR APPROVED CON	
1. Check statute reference as applicable to the **original CON application** (see statute for detail or original CON authorization): _____ 19a-154...Additional function or service, Change of Ownership prior to licensure _____ 19a-155...Capital Expenditure for major medical equipment exceeding $400,000 or other capital expenditure exceeding $1,000,000.	
2. Enter $1,000.00 on "Total Fee Due" line (SECTION C) if section 19a-155 is not checked, and skip to SECTION C, otherwise go on to line 3 of this section.	
3. Section 19a-155 fee calculation (applicable if section 19a-155 is checked above **OR** if both 19a-154 and 19a-155 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional fee: (Incremental Capital Expenditure Assessment) _____ (To calculate: Total requested incremental Capital expenditure including capitalized financing costs multiplied time .0005 and round to nearest dollar.) ($_____x .0005)	$ _____.00
c. Sum of Base Fee plus Additional Fee: _____	
d. Enter the amount shown on line B3c. on "Total Fee Due" line (SECTION C)	$ _____.00
SECTION C TOTAL FEE DUE: _____	$ _____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

As of January 1,1993, all Certificate of Need applications and requests to modify a Certificate of Need decision must include a filing fee per Section 19a-160-65b of the Regulations of Connecticut State Agencies. Please complete the attached Certificate of Need Filing Fee Computation Schedule and attach the proper fee in a certified check or cashier's check, made out to "Treasurer, State of Connecticut."

Prior to the submission of the application, please contact the Assistant Director of Operations to discuss your filing date and status of your Letter of Intent.

If you have any questions regarding this matter, please contact me at 566-3880.

Sincerely,

Joan K. Symon

Joan K. Symon
Assistant Director of Operations

W:\CHHC\FORMS\MRGRCON

P.S.: Please note that duplicate forms have been sent to each co-applicant for your convenience since some portions of the forms must be filled out by each, with only one filing fee being required.

	Licensed (875)	Available (813)		Actual	Occupancy	Available Beds
OB/GYN						
OB	82	46		25	54%	21
High Risk	10	10		8	80.0%	2
GYN	48	36		25	69%	11
Bassinets	46	47		23	48%	24
TOTAL	186	139		81	58%	58
PSYCH						
10-7/8	26	26		22	84%	4
WIN. I	15	15		11	73%	4
CRC/HTRS	17	18		3	16.%	15
8-8	12	12		10	83%	2
Surgical ICUs						
NICU	10	10		10	100%	0
SICU	11	10		10	100%	0
CTICU	18	18		18	100%	0
TOTAL	39	38		38	100%	0

CC: J. Zaccagnino, M. Borgstrom, T.B. Condon, B. Price, V. Conti, E. Cadman,M.D., Art Lemay, Ronald Merrell, M.D. (FMB102), Clinical Directors

Revised
7/17/95

6 cc

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

1049 Asylum Avenue
Hartford, CT 06105-2431
Phone: (860) 566-3880

November 7, 1995

Robert J. Trefry
President and CEO
Southern Connecticut Health Systems, Inc.
267 Grant Street
Bridgeport, CT 06610

Frank Tiedemann
Senior Vice President, System Development
Yale-New Haven Health Services Corp.
789 Howard Avenue
New Haven, CT 06504

Re: Application for Certificate of Need
Other Than Long Term Care - Affiliations/Mergers
LOI # 95-163

Dear Sirs:

Effective July 1, 1995, pursuant to Public Act ("P..A.") 95-257, the Office of Health Care Access ("OHCA") constitutes a successor agency to the Commission on Hospitals and Health Care ("Commission") and the Commission's regulations until amended, repealed or superseded pursuant to law shall remain in effect.

On November 1, 1995, the Office of Health Care Access ("OHCA") received your Letter of Intent ("LOI") dated November 1, 1995. Pursuant to Sections 19a-154 and 19a-155,of the Connecticut General Statutes ("C.G.S."), as amended, your LOI will be considered to be current from **November 1, 1995** to **March 1, 1996**, and will allow for filing of your Certificate of Need ("CON") between **January 30, 1996** and **March 1, 1996**. A complete current LOI must be on file with OHCA not less than 90 days before a Certificate of Need ("CON") application may be considered filed with OHCA. A current LOI is one not more than 120 days old.

OHCA is required pursuant to Sections 19a-153, 19a-154, and Section 19a-155, C.G.S., as amended, to take into consideration certain criteria in its review of CON applications. Please address the questions found in the enclosed CON application related to these criteria as they pertain to your proposal.

When responding to the questions, please repeat each question prior to the answer. If you indicate that the question is "not applicable," please provide an explanation and proper justification. The application should be paginated using consecutive numbering and page numbers should be referenced on a Table of Contents. An original and five (5) copies of the responses with all supporting documentation should be filed with OHCA in the format prescribed in Section 19a-160-27 of OHCA's Regulations and in the time frames described in Sections 19a-154 and 19a-155 C.G.S., as amended, as set forth on page 1 of this correspondence. All subsequent material filed with OHCA will be required in this format and an original and five (5) copies of all material is necessary.

CON DOCKET NO _____ REQUESTED FACILITY (DEPARTMENT) INCREMENTAL

CON PROJECT _____ SUMMARY OF REVENUE, EXPENSE, AND VOLUME STATISTICS Attachment II

APPLICANT _____

SPECIFY TOTAL FACILITY OR DEPARTMENT _____

LINE	LINE DEFINITION	(1) CURRENT YEAR 199__ REQUESTED	(2) CYR + 1 199__ ___ MONTHS	(3) CYR + 2 199__ ___ MONTHS	(4) CYR + 3 199__ ___ MONTHS	(5) CYR + 4 199__ ___ MONTHS	(6) CYR + 5 199__ ___ MONTHS	(7) CYR + 6 199__ ___ MONTHS	(8) CYR + 7 199__ ___ MONTHS
1	GOVERNMENT GROSS PATIENT REVENUE								
2	NON-GOVT GROSS PATIENT REVENUE								
3	TOTAL GROSS PATIENT REVENUE (1+2)								
4	GOVT DEDUCTIONS FROM GROSS REVENUE								
5	NET BAD DEBTS								
6	FREE CARE								
7	TOTAL UNCOMPENSATED CARE (5+6)								
8	NON-GOVT CONTRACTUAL ALLOWANCES								
9	* ALT DELIVERY SYS (HMO) ALLOWANCES								
10	OTHER ALLOWANCES								
11	TOTAL NON-GOVT DEDUCTIONS FROM G.R. (7+8+9+10)								
12	TOTAL DEDUCTIONS FROM GROSS REVENUE (4+11)								
13	TOTAL PAYMENTS (NET REVENUE) (3-12)								
14	* INPATIENT GROSS REVENUE								
15	* OUTPATIENT GROSS REVENUE								
16	OTHER OPERATING REVENUE								
17	REVENUE FROM OPERATIONS								
18	NON-PHYSICIAN SALARIES								
19	PHYSICIAN SALARIES								
20	FRINGE BENEFITS - NON PHYSICIAN								
21	FRINGE BENEFITS - PHYSICIAN								
22	OTHER SUPPLY & DRUGS								
23	OTHER THAN SUPPLY & DRUGS								
24	PHYSICIAN FEES								
25	MALPRACTICE								
26	LEASES - ANNUAL								
27	LEASES - MULTIYEAR								
28	TOTAL LEASES (26+27)								
29	DEPARTMENTAL DEPRECIATION								
30	PLANT DEPRECIATION								
31	TOTAL DEPRECIATION (29+30)								
32	INTEREST								
33	EXPENSE RECOVERY (ENTER AS NEGATIVE)								
34	TOTAL NET OPERATING EXPENSES (SUM(18..25,26,31..33))								
35	GAIN/(LOSS) FROM OPERATIONS (17-34)								
36	NON-OPERATING REVENUE								
37	REVENUE OVER/(UNDER) EXPENSES (35+36)								
38	FULL TIME EQUIVALENTS								
39	DISCHARGES								
40	PATIENT DAYS								
41	* CASE MIX INDEX								
42	** OTHER STATISTIC (SPECIFY)								
43	RATE IMPACT								

 * Applicable to acute care hospitals only. ** Other statistic required if departmental schedule

Yale-New Haven Health Services Corp.
789 Howard Avenue
New Haven, CT 06504

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

November 1, 1995

This will acknowledge receipt of a Letter of Intent regarding affiliation of Yale-New Haven Health Services Corporation and Southern Connecticut Health Systems, Inc. to Ms. Joan Symon, Assistant Director of Operations at the Office of Health Care Access.

SIGNED: Joan Peters
For The Office of Health Care Access

Date: 11/1/95

Time: 3:20pm

Please forward a copy of the appropriate CON application forms and requests for any additional information to Frank Tiedemann at Yale-New Haven Health Services Corporation. Also, since this affiliation will not affect in any substantive way the operation of either hospital, the applicants would greatly appreciate the assistance of OHCA in expediting any CON review process, including making a determination without holding a hearing.

Thank you for your consideration.

Sincerely,

Robert J. Trefry
President and Chief Executive Officer
Southern Connecticut Health System, Inc.

Frank Tiedemann
Senior Vice President, System Development
Yale-New Haven Health Services Corporation

RJT/FT:mrg

F5396

le-New Haven Health Services Corp.
9 Howard Avenue
ew Haven, CT 06504

Southern Connecticut Health System, Inc.
267 Grant Street
Bridgeport, CT 06610

November 1, 1995

Ms. Joan Symon
Assistant Director of Operations
Office of Health Care Access
1049 Asylum Avenue
Hartford, CT 06105

RE: Affiliation of Yale-New Haven Health Services Corporation and Southern Connecticut Health Systems, Inc.; Letter of Intent

Dear Ms. Symon:

We are writing to inform the Office of Health Care Access ("OHCA") of a proposed affiliation between Yale-New Haven Health Services Corporation ("YNHHSC," the parent corporation of Yale-New Haven Hospital) and Southern Connecticut Health System, Inc. ("SCHS, Inc." the parent corporation of Bridgeport Hospital). The affiliation is designed to establish a strategic alliance between the two systems, enabling these organizations to remain competitive in a changing marketplace by enhancing quality of care and controlling costs. As part of the affiliation, YNHHSC will become the parent corporation of SCHS, Inc. The governing boards and financial structures of each system will remain separate. The Medical Staff appointments and licensure of two hospitals will remain separate.

This proposed affiliation will not involve or result in the introduction of any new functions or services nor the expansion or termination of any functions or services at either hospital. There will be no capital expenditures associated with the affiliation. As such, we would like to explore as appropriate whether any approval of this affiliation by OHCA is required.

In the event it is determined that certificate-of-need approval is required, this letter is submitted as a letter of intent pursuant to section 19a-154 of the Connecticut General Statutes. The CON applicant would be Yale-New Haven Health Services Corporation, and, if requested by OHCA, Southern Connecticut Health System, Inc. as applicant. The CON application would seek approval as required for the affiliation described above. As noted, there would be no capital cost. The two hospitals would continue to be located at their present locations in New Haven and Bridgeport, Connecticut.

Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, March 30, 2016 4:20 PM
To: Greer, Leslie
Cc: Martone, Kim; Hansted, Kevin
Subject: Fw: 15-32033_YNHHSC and L+M - Second Completeness Question Responses
Attachments: DN 5-32033_YNHHS LM Completeness 2nd Round_FINALMarch 30 2016.pdf; DN 5-32033_YNHHS LM Completeness 2nd Round_FINALMarch 30 2016.docx; nancyr_3-30-2016_15-19-29.pdf

Lealie,

Please add to the record.

Thank you,

Steve

From: Rosenthal, Nancy <Nancy.Rosenthal@greenwichhospital.org>
Sent: Wednesday, March 30, 2016 3:29:52 PM
To: Lazarus, Steven; Carney, Brian; Ciesones, Ron; Riggott, Kaila
Subject: FW: 15-32033_YNHHSC and L+M - Second Completeness Question Responses

Steve, Brian, Ron and Kaila,

Attached is the cover letter and Word/Adobe responses to the second set of completeness questions for the affiliation of L+M Corp and YNHHSC. Thank you for your consideration of this important project.

Thank you.

Nancy

Nancy Rosenthal
V.P., Strategy and Regulatory Planning

Yale New Haven Health System
2 Howe Street, Room 307
New Haven, CT 06511

203-688-5721

Nancy.Rosenthal@ynhh.org
www.ynhhs.org

YALE NEW HAVEN HEALTH

March 30, 2016

Ms. Kimberly Martone
Director of Operations
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation (DN: 15-32033-CON) – 2nd Completeness Letter Responses

Dear Ms. Martone:

Please find attached to this email communication, an MS Word and Adobe Acrobat file containing the responses to the second set of completeness questions posed by the Office of Healthcare Access on February 4, 2015.

We appreciate OHCA's time and effort related to this critically important proposal. Please feel free to contact me at (203) 688-5721 with any questions.

Sincerely,

Nancy Rosenthal
Vice President, Strategy and Regulatory Planning

Copy to: Steven Lazarus
Brian Carney
Ronald Ciesones
Kaila Riggott

Enclosures

789 Howard Avenue
New Haven, CT 06519

Yale-New Haven Health Services Corporation
Lawrence + Memorial Corporation

Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation
Docket Number: 15-32033-CON

Responses to Completeness Questions – 2nd Letter

March 30, 2016

1. **Provide or address the following regarding prices, charges and cost savings as related to this proposal and past Yale New Haven Health Services Corporation ("YNHHSC") hospital affiliations:**

    a. **Explain the impact on prices charged to patients that received health care services at the Hospital of St. Raphael ("HSR") main and satellite campuses both before and after the acquisition of HSR by YNHHSC. Provide a detailed explanation for any increases or decreases in price structure, average pricing and pricing policies following the acquisition.**

    In the aggregate, rates have not increased by virtue of the integration, in part, because YNHH had agreed to blend the commercial rates for most YNHH and HSR payers so that commercial rates before and after the integration were essentially equivalent[1] . However, comparison of rates between the former HSR and YNHH is akin to proverbially comparing apples and oranges, because so many changes were made as the result of the integration of HSR into YNHH.

    As previously stated in this Application, YNHHSC does not negotiate rates on a system-wide basis for its affiliated providers. Rather, YNHHSC negotiates with relevant payers based upon each provider's individual cost structure, intensity of service, payer relationship and physician relationships. YNHHSC's managed care department does negotiate on behalf of all the providers in YNHHS, which provides economies of scale from consistent billing protocols, care management arrangements, management of denials, and other non-financial details of the payer agreements. However, the financial terms of each payer agreement are unique to each institution, and there are no common rates across all YNHHSC providers. Thus, pricing for each YNHHSC provider is not arbitrarily established, without regard to the operational needs of the provider or each payer's unique pricing policies or methodologies. More importantly, YNHHSC does not control its reimbursement; rather, rates are set through negotiations with each payer. With respect to government payers, who represent approximately sixty percent (60%) of the patient mix at YNHH (both the York Street campus and the former HSR campus), reimbursement rates are not at all negotiated; instead, they are established by the governmental payer.

[1] YNHH agreed to "budget neutrality" for six of its largest payers. It is also worth noting that in the last four years since YNHH took over the operations on the former HSR campus, governmental reimbursement has progressively decreased while taxation of hospitals has progressively increased. Therefore, comparing prices at HSR before YNHH assumed operations with now is not an accurate assessment of how the integration has affected the price of health care. By way of example, see Memo to hospitals on "Supplemental Payments" from the State of Connecticut Office of Policy and Management attached hereto as Exhibit A.

At the time of the HSR CON filing (see Docket Number: 12-31747-CON and 12-31747-MDF), the financial viability of HSR was in question. Had YNHH not purchased the assets of the HSR, it is very likely that many of the patients who had historically frequented the HSR would have turned to YNHH as their provider of choice. Instead of allowing the hospital to languish, with the strong support of the community, YNHH purchased the hospital and invested significant resources and capital into the HSR campus, transforming the level of care on the HSR campus, all the while keeping most of the HSR workforce intact.

b. Provide a detailed comparison of risk-adjusted prices for health care services currently provided at L+M, Yale-New Haven, Greenwich and Bridgeport Hospitals and provide supporting evidence. Identify any assumptions made in this comparison. Discuss whether and how Greenwich and Bridgeport Hospital's affiliation with the YNHHSC system has provided identifiable benefits to payers and consumers as a result of any changed pricing structure, in the 3 years immediately after these affiliations and at present.

Currently, none of the hospitals referenced above have the ability to provide the specific analysis relating to risk-adjusted pricing because there is no such standard industry metric that measures patient acuity or other variables that may affect cost and price. In addition, even if L+M and the current YNHHS hospitals had the ability to conduct a risk-adjusted analysis, such information, which would include pricing information, is competitively sensitive, and could not be shared under applicable antitrust laws. As stated earlier, each of the above-referenced hospital providers has different negotiated rates with each of the payers, subject to contractual confidentiality provisions imposed by the payer. Moreover, and as stated earlier, YNHHSC does not negotiate its provider rates on a system-wide basis, but rather negotiates each provider's rates in accordance with the specific provider's cost structure. It is also assumed in this Application that the costs associated with the transformation from volume to value-based purchasing will be less costly for L+M, and any of the other hospitals mentioned above, by virtue of the cost efficiencies achieved by being part of the YNHHSC System.

c. Describe in detail how the prices for health care services at L+M will be affected following the YNHHSC ownership change.

As previously stated, the transaction will not result in any change in the L+M Hospital chargemaster, and there is no evidence that prices will go up as a result of the proposed affiliation. The Federal Trade Commission reviewed the affiliation and declined to investigate it further because there was no reason to conclude that the affiliation would lessen competition or allow the applicants to raise prices for general acute-care hospital services. To the extent that L+M can achieve greater operational efficiencies and

economies of scale through its affiliation with YNHHSC, L+M's ability to control costs will in fact be more favorable than that of a standalone community hospital.

d. Discuss in detail and provide the associated dollar amounts for any cost savings achieved at Greenwich Hospital, Bridgeport Hospital and HSR following their affiliation with YNHHSC. Specify the timeframes related to any identified cost saving initiatives for the Greenwich and Bridgeport affiliations.

As a result of consolidated corporate and operational infrastructures, Bridgeport Hospital's and Greenwich Hospital's affiliations with YNHHSC have yielded significant cost savings. Recent examples of the cost savings in supply chain management, information technology infrastructure and insurance coverage for Bridgeport Hospital and Greenwich Hospital are as follows:

- *Supply Chain:*

System-based contracting initiatives and other system-wide cost savings initiatives have resulted in annual cost savings for both Greenwich Hospital and Bridgeport Hospital as described below. For example, cost savings were achieved through standardization of supply and pharmaceutical purchases along with integration of service contracts, cost avoidance was achieved through volume discounts and rebates, and capital avoidance was achieved by virtue of efficient utilization of space, information technology and medical equipment existing within the system.

	Hospital Fiscal Year						
Entity	**2015**	**2014**	**2013**	**2012**	**2011**	**2010**	**Sub Total**
BH	2,808,051	4,010,478	2,683,641	3,752,395	2,854,590	2,896,549	19,005,704
GH	2,581,091	3,413,779	2,334,711	2,219,950	1,845,579	1,411,870	13,806,980
BH/GH Total	**5,389,142**	**7,424,257**	**5,018,352**	**5,972,345**	**4,700,169**	**4,308,419**	**32,812,684**

Savings related to supply chain initiatives can be broken down into three general categories: Operational Cost Savings, Operational Cost Avoidance, and Capital Cost Avoidance. The below table provides a breakout.

Cost Savings	22,966,807
Cost Avoidance	6,757,941
Capital Avoidance	3,087,936
	32,812,684

- *Information Technology Integration Efforts:*

The implementation of Epic across the YNHHSC system has resulted in a reduction of expenses associated with its legacy information technology systems. Over a four year period, the costs associated with contracts related to pre-Epic systems have gradually decreased to a point that YNHHSC now gets the benefit of an improved EMR at a lower cost.

- *Insurance:*

In 2011, by consolidating property insurance coverage under a single contract YNHHSC was able to generate reoccurring annual savings of $147, 000, of which $84, 000 is associated with cost reductions at Bridgeport Hospital and Greenwich Hospital. Savings such as these would not have been possible if each entity procured the insurance separately.

In 2005, YNHHSC had determined that Bridgeport Hospital and Greenwich Hospital had saved $580,000 and $700,000 respectively each year in professional and general liability insurance costs, resulting from access to YNHHSC's insurance carrier (a federal risk retention group in which YNHH is a shareholder).

With respect to HSR, cost savings resulting from the integration of HSR have been significant and regularly reported to OHCA. Pursuant to the Agreed Settlement dated June 27, 2012, YNHH has provided semi-annual reports to OHCA outlining the integration activities and cost savings achieved since the acquisition. As of November 30, 2015, cost savings have exceeded $213 million, well above the projected savings of $198.3 million. In general, savings have been achieved through a variety of initiatives, including but not limited to, the areas of supply chain management, insurance, back office functions and standardization of clinical practices.

e. The response provided several examples where costs will increase (e.g., the fringe benefit package for NEMG employees and additional staff and supplies for an anticipated increase in volume). Complete the table below providing data on the incremental expenses for the first three years of the proposal for the combined health system.

Incremental Expenses of the Affiliation* ($ in millions)	FY 2016	FY 2017	FY 2018
NEMG Fringe Benefits	$562,875	$1,125,750	$1,125,750
Non-Epic ITS Legacy System Wind Down	$338,424	NA	NA
Additional Staff and Supplies for Incremental Volume**	$3,123,013	$7,877,657	$10,058,134
Depreciation for Non Epic YNHHS ITS System Integration	$161,689	$323,378	$323,378

*The above expense detail represents incremental cost due to the affiliation only
**This incremental cost relating to supplies and staff for incremental volume will be offset by the associated additional revenue relating to the $85 million dollar commitment relating to investments in clinical programs, services and capital.

2. Page 26 of the Application indicates YNHHSC will commit $300 million to the proposal, however the response indicated a commitment of $316 million from the following sources:

$163 million - L+M base operating cash flows
$ 68 million - Incremental cash flows from synergies/efficiencies
$ 85 million - YNHHSC
$316 million

Provide the following as it relates to the $300 million commitment of YNHHSC:

a) verification of the exact dollar amount of the YNHHSC commitment and its funding sources;

The Application does not indicate a commitment from YNHHSC of $316 million. Pursuant to the Affiliation Agreement, YNHHSC agreed to commit up to $300 million in resources in the Yale New Haven Health System's Eastern Connecticut and Western Rhode Island region over a period of five years to enhance and support clinical and operational capabilities and services consistent with community need, the YNHHSC strategic plan and mutually agreed upon business plans which display a positive return on investment. Please see the Affiliation Agreement at Attachment III of the Application at page 81.

The $300 million is composed of $85 million in capital and resources from YNHHSC as described in (1) and (2) below and the deployment of $215 million in additional resources as described in (3) below. The Applicants' response to Question 27a of OHCA's Completeness Questions dated January 5, 2016, was intended to explain possible revenue sources with respect to the $215 million dollar commitment to the Eastern Connecticut and Western Rhode Island region (over a five year period) that will be funded by YNHHSC and its affiliates, including but not limited to L+M. While the Applicants anticipate that some of the $215 million in revenue may be sourced from the projected $68 million that L+M is expected to gain from system synergies and efficiencies, along with the $163 million that would otherwise have funded L+M's capital spending without the affiliation, it must be understood that these are projections. Accordingly, the Applicants never intended that these two sources from L+M alone would fund the commitment; instead, these numbers were provided as examples of possible sources to fund the commitment. In the event that market forces, continued Medicaid reimbursement reductions, and/or increases in state hospital taxes substantially change the financial projections of either Applicant, the mutually agreed-upon business plans would prudently reflect such changes.

(1) With respect to the $85 million commitment in capital and resources by YNHHSC, YNHHSC agrees to commit an aggregate of $41 million in resources allocated as follows:

- Implementation of Epic, Lawson and other IT platforms;
- Effectuation and implementation of branding;
- Up to $10 million in value associated with participation and access to YNHHSC population health infrastructure; and
- Recruitment and development of clinical programs and services.

(2) As for the remainder of the $85 million commitment by YNHHSC, YNHHSC agrees to commit an additional $44 million to the clinical programs listed below (along with such other programs mutually agreed upon), provided that such investments are consistent with community need, the YNHHSC strategic plan and mutually agreed upon business

plans which display a positive return on investment to the clinical programs listed below along with such other programs mutually agreed upon:

- Expansion of primary care network and ambulatory presence, including ambulatory surgery;
- Access to pediatric specialty services;
- Development of a multi-disciplinary musculoskeletal center with orthopedic, neurosurgery, spine and physiatry clinical complements;
- Expansion of maternal fetal medicine and obstetrics capabilities;
- Enhancement of oncology services associated with Smilow Cancer Hospital;
- Reintroduction and expansion of bariatric and/or laparoscopic surgical programs;
- Expansion of neuromuscular and stroke programs;
- Development of a multidisciplinary vascular program and enhancement of cardiac services including electrophysiology;
- Enhancement of endocrinology/thyroid services;
- Development of population health and risk contracting capabilities and participating in population health infrastructure;
- Continued access to SkyHealth;
- Expanded emergency services; and
- Physical plant and infrastructure maintenance, development and renovations.

In summary, between items listed in (1) and (2) above, YNHHSC (alone) will invest $85 million in Eastern Connecticut and Western Rhode Island.

(3) Finally, YNHHSC along with its affiliates, (including L+M) will fund the remaining $215 million that will also support the projects listed in (2) above; provided they are consistent with community need, the YNHHSC strategic plan and mutually agreed upon business plans and will display a positive return on investment.

b) a detailed explanation of the sources of revenue that may be included as part of L+M's base operating cash flows;

The L+M base operating cash flows includes the net patient revenue associated with the clinical activities, and non-operating activities that exist at L+M today. In the multiyear forecast for L+M, independent of the proposed affiliation, these cash flows fund the anticipated capital spending, and are represented on the profit and loss statements as depreciation. As part of the proposed affiliation, YNHHSC will provide the funding source for the capital represented in this baseline forecast. It is for this reason that the $163 million in anticipated capital spend is included as a funding source from YNHHSC, and is categorized as L+M base operating cash flows.

c) a breakdown of the $68 million in efficiencies and synergies relating to allocation of costs across the system.

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	5 Year Total
Category						
Incremental Volume - IP and OP	3,048	7,691	11,381	14,526	17,657	54,303
Corporate Services Integration	(1,623)	5,543	7,482	7,678	7,657	26,737
Medical Group	(1,398)	(2,846)	(2,847)	(2,848)	(2,849)	(12,788)
Yearly Total	**27**	**10,388**	**16,016**	**19,356**	**22,465**	**68,252**

3. **It appears from the response on page 624 that YNHHSC's $300 million commitment includes significant contributions from the operations of L+M (approx. $215 million), while only $85 million is coming from YNHHSC. Provide the following:**

   a) **Specific details of how L+M's contribution ($215 million) will be funded, considering the L+M System had operating losses of more than $36 million in fiscal years (FY) 2013-2015 and only $35 million in incremental operating gains are projected cumulatively from FYs 2016-2019.**

      As discussed above in response to question 2a, L+M is not funding the $215 million alone. Rather, funding is intended to come from YNHHSC and its affiliates.

   b) **If L+M is unable to achieve its funding level contribution from operations, how will the balance of the commitment be funded?**

      As discussed above in response to question 2a, L+M is not funding the $215 million alone. Rather, funding is intended to come from YNHHSC-and its affiliates. If market forces or continued State hospital taxes and Medicaid rate reductions result in L+M being unable to achieve the financial performance and synergies underpinning the forecast, the parties would consider other opportunities to achieve similar results, or would make other adjustments as needed to address the economic reality. This is further outlined in Section 2.11(d) of the Affiliation Agreement, which states that if L+M's financial performance materially deviates from certain metrics set forth in Exhibit 2.11, then this $215 million in resource commitment will be revised in a way that is mutually agreed upon by YNHHSC and L+M.

4. **Has the financial performance (e.g., operating margin) of Bridgeport and Greenwich Hospitals improved because of their affiliations with YNHHSC? At what point in time after the affiliations in the 1990s did any financial impact (specific to the YNHHSC affiliation) begin to occur for these two hospitals? What financial impact on these two hospitals and their patients continues to be experienced as a result of the ongoing affiliation with the YNHHSC system? Provide details.**

   Please see response to question 1d above. Both Bridgeport and Greenwich Hospitals' financial performance has improved since their affiliation with YNHHSC as described above. In the case of Bridgeport Hospital, which was facing serious economic pressures prior to the affiliation, Bridgeport Hospital is now more financially stable with a stronger future. Given the fact that

these affiliations occurred over twenty (20) years ago, it is difficult to identify the exact date when performance improved, but based on performance over the last 4-5 years it is clear that both hospitals and their patients are benefitting significantly from their respective affiliations. Had these two hospitals remained as standalone entities, they would have not achieved the level that they are performing at today. More importantly, given increased demands by governmental and commercial payers for greater value with significantly lower reimbursement, both hospitals are more strongly positioned to transform their delivery of care into the future.

In response to OHCA's request, YNHHS has provided the CON materials for Greenwich and Bridgeport Hospitals (Docket Numbers 96-513 and 97-559) under separate cover.

EXHIBIT A

STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

To: Chief Financial Officer

From: Benjamin Barnes
Secretary

Subject: Supplemental Payments

Date: March 2, 2016

Please be advised that I have asked the Department of Social Services to hold on making any additional supplemental payments (through either the inpatient supplemental pool or the small hospital pool) until we have identified the steps needed to address this fiscal year's budget deficit. While I hope to have this task completed later this month, due to the significant drop in revenues, I am not optimistic that we will be able to move forward with any further state payments this fiscal year. This decision will also impact federally qualified health centers, which will be receiving a similar letter.

I apologize for any inconvenience this may cause.

Greer, Leslie

From: Carney, Brian
Sent: Tuesday, May 10, 2016 10:59 AM
To: Nancy.Rosenthal@ynhh.org; Rosenthal, Nancy
Cc: Martone, Kim; Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Ciesones, Ron; Greer, Leslie
Subject: Docket numbers: 15-32032-CON & 15-32033-CON Deemed Complete
Attachments: 15-32032-con_201605101034.pdf; 15-32033-con_201605101035.pdf

Nancy,

As directed, please see attached letters deeming complete docket numbers: 15-32032-CON & 15-32033-CON.

Please respond to confirm receipt of this email.

Thanks,
Brian Carney

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053
Email: brian.carney@ct.gov
Web: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

May 10, 2016

Via Email Only

nancy.rosenthal@ynhh.org
Nancy Rosenthal
Senior Vice President, Health Systems Development
Yale New Haven Health System
789 Howard Avenue
New Haven, CT 06519

RE: Certificate of Need Application, Docket Number: 15-32033-CON
Acquisition of L+M Health Care System, Inc. by Yale New Haven Health System, Inc.
Certificate of Need Completeness Letter

Dear Ms. Rosenthal:

This letter is to inform you that, pursuant to Section 19a-639a (d) of the Connecticut General Statutes, the Office of Health Care Access has deemed the above-referenced application complete as of May 10, 2016.

If you have any questions concerning this letter, please feel free to contact me at (860) 418-7012.

Sincerely,

Steve Lazarus KR

Steven W. Lazarus
Associate Health Care Analyst

Phone: (860) 509-8000 • Fax: (860) 509-7184 • VP: (860) 899-1611
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

Greer, Leslie

From: Rosenthal, Nancy <Nancy.Rosenthal@greenwichhospital.org>
Sent: Tuesday, May 10, 2016 11:41 AM
To: Carney, Brian
Cc: Martone, Kim; Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Ciesones, Ron; Greer, Leslie
Subject: RE: Docket numbers: 15-32032-CON & 15-32033-CON Deemed Complete

Thank you all!

Nancy Rosenthal
V.P., Strategy and Regulatory Planning

Yale New Haven Health System
2 Howe Street, Room 307
New Haven, CT 06511

203-688-5721

Nancy.Rosenthal@ynhh.org
www.ynhhs.org

From: Carney, Brian [mailto:Brian.Carney@ct.gov]
Sent: Tuesday, May 10, 2016 10:59 AM
To: Rosenthal, Nancy; Rosenthal, Nancy
Cc: Martone, Kim; Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Ciesones, Ron; Greer, Leslie
Subject: Docket numbers: 15-32032-CON & 15-32033-CON Deemed Complete

Nancy,

As directed, please see attached letters deeming complete docket numbers: 15-32032-CON & 15-32033-CON.

Please respond to confirm receipt of this email.

Thanks,
Brian Carney

Brian A. Carney, MBA
Associate Research Analyst
Office of Health Care Access
CT Department of Public Health
410 Capitol Avenue, MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Phone: (860) 418-7014
Fax: (860) 418 7053

Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, May 11, 2016 5:13 PM
To: 'nancy.rosenthal@ynhh.org'
Cc: Carney, Brian; Lazarus, Steven; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: Yale New Haven Health System Hearing Notice DN's 15-32032-CON & 15-32033-CON
Attachments: 15-32032-CON 15-32033-CON.pdf

Tracking:

Recipient	Delivery
'nancy.rosenthal@ynhh.org'	
Carney, Brian	Delivered: 5/11/2016 5:14 PM
Lazarus, Steven	Delivered: 5/11/2016 5:14 PM
Riggott, Kaila	Delivered: 5/11/2016 5:14 PM
Hansted, Kevin	Delivered: 5/11/2016 5:14 PM
Martone, Kim	Delivered: 5/11/2016 5:14 PM
Olejarz, Barbara	Delivered: 5/11/2016 5:14 PM

Ms. Rosenthal,
Attached is the hearing notice for DN's 15-32032-CON and 15-32033-CON being held on June 15, 2016.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

May 11, 2016

Nancy Rosenthal
SVP, Strategy and Regulatory Planning
Yale-New Haven Health System
5 Perryridge Road
Greenwich, CT 06830

RE: Certificate of Need Application, Docket Number 15-32032-CON and 15-32033-CON

Docket Number: 15-32032-CON

Northeast Medical Group ("NMG") and L&M Physician Association ("L&MPA")
Transfer of Ownership of a Group Practice by Merger of L&MPA into NMG

Docket Number: 15-32033-CON

Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M")
Acquisition of L+M by YNHHSC

Dear Ms. Rosenthal,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Northeast Medical Group, Inc., L&M Physician Association, Inc., Yale New Haven Health Services Corporation and L&M Corporation ("Applicants") on April 29, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

NMG and L&MPA
YNHHSC and L+M

May 11, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc.
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Docket Number:	15-32033-CON
Proposal:	Acquisition of L+M by YNHHSC

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date:	June 15, 2016
Time:	3:00 p.m.
Place:	Connecticut College Blaustein Humanities Center, Building #8 Ernst Common Room (Corner of Cro Blvd/Chapel Way) 270 Mohegan Avenue New London, CT 06320

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Day* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

NMG and L&MPA
YNHHSC and L+M

May 11, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

May 11, 2016 P.O. #54772

The Day
47 Eugune O'Neil Drive
New London, CT 06320

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, May 13, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC;lmg

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

The Day May 11, 2016
Notice of Public Hearing, Docket Number 15-32032-CON and 15-32033-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc.
Town:	Stratford
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Town:	New London
Docket Number:	15-32033-CON
Proposal:	Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation
Date:	June 15, 2016
Time:	3:00 p.m.
Place:	Connecticut College Blaustein Humanities Center, Building #8 Ernst Common Room (Corner of Cro Blvd/Chapel Way) 270 Mohegan Avenue

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Wednesday, May 11, 2016 4:12 PM
To: Greer, Leslie
Subject: Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

Don't forget to ask for ideas to expand your diversity coverage.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wednesday, May 11, 2016 at 4:05 PM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 5/13. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Thursday, May 12, 2016 4:19 PM
To: Greer, Leslie
Subject: FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice
Attachments: 15-32032 and 15-32033 The Day.docx

Good afternoon,

This notice is set to publish tomorrow.
$483.18

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Wed, 11 May 2016 16:12:03 -0400
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wednesday, May 11, 2016 at 4:05 PM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 5/13. For billing purposes, please refer to P.O. 54772. In addition, when the “proof of publication” becomes available, please forward me a copy.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

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Customer Service: Monday-Friday 8:00AM - 4:30PM | class@theday.com | 1.860.701.4200

Public Notices

21034

City of New London
Connecticut
LEAD HAZARD REDUCTION PROGRAM
(L-HARP)
181 State Street
New London, CT 06320
(860) 447-5243

INVITATION FOR BIDS

The City of New London, through the Lead Hazard Reduction Program (L-HARP), will receive bids for residential lead abatement for:

63 Faire Harbour Place
&
32 South Ledyard Street
New London, CT 06320

63 Faire Harbour Place: Thursday, May 19, 2016 at 2:00 p.m.
Friday, May 20, 2016 at 9:00 a.m.

32 South Ledyard Street: Thursday, May 19, 2016 at 2:45 p.m.
Friday, May 20, 2016 at 9:45 a.m.

A site inspection is mandatory for all contractors planning to bid. Sealed bids will be accepted at 181 State Street, New London, Connecticut until:

63 Faire Harbour Place: 2:00 p.m. on Friday, May 27, 2016
32 South Ledyard Street: 2:05 p.m. on Friday, May 27, 2016

At which time all bids will be opened publicly. Only bids by pre-registered contractors will be accepted.

Documents pertaining to the scope of work and specifications may be obtained from the L-HARP Office at the above address, telephone (860) 437-6327. Addenda, if any, will be issued only to contractors who, by our records, have obtained the original specifications.

The City of New London hereby notifies all bidders that it will affirmatively insure that in any contract entered into pursuant to this advertisement, qualified Minority Business Enterprises will be afforded full opportunity to submit bids in response to this invitation and that they will not be discriminated against on the grounds of race, color, national origin, sex, mental retardation or physical disability including but not limited to blindness, in consideration for an award.

The City is an Equal Opportunity Employer and adheres to the practices of Fair Housing and Affirmative Action.

21024

Office of Health Care Access Public Hearings

Statute Reference: 19a-638

Applicant(s): Northeast Medical Group, Inc.
L&M Physician Association, In

Town: Stratford

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation
L&M Corporation

Town: New London

Docket Number: 15-32033-CON

Proposal: Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

Date: June 15, 2016

Time: 3:00 p.m.

Place: Connecticut College
Blaustein Humanities Center, Building #8
Ernst Common Room (Corner of Cro Blvd/Chapel Way)
270 Mohegan Avenue

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 10, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

20966

PLANNING AND ZONING COMMISSION
TOWN OF STONINGTON

NOTICE OF PUBLIC HEARING

Pursuant to the General Statutes of the State of Connecticut revision of 1958 and all amendments thereto, and pursuant to the Zoning Regulations for the Town of Stonington, Connecticut, the Planning and Zoning Commission hereby gives notice that it will hold a Public Hearing at the **Mystic Middle School**, 204 Mistuxet Ave., Mystic, CT, on **Tuesday, May 17, 2016 at 7:30** p.m. on the following application(s):

PZ1608SUP Goran & Desiree Subotic – Special Use Permit application to extend the current permitted hours of operation to Monday thru Saturday, 9:00 AM to 9:30PM, and Sunday, no later than 8:00 PM. Property located at 325 Mistuxet Ave., Mystic. Assessor's Map 133 Block 6 Lot 5B. Zone RA-40.

PZ1610SPA New Prospect, LLC (Dan Barber) –Site Plan application for the renewal of previously approved Site Plan Application for the development of a 38-unit attached housing project (Prospect Place). Properties located on Mechanic and Prospect Streets, Pawcatuck, CT. Assessor's Map 4, Block 18, Lot 3B & Map 4, Block 16, Lot 7. Zone NDD-1.

AT SUCH HEARING ANY PARTY MAY APPEAR IN PERSON OR BE REPRESENTED BY AN AGENT OR BY AN ATTORNEY.

Any disabled person requiring auxiliary aids or services for effective communication or access at this hearing should contact the Department of Planning at (860) 535-5095 ten days prior to the hearing date.

Dated at Stonington, Connecticut, this **3rd day of May, 2016.**

John Prue, Chairman

21037

Town of Waterford
Board of Selectmen
Invitation to Bid
Oversized Bulky Waste Disposal #16-123

The Purchasing Agent will accept sealed bids for **Oversized Bulky Waste Disposal** until 11:00 am on May31, 2016. Please see the Town of Waterford website at http://www.waterfordct.org for packets and all information regarding this Bid. Packets may also be picked up in the Purchasing Office. Any questions regarding this proposal are to be directed to the Purchasing Agent at krotella@waterfordct.org.
The Board of Selectmen reserves the right to reject any or all bids, in whole or in part, and to waive any informality in any bid when such action is deemed in the best interest of the Town; their decision is final.

Kate Rotella
Purchasing Agent

21008

PUBLIC AUCTION

Of abandoned mobile home located at
Yoselevsky's Mobile Home Park
8A Meetinghouse Lane, Montville, CT 06353

By Order of the Superior Court at Norwich
Docket # KNO -CV15-6100919-S
the undersigned has been authorized to sell the following property under terms and conditions hereinafter set forth:
PROPERTY: Ritz Craft Mobile Manufactured Home,
Model Number: CMDL 550
Serial Number: 0106867260
Year of Manufacturer: 1986
DATE OF SALE : Saturday, May 21, 2016
TIME OF SALE : 12 O'Clock-Noon
PLACE OF SALE : 8A Meetinghouse Lane, Montville, CT
INSPECTION : One half-hour before sale
DEPOSIT : 10% of accepted bid
(certified funds/bank draft or cash)
PURSUANT TO CONNECTICUT GENERAL STATUTES SECTION 21-80(e)(4), THE SALE OF THIS PROPERTY WILL EXTINGUISH ALL PREVIOUS OWNERSHIP AND LIEN RIGHTS
For further information, contact Attorney Narcy Z. Dubicki,
Attorney for MAY REALTY, LLC
Telephone Number-860-443-1864
Subject to other terms and conditions to be announced at the time of sale.

21025

TOWN OF WATERFORD
Representative Town Meeting
District 2
Notice of Vacancy & Special Election

Pursuant to Section 3.1.10 of the Charter of the Town of Waterford, Connecticut, notice is hereby given that a vacancy in the membership of the Waterford Representative Town Meeting from the Second Voting District has occurred by reason of the resignation of Theodore Olynciw. Said vacancy shall be filled for the term, ending December 4, 2017, at a Special Meeting of the representatives from the Second Voting District at 7:10 P.M., Monday, June 6, 2016, in the Office of the Town Clerk, 15 Rope Ferry Road.

Dated at Waterford, Connecticut, this 10th day of May, 2016.

David L. Campo
Waterford Town Clerk

20942

STATE OF CONNECTICUT
SUPERIOR COURT
Judicial District of NORWICH/ NEW LONDON
At: NEW LONDON
Docket Number: FKNLCV136016654S
Plaintiff's Name: **RBS Citizens, NA.**
V.
Defendant's Name: Rodriguez, Erik D Ct Al
Order Regarding:
04/06/2016 107.00 Motion for Order Of Notice
This foregoing, having been considered by the Court, is hereby:
Order: Granted
Notice to: ERIK D. Rodriguez and Leticia Mercado
The plaintiff has named you as a defendant in the complaint brought to the above named court seeking foreclosure of the mortgage on the property located at 24 BLOOMINGDALE ROAD, QUAKER HILL, CT 06365. This complaint was returnable to the above named court on 3/13/2013 and is now pending therein.
The court finds that the defendant (s)listed below has (have) not appeared in this action, and, so far as the plaintiff knows, has (have) not received actual notice of the institution or pendency of it; that so far as its known each resides at 3123 MESA VERDE DRIVE, APT. 2707, ORLANDO, FLORIDA 32837.
Now therefore, it is hereby ordered that further notice of the institution and pendency of this action be given to each such defendant by some proper officer (or person) causing a true and attested copy of this order to be published in ORLANDO SENTINEL AND THE NEW LONDON DAY once a week for 2 successive weeks, commencing on or before 6/2/2016 and then return of such service to made to this court.
Judicial Notice (JDNO) was sent regarding this order.
Order Number 419136
Judge: EMMET COSGROVE
ATTEST: A TRUE COPY
Joseph LoGioco, State Marshall

OS4156296 5/6, 5/13/2016

20941

Stonington Fire District

MEETING

All qualified voters of the Stonington Fire District are hereby warned that a meeting of said Fire District will be held on May 16, 2016 at 7.00PM at the Stonington Community Center, 28 Cutler Street, Stonington CT for the purpose of the following.

1. Call meeting to order.
2. Reading of the Secretary's minutes.
3. Reading of the Treasurers Report.
4. Reading of the Tax Collectors Report.
5. Election of Officers
6. Old Business
7. New business
8. Accept proposed budget
9. Other business brought before the voters
10. Adjournment

William B. McDonough
Secretary/Treasurer

21028

ZONING BOARD OF APPEALS
TOWN OF STONINGTON, CONNECTICUT
NOTICE OF DECISION

At the Regular Meeting of the Zoning Board of Appeals held on May 10, 2016 the following decisions were made:

ZBA #16-06 JBRV LLC (Robert Valenti) – Seeking a variance from ZR 7.12.7.1.2 to increase the allowed wall signage from 48.5 sq. ft. to 106 sq. ft. Property located at 72 Jerry Browne Rd., Mystic CT 06355. Assessor's Map 164 Block 2 Lot 3; Zone GC-60. **"FORD" SIGN APPROVED/"VALENTI" SIGN-DENIED.**

ZBA #16-07 Regis & Delphine Doyonnas – Seeking a variance from ZR 5.1.1 to reduce the 50' front yard setback to 25' to construct a deck and one story addition. Property located on 74 Wolf Neck Road, Stonington. Assessor's Map 139 Block 2 Lot 1; Zone RR-80. **APPROVED.**

Dated at Stonington, CT this 11th day of May, 2016

Bill Lyman, Acting Chairman

21029

Notice of Permit Application
Town: New London

Notice is hereby given that The Thames Shipyard & Repair Company will submit to the Department of Energy and Environmental Protection an application under Section(s) Section 22a-361 to conduct work in tidal coastal or navigable waters of the state. Specifically, the applicant proposes to conduct maintenance dredging at the North Pier and entrance channel to the facility. The proposed dredging is necessary to ensure ongoing operations of this existing water dependent use. The proposed activity will take place at 50 Farnsworth Street, New London and will potentially affect: coastal or aquatic resources and the Thames River. Interested persons may obtain copies of the application from Becky Meyer, Milone & MacBroom, Inc., 99 Realty Drive, Cheshire, CT 06410; (203) 271-1773. The application will be available for inspection at the Office of the Department of Energy and Environmental Protection, Office of Long Island Sound Programs, 79 Elm Street, Hartford, CT 06106- 5127 telephone 860-424-3034 from 8:30 to 4:30 Monday through Friday. Please call in advance to schedule review of the application.

21032

TOWN OF LEDYARD
INLAND WETLANDS & WATERCOURSE COMMISSION
NOTICE OF DECISIONS

On May 3, 2016 the Ledyard IWWC rendered decisions on the following applications:

IW 16-2: Ledyard Meadows Estates, LLC, 809 Colonel Ledyard Hwy for proposed 2-lot re-subdivision and construction of a multi-family residential apartment community. **APPROVED** with stipulations.

IW 16-5 AR: Mark Perkins, 576 Lantern Hill Rd.–As of Right determination for clearing property in the Upland Review Area for agricultural purposes. **APPROVED**

A copy of these applications and decisions is available in the Land Use Office, 741 Colonel Ledyard Hwy, Ledyard, CT (860) 464-3266. Any person aggrieved by these decisions may appeal to the Superior Court within 15 days of this notice.

21013

TOWN OF LEDYARD NOTICE OF DEMOCRATIC CAUCUS
To enrolled members of the Democratic Party of the Town of Ledyard, Connecticut. Pursuant to the Rules of the Democratic Party and State election laws, you are hereby notified that a caucus will be held on Thursday, May 19, 2016, at 7:00 P.M. at the Town Hall Annex, 741 Colonel Ledyard Highway, Ledyard, CT to endorse selection for Registrar of Voters and to transact other business as may be proper to come before said caucus. Dated at Ledyard, Connecticut, on May 11, 2016, by Ledyard Democratic Town Committee Chairperson,
Elizabeth Peterson.

20918

NOTICE OF PUBLIC SALE OF PERSONAL PROPERTY
Notice is hereby given that Extra Space Storage will sell at public auction, on May 19th, 2016 at 2:30 PM to satisfy the lien of the owner, personal property described below belonging to those individuals listed below at location indicated:
Extra Space Storage
215 Gold Star Hwy,
Groton, CT
860-446-2030

Unit 32 Gregory Moore
Unit 103 Briana Sullivan
Unit 175 Linda Loughborough
Unit 181 Stacy Foster
Unit 312 Ronald Adams
Unit 313 Monique Durham
Unit 399 Melissa Hewlitt
Unit 465 Gregory Moore
Unit 588 Daven Harmon
Contents of above units: Household Goods and Misc. Items.
The auction will be listed and advertised on www.storagetreasures.com. Purchases must be made with cash only and paid at the above referenced facility in order to complete the transaction. Extra Space Storage may refuse any bid and may rescind any purchase up until the winning bidder takes possession of the personal property.

21018

Wamphassuc Point Association
Notice of Annual Meeting

The ASSOCIATION will hold its annual meeting at the Stonington Community Center on Thursday, May 26, 2016 at 5:30 PM to conduct the following business:

1. Approval of treasurer's report and proposed budget for fire protection and administrative expenses.
2. Approval of tax levy to become due and payable on July 1, 2016.
3. Election of four officers and two directors.
4. Consideration of such other lawful business as may be brought before the meeting.

Dated at Stonington, CT this 4th day of May, 2016.

Charles Danis, President, by direction of the Board of Directors

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21022

TOWN OF GROTON
ZONING COMMISSION
NOTICE OF DECISIONS
The Town of Groton Zoning Commission, at its meeting on May 4, 2016 took the following action:
Special Permit #346, 0 Route 12, PIN 178018417370, NMDD Zone (Lighthouse Point LLC, Owner; A.R. Building Company, Inc., Applicant) –Approved with conditions
Special Permit #347, 24 West Main Street, PIN 261918412001, WDD Zone (State & Elizabeth Lawrence, Owner; Cheryl Robdau, Applicant) - Approved
Additional information concerning the above actions may be obtained from the Planning Department, 134 Groton Long Point Road. Dated this 13th day of May, 2016 at Groton, Connecticut.
Susan Sutherland, Chairperson

21030

TOWN OF GROTON
PLANNING COMMISSION
NOTICE OF DECISION
The Town of Groton Planning Commission, at its meeting on May 10, 2016 took the following action:
1. HOME Salon and Spa (SIT16-06), 1045-1047 Poquonnock Road -Approved with modifications
2. Drawbridge at 24, (CSP16-01), 24 West Main Street – Approved
Additional information concerning the above decision may be obtained from the Planning Department, 134 Groton Long Point Road. Dated this 13th day of May, 2016 at Groton, Connecticut.
James Sherrard, Chairman

General Help

INSURANCE CUSTOMER SERVICE REP
Griswold area, license preferred but not required.
Send resume to jayl@seagencies.com

FAIRE HARBOUR LANDINGS APARTMENT COMMUNITY
Is looking to Hire a
PAINTER
Seeking experienced and reliable Painter for apartments in Groton/ New London area. Valid driver's license & vehicle required. Must be able to do quality work. Must pass background checks & drug test. Benefits available.
Email Resumes to:
careers@landingsgroup.com
or Apply at:
11-O Anthony Road
New London, CT

True Value
Is looking to Hire!
CASHIER
(Full Time)
&
SALES ASSOCIATES
(Full/Part Time)
Housewares & Clothing/Pet Dept.
Friendly, outgoing, willing to work in a hardware store environment. Must be able to work Sundays. Exp preferred. FT Benefits Inc: 100% Employer Match 401K, Sick Time, Vacation, Medical Ins, Employee Discount.
Apply In Person
True Value
300 Flanders Rd.
East Lyme, CT 06333

The Captain Daniel Packer Inne
RESTAURANT & PUB
LINE COOKS, PREP & PANTRY & DISH POSITIONS
APPLY IN PERSON
Captain Daniel Packer Inne
32 Water St., Mystic

OCEAN BEACH PARK CT NEW LONDON
OCEAN BEACH PARK
Will be Hosting a
JOB FAIR
For Summer Employment
Sunday
May 15th., 2016
Noon to 2PM

Hotel / Restaurant / Food

SERVERS WANTED
Apply in person at
Groton Townhouse Rest,
355 Route 12, Groton, CT

SAYBROOK POINT INN · SPA · MARINA
NOW HIRING!
•HOUSEKEEPERS
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•HOSTESS
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•FRONT DESK
•MARINA STAFF
•CULINARY
•HOUSE PERSONS
(3rd Shift, $12 per hour/ Negotiable based on experience)
Apply online at:
www.saybrook.com
or stop by
2 Bridge St., Old Saybrook
860-395-2000

Announcements

Notes of Interest

CT SCRAP Will buy your scrap steel, copper & aluminum. 33 Pequot Rd Uncasville 860-848-3366

Automotive

Auto Parts & Accessories

1968 CORVETTE
Transmission Rebuilt
Muncie 4 Speed
Rally Wheel,
Derbi Caps & (2) 15x7 Rally Wheels
CALL 860-376-3305

Snow tires — New Firestone Winterforce, size 205/65-R15. 4/ $240. 860-443-6603

Automobiles

1993 LINCOLN TOWN CAR: Black, 89K, MINT Int, Needs Brakes, $3750 OBO Call 860-287-1929

2004 Toyota Tacoma Xtracab 40k HONEST mi; 2wd 4cyl 5spd stick; LineX; mint cond. $10k. 860-572-2928 —

Buick LeSabre 2004 — auto, air cond, 119k. Good condition. $2,350. 860-235-8147 or cell 860-625-9369

WE BUY
CARS, TRUCKS, & SUV'S
All Makes & Models. Ask For Pete Sabo At: Bob Valenti Auto Mall. 860-536-4931

Recreational Vehicles

Class A Itasca Sunova 33C, excellent condition, many options, 31,900 miles, desirable Floor plan, new tires, batteries. Can be seen in Mystic. **For Additional Info call 860-614-4837**

Trucks

2003 Dodge-4dr, 2500 series. Hemi, 127k, new paint/tires, brakes & recent tuneup. $6,500 OBO. 860-604-3316.

Wanted Automotive

ROSS RECYCLING
WILL BUY YOUR
Junk Cars, Trucks, Trailers
Pick Up is Available
Call 860-848-3366

Employment

Drivers

DRIVER'S WANTED!!
Seasonal Neighborhood Ice Cream Truck.
Weekdays & Weekends.
CALL 860-739-0532

General Help

CDL Class B Driver/ Groundman Position/Climber Allied Tree Experts
FT, CDL license required. Will train the right person.
860-572-7199

Marine/ Boats

Boats

Hard Bottom Inflatable Dinghy, Caribe 10X w/15HP, Mercury Outboard Motor, Like NEW! 860-444-7801 Jim

LOOK
TWO Bombadier Jet Skis — 2006's, 3- seaters, 255 hsp. New Batteries, Not base models, Bought New, Original owner, Stored inside, Always winterized, Low hours, Covers, New double trailer included. Well taken care of, in excellent condition, Asking 18,500.00 or BO, Call Greg @ 8603898362

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Old/Antique Oriental RUGS
In Almost Any Condition
Call 401-500-2758
BILL TREMBLAY
Carpet Cleaning Experts

Furniture

LOVE SEAT /RECLINERS
SOFA RECLINERS
Navy, 1 Year Old. Asking SOLD!!!

Household Goods

Lenox China (Somerset Set) Gold Rim — Made in USA, Service for 12 + extra pcs. $800 OBO. 860-442-7290

Weber 22" Kettle Charcoal Grill — Used 3 times. $40 860-443-6603

Weber Gas Grill — Spirit E-210, 2 burner, excellent condition, Inc. tank w/gas & cover $85. 860-691-0512.

Lawn / Garden Items

2007 CRAFTSMAN Garden Tractor: 20 HP, 46" Mower Deck, 3 Bagger. New Battery, 4900 Hours, Serviced Annually, $600 or B/O. Call 860-444-0233

ARBORVITAE SPRING SALE!
Dark Green, Emerald's, Green Giant, For Beautiful Privacy Borders, **FREE DELIVERY** & Planting! Start at $59
860-712-5359 cttrees.com

COW MANURE COMPOST $10 a Tractor Bucket. 9-11 on Sat. Chuck Hill Farm Rt-164, Preston. 860-949-2434

DWARF LILACS — LARGE POTS ALL POTTED IN BLOOM $10 860-464-8500

Lawn / Garden Items

PERENNIAL PLANTS — LARGE VARIETIES LOCALLY GROWN $4 EACH 860-464-8500

SEEDS — ANNUAL & PERENNIAL LG. ASST. UNUSUAL VARIETIES $.50 PER PACK 860-464-8500

SHRUBS — BOXWOOD 8" TALL - PRIVET HEDGE 15" TALL $10 EACH 860-464-8500

Musical Instruments

Baldwin piano — Console style.in good shape.great for beginners.$199.00 possible help w delivery

Other Miscellaneous

NASCAR TICKETS
2 Nascar Tickets
Dover Int. Speedway
5/15/16 @ 1:00
Start/Finish Line
Petty Section 100
Row 42
Seats 15 & 16
$225.00
Call 860-884-7339

NASCAR TICKETS
2 Nascar Tickets
Dover Int. Speedway
5/15/16 @ 1:00
Turn 2 Section 204
Ro 58, Seats 7 & 8
$150.00
Call 860-884-7339

Teac Reel to Reel Tape Recorder — Comes with all accessories & spare tapes. $200. 860-572-0281

Sporting Goods

Brunswick Pool Table — 4X8, Slate bed, comes with all accessories. $250. 860-572-0281

Stereo, TV, Radio

CD Player/5 Disc Changer — Technics SL-PD867. + Remote Manual & Wires. 1994/ Japan. $50. 860.535.0099

JBL Pro Computer/TV/Tablet Speakers — Complete w/All Cables & Power Cord. Excellent Cond. $20 860.917.6364

Toshiba DVD Player — SD-4100. Sleek Black Color. Slimline Design: 17"L x 8"D x 1.5"H. $15. 860.917.6364

Vintage Stereo Receiver — GE RA200A. 1975/Japan. Blue Analog. Wood Case. Excllent Cond. $100. 860.535.0099

Wanted to Buy

A AAKIN ANTIQUES
Cash for Coins, Gold, Silver, Watches, And All Jewelry, Dolls, Wind-up Toys, Anything Military, All Musical Instruments, Mic's, Speakers, Amps. Anything Old.
FREE HOUSE CALLS
860-445-4463 /860-235-7318

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ACQUIRING ALL Antiques, Vintage, Electronics, Audio, Musical Instruments, Ham Radios, Jewelry, Watches, Art, Toys, Military plus more. One item or entire estate. Cash Paid. Call 860-707-9350

CT SCRAP Will buy your scrap steel, copper & aluminum. 33 Pequot Rd Uncasville 860-848-3366

LOOK
WE BUY ANTIQUES
Cash paid for Antiques and quality used Furniture, Old Clocks, Paintings, Sterling Silver, Jewelry, Nautical & Military Items. **Call Gary at THE ANTIQUES DEPOT, For Free In House Appraisal. Call 860-388-3121**

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TO ADVERTISE YOUR GARAGE OR YARD SALE CALL 860.701.4200

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ESTATE SALE. Fri & Sat, 8-2, 41 Woodridge Circle
Large Home.
Mid century modern/Asian
www.wemakeitbetterct.com

GALES FERRY MOVING SALE! Everyday for rest of month. 150B Military Hwy. COME WHENEVER!!

GROTON — MULTI FAMILY, Sat, 9-3. 107 Morse Ave. Motorcycle parts, HH goods and more. ESTATE SALE,Sat 9-3, 120 Morse Ave. Some furn, clothing & HH.

GROTON: Sat, 9-2pm. 23 Nicholas Ave. Decor, Vintage-Antiques,Collectibles, Jewelry, Sea-Themed Stuff. Newer Clothes & More!

Hamburg Lyme — 3 Famlies, Estate Sale. 56 Sterling City Rd. Sat 5/14, 9-3pm. Rain date 5/15

Lyme — 6 Old Hamburg Rd. 5/14 - 5/15 Antiques, Furniture, Electronics, Sporting Goods, Home Goods, Tools, Toys, Games, Much More.

LYME: Rt.156 Congregational Church
ANNUAL SPRING RUMMAGE SALE
Sat. May 21st, 9am - 1pm.
Donations accepted between May 16th - 19th.
CALL 860-434-0220
For More Information

MYSTIC
ST. PATRICK ANNUAL YARD SALE & SILENT AUCTION
32 East Main St.
Fri. 5-7, Sat 9-2 & Sun 9:30-11:30pm.
Any Questions?
Call 860-941-9640

Mystic — Yard Sale: 15 Burrows St. Sat 5/14 - Sun 5/15 9-3 Furniture, Tools, Collectibles, Oil Lamps, Longaberger, Electronics, more!

LOOK
NEW LONDON OCEAN BEACH BOARDWALK
Sat. May 14th, 9AM - 3PM
(Rain Date: May 21st)
Tag/Craft Sale,
50/50 Raffle.
NO EARLY BIRDS!
More Info Call Marie
860-235-6987
After 2:30pm

Norwich — 49 Case St Sat May 14 8-1 Many antiques! Furniture, desks, beds, rugs, lamps, golf clubs, dishes

OAKDALE: 11 Velgouse Rd. (Off Raymond Hill Rd.) 6 FAMILY SALE!! 8am - 3pm TODAY!

Pawcatuck — Estate Sale, Sat 5/14, 8-3pm, 65 Courtland St. Whole house, great stuff. Loaded. Worth it!

Salem — 553 Hartford RD Sat. 05/14 9AM-12PM
jute box, antique love seat, 05 Johnson 25 HP,misc items

WATERFORD ESTATE SALE! Fri & Sat, May 13th & 14th. 9am - 2pm.
5 Trumbull Rd.
HH, Clothes, Collectibles, Garden, Books, Kid's, Toys, Books & Rocking Horse

WATERFORD HUGE SALE: Sat, 9-3pm. 211 Great Neck Rd. Antiques, Furn, HH, Tools, Garden, Toys, Fabric, Fishing, Books & More

Waterford — Multi Family Sat, 8-3pm, 59 Gallup Lane. Tools, original photographs. Great prices.

Waterford — Multi Family Sat only, 8-12pm, 9 Rock Ridge Drive (off of Cross-roads). Something for everyone. 11-noon fill a bag for $4

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, June 02, 2016 2:01 PM
To: 'nancy.rosenthal@ynhh.org'
Cc: Lazarus, Steven; 'Carney, Brian'; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Lawrence & Memorial Hospital Hearing Notice
Attachments: 32032 & 32033.pdf

Tracking:

Recipient	Delivery
'nancy.rosenthal@ynhh.org'	
Lazarus, Steven	Delivered: 6/2/2016 2:01 PM
'Carney, Brian'	Delivered: 6/2/2016 2:01 PM
Riggott, Kaila	Delivered: 6/2/2016 2:01 PM
Hansted, Kevin	Delivered: 6/2/2016 2:01 PM
Martone, Kim	Delivered: 6/2/2016 2:01 PM

Ms. Rosenthal,
Attached is the replacement hearing notice for Lawrence & Memorial Hospital being held on June 27, 2016.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

June 2, 2016

Nancy Rosenthal
SVP, Strategy and Regulatory Planning
Yale-New Haven Health System
5 Perryridge Road
Greenwich, CT 06830

RE: Certificate of Need Application, Docket Number 15-32032-CON and 15-32033-CON
Docket Number: 15-32032-CON
Northeast Medical Group ("NMG") and L&M Physician Association ("L&MPA")
Transfer of Ownership of a Group Practice by Merger of L&MPA into NMG
Docket Number: 15-32033-CON
Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M")
Acquisition of L+M by YNHHSC

Dear Ms. Rosenthal,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Northeast Medical Group, Inc., L&M Physician Association, Inc., Yale New Haven Health Services Corporation and L&M Corporation ("Applicants") on April 29, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

NMG and L&MPA
YNHHSC and L+M

June 2, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc.
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Docket Number:	15-32033-CON
Proposal:	Acquisition of L+M by YNHHSC

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date:	June 27, 2016
Time:	3:00 p.m.
Place:	New London High School (Auditorium) 490 Jefferson Avenue New London, CT 06320

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Day* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

NMG and L&MPA
YNHHSC and L+M

June 2, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kentfield, Department of Public Health
Chris Stan, Department of Public Health
DeVaughn Ward, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

June 2, 2016 P.O. #54772

The Day
47 Eugune O'Neil Drive
New London, CT 06320

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, June 3, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC;lmg

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

The Day
Notice of Public Hearing, Docket Number 15-32032-CON and 15-32033-CON

June 2, 2016

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc.
Town:	Stratford
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Town:	New London
Docket Number:	15-32033-CON
Proposal:	Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation
Date:	June 27, 2016
Time:	3:00 p.m.
Place:	New London High School 490 Jefferson Avenue New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 22, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Thursday, June 02, 2016 11:48 AM
To: Greer, Leslie
Subject: Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Good day!

Thanks so much for your ad request.
We will be in touch shortly and look forward to serving you.

Remember to ask about diversity options when you receive your quote. Remember, "Quotes are Free". You only pay for the placements you approve.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Thursday, June 2, 2016 at 11:29 AM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/3/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Thursday, June 02, 2016 4:47 PM
To: Greer, Leslie
Subject: FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice
Attachments: 15-32032 and 15-32033 The Day REVISED.docx

Good afternoon,

This notice is set to publish tomorrow.
$453.51

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Thu, 2 Jun 2016 11:47:34 -0400
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Thursday, June 2, 2016 at 11:29 AM
To: Ads Desk <ads@graystoneadv.com>
Subject: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/3/16. For billing purposes, please refer to P.O. 54772. In addition, when the “proof of publication” becomes available, please forward me a copy.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

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Public Notices | Public Notices | Public Notices

21327

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc
Town:	Stratford
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Town:	New London
Docket Number:	15-32033-CON
Proposal:	Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation
Date:	July 11, 2016
Time:	3:00 p.m.
Place:	Holiday Inn New London – Mystic Area 35 Governor Winthrop Boulevard – Ballroom New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 6, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

21324

TOWN OF GROTON

WATER POLLUTION CONTROL AUTHORITY

Sanitary Sewer Use Rate Schedule

2016/2017

The Town of Groton Water Pollution Control Authority hereby adopts the following revised Sanitary Sewer Use Rate Schedule:

A. For FYE17 commencing July 1, 2016 the residential use charge shall be $30.50 per month for each residential dwelling unit which charge shall be paid quarterly to the Town of Groton Water Pollution Control Authority. This represents an increase of $1.50 over the current FYE16 rate of $29.00 per month for each residential dwelling unit.

B. For FYE17 commencing July 1, 2016 the industrial and commercial rate shall be $0.0486 per cubic foot or water consumed for each industrial or commercial user, provided no industrial or commercial user shall pay less than $30.50 per month, which charge shall be paid monthly to the Town of Groton Water Pollution Control Authority. This represents an increase of $over the current FYE16 rate of $0.0462 per cubic foot.

C. The above rates shall apply to all users of Town sanitary sewer service within the Town of Groton, Connecticut.

D. All previous rate schedules in force at the time of the adoption of the within schedule are hereby superseded as of June 30, 2016.

DATED at Groton, Connecticut this 21st day of June, 2016.

David Williams
Chairman
TOWN OF GROTON
WATER POLLUTION CONTROL AUTHORITY

21321

TOWN OF SALEM
ATTENTION SALEM TAXPAYERS
FIRST INSTALLEMENT NOTICE

Notice is hereby given to the taxpayers of the Town of Salem that I have a warrant to collect a tax of 31.7 mills on a dollar on the levy of October 1, 2015 which is due and payable as follows:

1) Real Estate and Personal Property bills over$100.00 may be paid in full, or in two equal installments: first installment due on July 1, 2016 and the second installment on January 1, 2017.
2) Real Estate and Personal Property tax bills under $100.00 are due in full on July 1, 2016.
3) Motor Vehicle taxes are due in full July 1, 2016, regardless of the amount.

You have one month from the due date to pay taxes/installment without interest or penalty. Failure to make payment within the prescribed time will invoke a penalty of 1 1/2 % per month (18% per year) with a $2.00 minimum on each tax bill.

Taxpayers who do not have a bill for the Oct. 1, 2015 list should contact the Salem Tax Collector's office for a duplicate bill. **CT State Statute 12-130 Failure to receive a bill does not invalidate the taxes or respective penalties should the account become delinquent.**

Taxes may be paid at the Salem Town Office building with cash or check Monday thru Thursday from 8:00 a.m. to 5:00 p.m. (Thursday from 8:00 a.m. to 6:00 p.m. for the months of July and January only.) **The town hall is closed on Friday. Payment can also be made online unsing a checking account,credit or debit card at Salemct.gov.**

Dated at Salem Connecticut the 24th day of June 2015.

Cheryl A. Philopena C.C.M.C.
Tax Collector
Town of Salem

21185

TOWN OF MONTVILLE
ZONING BOARD OF APPEALS
NOTICE OF PUBLIC HEARING

The Montville Zoning Board of Appeals will hold a regular meeting and public hearing on Wednesday, July 6, 2016 commencing at 7:00 p.m. in Council Chambers at Montville Town Hall for the following application: **#216ZBA02-189 Connecticut Blvd (M92 L186), Oakdale, CT-Roseanne C. Marks for variance of Zoning Regulations Sections 9.6 (R-20 Min. Side Yard Setback) to construct a detached garage 5.26' from the north side boundary line.**
John R. MacNeil, Chairman
Montville Zoning Board of Appeals

21333

TOWN OF GROTON
ZONING BOARD OF APPEALS
NOTICE OF DECISION

The Town of Groton Zoning Board of Appeals, at its meeting on June 22, 2016, took the following action:
ZBA#16-07 - 49 Watrous Avenue, Brian Barbour/ Owner for a variance to Section 5.2 to allow a 29 foot front yard setback in lieu of the required 50 feet. PIN#270014435910, RU-40 Zone – Approved with modifications
Additional information concerning the above decision may be obtained from the Planning Department, 134 Groton Long Point Road. Dated this 24th day of June, 2016, at Groton, Connecticut.
Ed Stebbins, Chairman

Public Notices | Public Notices | Public Notices

21325

DECISION NOTICE

PLANNING AND ZONING COMMISSION
TOWN OF STONINGTON, CONNECTICUT 06378

Pursuant to the Connecticut General Statutes and the Subdivision and Zoning Regulations of the Town of Stonington, revision of 1958 and all amendments thereto, the Planning and Zoning Commission at their regular meeting held on June 21, 2016, at Mystic Middle School, 204 Mistuxet Avenue, Mystic, CT, voted on the following application(s) as indicated:

PZ1613BR Denison Pequotsepos Nature Center – Bond Reduction/Release application for release of a $25,078.30 Erosion and Sedimentation control bond posted to satisfy requirements of approved Special Use Permit application PZ1418SUP & CAM. Property located at 162 Greenmanville Ave., Mystic. Assessor's Map 172 Block 2 Lot 5. Zones RM-15 & RA-40. **Approved.**

PZ1608SUP Goran & Desiree Subotic – Special Use Permit application to extend the current permitted hours of operation to Monday thru Saturday, 9:00 AM to 9:30PM, and Sunday, no later than 8:00 PM. Property located at 325 Mistuxet Ave., Mystic. Assessor's Map 133 Block 6 Lot 5B. Zone RA-40. **Approved with Stipulations.**

PZ1611RA Suzanne R. Moore – Regulation Amendment to ZR Section 4.3.4 Buffer Requirements to change the buffer requirements in the LS-5 Zone to fifteen (15) feet of screening for a commercial use adjoining a residential zone, and eliminating the screening requirements of ZR Sections 4.3.4.2 and 4.3.4.3. **Denied.**

PZ1614SUP McQuade's Mystic, LLC (S & K Wilson) – Special Use Permit application for a recreational facility (escape room adventure), in an existing multi tenant building. Property located at 14 Clara Drive, Mystic. Assessor's Map 164 Block 4 Lot 3. Zone TC-80. **Approved.**

Dated at Stonington, Connecticut, this **22nd day of June, 2016**

David Rathbun, Acting Chairman

21226

TOWN OF STONINGTON & FIRE DISTRICTS, ASSOCIATIONS & BOROUGHS
STONINGTON, MYSTIC, QUIAMBAUG, OLD MYSTIC, LORDS POINT, WAMPHASSUC PT & STONINGTON BOROUGH
OFFICE OF THE TAX COLLECTOR
LEVY OF 2015

All property owners in the Town of Stonington & Fire Districts, Associations & Boroughs are hereby notified that taxes on land, buildings, personal property and motor vehicle taxes where applicable, are due and payable July 1 through August 1, 2016. Taxes not paid within one month of due date will be delinquent and subject to 1-1/2 % interest per month from original date due, e.g., if paid on August 2, 2016 there will be a 3% charge. Minimum interest is $2 per tax bill. (Sec. 12-146 of the Connecticut General Statutes)

COLLECTIONS - STONINGTON TOWN HALL
152 Elm St., Stonington
8:30 am to 4:00 pm – Monday thru Friday

Linda Camelio
Stonington Tax Collector

21326

THE UNIVERSITY OF CONNECTICUT
REQUEST FOR STATEMENTS OF QUALIFICATIONS
FOR
TRADE LABOR CONTRACTOR FOR ACADEMIC RENOVATIONS
PROJECT NUMBER 060116JP

RELEASED June 24, 2016
PROPOSALS DUE: July 21, 2016 by 2:00 PM

THE UNIVERSITY OF CONNECTICUT IS AUTHORIZED TO SOLICIT EXPERIENCED GENERAL CONTRACTING FIRMS TO PROVIDE TRADE LABOR SERVICES FOR ACADEMIC RENOVATIONS ON THE STORRS AND REGIONAL CAMPUSES.

TO FIND OUT MORE ABOUT THIS RFP AND THE REQUIREMENTS FOR SUBMISSION, PLEASE VISIT OUR WEBSITE; http://cpca.uconn.edu; OR www.das.ct.gov//cr1.aspx?page=12

21264

Town of Groton,
Fire Districts, Subdivisions and Special Tax Districts
located in the Town of Groton
Tax Collector's Notice of Taxes Due

All property owners in the Town of Groton are hereby notified that taxes on land, buildings, and personal property including motor vehicles will be due and payable July 1, 2016, based on the Town of Groton abstract of October 1, 2015.
The Town of Groton and the Groton Sewer District real estate and personal property tax bills over $100 may be paid in full or in two installments. The first installment will become due July 1, 2016. The second installment will become due January 1, 2017. Real estate and personal property taxes under $100, motor vehicle taxes, and all other fire district/political subdivision taxes will become due in full July 1, 2016.
These taxes shall be payable without penalty on or before August 1, 2016. All taxes paid after that date will become delinquent and due immediately and subject to interest at the rate of one and one-half percent (1.5%) per month or fraction thereof from the due date. **Failure to send out or receive any such bill or statement shall not invalidate the tax or interest.**

PAYABLE AT:
GROTON TOWN HALL, TAX DIVISION
45 FORT HILL ROAD, GROTON, CT
8:30 AM TO 4:30 PM MONDAY – FRIDAY
For other payment options and information, visit the town website at www.groton-ct.gov.

Cynthia L. Small, CCMC, Tax Collector

Public Notices | Public Notices

21319

TAX COLLECTOR'S NOTICE
TOWN OF LEDYARD

All persons liable to pay property taxes in the Town of Ledyard on the October 1, 2015 Grand List are hereby notified that any Real Estate or Personal Property Tax of 100.00 dollars and under is due and payable in full on July 01, 2016. If the tax is more than 100.00 dollars, it may be paid in two installments. The first installment is due and payable July 01, 2016, and the second installment is due and payable on January 01, 2017. All Motor Vehicle Taxes are due and payable in full on July 01, 2016.

If payment is not made by August 1, 2016, the amount due will become delinquent and subject to interest at the rate of eighteen per annum (one and one-half percent per month) from July 1, 2016. The minimum interest is 2.00 dollars. Failure to receive a tax bill does not invalidate the taxes or the interest that accrues.

For collecting said tax, the Tax Collector will maintain the following office hours in the Town Hall:

Monday - Friday 8:30 A.M. to 4:00 P.M.

Current taxes may also be paid at the Dime Savings Bank – Ledyard branch, during the month of July.

Joan L. Carroll, CCMC
Tax Collector

21236

TOWN OF GROTON
ZONING COMMISSION
NOTICE OF PUBLIC HEARING

Notice is hereby given that the following public hearing will be held on July 6, 2016 at 6:30 p.m. in Community Room 2, Town Hall Annex, 134 Groton Long Point Road, in said Town, to consider the following:
Special Permit #349, 10 Water Street, PIN 261918306539, WDD Zone. Proposal is to convert 750 square feet of retail to a standard restaurant with up to 200 square feet of seating area. Review is per Sections 6.3 and 8.3 of the Zoning Regulations. (The Mystic Group at Mystic LLC, Owner; Melody Pere, Applicant)
Application is on file and available for public inspection during normal business hours at the Planning Department, 134 Groton Long Point Road. Dated this 24th day of June 2016 at Groton, Connecticut.
Susan Sutherland, Chairperson

21228

TOWN OF GROTON
PLANNING COMMISSION
NOTICE OF PUBLIC HEARING

Notice is hereby given that a public hearing, at which parties of interest and citizens will have an opportunity to be heard, will be held on June 29, 2016 at 6:30 p.m. in Community Room 1, Town Hall Annex, 134 Groton Long Point Road, in said Town, to consider the draft 2016 Groton Plan of Conservation and Development. A copy of the plan is on file and available at the office of the Town Clerk, Town of Groton, for public inspection. Copies are also available on the Town's Website and in the Office of Planning and Development Services.
For more information, contact the Office of Planning and Development Services at 860- 446-5970. Dated this 24th day of June, 2016 at Groton, Connecticut.
James Sherrard, Chairman

Automotive

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2005 Chevrolet SSR Convertible Pickup — Only 14,500 miles, 395 HP engine, rare six-speed in mint condition. Loaded with options. $29,995. 860-516-4358

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Hyundai XG350 2004 Sedan — 71K One owner Excellent $4700 860-739-7512

Toyota RAV4 — 2.0L L4 Engine, no accidents or damages, 82K miles, runs very good.$3300 Please call me at 2489528138

WE BUY CARS, TRUCKS, & SUV'S All Makes & Models. Ask For Pete Sabo At: Bob Valenti Auto Mall. 860-536-4931

Motorcycles / Dirtbikes

1976 BMW Classic 900 CC — $3,200. 860-912-7706. In Mystic

Sport Utility Vehicles

2001 Jeep Wrangler Sport — 6 Cly, 5spd, hard top, lifted, many extras, good cond. $7,800. OBO 860-428-5400

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Announcements

Notes of Interest

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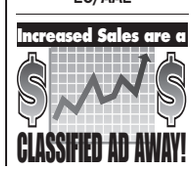

Employment

Drivers

Financial / Accounting

Accountant
Construction background. Steel fabricator and erector. Job costing and work in progress. Internal monthly statements, cash flow projections. Able to do union payrolls, Timberline / Excel / Fabtrol for shop fabrication. Excellent opportunity for aggressive and willing to work person. Excellent salary.
info@capcoerectors.com

General Help

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Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, June 14, 2016 9:31 AM
To: Nancy Rosenthal (Nancy.Rosenthal@greenwichhospital.org)
Cc: Carney, Brian; Riggott, Kaila; Ciesones, Ron; Greer, Leslie
Subject: Emailing - 15-32032 & 15-32033 Request for Prefile and Issues.pdf
Attachments: 15-32032 & 15-32033 Reqeust for Prefile and Issues.pdf

Good Morning Nancy,

Please see the attached Request for Prefile Testimony and Issues in the upcoming combined hearing in the above referenced matter on June 27th. If you have any questions regarding the correspondence, please feel free to contact Brian Carney (brian.carney@ct.gov) or me directly.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

June 14, 2016

Via Email Only

Nancy Rosenthal
Senior Vice President, Strategy and Regulatory Planning
Yale-New Haven Health Services Corporation
5 Perryridge Road
Greenwich, CT 06360

RE: Certificate of Need Application, Docket Numbers 15-32032-CON and 15-32033
Transfer of Ownership of Group Practice by merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc. and Transfer of ownership of L+M Corporation to Yale New Haven Health Services Corporation
Request for Prefile Testimony and Issues for Combined Public Hearings

Dear Ms. Rosenthal,

The Office of Health Care Access ("OHCA") will hold a public hearing on the above docket numbers on June 27, 2016. The hearing is at 3:00 p.m. at New London High School – Auditorium, 490 Jefferson Avenue, New London, Connecticut. Pursuant to the Regulations of Connecticut State Agencies § 19a-9-29(e), any party or other participant is required to prefile in written form all substantive, technical, or expert testimony that it proposes to offer at the hearing. Yale-New Haven Hospital ("Applicant") submit prefiled testimony by 4:00 p.m. on **June 22, 2016**.

All persons providing prefiled testimony must be present at the public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing. If you are unable to meet the specified time for filing the prefiled testimony you must request a time extension in writing, detailing the reasons for not being able to meet the specified deadline.

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Additionally, please find attached OHCA's Issues. Please respond to the attached Issues in writing to OHCA by 4:00 p.m. on **June 22, 2016**.

Please contact Brian Carney or me at (860) 418-7001 if you have any questions concerning this request.

Sincerely,

Kevin T. Hansted
Hearing Officer

Attachment

Office of Health Care Access

Public Hearing Issues

Docket Number: 15-32032-CON: Transfer of Ownership of Group Practice by merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.; and

Docket Number: 15-32033-CON: Transfer of ownership of L+M Corporation ("L+M") to Yale New Haven Health Services Corporation ("YNHHSC")

The Applicants should be prepared to present and discuss supporting evidence on the following issues:

- The clear public need for the proposal.
- The effect of the proposed transfer of ownership on the residents of the region with respect to health care services, including how access to services (including specialty care) will be maintained or improved in the area following the acquisition.
- Describe the benefits achieved in the Bridgeport/Greenwich Hospital service areas following the YNHHSC affiliation, in terms of financial stability or enhanced programs or services.
- Please describe how successful the CHNA implementation plan has been in addressing priority health issues in L+M's service area.
- How will the proposal affect community health improvement spending (community benefits) and community building activities in L+M's service area?

Greer, Leslie

From: Martone, Kim
Sent: Friday, June 17, 2016 1:14 PM
To: Riggott, Kaila; Lazarus, Steven; Carney, Brian; Ciesones, Ron
Cc: Greer, Leslie
Subject: FW: CON Application Dockets 15-32032 and 15-32033
Attachments: 2016 0617 CON APP DOCKET #15-32032 FROM DISTRICT 1199.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Deborah Chernoff [mailto:dchernoff@seiu1199ne.org]
Sent: Friday, June 17, 2016 12:55 PM
To: Martone, Kim; Hansted, Kevin
Subject: CON Application Dockets 15-32032 and 15-32033

Attached please find District 1199's petition for Intervenor status in the above-cited CON applications. Hard copy to follow by mail.

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.

- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

Community Accountability and Monitoring:

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local' boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
    - Members of the Governor's Health Care Cabinet
    - Members of the Governor's Certificate of Need Review Task Force, and;
    - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.[8] . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

CONNECTICUT CITIZEN ACTION GROUP

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programing directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

UNITE HERE CONNECTICUT

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make $12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

CONNECTICUT HEALTH POLICY PROJECT

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients Of those, more than 1,000 health care workers live in Lawrence and Memorial's Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

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Public Notices

21195

TOWN OF SALEM, CONNECTICUT
PATH COMMITTEE SALEM MULTI-USE PATH CROSSING NO. 3

INVITATION TO BID

Sealed Bids for **Path Committee Salem Multi-Use Path Crossing No. 3** will be received by the Town of Salem at the Issuing Office until **2:00 PM** local time on **June 23, 2016** at which time the Bids received will be publicly opened and read aloud. **The Project consists of the preparation of the approach trail and cast in place concrete substructure for the Town to later install a fiberglass pedestrian superstructure.**

Bids will be received for a single prime Contract. Bids shall be on a lump sum and unit price basis as indicated in the Bid Form.

The Issuing Office is the **Office of the Town Clerk, Salem Town Hall, 270 Hartford Road, Salem, Connecticut 06420-3809.** Prospective Bidders may examine the Bidding Documents at the Issuing Office during normal business hours.

Printed copies of the Bidding Documents may be obtained from the Issuing Office upon payment of a **$100** non-refundable fee for each set. PDF copies are available upon request after the receipt of the non-refundable fee. Checks shall be payable to **"Town of Salem"**. There will be an additional $10 charge if Bidding Documents are mailed. To receive the documents via package services, send a completed pre-paid pickup label from either UPS or FEDEX to the Issuing Office.

The date that the Bidding Documents are transmitted by the Issuing Office will be considered the Bidder's date of receipt of the Bidding Documents. Partial sets of Bidding Documents will not be available from the Issuing Office. Neither Owner nor Engineer will be responsible for full or partial sets of Bidding Documents, including Addenda if any, obtained from sources other than the Issuing Office.

A pre-bid conference will be held at **2:00 PM** local time on **June 13, 2016 at Salem Town Hall, 270 Hartford Road, Salem, Connecticut 06420-3809.** Attendance at the pre-bid conference is encouraged but is not mandatory.

Bids must be accompanied by a Bid Bond or a certified check in the amount of five percent of the Bid.

The successful Bidder will be required to provide Performance and Payment Bonds each in the amount of one hundred percent of the Contract Price.

The Contract Documents require affirmative action of the Contractor and any subcontractors to ensure equal employment opportunity as noted in Governor's Executive Orders 3 and 17.

The Owner is exempt from payment of Sales and Use Taxes on all materials and equipment to be permanently incorporated in the Work. These taxes shall not be included in the Bid.

Unless provided for by the Instructions to Bidders, no Bid may be withdrawn until sixty (60) days after the Bid Opening. The Town reserves the right to: reject any or all Bids; make extensions to review Bids; waive informalities or defects in Bids; and accept the Bid that, in the Town's judgment, will be in its best interests.

Owner: Town of Salem, Connecticut
Date: **June 1, 2016**
+ + END OF INVITATION TO BID + +

21200

Notice of Tentative Determination to Approve a Point Source New Source Review Permit Application

Applicant: Thames Shipyard & Repair Company
Application Nos: 200801207 & 200801208
City/Town: New London, CT

The Commissioner of the Department of Energy and Environmental Protection (DEEP) hereby gives notice that a tentative determination has been reached to approve the following applications. The proposed activity will affect air resources. The Commissioner also gives notice that a hearing may be held on this application if the Commissioner determines that the public interest will best be served thereby, and shall hold a hearing as provided below.

Applicant's Name and Address:	Thames Shipyard & Repair Company, 2 Ferry Street, New London, CT 06320
Contact Name/Phone/Email:	Mr. Adam Wronowski, 860-442-5349, adam@longislandferry.com
Type of Permit:	New Source Review permits for Two Floating Dry Docks
Relevant Statute(s)/Regulation:	CGS 22a-174, Clean Air Act Amendments of 1990
Facility Location:	50 Farnsworth Street, New London, CT 06320

INFORMATION REQUESTS/PUBLIC COMMENT
Interested persons may obtain copies of the application from the applicant at the above address. The application, proposed permits and supporting documentation are available for inspection at DEEP, Bureau of Air Management, 79 Elm Street, 5th floor, Hartford, CT from 8:30 AM to 4:30 PM Monday through Friday and at other times by appointment. All interested persons are invited to express their views on the tentative determination concerning this application in accordance with Sections 22a-3a-5(b) and 22a-174-2a(c) of the Regulations of Connecticut State Agencies. Written comments or a request for a public hearing on the application should be directed to Ms. Valerie Galo, Bureau of Air Management, DEEP, 79 Elm Street, Hartford, CT 06106-5127, no later than 30 days from the publication date of this notice. Comments regarding this application may be submitted via electronic mail to: valerie.galo@ct.gov.

PETITIONS FOR HEARING
Petitions for a hearing should include the application numbers noted above and also identify a contact person to receive notifications. Petitions may also identify a person who is authorized to engage in discussions regarding the application and, if resolution is reached, withdraw the petition. Original petitions must be mailed or delivered within the comment period noted above to: DEEP Office of Adjudications, 79 Elm Street, 3rd floor, Hartford, 06106-5127. Petitions cannot be sent by fax or email. For additional information go to www.ct.gov/deep/adjudications.

ADA PUBLICATION STATEMENT
The Department of Energy and Environmental Protection is an Affirmative Action and Equal Opportunity Employer that is committed to the requirements of the Americans with Disabilities Act. To request an accommodation, call 860-424-3194, or deep.hrmed@ct.gov.

21199

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc.
Town:	Stratford
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Town:	New London
Docket Number:	15-32033-CON
Proposal:	Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation
Date:	June 27, 2016
Time:	3:00 p.m.
Place:	New London High School 490 Jefferson Avenue New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than June 22, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone 860-418-7001.

21080

PLANNING AND ZONING COMMISSION
TOWN OF STONINGTON
NOTICE OF PUBLIC HEARING

Pursuant to the General Statutes of the State of Connecticut revision of 1958 and all amendments thereto, and pursuant to the Zoning Regulations for the Town of Stonington, Connecticut, the Planning and Zoning Commission hereby gives notice that it will hold a Public Hearing at the Mystic Middle School, 204 Mistuxet Ave., Mystic, CT, on **Tuesday, June 7, 2016 at 7:30 p.m.** on the following application(s):

PZ1604SUP 30 Extrusion, LLC (Carl Bardy, Jr.) – Special Use Permit application for the construction of a 28,700± square foot mini-warehouse storage facility consisting of 5 one-story buildings (5th building likely build in second phase), and associated parking, landscaping, and drainage. Property located at 30 Extrusion Dr., Pawcatuck. Assessor's Map 36 Block 4 Lot 2E.

PZ1609RA Andrew Halsey – Regulation Amendment to ZR Section 7.2 Groundwater Protection Overlay District (GPOD) to add conditional uses (Assembly Woodworking) in the GC-60 Zoning District.

AT SUCH HEARING ANY PARTY MAY APPEAR IN PERSON OR BE REPRESENTED BY AN AGENT OR BY AN ATTORNEY.

Any disabled person requiring auxiliary aids or services for effective communication or access at this hearing should contact the Department of Planning at (860) 535-5095 ten days prior to the hearing date.

Dated at Stonington, Connecticut, this **17th day of May, 2016.**

John Prue, Chairman

21121

TOWN OF GROTON
ZONING BOARD OF APPEALS
NOTICE OF PUBLIC HEARING

The Zoning Board of Appeals will hold a public hearing on Wednesday, June 8, 2016 at 7:00 p.m. in Community Room 1, Town Hall Annex, 134 Groton Long Point Road, to hear the following:
ZBA#16-07 – 49 Watrous Avenue, Brian Barbour/Owner for a variance to Section 5.2 to allow a 29 foot front yard setback in lieu of the required 50 feet. PIN#270014435910, RU-40 Zone
Applications are on file and available for public inspection during normal business hours at the Planning Department, 134 Groton Long Point Road, Groton, CT. Dated this 3rd day of June, 2016 at Groton, CT.
Ed Stebbins, Chairman

21172

NOTICE OF PUBLIC SALE OF PERSONAL PROPERTY

Notice is hereby given that Extra Space Storage will sell at public auction, on June 16th, 2016 at 2:30 PM to satisfy the lien of the owner, personal property described below belonging to those individuals listed below at location indicated:
Extra Space Storage
215 Gold Star Hwy,
Groton, CT
860-446-2030
Unit 142 James Horwath
Unit 164 Kellee Holmes
Unit 176 Ebony Haney
Unit 211 Lisa Stanhope
Unit 233 Jasmine Wright
Unit 234 Richard Koester
Unit 282 Misty Gove
Unit 331 Monique Durham
Unit 547 Marian Riley
Unit 569 Yeo Seon Paparella
Contents of above units: Household Goods and Misc. Items.
The auction will be listed and advertised on www.storagetreasures.com. Purchases must be made with cash only and paid at the above referenced facility in order to complete the transaction. Extra Space Storage may refuse any bid and may rescind any purchase up until the winning bidder takes possession of the personal property.

21138

LIQUOR PERMIT

Notice of Application

This is to give notice that I,
EDUARDO MARTONE
350 BROWNSTONE RDG
MERIDEN, CT 06451-3624

Have filed an application placarded 05/27/2016 with the Department of Consumer Protection for a RESTAURANT WINE & BEER PERMIT for the sale of alcoholic liquor on the premises at
11 E PATTAGANSETT RD
NIANTIC CT 06357-2311

The business will be owned by CASTELLO PIZZA & MARKET LLC
Entertainment will consist of: Acoustics (Not Amplified) Disc Jockeys Karaoke Live Bands Comedians

Objections must be filed by:
07/07/2016

EDUARDO MARTONE

P21196
COURT OF PROBATE, District of New London. NOTICE TO CREDITORS. ESTATE OF **Henry Harry Tessman, Jr. (16-00250)** The Hon. Mathew H. Greene, Judge of the Court of Probate, New London Probate District, by decree dated May 26, 2016, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Pamela M. Rowe, Clerk. The fiduciary is:
Jonathan N. Tessman,
180R Rope Ferry Rd.
Waterford, CT 06385

21186

TOWN OF STONINGTON
Board of Selectmen
Notice of Public Hearing

Notice is hereby given that the Board of Selectmen of the Town of Stonington will conduct a Public Hearing for the Town of Stonington on June 8, 2016 at 7:00 p.m. at the Stonington Police Department to discuss the 2016 Neighborhood Assistance Act Tax Credit Applications.

At this hearing, interested persons may appear and be heard and written communications will be received. If unable to attend, please forward written communications to the Board of Selectmen, 152 Elm Street, Stonington, CT 06378 by June 7, 2016.

Dated at Stonington, Connecticut this 1st day of day of June, 2016.

/s/_____
Robert R. "Rob" Simmons
First Selectmam

21201

TOWN OF EAST LYME
NOTICE OF PUBLIC AUCTION

The Town of East Lyme will auction all property possessions resulting in an eviction at the following address: Kristin M. O'Shaughnessy and Heather LeClaire AKA Jane Doe 1 of 81 East Pattagansett Road, Unit 42, East Lyme, CT. Auction will take place on June 10, 2016 at 10:00 a.m. at Rent a space at 9 King Arthur Drive, Niantic, CT.

21145

LIQUOR PERMIT

Notice of Application

This is to give notice that I,
LORENZO A MEJIA
62 FULLER ST
NEW LONDON, CT 06320-2728

Have filed an application placarded 04/20/2016 with the Department of Consumer Protection for a RESTAURANT WINE & BEER PERMIT for the sale of alcoholic liquor on the premises at
725 COLONEL LEDYARD HWY
LEDYARD CT 06339-1511

The business will be owned by: MEJIA LLC
Entertainment will consist of: None None None None None None None

Objections must be filed by: 06/01/2016

LORENZO A MEJIA

P21197
COURT OF PROBATE, Niantic Regional Probate District. NOTICE TO CREDITORS. ESTATE OF **Ralph Charles Lanzetti, (16-0184)** The Hon. Jeffrey A. McNamara, Judge of the Court of Probate, District of Niantic Regional Probate District, by decree dated, ordered that all claims must be presented to the fiduciary at the address below. Failure to promptly present any such claim may result in the loss of rights to recover on such claim. Deborah Maker, Clerk. The fiduciary is:
Patricia J. Lanzetti, 6 N. Ledge Rock Road, Niantic, CT 06357

Merchandise

Antiques/ Collectibles /Art

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Reversed painting — on dome glass,$100 txt for pix 860-460-6530

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87" BEIGE LEATHER RECLINING SOFA, Good Cond. $195 Call 860-885-1961

bakers rack — Green with butcher block and wine bottle holders, txt for pic 860-460-6530 $80

chair — Lee Industries recliner chair, made in NC, $60 860-460-6530

chairs — set of six ladder back including to captains, $100 text for pix 860-460-6530

drop leaf table — 18 x 42 down 42 x 42 up $100 txt for pix 869-460-6530

Lane Cedar chest — Excellent condition with bottom drawer $200 txt for pix 860-460-6530

Pennsylvania Oak Dining Rm Set w/ 6 Chairs, 2 Captain, 42x54x82 $700 & Sofa 86x34, $400 or B/O. Call 860-223-3234

Set of (4) - $100
Excellent condition
Wrought iron with faux leather seats
860-796-5177

table & chairs — 42 "Round table that goes to 58" oval w/built in leaf $125 txt for pix 860-460-6530

tea cart — By Imperial, great condition $100 txt for pix 860-460-6530

Household Goods

AC — Kenmore Energy star 5600 BTU $60 860-460-6530

SALE
Groton - LARGE 2-Day Yard Sale — 8 am - 2 pm Fri 6/10 & Sat 6/11. 120 Walker Hill Rd, Groton. MANY household items, furniture, clothing & MORE!

mirror — very nice mahogany mirror $50, txt for pix 860-460-6530

Lawn / Garden Items

ARBORVITAE SPRING SALE!
Dark Green, Emerald's, Green Giant, For Beautiful Privacy Borders, FREE DELIVERY & Planting! Start at $59
860-712-5359
www.cttrees.com

ARIENS Riding/Tractor Lawn Mower + Utility Trailer. $675 or B/O. Call 860-910-0931

Mulch Hay — $2.50 bail. Call 860-859-2412

PERENNIAL PLANTS — LARGE VARIETIES LOCALLY GROWN $4 EACH 860-464-8500

SHRUBS — BOXWOOD 8" TALL - PRIVET HEDGE 15" TALL $10 EACH 860-464-8500

Other Miscellaneous

10X8 SHED: X-Wide, 64in, DBL Doors, 8ft High Roof Peak. 4 Windows. $600. Brown Color. 860-334-6662

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All NEW Walls.
Must Pick-up & Take Down.
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Coleman 5000 Watt Generator, 9HP, NEW! $300, Ryobi Table Saw, BT3000, Delta Chop Saw $150 for both. 860-608-9002 Bob

Digital Dual Coaxial Cable — Eagle Aspen Brand. 36 Feet. With Connectors. 2.25 GHz. 18 AWG. $20. 860.917.6364

LAZY BOY LIBERTY POWER RECLINER. Excellent Cond, Gray, $600 Call 860-415-9185

Superman DVD Boxed Set — Collector's Edition. Films I-IV. 2001. Hard Slip Box. Exclint Co. $10. 860.535.0099

Stereo, TV, Radio

CD Player/5 Disc Changer — Technics SL-PD867. + Remote Manual & Wires. 1994/ Japan. $60. 860.535.0099

DVD Player — Toshiba SD-2710. w/Remote, Audio Cables & Manual. 17"L x 8.5"D x 3"H. $20. 860.917.6364

Stereo, TV, Radio

Sony stereo — amp,tuner, 5 cd changer in glass door cabinet, 2 speakers plus sub woofer $100 860-460-6530

VCR VHS Player & Recorder — Toshiba M662. w/Remote, Cables & Manual. Excellent Cond. $35. 860.917.6364

Vintage Stereo Receiver — GE RA200A. 1975/Japan. Blue Analog. Wood Case. Exclient Cond. $100. 860.535.0099

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ACQUIRING ALL Antiques, Vintage, Electronics, Audio, Musical Instruments, Ham Radios, Jewelry, Watches, Art, Toys, Military plus more. One item or entire estate. Cash Paid. Call 860-707-9350

CT SCRAP Will buy your scrap steel, copper & aluminum. 33 Pequot Rd Uncasville 860-848-3366

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Cash paid for Antiques and quality used Furniture, Old Clocks, Paintings, Sterling Silver, Jewelry, Nautical & Military Items. Call Gary at THE ANTIQUES DEPOT, For Free In House Appraisal.
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Employment

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For its morning shift. 6am-10am, Mon-Fri & Other Drivers for afternoon shift. 1pm-4pm. Seniors and Others urged to apply. Call Crystal regarding the positions,
860-443-1655

Transit Bus Operator — 9 Town Transit seeking P/T drivers. CDL w/P&F req. Visit 9towntransit.com/employment or call 860-510-0429 x102. EOE

General Help

EXPERIENCED PAINTER
Full time/Full Benefits/ Pay by experience/Call BD Remodeling Fishers Island 860-912-2318

HVAC TECHNICIAN
R & W Heating Energy Solutions, LLC
Is seeking a Licensed HVAC Technician.
R&W Heating Energy Solutions, LLC is a small, forward-thinking, family-owned and operated HVAC business.
Job Requirements/ Responsibilities (Include, But Not Limited To):
- Minimum B2 License (No Apprentices')
- Experience with Oil Heat, Natural Gas and/or Propane Heat
- Experience with Ductless Split Heat Pumps and A/C Equipment
- Must be Able to Maintain a Friendly and Professional Presence in Any and All Relations with Customers
- Must be Flexible: Able to Work Independently AND Able to Work Closely Alongside Other Technicians, Both in a Positive and Efficient Manner
- Must be Able to Work a Rotating On-Call Schedule, Including Some Nights, Weekends, and Holidays
- Must Have Clean CT Driving Record
Please email resume to:
rwheating-hq@sbcglobal.net
NO PHONE CALLS

P/T Counter Help
Apply in Person at Caffe NV
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Waterford

Human Services

United Community & Family Services
We're Growing!
UCFS is currently seeking qualified Billingual Spanish speaking applicants for the following positions.
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•Intake Specialist
UCFS has been a cornerstone in the community since 1877 providing an array of client centered Health & Human Services to Eastern CT.UCFS offers competitive compensation and benefits including 8.5% 401(k) Employer contribution.
Visit www.ucfs.org/Job_Opportunities for position details.
Fax: 860-823-3060
EEO/M/F/V/H

Paralegal/Legal

LEGAL ASSISTANT
Groton office,
Hrs 8:30-5:30pm, Mon-Fri.
Send resume to:
JP Zeppieri, PO Box 1005
Groton, CT 06340

Marine/ Boats

Boats

20ft Boat Trailer, New Bearings, $600 Call 860-739-0749

Announcements

Notes of Interest

CT SCRAP Will buy your scrap steel, copper & aluminum. 33 Pequot Rd Uncasville 860-848-3366

Automotive

Automobiles

2000 VW Golf — Auto, needs tranny work. $1,200 OBO 860-885-9241

2002 Volvo S80 — 4DR, auto, moon roof, leather, alloy wheels, V6. Very safe. $1,500. 860-848-9160

VW Jetta SE — 2013, 38000 miles, 31 mpg, sunroof, heated seats and mirrors, 5spd, asking $12,900.00 860-614-4837

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All Makes & Models. Ask For Pete Sabo At: Bob Valenti Auto Mall. 860-536-4931

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1998 HD Dyna Wide Glide Red, 15,000 Miles, Excellent Condition, $5000 Call 860-536-0211

Trucks

2000 FORD 550 DIESEL TOW VEHICLE, 5th Wheel, Goose Neck & Front Hitch Receiver, Snow Plow Incl'd, 194K, $10,500. Call Bob 401-527-8501. N. Stonington

Wanted Automotive

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WILL BUY YOUR
Junk Cars, Trucks, Trailers
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Ledyard — 394 pumpkin hill rd Sat June 4, 8 to 1pm large yard sale small appliances furniture and fine china

Mystic 78 Breezy Knoll — Sat 6/5, 8-1 A bit of everything; clothing, furniture, household, outdoors, sports

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Old Lyme — Community Wide tag sale, Old Colony Beach Club Association, off RT 156. Sat 6/4 & Sun 6/5

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WATERFORD: Sat & Sun, 9am-4pm. 17 Colonial Dr. HH, Drexel Heritage Brand Furniture X-Cond & More

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Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Address	Address
_____	_____
Telephone	Telephone
_____	_____
Email	Email

UNITE HERE Connecticut

Signature

Name

Title

Address

Telephone

Email

Connecticut Health Policy Project

Signature

Name

Title

Address

Telephone

Email

National Physicians Alliance Connecticut

_____
Signature

_____
Name

_____
Title

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Address

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Telephone

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Email

United Action Connecticut

_____
Signature

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Name

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Title

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Address

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Telephone

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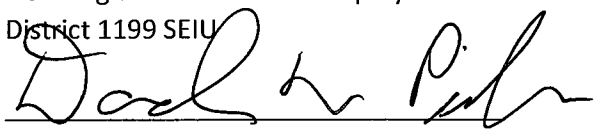
Email

New England Health Care Employees Union
District 1199 SEIU



Signature

David W. Pickus
Name

President
Title

77 Huyshope Avenue, First Floor, Hartford, CT 06106
Address

(860) 549-1199
Telephone

dpickus@seiu1199ne.org
Email

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[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

Greer, Leslie

From: Martone, Kim
Sent: Friday, June 17, 2016 1:26 PM
To: Riggott, Kaila; Lazarus, Steven; Carney, Brian; Ciesones, Ron
Cc: Greer, Leslie
Subject: FW: Connecticut Citizen Action Group
Attachments: Connecticut Citizen Action Group 6-17-16.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Ann Pratt [mailto:ann.prattccag@gmail.com]
Sent: Friday, June 17, 2016 1:17 PM
To: Martone, Kim; Hansted, Kevin
Cc: Henry F. Murray
Subject: Connecticut Citizen Action Group

Dear Ms. Martone and Mr. Hansted,

Please find attached Connecticut Citizen Action Group's signed statement requesting intervenor status in two Certificate of Need Applications, Docket # 15-32032 and Docket # 15-32033.

Please let me know if you need any additional information.

Thank you.

Ann Pratt

--

Ann Pratt
Director of Organizing
Connecticut Citizen Action Group
30 Arbor Street
Hartford, CT 06106

ann.prattCCAG@gmail.com
860-209-1234
Putting People First

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.

- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

Community Accountability and Monitoring:

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local' boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
    - Members of the Governor's Health Care Cabinet
    - Members of the Governor's Certificate of Need Review Task Force, and;
    - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.[8] . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

CONNECTICUT CITIZEN ACTION GROUP

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programing directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

UNITE HERE CONNECTICUT

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make $12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

CONNECTICUT HEALTH POLICY PROJECT

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients Of those, more than 1,000 health care workers live in Lawrence and Memorial's Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
_____	_____
Signature	Signature
_____	Tom Swan
Name	Name
_____	Exec. Director
Title	Title
_____	30 Arbor St Hartford CT 06106
Address	Address
_____	860 233 2181
Telephone	Telephone
_____	tswan@ctcag.org
Email	Email

UNITE HERE Connecticut

Signature

Name

Title

Address

Telephone

Email

Connecticut Health Policy Project

Signature

Name

Title

Address

Telephone

Email

National Physicians Alliance Connecticut

Signature

Name

Title

Address

Telephone

Email

United Action Connecticut

Signature

Name

Title

Address

Telephone

Email

New England Health Care Employees Union
District 1199 SEIU

_____

Signature

_____

Name

_____

Title

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Address

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Telephone

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Email

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[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
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Greer, Leslie

From: Martone, Kim
Sent: Friday, June 17, 2016 3:04 PM
To: Riggott, Kaila; Carney, Brian; Lazarus, Steven; Ciesones, Ron
Cc: Greer, Leslie
Subject: FW: Petition to file for Intervenor status Certificate of Need Application, Docket # 15-32032, Docket # 15-32033
Attachments: Intervenor Petition Final AFT (3).docx

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: John Brady [mailto:JBrady@aftct.org]
Sent: Friday, June 17, 2016 2:34 PM
To: Martone, Kim; Hansted, Kevin
Subject: Petition to file for Intervenor status Certificate of Need Application, Docket # 15-32032, Docket # 15-32033

Ms. Martone and Mr. Hansted,
Please find the attached petition to file for intervenor status on the Certificate of Need Application, Docket # 15-32032, Docket # 15-32033.
Please contact me if you have any questions.
Thank you,
John

John Brady RN
AFT Connecticut Executive Vice President
O (860)257-9782 x107
F (860)257-8214
C (860)908-9711

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

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We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

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- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

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- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

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When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

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- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

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AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

CONNECTICUT CITIZEN ACTION GROUP

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programing directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

UNITE HERE CONNECTICUT

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make $12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

CONNECTICUT HEALTH POLICY PROJECT

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU

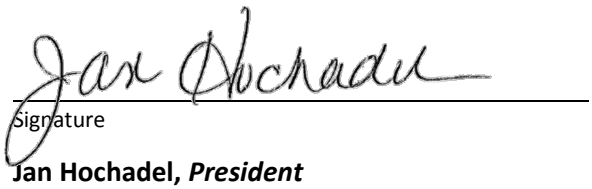
District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients Of those, more than 1,000 health care workers live in Lawrence and Memorial's Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,



Signature

Jan Hochadel, *President*
AFT Connecticut
35 Marshall Road
Rocky Hill, CT 06067
(860) 257-9782 x111
jhochadel@aftct.org

Signature

John Brady RN, *Executive Vice President*
AFT Connecticut
35 Marshall Road
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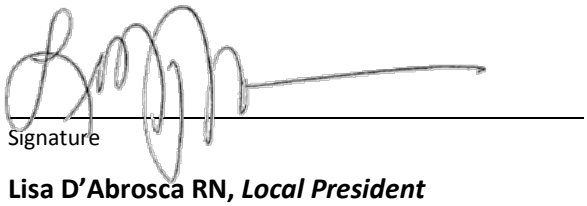
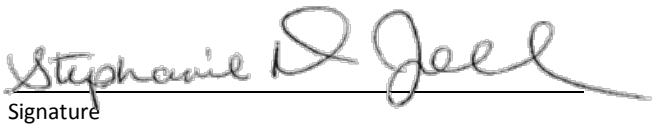


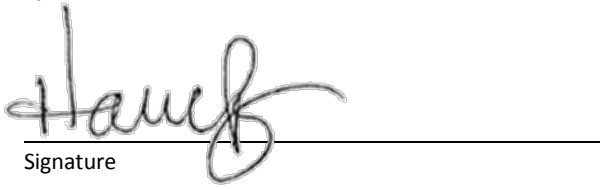
Signature

Lisa D'Abrosca RN, *Local President*
L&M RNs #5049
43 Converse Place
New London, CT 06320
(860) 389-6620
sprinttrack@hotmail.com



Signature

Stephanie Johnson, *Local President*
L&M LPNs & Techs #5051
43 Converse Place
New London, CT 06320
(860) 961-1635
lm5051pres@att.net



Signature

Harry Rodriguez, *Local President*
L&M Healthcare Workers #5123
355 Boston Post Rd.
Waterford, CT 06385
(860) 389-7259
harryzep@hotmail.com

Signature

Martha Marx RN, *Local President*
Visiting Nurses of SECT #5119
4 Harbor Lane
New London, CT 06320
(860) 287-0941
mmarxrn@yahoo.com

[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

Greer, Leslie

From: Martone, Kim
Sent: Friday, June 17, 2016 3:05 PM
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Ellen Andrews, PhD
CT Health Policy Project
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UNITE HERE Connecticut	Connecticut Health Policy Project
	
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Signature	Signature
	Ellen Andrews
_____	_____
Name	Name
	Executive Director
_____	_____
Title	Title
	760 Chapel Street, New Haven CT 06510
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Address	Address
	(203) 562-1636
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Telephone	Telephone
	Andrews@cthealthpolicy.org
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Email	Email

National Physicians Alliance Connecticut

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United Action Connecticut

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New England Health Care Employees Union
District 1199 SEIU

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[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

Greer, Leslie

From: Martone, Kim
Sent: Friday, June 17, 2016 3:07 PM
To: Riggott, Kaila; Carney, Brian; Ciesones, Ron; Lazarus, Steven
Cc: Greer, Leslie
Subject: FW: Yale New Haven Health System and Lawrence & Memorial Hospital - CON 15-32033; L & M Physician Association and Northeast Medical Group - CON 15-32032
Attachments: l&m appearance_20160617133336508.pdf; l&m ltr ohca_20160617133304384.pdf; Intervenor Petition Final.pdf

Importance: High

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Henry F. Murray [mailto:hfmurray@lapm.org]
Sent: Friday, June 17, 2016 2:06 PM
To: Martone, Kim; Hansted, Kevin
Subject: Yale New Haven Health System and Lawrence & Memorial Hospital - CON 15-32033; L & M Physician Association and Northeast Medical Group - CON 15-32032
Importance: High

Dear Ms. Martone and Mr. Hansted:

Attach please find an electronic version of my appearance on behalf of a coalition of organizations that filed an application today for Intervenor status in the above referenced matters. Each organization is signing and sending the application to OCHA today but as a courtesy I have also included an electronic version of that application with this notice of appearance. As I state in my attached cover letter I would like to get a copy of the Service Sheet in these matters so I can forward my appearance to counsel for the Petitioners. Thank you.

Hank Murray

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue

Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

C-126

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

RUTH L. PULDA
1933-2008

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

WRITER'S DIRECT DIAL:
(860) 570-4635
EMAIL:hfmurray@lapm.org

June 17, 2016

Kimberly Martone, Director of Operations
Kevin Hansted, Hearing Officer
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, CT 06106

Re: Certificate of Need Applications,
OHCA Docket No. 15-32032- CON, Merger of L & M Physicians Association and Northeast Medical Group, Inc. and,
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation

Dear Ms. Martone and Mr. Hansted:

Attached please find my appearance entered on behalf of a coalition of organizations who have requested intervenor status in the above captioned matters. I have also attached a copy of the intervenor application which the organizations are filing today. Please send me the service sheet for these two matters at your earliest convenience. Thank you.

Very truly yours,

Henry F. Murray

HFM:vds
Enclosure

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

In Re:

Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation	:	CON 15-32033
Proposal for a Merger of L & M Physicians Association and Northeast Medical Group, Inc.	:	CON 15-32032
	:	June 17, 2016

APPEARANCE

Please enter the appearance of LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, PC before the Office of Health Care Access in the above captioned matters on behalf of proposed Intervenors, AFT Connecticut, Connecticut Citizen Action Group (CCAG), UNITE HERE Connecticut, National Physicians Alliance in Connecticut (NPA-CT), Connecticut Health Policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU.

Henry F. Murray, Esq.
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557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821 (T)
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June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.

- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

Community Accountability and Monitoring:

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local' boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
    - Members of the Governor's Health Care Cabinet
    - Members of the Governor's Certificate of Need Review Task Force, and;
    - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

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New England Health Care Employees Union
District 1199 SEIU

_____
Signature

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Name

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Title

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Address

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Telephone

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Email

[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

Greer, Leslie

From: Martone, Kim
Sent: Monday, June 20, 2016 8:03 AM
To: Hansted, Kevin; Riggott, Kaila
Cc: Greer, Leslie
Subject: FW: L & M intervenor
Attachments: NPA-CT application.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Henry F. Murray [mailto:hfmurray@lapm.org]
Sent: Friday, June 17, 2016 4:24 PM
To: Martone, Kim
Subject: L & M intervenor

Kim, here is the intervenor application for NPA-CT.

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

please notify the sender at the telephone numbers and email addresses above and delete the transmittal and any attachments. THANK YOU

Please think about the environment before deciding to print this email.

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.

- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

Community Accountability and Monitoring:

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local' boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
    - Members of the Governor's Health Care Cabinet
    - Members of the Governor's Certificate of Need Review Task Force, and;
    - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.[8] . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

CONNECTICUT CITIZEN ACTION GROUP

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programing directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

UNITE HERE CONNECTICUT

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make $12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

CONNECTICUT HEALTH POLICY PROJECT

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients Of those, more than 1,000 health care workers live in Lawrence and Memorial's Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
_____	_____
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_____	_____
Name	Name
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Title	Title
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Address	Address
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Telephone	Telephone
_____	_____
Email	Email

UNITE HERE Connecticut

Signature

Name

Title

Address

Telephone

Email

Connecticut Health Policy Project

Signature

Name

Title

Address

Telephone

Email

NATIONAL PHYSICIANS ALLIANCE
CONNECTICUT

United Action Connecticut

Signature

Alicia M. Dodson, MD

Name

Steering Committee Chair, NPA, CT
Title

202.420.7896 888
16th Street NW Suite 800, PMB #835,
Washington DC 20006
www.npalliance.org

Address

Telephone

dodson.a@gmail.com
Email

Signature

Name

Title

Address

Telephone

Email

New England Health Care Employees Union
District 1199 SEIU

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Greer, Leslie

From: Martone, Kim
Sent: Monday, June 20, 2016 8:05 AM
To: Greer, Leslie
Subject: FW: Petition for intervenor status
Attachments: 20160617154950.pdf; ATT00001.htm

Kimberly R. Martone
Director of Operations, Office of Health Care Access Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

-----Original Message-----
From: Dodson, Alicia [mailto:DodsonA@chc1.com]
Sent: Friday, June 17, 2016 4:08 PM
To: Martone, Kim
Subject: Petition for intervenor status

Hi Ms Martone,

Please see the attached petition from the coalition for intervenor status. Signed by NPA-CT today. Thank you for your review. Sincerely,

Alicia M. Dodson, MD

http://www.linkedin.com/in/aliciadodsonmedpedsdoc

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
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REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

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Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

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In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
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Title	Title
_____	_____
Address	Address
_____	_____
Telephone	Telephone
_____	_____
Email	Email

UNITE HERE Connecticut

Signature

Name

Title

Address

Telephone

Email

Connecticut Health Policy Project

Signature

Name

Title

Address

Telephone

Email

NATIONAL PHYSICIANS ALLIANCE
CONNECTICUT

United Action Connecticut

Signature

Alicia M. Dodson, MD

Name

Steering Committee Chair, NPA, CT
Title

202.420.7896 888
16th Street NW Suite 800, PMB #835,
Washington DC 20006
www.npalliance.org

Address

Telephone

dodson.a@gmail.com
Email

Signature

Name

Title

Address

Telephone

Email

New England Health Care Employees Union
District 1199 SEIU

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Greer, Leslie

From: Martone, Kim
Sent: Monday, June 20, 2016 8:05 AM
To: Greer, Leslie
Subject: FW: Application for intervenor status
Attachments: Intervenor Petition Final UH sigs.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: John Canham-Clyne [mailto:jcc@unitehere.org]
Sent: Friday, June 17, 2016 4:07 PM
To: Martone, Kim; Hansted, Kevin
Subject: Application for intervenor status

Ms. Martone, Mr. Hansted:

Please find attached UNITE HERE Connecticut's signed copy of our application for intervenor status as part of a coalition with Connecticut Citizen Action Group, AFT Connecticut, United Action Connecticut, New England Health Care Employees Union District 1199 SEIU, the National Physicians Alliance, Connecticut, and the Connecticut Health Policy Project, in the matters of Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and; Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC.*

Please refer all questions and correspondence to:

John Canham-Clyne
425 College St.
New Haven 06511
203-668-2064
jcc@unitehere.org

Thank you.

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

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Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.

- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

Community Accountability and Monitoring:

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local' boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
    - Members of the Governor's Health Care Cabinet
    - Members of the Governor's Certificate of Need Review Task Force, and;
    - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.[8] . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

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President
UNITE HERE Local 34
Kennington@yaleunions.org

Bob Proto
President
UNITE HERE Local 35
proto@yaleunions.org

Constance Holt
Secretary-Treasurer
UNITE HERE Local 217
CHolt@unitehere.org

UNITE HERE CONNECTICUT
425 College St.
New Haven CT 06511
(203) 624-5161

Please direct correspondence to:

John Canham-Clyne
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New Haven CT 06513
203-668-2064
jcc@unitehere.org

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National Physicians Alliance Connecticut

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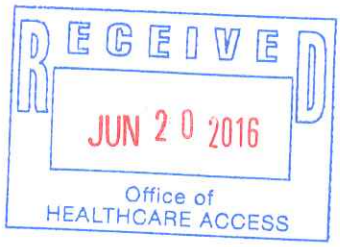
June 17, 2016



Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
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Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

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NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

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Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

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UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

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At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Address	Address
_____	_____
Telephone	Telephone
_____	_____
Email	Email

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Signature

Name

Title

Address

Telephone

Email

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Signature

Name

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Address

Telephone

Email

National Physicians Alliance Connecticut	United Action Connecticut
	John S. Volpini
Signature	Signature
	John S. Volpini
Name	Name
	President, Board of Directors
Title	Title
	185 Miller Avenue, Meriden, CT 06450
Address	Address
	(203) 443-3431
Telephone	Telephone
	stevevolpini2@gmail.com
Email	Email

New England Health Care Employees Union
District 1199 SEIU

_____
Signature

_____
Name

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Title

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Telephone

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[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

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Very truly yours,

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Name	Name
_____	Exec. Director
Title	Title
_____	30 Arbor St Hartford CT 06106
Address	Address
_____	860 233 2181
Telephone	Telephone
_____	tswan@ctcag.org
Email	Email

UNITE HERE Connecticut

Signature

Name

Title

Address

Telephone

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Connecticut Health Policy Project

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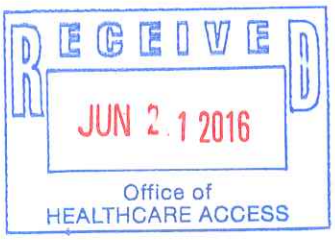

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
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AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

CONNECTICUT CITIZEN ACTION GROUP

Connecticut Citizen Action Group is a statewide membership organization dedicated to involving the residents of Connecticut in bringing about a fair and equitable society. For over 40 years, CCAG has been at the forefront of advocating for a high quality, affordable and fully accessible health care system for all Connecticut residents. CCAG has worked effectively to advance health care policies that strengthen consumer access to fair, affordable health care services, coverage and benefits. CCAG's health care reform work includes monitoring hospital consolidation and regulation, expanding and protecting Medicaid coverage and benefits, and strengthening the ACA law.

CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programing directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

UNITE HERE CONNECTICUT

UNITE HERE Connecticut is a labor organization representing more than 7,000 employees in Connecticut, including 250 in the primary and secondary service areas of L+M Hospital. We bargain health benefits for all of our members in the state, and have a powerful interest in preserving access to affordable, high quality health care. UNITE HERE members cook and serve food in corporate, university and K-12 cafeterias. These are low-wage, seasonal, often part-time jobs. For them, comprehensive, affordable health insurance coverage is essential to achieving any hope of a middle class life. UNITE HERE members at Electric Boat in New London are engaged in bargaining for health benefits. Members currently pay 20% of the cost, which is unaffordable for workers who make $12 per hour. If regional costs continue to escalate, workers will be forced to drop coverage, or be forced to choose between rent and health care. The price structure of the Greater New London market is vital to our members' future well-being.

UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

CONNECTICUT HEALTH POLICY PROJECT

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

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President
UNITE HERE Local 35
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Constance Holt
Secretary-Treasurer
UNITE HERE Local 217
CHolt@unitehere.org

UNITE HERE CONNECTICUT
425 College St.
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(203) 624-5161

Please direct correspondence to:

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Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

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Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
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Signature	Signature
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Title	Title
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Address	Address
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Telephone	Telephone
_____	_____
Email	Email

UNITE HERE Connecticut

Signature

Name

Title

Address

Telephone

Email

Connecticut Health Policy Project

Ellen M Andrews

Signature

Ellen Andrews

Name

Executive Director

Title

760 Chapel Street, New Haven CT 06510

Address

(203) 562-1636

Telephone

Andrews@cthealthpolicy.org

Email

National Physicians Alliance Connecticut

Signature

Name

Title

Address

Telephone

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United Action Connecticut

Signature

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New England Health Care Employees Union
District 1199 SEIU

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[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
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[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
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June 17, 2016

Ms Kimberly Martone, Director
Mr. Kevin Hansted, Hearing Officer
Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

- Applicants' refusal to respond to OHCA's data request alone is grounds for rejection. Employee premium and point of service cost-sharing are exploding, putting needed services out of reach of many people with insurance, and threatening the coverage expansion under the Affordable Care Act. New London County's median family income lags the state average, and in the city of New London median family income is less than 60% of the state average. We will offer firsthand evidence of the pressure that systemic costs in the New London area are putting on patients, and describe the challenge of attempting to create a tailored health plan for low-wage service workers as Connecticut's provider systems consolidate.

- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

outreach, and follow up services that a community needs are in place. We cannot afford another Windham.

- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

Community Accountability and Monitoring:

- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
- L+M Hospital must remain under the control of a locally controlled Board of Directors with decision making authority and accountability to the community. Despite public protestations to the contrary, under the applications as proposed, YNHHS will have ultimate authority over all meaningful decisions at L+M, including nominating members of the "local' boards.
- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
    - Members of the Governor's Health Care Cabinet
    - Members of the Governor's Certificate of Need Review Task Force, and;
    - Members of the steering committee of L+M's current Community Needs Assessment process.

The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

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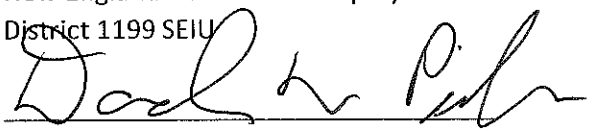

Signature

David W. Pickus
Name

President
Title

77 Huyshope Avenue, First Floor, Hartford, CT 06106
Address

(860) 549-1199
Telephone

dpickus@seiu1199ne.org
Email

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[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
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LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

C-126

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
EMAIL:hfmurray@lapm.org

June 17, 2016

Kimberly Martone, Director of Operations
Kevin Hansted, Hearing Officer
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, CT 06106

Re: Certificate of Need Applications,
OHCA Docket No. 15-32032- CON, Merger of L & M Physicians Association and Northeast Medical Group, Inc. and,
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation

Dear Ms. Martone and Mr. Hansted:

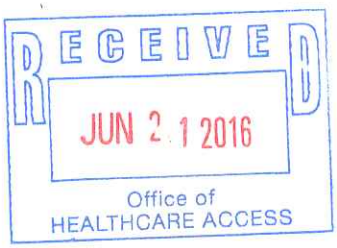
Attached please find my appearance entered on behalf of a coalition of organizations who have requested intervenor status in the above captioned matters. I have also attached a copy of the intervenor application which the organizations are filing today. Please send me the service sheet for these two matters at your earliest convenience. Thank you.

Very truly yours,

Henry F. Murray

HFM:vds
Enclosure

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS



In Re:

Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation	:	CON 15-32033
Proposal for a Merger of L & M Physicians Association and Northeast Medical Group, Inc.	:	CON 15-32032
	:	June 17, 2016

APPEARANCE

Please enter the appearance of LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, PC before the Office of Health Care Access in the above captioned matters on behalf of proposed Intervenors, AFT Connecticut, Connecticut Citizen Action Group (CCAG), UNITE HERE Connecticut, National Physicians Alliance in Connecticut (NPA-CT), Connecticut Health Policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU.

Henry F. Murray, Esq.
LIVINGSTON, ADLER, PULDA, MEIKLEJOHN
& KELLY, P.C.
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821 (T)
860.232.7818 (F)
hfmurray@lapm.org

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Office of Health Care Access
410 Capitol Ave.
Hartford CT 06106

REFERENCE: Certificate of Need Application, Docket # 15-32032, *Northeast Medical Group (NMG) and L&M Physician Association: Transfer of Ownership of a Group Practice by merger of L&MPA and into NMG*, and;

Certificate of Need Application, Docket # 15-32033, *Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation: ("L+M"), Acquisition of L+M by YNHHSC*

Dear Ms. Martone and Mr. Hansted:

The undersigned organizations seek intervenor status in the two above-referenced dockets as a coalition of faith-based organizations, physicians, labor organizations and health policy leaders. The interests of each organization are directly affected by the acquisition of Lawrence and Memorial Health by Yale-New Haven Health Services Corporation, as described below. Accordingly we seek full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Collectively, we represent in various ways more than 8,000 residents of L+M Hospital's primary and secondary service areas, and more than 75,000 residents statewide whose interests are affected by the ongoing consolidation of the state's health care system.

We support Governor Malloy's Executive Order 51, and urge OHCA not to render any decision on these applications until January 2017 or until the Governor's Task Force has reviewed the state's Certificate of Need laws, and made recommendations. If statutory deadlines force OHCA to decide the case, OHCA must follow the letter of Executive Order 51 and deny the application. Please note that among the intervenors are two members of the Task Force.

Even if the application does not ripen for decision until next year, as currently written it must be rejected. The deal fails to protect patients from escalating costs or to ensure local access to the fullest possible range of services. The application does not describe an adequate investment in community health needs, given that the community will lose any measure of control to a multi-billion dollar system from out of town. Any transaction in the future must provide for adequate oversight and accountability to the local community. In our submissions to the Commission as Intervenors we will also demonstrate that in attempting to address these issues, applicants have submitted inaccurate, misleading or incomplete information.

Cost and Price:

- OHCA requested comparative risk-adjusted prices for L+M Hospital and the three Yale-New Haven system hospitals: Bridgeport, Greenwich, and Yale-New Haven. YNHHS claims that such data do not exist, and that if the data did exist, they would not submit them.[1] In fact, adjusted prices for the most common diagnoses at L+M are consistently lower than other Yale-New Haven system hospitals. YNHHS has also refused to supply actual data on prices before and after their takeovers of the Hospital of St. Raphael, Greenwich Hospital and Bridgeport Hospital.

- Without relevant data, OHCA cannot evaluate the transaction. The deal will leave Yale-New Haven with nearly 60% market share from New York to Rhode Island, and more than 80% in L+M's primary service area.[2] Consolidation in such markets most often leads to price increases of 20% or more.[3]

- Through an analysis of billions of claims, provider pricing has been proven the most influential factor in regional private sector health care costs, and market power is the most potent price driver.[4] YNHHS's description of negotiating prices separately for each hospital is irrelevant. The available evidence shows that separate price negotiations do not blunt the power of monopoly pricing.[5]

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- With out of pocket costs skyrocketing, Yale-New Haven's record of abusive debt collection practices creates deep concerns about the future of vulnerable populations in the wake of the acquisition. YNHHS's aggressive use of liens, foreclosures, wage garnishment and bank executions in past years forced changes in the state's medical debt collection laws, and resulted in settlements worth tens of millions of dollars. L+M patients cannot risk a repeat in Southeastern Connecticut.

Community Access and Well-being:

When Hartford HealthCare bought Windham Hospital five years ago, it stated that "currently they will not be terminating any services," although Hartford left itself wiggle room to reduce "duplicative services" in the future. But the CON went on to state that one of the benefits of the deal to Windham would be to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[6] Now with the ICU and CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham. Our coalition has broad experience treating patients and working to ensure the transportation, community

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- Applicants told media outlets they will invest $300 million in our community's health. But YNHHS requires that all investment generate a "positive return on investment" (i.e. profit), and most of the $300 million will only come if L+M and other system hospitals hit profit targets.[7] We will present testimony from physician and community leaders who will identify and analyze the community's health needs, and demonstrate the fundamental inadequacy of the proposed "investment."

- A true investment in our community would preserve existing services, expand services in areas of critical need, especially the provision and coordination of mental and behavioral health services and expanded community outreach to underserved populations. L+M management has wasted millions of dollars on acquisitions and punitive labor relations, rather than focusing on community health needs. L+M's community health needs assessment is underway. That process is far more robust today than three years ago. While encouraging, there is no real commitment to making major investments to address the needs identified in the process.

- Applicants have offered no compelling rationale for the merger achieving quality improvement. The electronic medical record EPIC has already been installed, and tight clinical coordination and clear clinical communication are being achieved without the negative consequences of a takeover.

Workforce:

- L+M is New London's 2nd largest private sector employer. Going forward, L+M must ensure that its workforce represents the community at large, protect job quality by respecting collective bargaining agreements and using hiring best practices.

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- Given YNHHS's troubling record on collections, stonewalling on production of price data, and distorted claims about "investment," in the event of any transaction, L+M Hospital and the acquiring health system must negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs;
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- Rather than seek an unneeded merger, L+M Hospital must develop, finance and implement a Community Health Needs Assessment (CHNA), independent of its affiliated partner and will devote sufficient resources to address the health priorities identified in the needs assessment;
- The CHNA will be conducted every three years, and will include on-going accountability structures including independent monitoring for measuring implementation progress and effectiveness.

The Intervenors: Interests and Evidence

Collectively, the coalition includes thousands of L+M patients, local clergy, patient advocates, physicians, nurses and other caregivers, and leaders responsible for the purchase of health plans.

In addition to the specific interests of the various organizations, the coalition also brings a broad range of health care expertise to the proceedings. The coalition includes:

- Professors at Brown University and Columbia University Medical schools;
- Key statewide health care leaders:
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The coalition will present first-hand evidence from the entire range of the organizations' experiences in the Southeastern Connecticut health care system. In addition, the coalition will present expert analysis of the proposed acquisitions, including: data on Connecticut hospital market concentration; comparative price data; an exhaustive review of the rapidly growing literature on the impact of consolidation on cost, access, "efficiency" and quality, and; a breakdown of the Applicants' financial statements to shed light on claims of financial hardship.

AFT CONNECTICUT including Locals 5049, 5051, 5123 and 5119

AFT Connecticut is a statewide federation of the local unions of the American Federation of Teachers. Our locals have more than 1,800 members who work for Lawrence and Memorial Hospital and its affiliates. They all live in L+M's primary or secondary service area. They account for more than 50% of the total workforce at L+M, including the Visiting Nurses Association of Southeastern Connecticut. When counting non-L+M employees, altogether AFT Connecticut (State Federation) represents over 5,000 members who live in L+M's Primary and Secondary Service Areas.[8] . Based on AFT Connecticut's large concentration of members and their families in L+M services areas, the organization's interests are directly affected by the acquisition proposal, both as workers and as patients.

AFT Connecticut was previously granted intervenor status by OHCA in a 2004 CON hearing (04-30348-CON) involving the Hospital's desire to close the Hospital's OB/GYN clinic. AFT Connecticut will offer testimony on the efficiency of current L+M operations, the impact of aggressive expansion on core missions, and expert testimony on trends in consolidation, cost, prices, access and governance.

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CCAG has 500 members who live within the L+M catchment region, and will be directly impacted by potential increased costs, loss of local access, and changes in community programing directed toward health and well-being. Our members include a broad, diverse cross-section of the community including health care providers, child care providers, municipal workers, senior citizens, and educators. In addition to presenting testimony on the need for controlling cost and sustaining local community access to health care services, we will offer testimony on previous attempts to impose public accountability conditions on hospital acquisitions, and the need to impose strong community oversight, monitoring and accountability measures on this acquisition to ensure that the terms adequately and appropriately meet community health care needs and priorities, and that any such terms or conditions are actually carried out.

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UNITE HERE's Taft-Hartley fund, jointly administered by the union and management, has established a national health plan tailored specifically for food service workers. In Connecticut, nearly 1,000 members have enrolled in the past several years. In some cases, the savings compared to commercial plans have been large enough to maintain comprehensive coverage and actually reduce the cost to individual members. But the efficiency of this plan will not ultimately protect members if the state's largest hospital is permitted to grow unchecked.

UNITE HERE will offer evidence of the immediate impact of any pricing changes at L+M on service sector workers struggling at the margins of the health care system. UNITE HERE will also offer testimony based on experience establishing a specially designed Taft-Hartley health plan for food service workers in Connecticut, as market consolidation continues to drive prices up.

NATIONAL PHYSICIANS ALLIANCE IN CONNECTICUT (NPA-CT)

The National Physicians Alliance in Connecticut (NPA-CT) is part of a national 501(c)3 organization, the National Physicians Alliance (NPA), that creates research and education programs that promote health and foster active engagement of physicians with their communities to achieve high quality, affordable health care for all. The NPA offers a home to physicians across medical specialties who share a commitment to professional integrity and health justice. NPA-CT physicians are members of the staff of the parties involved in the affiliation and primary care physicians in the communities served by the two entities. As such, they have a key interest in assuring that their patients and communities have access to affordable, high-quality hospital care.

NPA will provide evidence that the purported clinical goals of the takeover – tight coordination of care and ease of communication and close cooperation among providers – can be achieved without the potential loss of local control and threat of monopoly economic power inherent in a takeover.

CONNECTICUT HEALTH POLICY PROJECT

Since 1999 as a nonprofit consumer advocacy organization, the CT Health Policy Project has labored to expand access to high quality, affordable health care for all Connecticut residents, with a particular focus on ensuring access for people in low-income communities of color. The proposed acquisition of Lawrence and Memorial Hospital/Health System by Yale-New Haven Hospital/Health System will undermine every part of our mission.

Executive Director Ellen Andrews, who sits on the Governor's Health Care Cabinet, will provide expert testimony regarding the impact of mergers and acquisitions on low-income consumers and the state Medicaid program.

UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients Of those, more than 1,000 health care workers live in Lawrence and Memorial's Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

AFT Connecticut	Connecticut Citizen Action Group
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Signature	Signature
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Name	Name
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Title	Title
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Address	Address
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Telephone	Telephone
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Email	Email

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National Physicians Alliance Connecticut

Signature

Name

Title

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New England Health Care Employees Union
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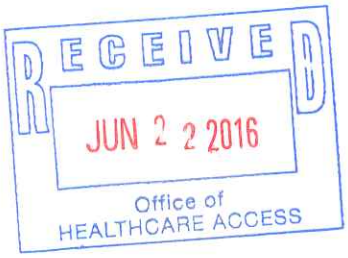
[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

June 17, 2016



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UNITED ACTION CONNECTICUT

United Action Connecticut is an interfaith, multiracial, multilingual organization of congregations and community organizations crossing political, economic, urban and suburban boundaries. UACT is dedicated to building powerful, broad based community organizations. UACT brings congregations together to help them grow and thrive, develop leaders and move into action on concrete issues of social equity and justice. UACT has been working actively toward health care reform for nearly a decade. UACT's New London area congregations include L+M physicians, caregivers and patients, whose interests in preserving community access to high quality affordable health care are directly affected by the applications.

UACT will offer evidence on the local need for access and associated social services that will allow all Greater New London residents to obtain the care they need in their immediate community. The evidence will focus specifically on challenges facing vulnerable populations, including seniors.

NEW ENGLAND HEALTH CARE EMPLOYEES UNION, DISTRICT 1199, SEIU

District 1199 represents approximately 25,000 health care workers in the state of Connecticut, including state employees, hospital employees, nursing home employees, direct care and professional workers at private Mental Health and Developmental Disability agencies and FQHCs, and home care workers providing personal care and support services to Medicaid recipients Of those, more than 1,000 health care workers live in Lawrence and Memorial's Primary and Secondary Service Areas.

At this time, District 1199 is also negotiating first Collective Bargaining Agreements for more than 300 low-wage nursing home employees of two skilled nursing facilities in New London (Crossings East and Crossings West), and one in Mystic, CT (Pendleton Health and Rehabilitation Center). Wages for these workers start at just $10.35 per hour and more than 40% are scheduled for fewer than 32 hours per week. The cost of providing health benefits to these workers is a key issue in difficult ongoing contract negotiations. Current premiums for these workers are so expensive that many elect not to take insurance coverage at all or take the least expensive plan in terms of premiums, resulting in high out-of-pocket and co-pay expenses.

Based on 1199's significant membership in L&M's service areas and the need to negotiate affordable insurance for low-wage workers within the service areas, 1199's interests are directly affected by potential price increases or service cuts that typically accompany mergers. Cost, access and the maintenance of quality healthcare services are of vital importance to the organization and to the communities in which 1199 members reside and receive acute care health services.

In sum, the undersigned organizations' interests are directly affected by the proposed Certificates of Need. Collectively, they bring vast experience and expertise to inform OHCA's decision, and each will provide evidence from a different perspective. Respectfully, we request full intervenor status with the right to submit pre-file testimony, and fully participate in the OCHA hearing including providing opening statements, presenting witness testimony and cross examining the applicants.

Very truly yours,

Signature

Jan Hochadel, *President*
AFT Connecticut
35 Marshall Road
Rocky Hill, CT 06067
(860) 257-9782 x111
jhochadel@aftct.org

Signature

John Brady RN, *Executive Vice President*
AFT Connecticut
35 Marshall Road
Rocky Hill, CT 06067
(860) 257-9782 x107
jbrady@aftct.org

Signature

Lisa D'Abrosca RN, *Local President*
L&M RNs #5049
43 Converse Place
New London, CT 06320
(860) 389-6620
sprinttrack@hotmail.com

Signature

Stephanie Johnson, *Local President*
L&M LPNs & Techs #5051
43 Converse Place
New London, CT 06320
(860) 961-1635
lm5051pres@att.net

Signature

Harry Rodriguez, *Local President*
L&M Healthcare Workers #5123
355 Boston Post Rd.
Waterford, CT 06385
(860) 389-7259
harryzep@hotmail.com

Signature

Martha Marx RN, *Local President*
Visiting Nurses of SECT #5119
4 Harbor Lane
New London, CT 06320
(860) 287-0941
mmarxrn@yahoo.com

[1] Certificate of Need Docket 15-32033, Transfer of Ownership of L+M to YNHHSC, p. 868.
[2] CCAG et al. *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion,* December 2015, p. 4.
[3] The Synthesis Project, "The Impact of Hospital Consolidation – Update". Robert Wood Johnson Foundation, June 2012, p. 2.
[4] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," Health Care Pricing Project, December 2015. http://www.healthcarepricingproject.org/
[5] Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices are Negotiated: Evidence from the Hospital Industry,"
[6] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.
[7] Docket 15-30233, p.
[8] Local member organizations in the L+M service areas include: Waterford Federation of Teachers; Mitchell College Faculty; Region 18 Non-Certified Ed Personnel (Old Lyme); Bozrah Federation of Teachers; Colchester Federation of Teachers; Salem Federation of Teachers; State Employees who are members of the State Employees Bargaining Coalition (SEBAC)

Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, June 22, 2016 3:26 PM
To: 'nancy.rosenthal@ynhh.org'
Cc: Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Olejarz, Barbara
Subject: Yale-New Haven Health Services Hearing Notice
Attachments: 32032_201606221507.pdf

Tracking:

Recipient	Delivery	Read
'nancy.rosenthal@ynhh.org'		
Lazarus, Steven	Delivered: 6/22/2016 3:26 PM	Read: 6/22/2016 3:47 PM
Carney, Brian	Delivered: 6/22/2016 3:26 PM	Read: 6/22/2016 3:31 PM
Riggott, Kaila	Delivered: 6/22/2016 3:26 PM	
Hansted, Kevin	Delivered: 6/22/2016 3:26 PM	
Martone, Kim	Delivered: 6/22/2016 3:26 PM	Read: 6/22/2016 3:26 PM
Olejarz, Barbara	Delivered: 6/22/2016 3:26 PM	

Ms. Rosenthal,
Attached are the rescheduled hearing notices for Yale-New Haven Health Services Corporation.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

June 22, 2016

Nancy Rosenthal
SVP, Strategy and Regulatory Planning
Yale-New Haven Health System
5 Perryridge Road
Greenwich, CT 06830

RE: Certificate of Need Application, Docket Number 15-32032-CON and 15-32033-CON
Docket Number: 15-32032-CON
Northeast Medical Group ("NMG") and L&M Physician Association ("L&MPA")
Transfer of Ownership of a Group Practice by Merger of L&MPA into NMG
Docket Number: 15-32033-CON
Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M")
Acquisition of L+M by YNHHSC

Dear Ms. Rosenthal,

With the receipt of the completed Certificate of Need ("CON") application information submitted by Northeast Medical Group, Inc., L&M Physician Association, Inc., Yale New Haven Health Services Corporation and L&M Corporation ("Applicants") on April 29, 2016, the Office of Health Care Access ("OHCA") has initiated its review of the CON applications identified above.

Pursuant to General Statutes § 19a-639a (f), OHCA may hold a hearing with respect to any Certificate of Need application.

This hearing notice is being issued pursuant to General Statutes § 19a-639a (f)

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

NMG and L&MPA
YNHHSC and L+M

June 22, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

Applicant(s): Northeast Medical Group, Inc.
L&M Physician Association, Inc.

Docket Number: 15-32032-CON

Proposal: Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group

Applicant(s): Yale New Haven Health Services Corporation
L&M Corporation

Docket Number: 15-32033-CON

Proposal: Acquisition of L+M by YNHHSC

Notice is hereby given of a public hearing to be held in this matter to commence on:

Date: July 11, 2016

Time: 3:00 p.m.

Place: Holiday Inn New London – Mystic Area
35 Governor Winthrop Boulevard – Ballroom
New London, CT 06320

The Applicants are designated as parties in this proceeding. Enclosed for your information is a copy of the hearing notice for the public hearing that will be published in *The Day* pursuant to General Statutes § 19a-639a (f) and 19a-486 (f).

Sincerely,

Kimberly R. Martone
Director of Operations
Enclosure

NMG and L&MPA
YNHHSC and L+M

June 22, 2016

Notice of Public Hearing; Docket Number(s) 15-32032-CON and 15-32033-CON

cc: Henry Salton, Esq., Office of the Attorney General
Antony Casagrande, Department of Public Health
Kevin Hansted, Department of Public Health
Wendy Furniss, Department of Public Health
Maura Downes, Department of Public Health
Jill Kennedy, Department of Public Health
Chris Stan, Department of Public Health
Brie Wolf, Department of Public Health
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC:lmg

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

June 22, 2016 P.O. #54772

The Day
47 Eugune O'Neil Drive
New London, CT 06320

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, June 24, 2016**. Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad. acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Kaila Riggott at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment
cc: Danielle Pare, DPH
Marielle Daniels, Connecticut Hospital Association

KRM:SWL:BC;lmg

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

The Day June 22, 2016
Notice of Public Hearing, Docket Number 15-32032-CON and 15-32033-CON

PLEASE INSERT THE FOLLOWING:

Office of Health Care Access Public Hearings

Statute Reference:	19a-638
Applicant(s):	Northeast Medical Group, Inc. L&M Physician Association, Inc.
Town:	Stratford
Docket Number:	15-32032-CON
Proposal:	Transfer of Ownership of a Group Practice by Merger of L&M Physicians Association into Northeast Medical Group
Applicant(s):	Yale New Haven Health Services Corporation L&M Corporation
Town:	New London
Docket Number:	15-32033-CON
Proposal:	Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation
Date:	July 11, 2016
Time:	3:00 p.m.
Place:	Holiday Inn New London – Mystic Area 35 Governor Winthrop Boulevard – Ballroom New London, CT 06320

Any person who wishes to request status in the above listed public hearing may file a written petition no later than July 6, 2016 (5 calendar days before the date of the hearing) pursuant to the Regulations of Connecticut State Agencies §§ 19a-9-26 and 19a-9-27. If the request for status is granted, such person shall be designated as a Party, an Intervenor or an Informal Participant in the above proceeding. Please check OHCA's website at www.ct.gov/ohca for more information or call OHCA directly at (860) 418-7001. If you require aid or accommodation to participate fully and fairly in this hearing, please phone (860) 418-7001.

Greer, Leslie

From: ADS <ADS@graystoneadv.com>
Sent: Wednesday, June 22, 2016 2:26 PM
To: Greer, Leslie
Subject: Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Good day!

Thanks so much for your ad request.
We will be in touch shortly and look forward to serving you.

If you would like to add diversity to this or future requests don't hesitate to ask. Remember, "Quotes are Free". You only pay for the placements you approve.

PLEASE NOTE: New Department of Labor guidelines allow web based advertising when hiring foreign nationals. To provide required documentation Graystone will retrieve & archive verification for the 1st and 30th days of posting for $115.00/web site. If required, notify Graystone when ad placement is approved.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061

E-mail new ad requests to: ads@graystoneadv.com
http://www.graystoneadv.com/

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wednesday, June 22, 2016 at 2:13 PM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/24/16. For billing purposes, please refer to P.O. 54772. In addition, when the "proof of publication" becomes available, please forward me a copy.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Robert Taylor <RTaylor@graystoneadv.com>
Sent: Thursday, June 23, 2016 5:05 PM
To: Greer, Leslie
Cc: Olejarz, Barbara
Subject: Re: DN's 15-32032-CON & 15-32033-CON Hearing Notice
Attachments: 15-32032 and 15-32033 The Day 2nd REVISION.docx

Good afternoon,

This notice is set to publish tomorrow.
$471.21

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com
2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wed, 22 Jun 2016 18:45:26 +0000
To: RTaylor <rtaylor@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: RE: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Thank you! I've attached the correct version.

From: Robert Taylor [mailto:RTaylor@graystoneadv.com]
Sent: Wednesday, June 22, 2016 2:44 PM
To: Greer, Leslie
Cc: Olejarz, Barbara
Subject: FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice
Importance: High

Hi Leslie,

Is this correct version (for us) to publish?

Thanks,

Robert Taylor
Graystone Group Advertising
www.graystoneadv.com

2710 North Avenue, Suite 200
Bridgeport, CT 06604
Phone: 203-549-0060
Toll Free: 800-544-0005
Fax: 203-549-0061

From: ADS <ADS@graystoneadv.com>
Date: Wed, 22 Jun 2016 14:26:09 -0400
To: RTaylor <rtaylor@graystoneadv.com>
Subject: FW: DN's 15-32032-CON & 15-32033-CON Hearing Notice

From: "Greer, Leslie" <Leslie.Greer@ct.gov>
Date: Wednesday, June 22, 2016 at 2:13 PM
To: Ads Desk <ads@graystoneadv.com>
Cc: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Subject: DN's 15-32032-CON & 15-32033-CON Hearing Notice

Please run the attached hearing notice in The Day by 6/24/16. For billing purposes, please refer to P.O. 54772. In addition, when the “proof of publication” becomes available, please forward me a copy.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman, Esq.
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

June 22, 2016

VIA HAND DELIVERY & EMAIL

Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308
Kevin.Hansted@ct.gov

Re: IN THE MATTERS OF: DOCKET NOs. 15--32032-CON and 15--32033-CON

Dear Attorney Hansted:

On behalf of the Applicants in the above-referenced matters, enclosed please find:

1. Shipman & Goodwin's Notice of Appearance Forms;
2. The Applicants' Objection to the Coalition's request for full intervenor status; and
3. Shipman & Goodwin's Certification that the above-referenced documents have been provided to the Coalition's attorney.

If you have any questions, please do not hesitate to contact me.

Sincerely yours,

Joan W. Feldman

Jwf/tja
Enclosure

Cc: Kimberly Martone
Director of Operations
Kimberly.Martone@ct.gov

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE NEW HAVEN HEALTH SERVICES CORPORATION	:	Docket No. 15-32033-CON
	:	June 22, 2016

NOTICE OF APPEARANCE

Please enter the appearance of Shipman & Goodwin LLP on behalf of Lawrence + Memorial Corporation and Yale-New Haven Health Services Corporation in the above entitled proceeding.

Respectfully Submitted,

LAWRENCE + MEMORIAL CORPORATION

YALE NEW HAVEN HEALTH SERVICES CORPORATION

By: _____

Joan W. Feldman, Esq.
jfeldman@goodwin.com
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919
Tel: 860-251-5104
Fax: 860-251-5211
Its Attorneys

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

June 22, 2016

VIA HAND DELIVERY & EMAIL

Kevin Hansted, Esq.
Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Avenue, MS #13HCA
P.O. Box 34048
Hartford, Connecticut 06134-0308
Kevin.Hansted@ct.gov

Re: Objection to the Coalition's Petition for Full Intervenor Status in the Matters of Docket NOs. 15-32032-CON and 15-32033-CON

Dear Attorney Hansted:

On behalf of the Applicants in the above-referenced Applications, I respectfully object to AFT Connecticut's, Connecticut Citizen Action Group's, UNITE HERE Connecticut's, National Physicians Alliance in Connecticut's, Connecticut Health Policy Project's, United Action Connecticut's, and New England Health Care Employees, 1199, SEIU's (collectively the "Coalition") petition for full intervenor status (the "Petition").

The Applicants share some of the same concerns set forth in the Coalition's Petition regarding healthcare costs, retaining services in the community and maintaining a commitment to local governance. Thus, we do not object to the Coalition's participation in the hearings for the above-referenced Applications as an intervenor. For the reasons described herein, however, we object to the Coalition's request to cross-examine the Applicants' witnesses, and to the scope of the testimony that the Coalition seeks to introduce.

While we do not object to the Coalition's ability to participate in the hearings as an intervenor, we object to their Petition for "full" intervenor status. More specifically, and in the interests of an orderly hearing and facilitating OHCA's fact-finding and application of the statutorily mandated criteria by which OHCA approves or denies applications, the Applicants believe that the Coalition's participation should be limited solely to submitting

pre-file testimony and presenting witness testimony at the hearing(s). The Coalition should not be allowed to make opening statements or cross-examine witnesses. The Applicants are concerned that if the Coalition were granted the right to cross-examine the Applicants' witnesses, it would provide a forum and an opportunity for the Coalition to address issues and grievances that are not relevant to the Applications at hand. Moreover, and as you know, OHCA has the right to ask the Applicants and their witnesses questions that can address any of the concerns set forth by the Coalition in its pre-filed testimony. By proceeding in this manner, OHCA will ensure that the hearings proceed in an orderly manner and focus only on the relevant issues within OHCA's jurisdiction.

Accordingly, we respectfully request that the Coalition's Petition for full intervenor status be denied and that said Petition be approved on a very limited basis as described herein. The Applicants believe that a more appropriate avenue for many of the Coalition's statements or grievances is through the public portion of the upcoming hearing(s) at which time OHCA may permit any member of the Coalition's views to be heard or outside these proceedings directly between the Applicants and the Coalition's members.

The Applicants request that should the Coalition be granted intervenor status, that OHCA limits the Coalition's testimony to a list of issues specified by OHCA prior to the hearings on the aforementioned Applications.

Finally, the Coalition states that Executive Order 51 requires OHCA to deny the Applications. While the Applicants recognize that OHCA is not in a position to decide the lawfulness of that Executive Order, we want OHCA to be aware that the Applicants disagree with the Coalition's statements regarding Executive Order 51. We are of the opinion that Executive Order 51 should not be enforced and/or adhered to by OHCA in the aforementioned proceedings.

Respectfully Submitted,

Joan Feldman, Esq.

Cc: Kimberly Martone
Director of Operations
Kimberly.Martone@ct.gov

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Notice of Appearances and the Applicants' Objection to the Coalition's petition for intervenor status were sent via e-mail the 22nd day of June, 2016 to:

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, CT 06105
hfmurray@lapm.org

Joan W. Feldman

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, June 23, 2016 10:33 AM
To: jfeldman@goodwin.com
Cc: 'nancy.rosenthal@ynhh.org'; Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: Ruling on Petition for Intervenor Status
Attachments: 32032 Ruling.pdf

Tracking:

Recipient	Delivery	Read
jfeldman@goodwin.com		
'nancy.rosenthal@ynhh.org'		
Lazarus, Steven	Delivered: 6/23/2016 10:33 AM	
Carney, Brian	Delivered: 6/23/2016 10:33 AM	Read: 6/23/2016 10:34 AM
Riggott, Kaila	Delivered: 6/23/2016 10:33 AM	
Hansted, Kevin	Delivered: 6/23/2016 10:33 AM	
Martone, Kim	Delivered: 6/23/2016 10:33 AM	

Attorney Feldman,
Attached is the Ruling on Petition for Intervenor Status.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, June 23, 2016 11:00 AM
To: 'delivingston@lapm.org'
Cc: 'nancy.rosenthal@ynhh.org'; Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim
Subject: OHCA Ruling on Petition for Intervenor Status
Attachments: 32032 Ruling.pdf

Tracking:

Recipient	Delivery
'delivingston@lapm.org'	
'nancy.rosenthal@ynhh.org'	
Lazarus, Steven	Delivered: 6/23/2016 11:01 AM
Carney, Brian	Delivered: 6/23/2016 11:01 AM
Riggott, Kaila	Delivered: 6/23/2016 11:01 AM
Hansted, Kevin	Delivered: 6/23/2016 11:01 AM
Martone, Kim	Delivered: 6/23/2016 11:01 AM

Attorney Murray,
Attached is the Ruling on Petition for Intervenor Status.

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTER OF:

Certificate of Need Applications by
Lawrence + Memorial Corporation;
Yale New Haven Health Services Corporation;
L+M Physicians Association; and
Northeast Medical Group, Inc.

Docket Numbers: 15-32032-CON
15-32033-CON

RULING ON PETITION FOR INTERVENOR STATUS

By petition dated June 17, 2016, AFT Connecticut, Connecticut Citizen Action Group, UNITE HERE Connecticut, National Physicians Alliance in Connecticut, Connecticut Health policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU ("Petitioners") requested Intervenor status in the public hearing to be held by the Department of Public Health ("DPH") Office of Health Care Access ("OHCA") regarding the Certificate of Need ("CON") applications filed under Docket Numbers: 15-32032-CON and 15-32033-CON. The Applicants filed an objection thereto on June 22, 2016.

Pursuant to Connecticut General Statutes § 4-177a, the Petitioners are hereby designated as Intervenors with full rights of at the hearing scheduled for July 11, 2016 at Holiday Inn, 35 Governor Winthrop Blvd., New London, Connecticut. As Intervenors with full rights, the Petitioners may participate as indicated below.

The Petitioners are granted the right to inspect and copy records on file with OHCA related to the CONs filed under Docket Numbers 15-32032-CON and 15-32033-CON and shall be copied on all pleadings, correspondence and filings submitted from this point forward by the Applicants until the issuance of a final decision by OHCA. As Intervenors with full rights of, the Petitioners may be cross-examined by the Applicants and the Petitioners have the right to cross-examine the Applicants. **The Petitioners shall file their pre-file testimony by the close of business on July 1, 2016.**

OHCA's jurisdiction in this matter is limited to the guidelines and principles set forth in Connecticut General Statutes § 19a-639. Therefore, with respect to pre-filed testimony, direct testimony, and any cross-examination at the hearing, the Petitioners are limited to those guidelines and principles as set forth below.

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

(1) Whether the proposed project is consistent with any applicable policies and standards adopted in regulations by the Department of Public Health;

(2) The relationship of the proposed project to the state-wide health care facilities and services plan;

(3) Whether there is a clear public need for the health care facility or services proposed by the applicant;

(4) Whether the applicant has satisfactorily demonstrated how the proposal will impact the financial strength of the health care system in the state or that the proposal is financially feasible for the applicant;

(5) Whether the applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region, including, but not limited to, provision of or any change in the access to services for Medicaid recipients and indigent persons;

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but not limited to, access to services by Medicaid recipients and indigent persons;

(7) Whether the applicant has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for the proposed services;

(8) The utilization of existing health care facilities and health care services in the service area of the applicant;

(9) Whether the applicant has satisfactorily demonstrated that the proposed project shall not result in an unnecessary duplication of existing or approved health care services or facilities;

(10) Whether an applicant, who has failed to provide or reduced access to services by Medicaid recipients or indigent persons, has demonstrated good cause for doing so, which shall not be demonstrated solely on the basis of differences in reimbursement rates between Medicaid and other health care payers;

(11) Whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and

(12) Whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care.

OHCA will make any additional rulings as to the extent of the hearing participation rights of the Petitioners throughout the hearing in the interest of justice and to promote the orderly conduct of the proceedings.

6/23/16
Date

Kevin T. Hansted
Hearing Officer

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTER OF:

Certificate of Need Applications by
Lawrence + Memorial Corporation;
Yale New Haven Health Services Corporation;
L+M Physicians Association; and
Northeast Medical Group, Inc.

Docket Numbers: 15-32032-CON
15-32033-CON

ORDER

The Applicants in the above-referenced matters shall file their pre-file testimony on or before the close of business on July 1, 2016.

6/23/16
Date

Kevin T. Hansted
Hearing Officer

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: 860-251-5104
Fax: 860-251-5211
jfeldman@goodwin.com

July 1, 2016

Via E-Mail & Hand Delivery
Kevin T. Hansted
Staff Attorney/Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Kevin.Hansted@ct.gov

RE: DOCKET NO. 15-32033-CON - AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION

Dear Mr. Hansted:

On behalf of the Applicants in the above referenced matter, enclosed please find the following:

1. The Applicants' responses to OHCA's "Public Hearing Issues" request dated June 14, 2016; and

2. Pre-filed Testimony for:
   a) Bruce Cummings;
   b) Ross Sanfilippo, DMD;
   c) Joseph Crespo;
   d) Thomas Balcezak;
   e) Monica Noether; and
   f) Marna Borgstrom.

Please do not hesitate to contact me at 860-251-5104 if you have any questions.

Sincerely,

Joan W. Feldman

Jwf/tja
Enclosures

15-32033 07/01/16 0877

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CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the foregoing documents were sent via electronic mail the 1st day of July, 2016 to:

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, CT 06105
hfmurray@lapm.org

Joan W. Feldman

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	DOCKET NO. 15-32033-CON July 11, 2016
MERGER OF L&M PHYSICIAN ASSOCIATION, INC. AND NORTHEAST MEDICAL GROUP, INC.	:	DOCKET NO. 15-32032-CON July 11, 2016

OHCA PUBLIC HEARING ISSUES

1. **The clear public need for proposal.**

   The Applicants are of the opinion and belief that there is a clear public need for the services it provides to the residents of the Eastern Connecticut region. More specifically, L+M is a vital resource to the community because it provides everyone with the healthcare they need, regardless of their ability to pay and regardless of the fact that the cost of efficiently providing such health care to those in need significantly exceeds government sponsored healthcare reimbursement (e.g., Medicaid). As stated in the Application and pre-filed testimony, L+M provides essential access and services to those individuals in the community that other providers are unwilling to accept because of their payer or socioeconomic status. Declining revenue from governmental payers coupled with increasing Connecticut hospital taxes have put enormous financial pressure on L+M's ability to continue to subsidize the level of services and access for which there is a clear public need. Given these realities and the associated demands of health care reform (discussed in greater detail in the Application), L+M's financial stability is considerably less certain. In order to responsibly address this financial instability and ensure that patients located in the Eastern Connecticut Region continue to have access to quality healthcare services, L+M is of the belief that it must affiliate with Yale New Haven Health to gain needed access to the operational and clinical infrastructure and expertise that Yale New Haven Health offers. Without this proposed affiliation, L+M believes that the quality of and access to the services that L+M provides will be reduced, all to the detriment of the residents of Eastern Connecticut.

2. **The effect of the proposed transfer of ownership on the residents of the region with respect to health care services, including how access to services (including specialty care) will be maintained or improved in the area following the acquisition.**

If OHCA approves the subject Applications, the Applicants are of the firm belief and opinion that the residents of the Eastern Connecticut will benefit from L+M being a more financially stable hospital. Financial stability for L+M means: more improvements in L+M's facilities, more investment in needed infrastructure, greater access to needed medical equipment and technology, expanded clinical service offerings, and job stability. The more investments that L+M can make in clinical service offerings and clinical programming for the community, the more financially stable L+M will become and the more L+M can promote the overall health and wellness of its community. In addition, access to capital for the infrastructure needed to improve and manage care, such as data analytics, will ultimately inure and contribute to the well-being of our residents in the Eastern Connecticut region. Denial of the Applications will force L+M to reduce scope, hours and type of clinical service offerings. As a direct consequence, the most vulnerable of our residents will have no choice but to go elsewhere for their healthcare. However, given the limited public transportation in the Eastern Connecticut region, this may not be a viable option for many of our patients.

The L+M Board of Directors will continue as a fiduciary board and as such, will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such clinical programs. L+M and Yale New Haven Health also expect that many of the clinical specialty services that were introduced by Yale New Haven Health at Greenwich Hospital and Bridgeport Hospital will also be offered in the L+M community, including bariatric surgery, endocrinology and vascular surgery to name a few.

3. **Describe the benefits achieved in the Bridgeport/Greenwich Hospital service areas following the YNHHSC affiliation, in terms of financial stability or enhanced programs or services.**

Greenwich and Bridgeport Hospitals have enhanced clinical service offerings to their communities as a result of the Yale New Haven Health affiliation. By way of example, the development of cancer, pediatric and cardiovascular surgical programs has increased the scope and level of acuity of clinical services provided by both Greenwich and Bridgeport Hospitals. As a result, both hospitals have been able to offer more advanced and sophisticated clinical offerings on a local basis with patient access to some of the best and brightest physicians in the nation. Each hospital has also benefitted from the sharing of evidence-based best practices, enhanced patient satisfaction, employee engagement and physician growth and engagement. Bridgeport Hospital and Greenwich Hospital have also achieved significant cost savings in areas such as, supply chain, information technology, and

insurance to name a few. Most importantly, since affiliating with Yale New Haven Health both hospitals are in stronger financials positions with consistent positive operating and net incomes.

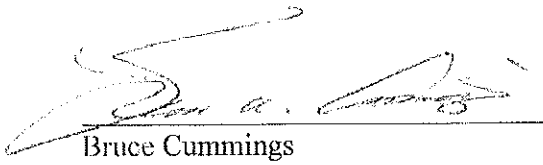
4. **Please describe how successful the CHNA implementation plan has been in addressing priority health issues in L+M's service area.**

   L+M's last community needs assessment was performed in 2013 and implementation has been ongoing by L+M on its own and through collaborative efforts among community stakeholders to ensure strategies are implemented and outcomes measured. Socioeconomic factors, physical environment, health behaviors and clinical care are all factors in the assessment and the plan. Areas of focus have been chronic conditions such as heart disease, obesity, diabetes, cancer, sexual health, asthma and behavioral health and is more particularly described in our Applications. L+M has been successful in implementing strategies to address the prioritized identified needs following our 2013 CHNA in partnership with a multi-sector community collaborative. L+M has measured process outcomes, but going forward, we believe that Yale New Haven Health will enhance L+M's analytical capabilities and support more robust program evaluation and tracking of outcome measures. L+M's challenge is to identify metrics on which it can obtain the data to measure whether it is moving the needle at all. A new CHNA will be completed shortly with the implementation plan completed and approved by the L+M board in August of 2016. Please see http://www.lmhealthcare.org/ for current information.

5. **How will the proposal affect community health improvement spending (community benefits) and community building activities in L+M's service area?**

   Pursuant to the Affiliation Agreement between the Applicants, there is a mutual commitment to maintain (at a minimum) the current level of spending on L+M community benefit programming. If the proposed affiliation is approved, the parties with share resources and knowledge in collaboration with other community organizations to achieve and offer the best and most effective community programs with the best outcomes. L+M will continue to perform its local community health needs assessment every three (3) years. If the proposed affiliation is not approved, it is very likely that L+M will need to reduce its community programming.

Respectfully submitted,



Bruce Cummings
President & CEO, Lawrence + Memorial Corporation

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	DOCKET NO. 15-32033-CON
	:	July 11, 2016

PRE-FILED TESTIMONY OF BRUCE D. CUMMINGS, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF LAWRENCE + MEMORIAL CORPORATION

Good afternoon, Attorney Hansted, and staff of the Office of Health Care Access ("OHCA"). My name is Bruce D. Cummings and I am the President & Chief Executive Officer of Lawrence + Memorial Corporation ("L+M"), the parent corporation of Lawrence + Memorial Hospital, Westerly Hospital, L&M Physician Association, Inc., and the Visiting Nurse Association of Southeastern Connecticut Inc., otherwise and collectively known as the L+M Healthcare System. I am most grateful to have this opportunity to speak with you and convey the many reasons for recommending to OHCA that it approve the above-referenced application (the "Application") which will allow L+M to affiliate with Yale-New Haven Health Services Corporation ("Yale New Haven Health") (collectively, the "Applicants").

While the Applicants believe that their above-referenced Application: (i) sets forth the specific reasons for the proposed affiliation (the "Proposal"); and (ii) comprehensively addresses all of the statutory criteria required for approval pursuant to

Connecticut General Statutes Section 19a-639[1], it is worth restating more concisely here today that the most important reason for this Proposal is to preserve continued access to high-quality affordable healthcare services for individuals in the Eastern Connecticut Region (the "Region"). As I will discuss herein, we firmly believe that if this Application is not approved, that access to services in the Region will be adversely impacted.

As you have most likely observed by now, the momentum of consolidation within the healthcare industry, on both a local, state and national level, is undeniable.[2] It is also quite evident that the momentum for consolidation is not merely a trend, but rather it is an appropriate solution for the provision of coordinated high quality care at a lower cost.

As OHCA is aware, Governor Malloy (the "Governor"), recently issued Executive Order 51. The Applicants believe that Executive Order 51 is void, unenforceable, and unconstitutional as relates to the Application[3] and strongly believe, as set forth below, that, judged against the proper legislatively prescribed criteria, their Application, along with the testimony provided through this legislatively prescribed process, will demonstrate convincingly to OHCA the benefits associated with the approval of the Application and, conversely, the serious harm that will result if OHCA denies it.

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[1] The statutory criteria in effect for CON applications filed prior to December 1, 2015.
[2] Forecasts by Moody's, the bond credit rating company, have consistently recognized that the hospitals that will fare the best in the future are those hospitals that are integrated with an integrated healthcare delivery system with access to the critical resources required to thrive in a demanding and competitive marketplace. See Moody's *Hospital Consolidation and Deferred Capital Support Issuance Volume* (March 5, 2012); see also Moody's: *US Not-for-Profit Hospital Outlook Remains Negative for 2014* (November 5, 2013).
[3] Deputy Commissioner refers to the Deputy Commissioner of the Connecticut Department of Public Health.

I. History of Collaboration.

L+M and Yale New Haven Health have a long history of clinical collaboration and support. At times during the past ten (10) years when L+M lacked either the capacity or the resources to offer certain specialty healthcare services to its patients, it has turned to and collaborated with Yale New Haven Health and/or its affiliates to provide such needed services within the L+M community. L+M has done so, not because it had longstanding plans to consummate a corporate affiliation with Yale New Haven Health, rather, it has historically chosen Yale New Haven Health because it offered and continues to offer high quality services for the Region's patients.[4] To date, clinical collaborations in the area of heart and vascular care, medical and radiation oncology, pediatric and neonatal services, neurosurgery and neurology have been extremely beneficial to the L+M community. In addition, and as a collateral benefit to these historical clinical collaborations, L+M's affiliated physicians have had regular clinical opportunities to advance their training and knowledge on both the L+M and Yale-New Haven Hospital campuses. However, as beneficial as these clinical collaborations are, they have not been sufficient to allow L+M to address the realities of health care today, as other market forces have created other imperatives for L+M that make this Proposal a necessity rather than a luxury.

II. Driving Forces for Affiliation.

[4] See Exhibit A attached hereto.

A. Health Care Reform. As mentioned above, consolidation is an outgrowth of a sea change in health care — a shift that requires hospitals to provide quality care, at lower cost and for a defined patient population over a continuum of care needs and settings. As hospitals and health systems undertake this transition from a traditional fee-for-service environment to a value-based delivery system, they will need access to all the components of a fully integrated healthcare delivery model.[5] In other words, this shift requires a robust portfolio of alternative care models and access to affordable capital to fund prohibitively expensive technology and resource development, along with data analytics to efficiently provide care and measurably improve the health of the population served. When you couple those imperatives with aging infrastructure, a growing population of older and sicker adults, and demands for more effective medical treatments and technologies, it becomes clear that the challenges for hospitals and health systems are daunting on many levels, not the least of which is financial.

These strategic and financial realities require organizations like L+M to determine whether they can remain viable as an independent community healthcare provider, or whether partnership with a larger established integrated healthcare delivery system is necessary. For L+M, this decision was gradual and not immediate. In fact, because L+M had initially intended to remain independent, it became one of the founding members of ValueCare Alliance, an organization formed by five (5) relatively independent hospitals to take advantage of shared best practices, and analytic tools. Within time, however, it became very apparent to L+M's leadership that this alliance

[5] See Moody's "Not-for-Profit Hospitals: The Pursuit of Value" (May 8, 2013); Moody's "*New Forces see also Driving Rise in Not-for-Profit Hospital Consolidation*" (March 8, 2012). See Exhibit B attached hereto.

was not enough to address all of L+M's mounting challenges (as more particularly described herein) in the rapidly changing healthcare market. Therefore, L+M's Board of Directors made the decision to approach Yale New Haven Health, a proven and trusted partner, to engage in discussions regarding a possible affiliation. After several months of focused and thorough discussions, combined with the realization that L+M and Yale New Haven Health held common visions, missions and goals for the Region, the Applicants entered into the Affiliation Agreement.[6]

B. Declining Financial Performance. One significant driving force behind L+M's decision to affiliate with Yale New Haven Health was its progressively declining financial performance over the last three (3) fiscal years. More specifically, during the last three (3) fiscal years, L+M has experienced an overall decline in its operating margins. This decline has been, in part, due to a number of factors, including: (i) State of Connecticut hospital tax increases coupled with budgetary rescissions (significantly reducing L+M Hospital's Medicaid supplemental pool payments and creating a net revenue reduction to L+M Hospital of approximately $12,700,000 in 2016 as compared to approximately $1,000,000 in 2013); (ii) no inflationary increases in Medicaid rates since 2008 despite the fact that the number of individuals on Medicaid has greatly increased; (iii) a significant reduction in federal disproportionate share hospital payments despite the significant number of Medicaid beneficiaries cared for by L+M; (iv) Medicare's and commercial payers' increasing shift from fee-for-service to value and

[6] "Consolidation offers the promise of greater operating efficiency and risk diversification across larger organizations, likely leading to stronger and more stable bond ratings for affected hospitals." See page 11 of Center for Healthcare Economics and Policy, *Hospital Realignment: Mergers Offer Significant Patient and Community Benefits* (January 23, 2014). See Exhibit C attached hereto.

risk-based payments; (v) a pervasive unwillingness by commercial payers to bear the burden of insufficient government funding for governmental payer programs, the uninsured or underinsured care (i.e., Medicaid, Medicare, and DSH reductions); and (vi) reductions in inpatient hospital utilization (e.g., significant changes in Medicare reimbursement shifting more patients to observation status from inpatient status despite the same resource commitment). All of these factors have had a cumulative and detrimental impact on L+M's financial status.[7]

In fact, on May 17, 2016, L+M's bond rating for its CHEFA Series F bonds was downgraded to a BBB+ rating from the A+ rating it was given just three (3) years earlier. According to the Standard & Poor's Global rating agency, this downgrade can be attributed to three (3) factors: "a sharp decrease in operating profitability in the last three fiscal years from historic levels, pressure from the Connecticut state hospital tax, the impact of which as incrementally increased each year, continued inpatient softness in fiscal 2016 with mix shift to outpatient; and a weakened balance sheet position with less financial flexibility than when the rating was initially assigned."[8] It is worth noting that in the same report, the rating agency stated that:

> There's upward rating potential if the integration with Yale New Haven Health System (which includes Yale New Haven Hospital) comes to fruition and provides immediate lift to financial performance and stability to the balance sheet and our group rating methodology would then apply.[9]

Currently, L+M is projecting a negative 4.9% margin compared with a budgeted loss of 1.2%. It is also worth stating that despite the decline in L+M's revenue and

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[7] "Hospitals are faced with an unprecedented threat to revenues...we expect revenue growth to continue to be weak and not able to keep pace with normal spending inflation." See Exhibit C attached hereto.
[8] See Exhibit D attached hereto.
[9] See Exhibit D attached hereto.

creditworthiness, L+M's demand for capital has been the greatest it has ever been for some of the reasons discussed herein.

C. Need for Capital. Health care reform requires innovative responses to meet the demands for higher quality care at a lower cost. Regardless of whether the chosen model is an accountable care organization or "ACO" [10], a clinically integrated organization (i.e. physician and hospital participants share financial risk for providing high quality care under alternative payment models), a patient-centered medical home, or population health programs, each of these initiatives will require a certain degree of size, depth and breadth of experience, and capital to be successful. In particular, each of these models must be large enough to: (i) maximize efficiencies through leveraging economies of scale; and (ii) access the logistical resources and data to develop evidence-based best practices for the purpose of achieving the highest levels of performance while assuming the risks associated with care management.[11]

For the last several years, Yale New Haven Health has been in the forefront of innovation in connection with its development of a population health management program to address an array of socioeconomic and environmental factors that are believed to influence health outcomes, reduce disparities, improve patient care management and reduce health care costs. "Aligning the needs and assets of the hospital

[10] Accountable care systems require that the health care system be large enough so that the cost savings are truly tied to quality improvements rather than fluctuations in care. See http://www.ama-assn.org/amednews/2009/08/31/gvsa0831.htm.

[11] "Research by Elliott Fisher, Mark McClellan, and colleagues demonstrates that such a program, implemented with the establishment of Accountable Care Organizations (ACOs), would benefit patients, payers, and providers. The ACO shared savings concept would eliminate waste, reduce overuse and misuse of care, and support the development of health systems that can deliver high quality, affordable care...." See http://www.dartmouthatlas.org/press/HA_Fisher_McClellan.pdf.

and community with metrics allows for meaningful and significant analysis."[12] Since more and more health care organizations are being asked to assume financial risk for a specific patient population, they need access to data on populations of a specified size "to help identify appropriate risk corridors and drivers of utilization and cost in various patient subpopulations."[13] While the potential to transform the delivery of health care in our Region is of vital importance to L+M, there is no question that L+M is without the capacity or capital to take on a project of this magnitude as an independent community hospital.[14]

As more fully described in the Application, the Proposal will allow L+M to continue to meet the needs of the Region through a strategic plan that will be jointly developed by the Applicants (the "Plan").[15] This Plan will specifically focus on the areas of greatest need for the L+M communities in the Region, including but not limited to, the creation of greater access to primary care, population health management, cost-effective alignment of service lines, including but not limited to, oncology, cardiology, neurosurgery, emergency medicine, surgery, orthopedics and behavioral health. As specifically stated in Section 2.3 of the Affiliation Agreement, the Applicants are

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[12] See Health Research & Educational Trust, *The Second Curve of Population Health* (March 2014). See Exhibit E attached hereto. For example, Yale New Haven Health conducts a community needs assessment and then develops specific and targeted community health programs. This assessment supported the growth of one program, Project Access, which connects uninsured community members to local health services and health resources. Another Yale New Haven Health program provides onsite care management for the health system's own employees living with chronic disease. This early-intervention initiative provides care coordination, navigation, coaching and goal setting to employees and their adult dependents. Within one year, this employee health program improved compliance with evidence-based care by 10 percent, brought risk-adjusted, per-member per-month spending in line with the general employee population and resulted in zero readmissions and avoidable admissions. The program also had 95 percent or higher participant satisfaction ratings. *Id.* at page 15.

[13] See An HFMA Value Project and Report, *Acquisition and Affiliation Strategies*, (June 2014) at page 2. https://www.hfma.org.

[14] See Health Research & Educational Trust, *The Second Curve of Population Health* (March 2014) at page 3.

[15] See CON at page 100.

committed to addressing the needs of the Region based upon ongoing L+M community health needs assessments:

> Each Party reaffirms its commitment to the delivery of high-quality, effective health care to the communities it serves, and to supporting, enhancing and sustaining the ability of the L+M Affiliates...to provide high-quality, cost-effective care that will drive broader efficiencies while increasing high quality outcomes, address increasing consumer demands for integrated collaborative care, manage risk more effectively, enhance the population health infrastructure, improve the efficient access to capital, and maintain and grow provider diversity, consumer choice and access to quality and affordable care. In furtherance of the foregoing, L+M may dedicate and commit at least $11,000,000 ("***L+M Community Benefit Funds***") to support community benefit programs and reinvestments in the communities that the L+M Affiliates serve, including, without limitation, instituting, maintaining, preserving, and/or reinvesting in ambulance services, mental health programs, smoking cessation programs, pediatric asthma programs, diabetes outreach, and/or services important to the community and/or at risk populations, in each case, as may be identified in a biennial community needs assessment or that otherwise are in furtherance of L+M's charitable mission....[16]

Specifically and subject to OHCA's approval of this Application, Yale New Haven Health has committed Three Hundred Million Dollars in resources to the Region (over a period of five (5) years) to enhance and support clinical and operational capabilities and services consistent with the needs of the Region. Forty-One of the Three Hundred Million Dollars will be dedicated (over a five (5)-year period) to the implementation of L+M's Epic, Lawson and other IT platforms; participation and access by L+M to Yale New Haven Health's Population Health infrastructure; and development of needed L+M clinical programs, including associated physician recruitment. Forty-Four of the Three Hundred Million Dollars will be committed by Yale New Haven Health to L+M to support a number of clinical programs and services

[16] See CON at pages 95-96.

as specified in the Affiliation Agreement.[17] Two-Hundred and Fifteen of the Three Hundred Million Dollars (along with a portion of the Forty-Four Million) will be committed to enhance clinical and operational capabilities and services, including but not limited to: expansion of L+M's primary care network and ambulatory presence; access to pediatric specialty services; development of a multi-disciplinary musculoskeletal center with orthopedic, neurosurgery, spine and physiatry clinical complements; expansion of maternal fetal medicine and obstetrics capabilities; enhancement of oncology services associated with the Smilow Cancer Hospital; reintroduction and expansion of bariatric and/or laparoscopic surgical programs; expansion of neuromuscular and stroke programs; development of a multidisciplinary vascular program and enhancement of cardiac services including electrophysiology; enhancement of endocrinology/thyroid services; development of population health and risk contracting capabilities and participation in population health infrastructure; continued access to SkyHealth; expanded emergency services; and physical plant and infrastructure maintenance, development and renovations.[18] Most importantly, it is expected that the proposed affiliation will produce enhanced revenue for L+M by virtue of the operating efficiencies achieved through expansion of scale and operational and clinical integration opportunities.

Clearly, there are significant patient and community benefits associated with the Proposal. Continued access for patients to quality and more cost-effective and affordable health care services are the ultimate goals of the Applicants. In the event that this Application is not approved, given L+M's rapidly deteriorating financial position and its

[17] See Section 2.11(c) of the Affiliation Agreement at CON at page 99.
[18] See Section 2.11(d) of the Affiliation Agreement at CON at page 99.

financial forecast without the Proposal, it is my opinion and belief that many of the programs discussed in this Application and some of those not discussed in the Application will be in serious jeopardy. Simply put, decreasing revenues and increasing hospital taxes will force us to make the type of difficult decisions that will inevitably negatively impact our community benefit programs and clinical offerings.

III. OHCA's Criteria for Approval.

A. The Criteria In Place Prior to December 1, 2015 Must Be Applied to the Application. In assessing the Application, OHCA must apply the criteria in place prior to December 1, 2015, as was intended and expressly enacted by the Connecticut legislature and cannot lawfully make findings or delay decision on the Application as purportedly dictated by paragraphs 5 or 7 of Executive Order 51.

Pursuant to Conn. Gen. Stat. § 19a-639 ("Section 19a-639"), OHCA is expressly empowered and directed to consider and make findings with respect to the factors established by the legislature in determining whether to approve a CON application.[19] These determinations must be made within a statutorily determined time-period.[20] Moreover, the legislature has determined that the Deputy Commissioner of Public Health "shall *exercise independent decision-making authority over all certificate of need decisions*."[21]

[19] Conn. Gen. Stat. § 19a-639(a) ("In any deliberations involving a certificate of need application filed pursuant to section 19a-638, ... the office *shall* take into consideration and make written findings concerning each of the following guidelines and principals ...." (emphasis added)); *see also* Conn. Gen. Stat. § 19a-630(13) ("'Office' means the Office of Health Care Access division within the Department of Public Health.").
[20] See Conn. Gen. Stat. § 19a-639a.
[21] See Conn. Gen. Stat. § 19a-612d (emphasis added).

The CON regulatory process is the regular subject of review by the Connecticut legislature. Most recently, in the 2015 legislative session, S.B. 811 was proposed and ultimately was passed as part of P.A. 15-146. Among other things, that Act amended Section 19a-639 to include additional factors that must be considered by OHCA when the transfer of ownership of a hospital is the subject of a CON application. Those additional factors, however, expressly do not apply "to a transfer of ownership of a hospital in which either a certificate of need application is filed on or before December 1, 2015, or where a certificate of need determination letter is filed on or before December 1, 2015."[22] Thus, the legislature has made an express determination that the criteria to be applied to CON applications prior to December 1, 2015 *must* be considered under the criteria in place prior to December 1, 2015. The Application was filed on or about October 7, 2015 and therefore must be considered under the criteria in place at that time.

On or about February 25, 2016, the Governor issued Executive Order 51 (the "Order"). Among other things, that Order (a) directs OHCA "not make any final decisions on any CON application .... Until January 15, 2017, insofar as permitted by law" or (b) "insofar as it becomes necessary for the Department of Public Health to act on an application" prior to January 15, 2017, directs OHCA to make adverse findings on three key criteria set forth in § 19a-639.[23] As discussed above, Executive Order 51 is unenforceable and thus, the appropriate criteria for assessing the Application are set forth in Section 19a-639 and the Deputy Commissioner must exercise independent decision-

[22] See Conn. Gen. Stat. § 19a-639(f).
[23] See Executive Order 51, ¶¶ 5 & 7.

making authority in assessing the Application. Applying the criteria mandated by the legislature, it is clear that the Application should be approved.

B. State-Wide Health Care Facilities and Services Plan. In accordance with the Guiding Principles set forth in the State-Wide Health Care Facilities and Services Plan ("Plan"), the Applicants set forth the reasons why they believe that the Proposal achieves the Plan's stated objectives:

- **Promote and support the long term viability of the state's health care delivery system;**

  If the Proposal is approved by OHCA, L+M will achieve the benefits more particularly described in the Affiliation Agreement, and thus, be positioned to achieve financial stability and remain a valuable component of the healthcare delivery system in the State.

- **Ensure that any regulated service will maintain overall access to quality health care;**

  If the Proposal is not approved by OHCA, L+M will be forced to reduce and terminate clinical services and will have no choice but to limit the type of clinical programing that directly benefits the community. Conversely, if the Proposal is approved by OHCA, the described capital commitments, innovative care strategies, and efficiencies associated with greater scale will allow L+M to continue to provide access to quality and affordable health care services in the Region.

- **Promote equitable access to health care services (e.g., reducing financial barriers, increasing availability of physicians) and facilitate access to preventive and medically necessary health care;**

  If the Proposal is not approved by OHCA, L+M will not have the capital to enhance access to primary care providers, recruit physicians, fund community benefit programs and avoid reduction and termination of health care services. If OHCA approves the Proposal, L+M will benefit from the capital commitment to be made by Yale New Haven Health as described herein and in the Affiliation Agreement.

- **Encourage and support health education, promotion and prevention initiatives;**

If the Proposal is not approved by OHCA, the community health programs that L+M presently provides and is committed to providing to meet the community health needs will either be terminated or reduced. If the Proposal is approved by OHCA, L+M will be able to maintain the health education, promotion and prevention initiatives that it regularly identifies through its regular community health needs assessments.

- **Encourage collaboration among health care providers to develop health care delivery networks;**

  L+M has a long history of collaboration with Yale New Haven Health and this Proposal will further enhance continued collaborations. While collaborative efforts are not enough in this instance, they are an ongoing and integral component to the Proposal.

- **Support the need for a sufficient health care workforce that facilitates access to the appropriate level of care in a timely manner (e.g., optimal number of primary and specialty care providers);**

  If the Proposal is not approved by OHCA, L+M will be less likely to attract, recruit and maintain the specialty and primary care physicians needed in its community and thus, access to an adequate number of primary care providers and certain health care specialists will be unavailable to patients of L+M. Dr. Lehrach, the President of L&M Physician Association, Inc. will address the recruitment of primary and specialty care physicians in his testimony today.

- **Maintain and improve the quality of health care services offered to the state's residents;**

  If the Proposal is approved by OHCA, L+M will have access to the infrastructure for population health programming, IT platforms and other innovative health care delivery models to provide evidence-based services.

- **Promote planning that helps to contain the cost of delivering health care services to its residents;**

  The Applicants have a shared commitment for strategic planning in the Region. If the Proposal is not approved, L+M will continue to experience financial uncertainty which will inevitably result in L+M not being positioned to address the health care needs of the community to the extent it would otherwise be able to do if the Proposal is approved.

- **Encourage regional and local participation in discussions/collaboration on health care delivery, financing and provider supply;**

  L+M's Board is constituted of diverse representatives from the Region and is committed to addressing the health care needs of the community in accordance with its charitable purpose and mission.

- **Promote public policy development through measuring and monitoring unmet need; and**

  The Applicants are charitable organizations and, thus, are required and committed to continually assess and meet the health care needs of the community.

- **Promote planning or other mechanisms that will achieve appropriate allocation of health care resources in the state.**

  The Applicants are committed to joint strategic planning to avoid unnecessary duplication in services and achieve the most efficient allocation of resources for the Region.

IV. Clear Public Need and Access to Care.

If L+M does not affiliate with Yale New Haven Health pursuant to the statutorily prescribed regulatory timeframe, it will be forced to reduce and or terminate services and consequently, reduce its staffing. A financial downward spiral for L+M would be counterproductive, hard to recover from, and is likely to result in L+M attempting to negotiate with third-party payers for significant rate increases (to cover losses),[24] and less access to care for the financially disadvantaged and underserved and most vulnerable members of the L+M community. Currently, the other hospital in the Region, Backus Hospital, is affiliated with Hartford HealthCare, and by virtue of that affiliation, Backus has a significant advantage over L+M with respect to access to capital and innovative care models, technology, specialty networks, physician recruitment, IT platforms and

[24] Higher prices are likely to result because of lack of scale, reduction of services and the inability to manage risk.

efficiencies associated with scale that L+M does not and will not have if the Proposal is not approved by OHCA. Thus, if the Proposal is either denied or delayed by OHCA, L+M will not be able to compete with Backus on the same level, and L+M will have no choice but to reduce services thereby negatively impacting the diversity of providers in the Region.

As demonstrated in its Application, L+M serves a large number of individuals who are on Medicaid and provides a significant amount of uncompensated care each year. Given the cuts in reimbursement by the State, L+M is seriously challenged with respect to maintaining access, transforming care and continuing to be a vital and significant employer in the Region. While the Proposal itself will not result in the reduction or termination of services within the Region, the mere delay or denial will have a significantly adverse impact on L+M.

V. Health Care Costs Will Not Be Adversely Affected by the Proposal.

Despite some very misinformed statements made by some regarding the impact that integration will have, or in particular, the impact that this Proposal will have on costs, none of those statements, opinions, positions or directives are based upon the actual facts or knowledge. The Applicants have no ability to increase the reimbursement that they receive from government payers, which for L+M Hospital represents approximately seventy percent (70%) of its payer mix, nor does L+M have the ability to unilaterally decide what reimbursements it receives from commercial payers. Yale New Haven Health does not contract with commercial payers on a system-wide basis, nor does

it negotiate a single DRG payment for all affiliated hospitals.[25] As stated in the Application, should this Proposal be approved, L+M's managed care contracts will be separately negotiated for L+M and it will be based upon the costs of care in the Region, not the cost of care of Yale-New Haven Hospital.

Moreover, because reimbursement is shifting from fee-for-service to risk-based contracting, any conclusion that this Proposal will result in an increase in hospital costs is outdated.

> The reliance on past (and in some cases quite distant past) merger activity reveals the imperative for a more comprehensive understanding of current market conditions, current merger motivations and more rigorous examination of merger effects to evaluate the likely benefits or competitive risks of current and future hospital transactions. Fundamentally different market conditions mean that past research can be ill-suited to infer the impact of current merger transactions. Past research may not capture dramatic changes ongoing in the healthcare industry, including transformative changes on the provider and insurer side, and the pressures and results of healthcare reform - particularly requirements for new technologies, new business models, innovative payment reform, and reduced reimbursements. Most of these oft-cited studies are based on mergers or data from the 1990s which occurred under substantially different market conditions than those present today. This may lead to incorrect and even misleading inferences on the impact of mergers in today's health care environment.[26]

There is ample evidence that affiliations like the one proposed here can result in significant cost savings and benefits in the following areas:

- Administrative and overhead savings;
- Reduced costs or reduced rate of cost/expense growth through improved operating efficiency or reduction/elimination of redundant services;
- Improved overall operations and efficiency;
- Realignment of services to achieve greater scale of operations or to improved quality of care delivered;

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[25] "The slow economic recovery has resulted in a reduction in patient volume and a weakening in payor mix (i.e., there is an increased proportion of revenue derived from Medicaid and Medicare which offer less generous reimbursement than do commercial payors)." See Exhibit C attached hereto.

[26] See Center for Healthcare Economics and Policy, *Hospital Realignment: Mergers Offer Significant Patient and Community Benefits* (January 23, 2014) at page 3.

- Reduction of excess capacity;
- Access to capital and improved ability to make necessary investments such as technology and update facilities or services; and
- Ability to maintain or expand services in a community (and thereby maintain quality of services or care and/or access to care).[27]

It is the position and belief of the Applicants that developing integrated information systems, coordinating care, improving efficiencies, engaging in evidence-based practices and incorporating population health improvements into the L+M culture, will ultimately reduce waste and inefficiencies and thus, decrease medical costs. The bottom line is that the factors that cause price variation include the acuity of the patient, the health of populations served and the underfunding of government-sponsored health care programs, *not* the consolidation proposed herein.

VI. Conclusion.

Recently, efforts by Penn State Hershey Medical Center and PinnacleHealth System to merge were challenged by the Federal Trade Commission. In an attempt to obtain an injunction blocking such merger, the Federal Judge denied the request for the injunction and stated the following, which we believe are relevant:

> After a thorough consideration of the equities in play, we find that the majority of these factors weigh in the public interest. The patients of Hershey and Pinnacle stand to gain much from a combined entity that is capable of competing with a variety of other merged and already growing hospital systems in the region. This decision further recognizes a growing need for all those involved to adapt to an evolving landscape of health care that includes, among other changes, the institution of the Affordable Care Act, fluctuations in Medicare and Medicaid reimbursement, and the adoption of risk-based contracting. Our determination reflects the healthcare world as it is, and not as the FTC wishes it to be. We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend hereto. Like the corner store, the community medical center

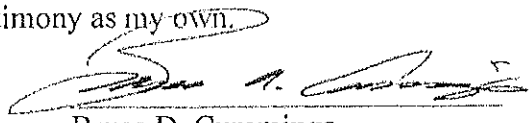
[27] See Center for Healthcare Economics and Policy, *Hospital Realignment: Mergers Offer Significant Patient and Community Benefits* (January 23, 2014) at page 13.

> is a charming but increasingly antiquated concept. It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither.[28]

If this Proposal is approved, the Applicants will be able to accomplish a wide range of objectives: value-based care delivery models; seamless care across all settings; proactive and systematic patient education; workplace competencies and education on population health; integrated, comprehensive IT that supports risk stratification of patients with real-time accessibility; and mature community partnerships to collaborate on community-based solutions. If this Proposal is denied or delayed by OHCA, despite the preponderance of evidence provided to OHCA by the Applicants, not only does the Region suffer, but the entire health care delivery system in the State of Connecticut suffers for all the reasons stated herein. For all of the above reasons, I urge OHCA to approve this Application.

[28] See Federal Trade Commission and Commonwealth of Pennsylvania vs. Penn State Hershey Medical Center and Pinnacle Health System, Civil Action No.: 1:15-cv-2362, (May 9, 2016).

I hereby adopt this pre-filed testimony as my own.



Bruce D. Cummings
President & CEO
Lawrence + Memorial Corporation

Exhibit A
(see attached)

July 22, 2015 Wednesday

SECTION: Pg. A.6

LENGTH: 726 words

HEADLINE: Yale-New Haven Hospital U.S. News ranking remains high but dips slightly

BYLINE: Ed Stannard

BODY:

NEW HAVEN >> Yale-New Haven Hospital is one of the nation's top- performing hospitals in eight of 16 specialties, according to U.S. News and World Report's latest rankings, but has dropped slightly in rank this year in all but psychiatry.

In that specialty, Yale-New Haven rose from No. 11 nationally to No. 10.

"It's not quite as many specialties as they were ranked in last year," when Yale-New Haven made the top 50 in 11 specialties, according to Ben Harder, chief of health analysis for U.S. News and World Report.

The hospital did not make U.S. News' honor roll of the top 15 hospitals nationally; No. 1 on that list is Massachusetts General Hospital in Boston. Only 137 hospitals, less than 3 percent of the nation's institutions, earned a national ranking in at least one specialty, U.S. News reported.

However, Yale-New Haven ranked No. 1 in the state this year, followed by Hartford Hospital and Danbury Hospital.

The complex care specialties in which Yale-New Haven made the top 50 were:

- Diabetes and endocrinology, No. 8.

- Psychiatry, 10.

- Pulmonology, 21.

- Gastroenterology and gastro-intestinal surgery, 22.

- Geriatrics, 25.

- Gynecology, 27.

- Cancer, 42.

- Ear, nose and throat, 43.

The high-performing specialties at **Yale**-New Haven that did not make the top 50 were cardiology and heart surgery; nephrology; neurology and neurosurgery; orthopedics; and urology. The "high performing" rating means they did better than 90 percent of U.S. hospitals, Harder said. The hospital went unranked in ophthalmology, rehabilitation and rheumatology.

Dr. Thomas Balcezak, chief medical officer for **Yale**-New Haven, said, "We continue to rank very highly in most specialties."

He pointed out that U.S. News "changes slightly the methodology every year. ... They try to do it in such a way that they can rank a high number of U.S. hospitals."

In addition to the complex care procedures, U.S. News rated the nation's hospitals in five "common care" procedures that most hospitals perform, whether they are trauma centers like **Yale**-New Haven or less specialized hospitals. While it ranks high in specialties such as diabetes and gynecology, **Yale**-New Haven is rated average in heart bypass, hip replacement and heart failure and below average in knee replacement and chronic obstructive pulmonary disease. "**Yale** did not distinguish itself," Harder said. "It was average or below average in each of those areas."

Smaller hospitals that do not specialize in complex diseases and procedures tend to do better in the common care areas, Harder said. For example, Waterbury Hospital was "not ... ranked in any of the adult specialties, and yet they did perform very well" in hip and knee replacements -- "better than 90 percent of the hospitals in the country," Harder said.

Lawrence + Memorial Hospital, which last week agreed to be acquired by the **Yale** New Haven Health System, was rated highly in hip replacements and average in knee replacements, heart failure and COPD, he said. Patients should look for at least an average ranking in such common procedures, Harder said.

Rating these procedures is important, Harder said, because "it helps patients and their physicians find the right hospital given their particular circumstances."

"We're proud of all of our services," Balcezak said -- "services that go up" in rankings, as well as "services that go down. They're excellent across the continuum."

Among the measures U.S. News uses to rate the top hospitals is patient safety. **Yale**-New Haven's grade of 2 out of 5 pulled down its specialty rankings, but the hospital did improve from a grade of 1 last year. "They did, in our analysis, improve on that measure," Harder said.

Balcezak said that "particularly in hospitals that have more complex kinds of patients" with "other challenges ... 95 or 98 percent performance only puts you in the 50th percentile.

"It's usually a documentation issue; it's not a clinical care issue," he said.

Balcezak said U.S. News uses Medicare billing data to measure patient safety and, "It isn't sensitive to true safety measures."

The Mayo Clinic in Rochester, Minnesota, was ranked No. 2 nationally, followed by Johns Hopkins Hospital in Baltimore and UCLA Medical Center in Los Angeles, which tied for third.

Yale-New Haven Hospital has 1,571 beds in its York Street and St. Raphael campuses and 1,664 doctors on its rolls, according to U.S. News.

LOAD-DATE: August 3, 2015

5 of 18 DOCUMENTS

Hartford Courant (Connecticut)

July 15, 2014 Tuesday
FINAL - 5 EDITION

SECTION: MAIN; Pg. A10

LENGTH: 340 words

HEADLINE: YALE-NEW HAVEN TOPS RANKING OF CONNECTICUT HOSPITALS; U.S. NEWS & WORLD REPORT

BYLINE: MIRANDA ZHANG, Courant Staff Writer

BODY:

Yale-New Haven Hospital ranked No. 1 in Connecticut in the latest best hospitals ranking released Tuesday by U.S. News & World Report.

None of the hospitals in Connecticut appeared on the overall national Honor Roll, a list of the nation's best 17 hospitals, led by Mayo Clinic in Rochester, Minn.

Yale-New Haven, however, was ranked nationally in 11 of 16 specialty categories. Each category lists the top 50 hospitals nationwide.

Yale-New Haven's top national rankings were No. 7 in diabetes and endocrinology -- it was No. 6 last year -- and No. 11 in psychiatry, same as last year.

"It's a very welcomed recognition, and it's difficult to earn the success in terms of reputation, high technology and clinical expertise," said Peter Herbert, chief medical officer at Yale-New Haven Hospital. The rankings are important to patients looking for excellent expertise, reputation and complex care, Herbert said.

Hospitals that are not nationally ranked in a specialty but have scores in the top 25 percent of all hospitals are recognized as high performers in that specialty.

Hartford Hospital, which placed second in the state, led all Connecticut institutions with a high performance ranking in 11 categories.

"It is an honor to be recognized once again as being among the best in the region," Stuart Markowitz, president of Hartford Hospital and senior vice president of Hartford HealthCare, said in a prepared statement. "It solidifies our

reputation for excellence in several service line areas, thanks to the steadfast dedication of every single Hartford Hospital staff member to deliver the best care in the safest environment."

Seven other Connecticut hospitals received numbers for high performance: St. Vincent's Medical Center in Bridgeport, St. Francis Hospital and Medical Center in Hartford, Middlesex Hospital in Middletown, Danbury Hospital, Lawrence + Memorial Hospital in New London, Stamford Hospital and William W. Backus Hospital in Norwich.

The U.S. News & World Report has been publishing the annual hospital rankings since 1990.

LOAD-DATE: July 15, 2014

13 of 18 DOCUMENTS

States News Service

July 16, 2013 Tuesday

LENGTH: 214 words

HEADLINE: YALE-NEW HAVEN HOSPITAL ONCE AGAIN RECOGNIZED BY U.S. NEWS AND WORLD REPORT

BYLINE: States News Service

DATELINE: NEW HAVEN, CT

BODY:

The following information was released by Yale-New Haven Hospital:

Yale-New Haven Hospital continues to rank among the top U.S. hospitals, according to U.S. News and World Report's annual "America's Best Hospitals." Of the nearly 5,000 hospitals surveyed, YNHH ranks nationally in 10 of 16 specialties.

Diabetes and endocrinology ranks in the nation's top 10 at #6, while psychiatry is at #11, gynecology at #14, and gastroenterology and GI surgery at #18. YNHH is also the only Connecticut hospital to be included in the U.S. News and World Report national listings and is among the highest ranked in the region.

In addition, Yale-New Haven is ranked among the best nationally in six other medical specialties: cancer, cardiology and heart surgery, ear, nose and throat, geriatrics, nephrology and pulmonology.

"For 22 consecutive years, Yale-New Haven's consistent presence in the U.S. News and World Report annual rankings shows the national recognition of our skilled physicians, nurses and staff and their dedication to providing safe, high-quality care to our patients and families," said Peter Herbert, MD, chief of staff at Yale-New Haven Hospital. "Across the entire hospital, this honor is a direct reflection of their hard work, compassion and commitment to the best patient care."

LOAD-DATE: July 18, 2013

Exhibit B
(see attached)

MOODY'S INVESTORS SERVICE

SPECIAL COMMENT

Not-for-Profit Hospitals: The Pursuit of Value

Demonstrating Patient Value Now Rivals Quest for Volumes

Table of Contents:

Analyst Contacts:

NEW YORK +1.212.553.1653

Lisa Goldstein +1.212.553.4431
Associate Managing Director
lisa.goldstein@moodys.com

Lisa Martin +1.212.553.1423
Senior Vice President
lisa.martin@moodys.com

John C. Nelson +1.212.553.4096
Managing Director - Public Finance
john.nelson@moodys.com

Summary

Providing quality healthcare services at an affordable cost will be integral to a hospital's financial strength as the sector begins a historic shift to value-based reimbursement after decades of following volume-based incentives. Measuring and proving value will become necessary for healthcare systems to maintain operating stability and distinguish themselves as market leaders.

Not-for-profit hospitals[1] are attempting to shift to a new quality-based business model that is driven by longer-term trends, notably excessive cost inflation, and by near-term reforms in government policies. The sector is facing reimbursement reductions and incentive changes imbedded in The Patient Protection and Affordability Act (ACA), in addition to cuts associated with federal deficit reduction. Private and government payers are increasing their emphasis on value by introducing risk-based contracts that create incentives for hospitals to achieve certain quality and cost targets or, in some cases, face financial penalties. Individuals and businesses have become more discerning in their healthcare purchases since the recession. Both payers and purchasers will accelerate their demand for high value healthcare products with the start of mandated insurance exchanges in 2014.

This report discusses two broad topics of creating value and measuring value.

» Creating value - there are four management objectives hospitals are pursuing during the business model shift:

1. Achieve breakeven performance with Medicare rates
2. Build scale through non-traditional methods
3. Improve patient experience
4. Cultivate informed leadership

[1] Unless noted otherwise, the term "hospitals or providers" used in this report includes single site hospitals as well as multi-site hospital systems

» Measuring value - there are six new credit indicators we will use to measure quality and demand in a value-based payment structure:

1. Unique patients
2. Covered lives
3. Employed physicians
4. Medicare readmission rates
5. All payer readmission rate
6. Risk-based revenues

Four Management Objectives to Create Value

There are four common objectives hospitals are seeking to create a high value healthcare product.

1: Achieve breakeven performance with Medicare rates

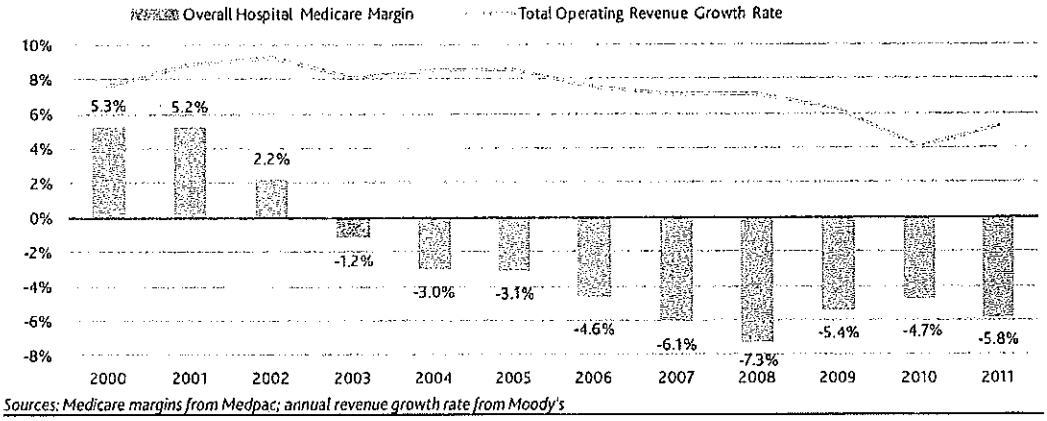
Expense reduction strategies have moved beyond removing "low hanging fruit" which has been a key strategy to improve operating efficiency since the 2008-09 financial crisis. Today's expense strategies involve overhauling operational processes with the aim of achieving breakeven performance with Medicare despite lower Medicare reimbursement rates.

Medicare is the largest single payer for most not-for-profit hospitals. Our medians show Medicare provided 43.7% of gross patient revenues for FY 2011. Most Moody's-rated hospitals report that they incur losses with Medicare on a total cost basis, an assertion that data from Medicare Payment Advisory Commission (Medpac) supports.

As Exhibit 1 shows, the most recent Medpac data available show that hospitals recorded a -5.8% overall margin on Medicare in 2011, continuing the trend of losses since 2003. Declining revenue growth during this same period increased pressure on hospitals to lower their costs, which many did through headcount reductions, revenue cycle improvements and other steps that were relatively easy to achieve compared to the more fundamental cost realignments now beginning.

EXHIBIT 1

Overall Medicare Margins Show Losses Since 2003 as Revenue Growth Rates Declined



Sources: Medicare margins from Medpac; annual revenue growth rate from Moody's

One of the most prevalent objectives is to reach breakeven performance with Medicare rates (on a total cost basis) by lowering costs. Some hospitals compute what the financial gap is to reaching breakeven performance by assuming every patient (including commercially insured) is paid at Medicare rates. This approach is based on the belief that over time blended rates from all payers, including commercial, exchange-based products, Medicaid, and self-pay patients, will equate to Medicare rates.

One specific strategy to lower costs is improving the flow of patients between clinical areas within the hospital. Discharge planning with the patient and family is also done to ensure that medications and post-care treatments are well understood, which is particularly important because of Medicare penalties for unplanned readmissions (discussed further in this report). Finally, many hospitals are opening lower-cost units designated exclusively for 23-hour observation patients who consume the same resources as an inpatient admission but for whom reimbursement is usually much less.

2: Build scale through non-traditional methods

Hospital management teams frequently face the question of optimal size. A hospital's strategy for growth will depend on the local market dynamics and long-term goals to support its charitable mission and provide high quality care that is affordable while remaining financially strong. Achieving scale may include expanding outside of a hospital's traditional geographic service area into a new state, city or suburb. A hospital may determine it must expand from a single site facility to multiple locations in order to grow its covered lives and gain greater efficiencies.

We expect full-asset mergers and acquisitions to continue.[2] Hospitals will also pursue scale through non-traditional consolidation strategies, which can diversify revenues while building size and expertise in managing a population. These contemporary consolidation strategies are taking various forms (see Exhibit 2). Our analysis of these new strategies takes a case-by-case approach. Rating implications will depend on the near-term financial and capital investment compared to the long-term impact on hospital performance and debt coverage.

EXHIBIT 2

Four Examples of Non-Traditional Diversification Strategies

Strategy	Examples	Rating implications
Create clinical centers of excellence; market to new purchasers of healthcare services	Wal-Mart's exclusive contracts with 6 not-for-profit healthcare systems for quaternary services*	New tertiary volumes from markets outside traditional service area viewed favorably
Diversify revenues by expanding into new geographic service areas	Christus Health (A1 stable, $3.7 billion revenues) adds healthcare operations in Mexico and Chile	Further diversification away from Texas and Louisiana viewed favorably
Create healthcare collaborative of independent hospitals to coordinate purchases, improve patient access and outcomes	BJC Collaborative comprised of: BJC HealthCare(Aa2 stable, $3.8 billion revenues), Saint Luke's Health System (A1 stable, $1.2 billion revenues; CoxHealth (A2 stable $1.9 billion revenues), Memorial Health System (A1 stable, $749 million revenues)	Credit positive if savings can be demonstrated
Create a network of like-size rural hospitals for supply savings, billing services, reference laboratory testing and other services	Aspen Valley Health District (Baa2 stable, $65 million revenues) is part of Western Healthcare Alliance	Credit positive; savings through group purchasing already demonstrated

Source: Moody's

* Participating hospitals are the following: Scott & White Healthcare (A1 stable); Cleveland Clinic (Aa2 stable); Mayo Clinic (Aa2 stable); Virginia Mason Medical Center (Baa2 stable); Geisinger Health System (Aa2 stable); Mercy Hospital (Springfield, MO, part of Mercy Health System, Aa3 stable)

[2] Please see "New Forces Driving Rise in Not-for-Profit Hospital Consolidation" March 2012 for more discussion on traditional mergers and acquisitions and their credit implications.

Some hospitals are returning to business lines previously divested, such as home health, rehabilitation and skilled nursing. Instead of taking ownership, however, many are entering joint venture arrangements with post acute care providers. These services will take on greater importance when the Centers for Medicare and Medicaid (CMS) implements bundled payments (pilot programs begin January 1, 2013), whereby a hospital is reimbursed for a single episode of care. The hospital must distribute the single payment to all parties involved in the delivery of care, including physicians and pre- and post- care providers.

Size and scale are important credit features, particularly because creating a high value healthcare system means having multiple patient access points and a continuum of care. One proxy for measuring scale is total operating revenues. Total operating revenues accounts for the highest weighting (25%) in our methodology and scorecard among the 10 financial and demand metrics.[3]

3: Improve Patient Experience

The third objective that hospitals are commonly pursuing to increase value is improving the patient experience. This strategy is a response to three main forces: (1) more selective consumers who are looking for high quality and convenience at an affordable price; (2) increasing competition for patient loyalty, especially in non Certificate-of-Need, high growth markets; and (3) new Medicare incentive payments.

Beginning October 1, 2012, Medicare rewards hospitals for favorable patient satisfaction scores through the Value Based Purchasing (VBP) program. The VBP is based on whether a hospital meets or exceeds the performance standards established with respect to the measures. With this program, CMS rewards hospitals based on actual quality performance on measures, rather than simply reporting data for those measures.[4] The VBP withholds Medicare inpatient payments to hospitals by 0% to 1% and will redistribute the funds to those hospitals that achieve the quality measures.[5]

Hospitals are using a variety of strategies to improve the patient experience. Examples include care navigators to accompany a patient through the course of his/her hospital treatments and team-based care models to determine a patient's treatment plan. Some hospitals are using social media applications to increase their brand and promote convenience, particularly with respect to emergency room waiting times. Some hospitals have added a Chief of Patient Experience in the c-suite to oversee these strategies.

Information technology (IT) plays a big role in coordinating care to improve the patient experience. Many hospitals have invested heavily in IT to create a single electronic medical record (EMR) that follows the patient through his or her continuum of care. Hospitals stand to gain federal reimbursement of their EMR costs through the American Recovery and Reinvestment Act (ARRA) stimulus plan if they demonstrate meaningful use of their EMRs. Additionally the migration to a single IT platform and away from a "best of breed" multi-vendor strategy will eliminate over-customization of software systems and the need for "bolt-on" applications to create interoperability between various platforms.

Our median financial data show that hospitals have increased their capital spending following a decline during the last recession while annual healthcare debt issuance has increased (Exhibit 3). Management

[3] Please see "Not-for-Profit Healthcare Rating Methodology" March 2012

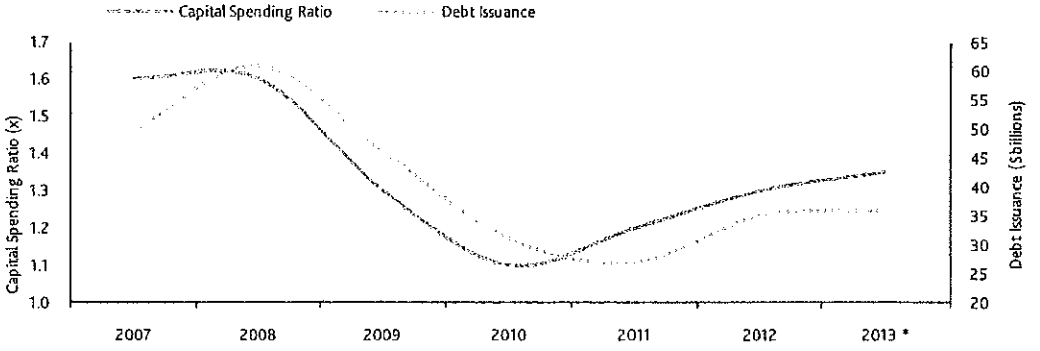
[4] Federal Register, http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/html/2011-10568.htm

[5] Kaiser Family Foundation, http://healthreform.kff.org/document-finder/cms/cms-final-rule-establishing-the-hospital-value-based-purchasing-program.aspx

teams are taking a more deliberate approach when planning capital needs with a noticeable movement away from bricks and mortar. We estimate that a growing share of the capital spend is for IT at one-quarter to one-third of a hospital's annual budget. IT spending is typically not a reasonable use of bond proceeds, given that the assets are short-lived.

EXHIBIT 3

Capital Spending and Debt Issuance Increase Post Recession



Source: Capital spending ratio from Moody's FY 2011 Hospital Medians (2008-2011) and FY 2012 Preliminary Medians; Healthcare debt issuance from Bond Buyer. Note, sample sets are different; healthcare issuance includes refunding and new money issuance
* 2013 Moody's estimate

Effective management involves identifying IT needs and funding sources and providing projections that show operating expenses associated with the installation. Some hospitals have shown stable financial performance during a period of IT installation while others have seen performance decline beyond initial expectations. Rating pressure may be thwarted if cash resources remain intact or if we believe the fundamental position of the provider has not been impaired.

4: Cultivate Informed Leadership

It is undeniably clear that effective management and governance is paramount to creating high value healthcare systems. Governance is one of the five key factors in our not for profit hospital methodology and strong governance is a common characteristic of financially successful and higher rated hospitals.

Simply stated, healthcare reform is a federal mandate to replace an antiquated and unsustainable reimbursement system with a more rational payment system based on value. The ACA is driving providers to re-examine their business model with an accelerated urgency. The 1984 conversion to a prospective payment system from cost-based reimbursement was a significant change, as was the Medicare rate reduction from the Balanced Budget Act of 1998. Likewise, the most recent recession lead to unprecedented patient volume declines and unexpected growth in uncompensated care. Each of these events lead to unplanned mid-course changes during the course of a single fiscal year. In some cases, hospitals re-adjusted budgets multiple times during the year, especially during the peak of the last recession.

The new ACA payment models will test management and governance in a profound way, particularly due to the ambiguity that exists in many of the law's requirements. The most successful hospitals will be able to quickly and effectively make changes mid course and re-adjust longer-term plans to respond to the rapidly changing dynamics in the industry.

Because of the process changes that may be required, many hospitals are adding executives and board members with atypical skills and backgrounds, including individuals with engineering and manufacturing backgrounds. Hospitals are recruiting managers with corporate backgrounds who bring consolidation expertise. Additionally, they are adding management and board members who come from industries with a heavy reliance on technology, particularly relevant given the large IT investment most hospitals are making.

Measuring Value: Moody's New Indicators

Earlier this year we introduced several new indicators to more accurately capture the changing payment and care models. These new indicators are part of our commitment to publish forward-looking, anticipatory ratings and research that look beyond the near term.

Our new indicators complement our historical volume-based statistics and add new ways to measure value.[6] In the coming months we will publish additional research on these new metrics that answers various questions received since announcing these new indicators. Over time we anticipate adding more metrics as new payment models evolve.

Three of the new indicators measure demand: unique patients, covered lives and employed physicians. Three of the new indicators measure reimbursement risk: Medicare readmissions rates, all-payer readmission rates and risk-based reimbursement contracts.

New measurements of demand

» **Unique patients** captures the number of individual patients who receive care at the hospital in a 12-month period, irrespective of inpatient or outpatient care. Unique patients differs from annual hospital admissions which count an individual's multiple stays at a hospital in a 12-month period. We expect that unique patients will be a key measurement of a hospital's market capture as population health management accelerates.

» **Covered lives** is similar to unique patients, measuring the number of individuals or beneficiaries that a hospital is responsible for, either through an exclusive contract, ACO contract, or through an ACO-like structure through Medicare, Medicaid and commercial payors. Covered lives also includes the members and beneficiaries of a hospital-owned health insurance plan.

» **Employed physicians** serves as a cursory predictor of referrals. We count the number of physicians paid by the hospital or associated foundation or clinic through a salary or management fee. We include hospital-based physicians and hospitalists but exclude faculty practice groups and contracted groups.

New measures of reimbursement risk

» **Medicare readmission rate (%):** On October 1, 2012 CMS began penalizing hospitals with high Medicare readmission rates for three clinical diagnoses: congestive heart failure, heart attack and pneumonia. Medicare readmissions reflect readmissions within 30 days of discharge as a percentage of total Medicare admission excluding readmissions that are part of the plan of care (based on CMS criteria and definition as of reporting date).

[6] Please see "New Analytical Indicators for a New Era in Healthcare" February 2013

» **All-payer readmission rate (%):** We fully expect that commercial payers will follow Medicare, placing a hospital's entire payer mix at risk. All-payer readmissions are within 30 days of discharge excluding readmissions that are part of the plan of care and include all payors and all clinical diagnoses.

» **Risk-based revenues (%):** We have added a new section in our annual data form that asks hospitals to provide data on the type of reimbursement methodology in its contracts. Along with the traditional forms of payment such as DRGs, per diems and traditional capitation in which hospital receives a per member/ per month payment, we are also including a risk-based revenue category. Risk-based revenues includes most of the emerging reimbursement models such as bundled payment and pay-for-performance, whereby reimbursement is based on the ability of the provider to delivery care at a cost lower than what is agreed upon.

Moody's Related Research

Outlook:

» US Not-For-Profit Healthcare Outlook Remains Negative for 2013, January 2013 (139377)

Rating Methodology:

» Not-for-Profit Healthcare Rating Methodology, March 2012 (139274)

Special Comments:

» New Forces Driving Rise in Not-for-Profit Hospital Consolidation, March 2012 (140181)

» Sequester Series: Medicare Reductions Present New Headwinds for Not-for-Profit Hospitals, April 2013 (152021)

» Lower US Healthcare Inflation Is Credit Positive for Not-For-Profit Hospitals, March 2013 (151484)

» Reduction of Medicaid and Medicare Disproportionate Share Hospital Payments a Looming Challenge for State sand Hospital, February 2013 (150991)

» New Analytical Indicators for a New Era in Healthcare, February 2013 (149724)

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Author
Lisa Goldstein

Production Associate
Miki Takase

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SPECIAL COMMENT

New Forces Driving Rise in Not-for-Profit Hospital Consolidation

Rating Impact to Vary

Table of Contents:

Analyst Contacts:

NEW YORK	1.212.553.1653
Lisa Goldstein *Associate Managing Director* lisa.goldstein@moodys.com	1.212.553.4431
John Nelson *Managing Director – Public Finance* john.nelson@moodys.com	1.212.553.4096

Summary

The growing trend toward not-for-profit hospital consolidation is positive for the financial health of many, but not all, hospitals. Consolidation offers the promise of greater operating efficiency and risk diversification across larger organizations, likely leading to stronger and more stable bond ratings for affected hospitals. However, given current looming headwinds confronting the sector, those hospitals left out of consolidations, especially smaller stand-alone hospitals that cannot match the financial, managerial or market access capabilities of larger multi-hospital systems, will face greater negative rating pressure going forward[1]. For bondholders or lenders, consolidation can also provide an exit strategy if bonds or loans are fully redeemed or assumed by the consolidator.

Akin to the last pronounced wave of hospital consolidation in the late 1990s to mid 2000s, the forces behind the current round of consolidation are numerous, with both similarities and differences. Reimbursement challenges, spiraling healthcare costs, and a slow economic recovery are some of the market forces that have ignited the national explosion of consolidation, much like in the past. Driven by healthcare reform and an unsustainable payment system, the deep and impactful financial changes that are undoubtedly coming have led many hospitals to seek long-term partnerships. The current consolidation participants vary greatly and consolidation models are different, each with unique credit risks.

In the past, hospital mergers and acquisitions (M&A) was the primary vehicle to consolidation with a goal to increase market share and leverage with payers. Gaining size and scale remains a key reason to consolidate. Because the opportunities to gain leverage and higher rates from commercial payers are quickly dissipating, size and scale are now a more important means to gaining greater efficiencies and driving waste and costs out of the delivery system. The ability to demonstrate lower costs while providing high quality care will be the key driver in governmental and commercial reimbursement going forward. Physician alignment, another form of consolidation that many are pursuing, is also a strategy to control costs and drive improved quality by adopting evidence-based medicine.

[1] See Moody's U.S. Not-For-Profit Healthcare Outlook Remains Negative for 2012, January 2012

This report outlines the drivers of current hospital consolidation strategies and what Moody's looks for when evaluating these strategies and their impact on bond ratings. We will publish additional research on our rating analysis of consolidations, including specific research on hospital-physician alignment strategies.

The New World of Consolidation

The Drivers: Weak Economy, Insurmountable Federal Deficit and Looming Reimbursement Changes New to the Equation

Many of the forces behind today's consolidation are similar to those in the past. However, this cycle's deeper and more prolonged economic downturn is the key backdrop driving the recent wave of consolidations (see figure 1). Data from Moody's FY 2010 medians showed a -0.4% decline in hospital admissions from FY 2009, the first time we have observed such a decline even during other economic downturns. Inpatient volumes are down for many hospitals, while uncompensated care has increased, creating greater financial challenges and contributing to many recent downgrades. Access to the capital markets has become more difficult for smaller and lower-rated hospitals, driving the need for many to seek a partner.

Spiraling healthcare costs and the insurmountable federal deficit necessitate reducing waste and gaining efficiencies through consolidation. Medicare reductions, such as those legislated by the Balanced Budget Act of 1997, drove much of the consolidation in the late 1990s and Medicare reductions continue to loom. In 2010, national healthcare expenditures represented 17.9% of GDP[2] and The Patient Protection and Affordable Care Act (federal healthcare reform) is focused on reducing Medicare costs. Annual reductions to Medicare inpatient hospital payment rates are now hardwired into the Medicare payment formula. Hospitals are also facing lower Medicare reimbursement related to bundled payment programs, readmissions, and continued recovery audit contractor (RAC) reviews that seek to recoup overpayments made to hospitals. Bundled payment programs in particular will reimburse hospitals a flat amount that must cover hospital, physician, and post-acute care costs, driving the need for greater efficiencies.

During the last consolidation wave in the late 1990s to mid 2000 period, hospitals generally received favorable annual increases from commercial payers that subsidized losses with governmental payers. Hospitals are now facing significant reimbursement changes from commercial payers that will force changes to how hospitals operate. Most hospitals now report moderate to low single-digit rate increases after years of double-digit increases as a result of leverage gained from consolidation. Some large hospital systems have proactively negotiated global cost and quality contracts that include a reduction in reimbursement rates and shifts much of the financial risk to the hospital. This new payment platform requires hospitals to achieve greater cost reductions and efficiencies to manage this risk, much as capitation did in the 1990s.

Managing increased regulation and absorbing the costs of regulation is another reason to consolidate. Already subject to close regulatory scrutiny, hospitals face even tighter regulations stemming from healthcare reform. Medicare more closely scrutinizes more closely hospital admissions, readmissions and in-hospital patient safety violations, for example.

Largely absent in the last consolidation wave, significant pension liabilities for hospitals with defined benefit plans is a new issue in consolidation discussions. Falling discount rates, lackluster long-term

[2] Centers for Medicare & Medicaid Services

investment returns and federal requirements to be 80% funded have created overwhelming pension obligations relative to unrestricted resources that many hospitals cannot afford, driving the need for a capital partner.

FIGURE 1

Factors Behind Current Consolidation Strategies Are Different

	Historical Factors:		Current Factors:
1	Medicare reimbursement pressures	1	All payers creating reimbursement pressures
2	Increased need for capital for inpatient facilities	2	Increased need for capital for outpatient facilities, information technology
3	Possibility that tax-exemption benefits will diminish	3	Pressure to justify tax-exempt status
4	Limited access to capital for lower-rated hospitals	4	Costly access to capital for smaller hospitals
5	Need to reduce operating expenses	5	Need for fundamental changes in healthcare delivery
6	Need to increase admissions, market share	6	Need to increase covered lives
7	Need for size and scale to leverage with payers	7	Need for size and scale to gain greater efficiencies
		8	Costly regulatory and compliance changes
		9	Riskier debt structures with costly interest rate swaps, onerous bank covenants
		10	Need for greater alignment with physicians, payers to create ACO or ACO-like structures
		11	Spiraling healthcare costs and insurmountable federal deficit
		12	Large unfunded pension liabilities
		13	Prolonged economic downturn

The Consolidators: New Players Join Traditional Participants

In this cycle, there is a noticeable difference in the type of participants involved in consolidations. In addition to the traditional market consolidators, such as large not-for-profit or established for-profit hospital companies, new players have entered the hospital industry.

One of the more interesting developments is the expansion of health insurance companies into healthcare services. Since the passage of healthcare reform, there have been several mergers, acquisitions and partnerships of insurers and provider systems with the goal of reducing healthcare costs and improving quality. The proposed affiliation between Highmark, Inc. in western Pennsylvania and West Penn Allegheny Health System is one of the largest movements of a payer into the hospital industry. Other recent examples include Humana's December 2010 acquisition of Concentra, which provides physical therapy, urgent care and occupational medicine, and WellPoint's August 2011 acquisition of CareMore Health Plan, a Medicare Advantage plan and clinic network[3].

Hospitals and payers are affiliating to form new coordinated global healthcare insurance plans, such as Banner Health Network and Aetna in Arizona. Steward Health Care and Tufts Health Plan, both in Boston, have also created a narrow network to provide healthcare services at a lower cost. We expect payer and provider affiliations to become more common as additional aspects of healthcare reform are defined and implemented and the demand for low cost/high quality healthcare escalates.

[3] See Moody's Affiliation with Highmark Would Be Credit Positive for West Penn Allegheny Health System, July 2011.

Private equity is not new to the hospital industry as many private equity funds have long backed some of the largest for-profit hospital companies, including HCA and Vanguard. However, two new private equity firms recently entered the hospital ownership model. In 2010, Cerberus acquired six-hospital system Caritas Christi Health System in Boston, now called Steward Health Care, and continues to pursue a growth strategy through the acquisition of other not-for-profit hospitals. In 2011, Oak Hill Capital Partners established a joint venture with Ascension Health, the largest faith-based hospital system in the country, to acquire distressed Catholic hospitals. If these ventures prove to be successful, we anticipate more private equity firms may enter the hospital industry through acquisition.

The Models: Innovative but not without Risk, Credit Implications Depend on a Number of Factors

We expect that full-asset mergers or acquisitions will be the most common form of consolidation strategies over the near term although some new models are evolving, each with different credit risks and implications for bond ratings (see figure 2).

In acquisition strategies, the "cost" of the acquisition may include debt and other obligations of the acquired hospital, such as pension liabilities, along with a multi-year capital commitment. When a for-profit hospital acquires a not-for-profit hospital, the debt is redeemed and the rating is withdrawn upon receipt and review of redemption documents.

In many not-for-profit merger strategies, the debt of both organizations is refinanced by debt of the newly combined organization, or the higher-rated entity may guarantee or assume the debt of the lower-rated provider. In other cases, each hospital may join each other's obligated group, effectively creating one new credit group. We will assess the impact of the guaranty on the higher rated credit or the creditworthiness of the combined organization. Sometimes the different debt securities of the merging hospitals are not changed, warranting a determination of the near-term and long-term impact on each borrower's rating.

Joint ventures between not-for-profit and for-profit healthcare systems are emerging across the country. The percentage of each party's ownership interest in the operations usually determines a hospital's tax status. In most joint ventures of this type, the for-profit company usually has majority ownership, which leads to redemption of all debt and exit strategy for bondholders. Health Management Associates, LHP Hospital Group and Lifepoint have engaged in this joint venture strategy usually with rural not-for-profit community hospitals, and we expect this trend to continue.

Joint operating companies (JOCs) or joint operating agreements (JOAs) between not-for-profit hospitals largely function like a full asset merger. Our assessment mostly weighs the strength of security on the bonds and which joint operating partner assumes the debt obligation. Accordingly, we evaluate the creditworthiness of a JOC or JOA if they provide security for the debt. As we have seen in the past, disruptions may occur if management and governance roles are complex or not clearly defined, such as requiring multiple approvals from multiple boards. In one instance, management at the JOA had to seek approvals from three different boards for capital spending, budgets, and strategies, creating an onerous process and ambiguity as to which board had final authority.

We expect to see some of the larger systems create separate obligated groups, particularly those that have a faith-based mission but want to merge with secular hospitals. Other not-for-profit systems have created joint ventures with for-profit companies to assist distressed hospitals with their financial and capital needs. Finally, some not-for-profit systems have different obligated groups largely because of state regulatory issues. Catholic Health East, for example, is the sole corporate member of St. Peter's Health Partners in Albany, NY. New York regulation currently prohibits hospitals from being

obligated on the debt of a corporate parent that is located outside of the state. Nonetheless, the Baa2 rating assigned to St. Peter's debt reflects the shared benefits of being part of a national system while Catholic Health East's A2 rating reflects its strong geographic diversity. Our ratings reflect the creditworthiness of the security pledged to the bondholders, which includes the impact of non-obligated entities on the obligated group, requiring an analysis of the entire enterprise to understand the management, governance, strategic and financial relationship among the various entities[4].

Irrespective of the model used, management teams should be able to engage in much better financial planning than in the past due to better technology to assess the short-term and long-term financial risks. These tools include much more sophisticated software tools to assess costs and clinical outcomes, and to produce more detailed financial data.

FIGURE 2

Consolidation Models Have Varied Rating Impact

	Consolidation Model	Credit Positives	Credit Negatives
1	Acquisition of a not-for-profit hospital by a for-profit hospital	100% debt repayment	N/A as rating is withdrawn
2	Acquisition of a not-for-profit hospital by larger not-for-profit hospital	100% debt repayment	N/A as rating is withdrawn
3	Merger between not-for-profit hospitals:		
	- scenario 1: debt remains outstanding for both hospitals with no change in debt security	» Greater synergies as a larger system with critical mass, particularly if in same or adjacent markets	» Hospital may lose local control over strategic direction and expenditures once part of a larger system; more restricted ability to determine capital spending may result in loss of market share
		» Ability to spread costs over a larger enterprise	» Increase demands on finite capital as part of a larger system
		» Greater diversification of cash flows	» Short-term merger difficulties, such as medical staff integration or cultural differences
		» Greater access to capital as a larger enterprise	» Governance issues of legacy hospitals; "us" versus "them" mentality
		» May result in higher rating for both organizations either immediately or over time	» Financial disruptions if financial systems are different, or reserve methodologies are different
	- scenario 2: debt is guaranteed by higher rated hospital	» Upgrade of lower rated hospital to that of higher rated hospital if guaranty meets Moody's methodology and Moody's determines there is no impact to the guarantor's rating	» Downgrade may occur if the performance of the lower rated hospital weakens the creditworthiness of the higher rated hospital
	-scenario 3: each hospital joins the other's obligated group	» May result in higher rating for both organizations either immediately or over time	» Downgrade may occur for the higher rated hospitals if the performance of the lower rated hospital weakens the creditworthiness
4	Affiliation between payer and not-for-profit hospital (no change in debt security)	» Access to larger unrestricted resources	» Untested strategy for both payer and provider
		» Benefits of joining larger enterprise with financial expertise	» Potential misalignment of focus and resources if mission is unclear and goals conflict, leading to a downgrade
		» May result in upgrade of hospital's rating if financial performance improves over the longer term	

[4] See Moody's Not-for-Profit Hospital and Health Systems Rating Methodology, January 2008

FIGURE 2

Consolidation Models Have Varied Rating Impact

	Consolidation Model	Credit Positives	Credit Negatives
5	Joint operating companies or agreements between not-for-profit hospitals	» Nearly the same as a full asset merger » Upgrade may occur if debt is guaranteed by the larger JOC hospital	» Disruptions may occur if leadership and governance roles are blurred or unclear from the start; multiple boards may create governance issues and inability to execute strategies
6	Joint ventures with between not-for-profit hospitals and for-profit hospitals	» Likely the same as an acquisition with 100% debt repayment	N/A as rating is withdrawn
7	Joint ventures between not-for-profit hospitals with for-profit hospitals to form limited liability company (LLC) for growth strategy	» Incremental cash flow; geographic diversification	» Credit implications may be present depending on the strategic and financial linkages of the LLC to the not-for-profit system, such as debt guarantees or potential capital calls; use of system's resources

Consolidation Through the Lens of a Bond Rating

For all types of consolidation models, our analysis incorporates the five key rating factors in our general rating methodology for not-for-profit hospitals. Below is a list of the key areas Moody's assesses within these broad rating factors. More detailed research on how we assess hospital consolidations will be forthcoming.

1. Governance and Management
   - » Clarity of roles for senior management team including the CEO, CFO and medical staff and nursing leadership
   - » Composition of parent and subsidiary boards and clearly defined reserve powers
   - » Extent of centralized functions, coordination and control over system entities
   - » Likelihood of successfully forming a cohesive governance structure that provides unified direction and avoids conflict caused by historical allegiances
   - » Ability of the board to execute strategies and respond to unforeseen challenges quickly
   - » Adequacy of disclosure practices to all stakeholders including bondholders
2. Market Position
   - » Integration of physician leadership to support the consolidation and goals to engage physicians in the planning and execution stages
   - » Plans to engage and align with community and teaching medical staff, employed and independent physicians, and small- and large-group practices
   - » Strategies to address merger of unionized and non-unionized hospitals
   - » Goals to achieve market share growth, increase covered lives

3. Operating Performance

   - Integrated operating, financial and capital plans that outline the short-term risks as well as the expected long-term benefits of the consolidation, including service and facility consolidation or coordination, IT interoperability and medical staff compatibility
   - Multi-year projections based on conservative assumptions of reimbursement, volumes and expense reductions
   - Scenario planning in the event of an economic downturn or unforeseen challenge and strategies to respond to these events
   - Thorough review by management of methodologies between the hospitals to assess accounting differences in areas such as charity care policies, provision for bad debt, discount policies and contractual allowances
   - Plans to address inequities in salary and benefits including pension plans
   - Approach to commercial payer contracting (centralized or local; payment methodologies, unified terms)

4. Balance Sheet and Capital Plan

   - Assessment of current and future capital needs and funding sources, including information technology, inpatient and ambulatory needs and pension requirements
   - Decisions on asset allocation and investment strategies, along with the use of consultants and investment managers

5. Debt Structure and Legal Covenants

   - Assessment of outstanding debt and lease obligations including covenants and exposure to third parties such as banks and swap counterparties
   - Decisions around debt obligations and changes to security packages
   - Receipt of all regulatory and bond approvals, including church approval, university approval, and municipal parent approval, if needed

Moody's Related Research

Special Comments:

- New Jersey Hospitals: M&A Activity Heats Up as Financial Challenges Rise, February 2012 (138898)
- Achieving Greater Cost and Quality Accountability Will Be Credit Positive for Not-for-Profit Hospitals in Era of Reform, May 2011 (132964)
- Hospital Revenues In Critical Condition: Downgrades May Follow, August 2011 (134473)

Outlook:

- U.S. Not-For-Profit Healthcare Outlook Remains Negative for 2012, January 2012 (139377)

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Author
Lisa Goldstein

Production Associates
Wing Chan
Judy Torre

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Exhibit C
(see attached)

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JANUARY 23, 2014

HOSPITAL REALIGNMENT: MERGERS OFFER SIGNIFICANT PATIENT AND COMMUNITY BENEFITS

MARGARET E. GUERIN-CALVERT

JEN A. MAKI, PHD

CRITICAL THINKING
AT THE CRITICAL TIME™

Table of Contents

HOSPITAL REALIGNMENT: MERGERS OFFER SIGNIFICANT PATIENT AND COMMUNITY BENEFITS

By Margaret E. Guerin-Calvert and Jen A. Maki, PhD*

Overview

Hospital mergers offer substantial benefits for patients and communities. This study provides a comprehensive review and analysis of hospital merger studies and trends that uncovers a reality rooted in research and quite different than what many people think.

Hospital consolidation has been much studied, but often on narrow issues without the comprehensive examination that provides understanding of its overall effects. The extensive review of trends and literature provided in this study illustrates this point and finds that there is not a sufficient appreciation of the positive contribution realignment makes to patients and communities.

All too frequently, conventional wisdom suggested by media coverage is that hospital realignment, mergers and consolidations systematically result in pricing power, with anticompetitively higher prices for those needing care. Yet, in terms of prices for consumers, this study's extensive review of the literature finds no consistent statistical relationship between consolidation patterns and hospital prices across the studies. What also can get lost is that these claims about hospital merger effects often rely on outdated data that do not reflect today's dynamic market conditions.

This comprehensive analysis of consolidation studies reveals hospital realignment offers benefits including improved service offerings, cost reduction, and enhanced competitiveness. Importantly, the analysis underscores that without realignment, patients and communities could face disruption and instability, hospital closures, and reduced access to care.

Under current conditions, hospitals are moving toward a new system of coordinated care as a means to maintain, improve, and expand access for patients. This trend comes as another broader trend is taking place with important implications across the economy: a spending slowdown in health care that many experts believe is structural and likely to continue. Currently, health care inflation is at record lows, as is spending growth at hospitals and other providers throughout the country.

Overall, the impact of hospital realignment – particularly in the challenging environment today – is much broader than what currently is being discussed. This study outlines and examines major systemic changes occurring across the health care system that are driven by a number of factors, such as policy, economic conditions and demographics. This analysis also highlights that many of the studies cited in recent media reports and by academia focus on hospital business transactions of the 1990s, a data set that is old and not representative of the operating environment in which hospitals compete.

KEY FINDINGS

- **Studies point to real benefits from hospital realignment – enhanced access, higher value and greater efficiency.**
- **Hospital realignment is driven by a mix of policy reforms and a changing economic landscape.**
- **Claims of negative realignment effects often cite outdated data not reflective of today's market or narrow studies not representative of most transactions.**
- **Government antitrust reviews underscore that the vast majority of mergers do not raise risks of a substantial lessening of competition.**
- **Fundamental realignment changes are underway within the context of a historic slowdown in the rate of healthcare spending.**

*Margaret E. Guerin-Calvert is President and Senior Managing Director, The Center for Healthcare Economics and Policy ("Center"), a separate business unit in the Economics Practice of FTI Consulting, Inc. She is also Senior Consultant, Compass Lexecon, a wholly owned subsidiary of FTI Consulting, Inc. Jen Maki is Director, The Center for Healthcare Economics and Policy. The report benefited from substantial assistance of our colleagues at the Center. *The views and opinions presented are solely those of the authors and the Center and do not necessarily reflect the views of FTI Consulting, Inc. or other organizations with which the authors are or have been affiliated.* The co-authors have worked on healthcare matters for a variety of healthcare entities, including providers, health plans, government, and associations.

Studies Point to Real Benefits of Hospital Realignment – Enhanced Access, Higher Value, Greater Efficiency

- A key driver of realignment has been the ability of hospitals to maintain services for their communities that otherwise might be reduced or eliminated through hospital downsizing or closure. Studies show that factors driving realignment include hospitals' financial circumstances, and the need to reduce redundant services, achieve efficient realignment and improve access to capital.
- The alternative to mergers or acquisitions is shown by some studies to be hospital closures, downsizing, or reduction in service mix. Hospital closures can reduce access to care and can result in negative welfare effects for the local community; literature found some negative impact on mortality rates.
- A review of literature on the benefits from mergers – including value, cost and efficiency – found that merger efficiencies can stem from:
  - Realignment of services to achieve greater scale of operations or to improve quality of care and enhance access to care. Economies of scale resulting from hospital mergers can result in sustained, measurable savings.
  - Access to capital and improved ability to make necessary investments such as upgrading technology and updating facilities or services.
  - Reduced costs or reduced rate of cost growth through improved operating efficiency, reduced administrative and overhead costs, and reduction or elimination of redundant services.
  - Reduction in excess capacity.
  - Reduction of costs through realignment, to benefit poorly performing or inefficient hospitals (hospitals with high prices and high costs).

A key driver of realignment has been the ability of hospitals to maintain services for their communities that otherwise might be reduced or eliminated through hospital downsizing or closure.

Hospital Realignment is Driven By a Mix of Policy Reforms and a Changing Economic Landscape

- Major systemic changes underway in the healthcare sector are driven by government policy changes as well as economic conditions and demographics. The challenges facing the healthcare industry include the slow economic recovery, reduced reimbursements, difficulty in obtaining capital, a changing infrastructure promoting coordination of care, and essential investments in and implementation of costly healthcare information technology ("IT") systems. Poor occupancy rates and excess capacity are a pressing concern in many areas. A review of the economic literature reveals that these types of factors have been drivers of past mergers.
- Key factors shaping healthcare delivery and realignment are:
  - Efforts to achieve "Triple Aim" goals of enhanced patient care, improved population health, and reduction in rate of increase in per-capita costs. Achieving these goals requires a broader focus on coordinated care delivery for populations rather than episodes of care; more efficient delivery systems of integrated and coordinated care are essential.
  - Shifts from inpatient to outpatient care and excess inpatient capacity, along with improvements in technologies enabling less invasive procedures and shorter stays, have resulted in a significant increase in outpatient care and a reduction in inpatient care, both of which generally improve the quality of care and lower the cost of delivering care.
  - Integrated delivery systems (or integrated delivery networks) provide the means for systems of hospitals (community and tertiary) and physicians to deliver a full spectrum of care to a community. The development and adoption of integrated delivery systems has been accomplished by adding hospitals and/or providers to a system and by expansion of outreach efforts of health systems to serve a wider community and population.

Claims of Negative Realignment Effects Often Cite Outdated Data Not Reflective of Today's Market or Narrow Studies Not Representative of Most Transactions

Recent press and academic articles convey divergent views about hospital merger and acquisition activity, including the key drivers and the likely impact of transactions upon price, value and access. Most agree that a variety of government policy, market, and hospital-specific factors create pressures and incentives for significant realignment of healthcare delivery accomplished by the creation of integrated systems or by mergers, affiliations, or acquisitions of hospitals. These pressures are particularly pressing for smaller stand-alone

hospitals. These articles acknowledge, as drivers for restructuring, the increasing financial pressures currently facing hospitals, and the need to transform healthcare delivery from its current fragmented state to improve care and reduce costs. At the same time, other articles suggest trends toward consolidation lead to potential anticompetitive effects across a broad array of mergers and often reference selected academic studies of price effects of mergers in the 1990s to draw inferences about what is happening today.

- This reliance on past (and in some cases quite distant past) merger activity reveals the imperative for a more comprehensive understanding of current market conditions, current merger motivations and more rigorous examination of merger effects to evaluate the likely benefits or competitive risks of *current* and future hospital transactions. Fundamentally different market conditions mean that past research can be ill-suited to infer the impact of *current* merger transactions. Past research may not capture dramatic changes ongoing in the healthcare industry, including transformative changes on the provider and insurer side, and the pressures and results of healthcare reform – particularly requirements for new technologies, new business models, innovative payment reform, and reduced reimbursements. Most of these oft-cited studies are based on mergers or data from the 1990s which occurred under substantially different market conditions than those present today. This may lead to incorrect and even misleading inferences on the impact of mergers in today's health care environment.

  Fundamentally different market conditions mean that past research can be ill-suited to infer the impact of current merger transactions.... Most of these oft-cited studies are based on mergers or data from the 1990s which occurred under substantially different market conditions than those present today.

  Our comprehensive review of available studies shows:

  - Many studies examine changes in concentration, not actual mergers. However, across studies, there is no consistently quantified relationship between changes in market concentration and observed hospital price increases.
  - Actual merger retrospectives show common market characteristics – such as fewer competitors and higher concentration – but inconsistent results on price effects, suggesting that market share and concentration alone may be poor predictors of competitive effects. This suggests that offsetting benefits or other dynamics likely are important factors.
  - It is difficult to generalize about merger effects from some studies due to methodology and approach. Several are based on simulations or models that either have not been validated against actual mergers or on assumptions that areas studied are actual markets or that no longer may be consistent with market conditions. Price predictions thus may be overstated.
- Price variation studies tend to be based on limited data and narrow samples. Empirical research demonstrates that many factors account for price variation, including cost of patient care, the severity of care, and the health of populations served. Price variation neither is necessary nor sufficient to demonstrate market power exercise in differentiated products, and differences in price levels are not indicative of market power.
- Studies reporting significant – 20% or more – price increases from mergers are specific cases involving selected transactions or data from mergers in highly concentrated markets and thus are not generalizable to all mergers and acquisitions or even to those in highly concentrated markets.

  However, across studies, there is no consistently quantified relationship between changes in market concentration and observed hospital price increases.

  - The majority of hospital acquisitions occur between hospitals located in different markets and would not be subject to the same market conditions that study authors hypothesize drove price increases.
  - Many "in-market" mergers occur in the largest metropolitan areas with many competitors and do not involve material changes in concentration.
  - Even the selected case studies show mixed results – concentrated markets alone did not yield statistically significant price increases.

Government Antitrust Reviews Underscore That the Vast Majority of Mergers Do Not Raise Risks of Substantial Lessening of Competition

- Antitrust review is a fact-intensive inquiry into whether a merger is likely substantially to lessen competition. Only a small proportion of actual hospital transactions raised significant risks of substantial lessening of competition. Only a minority of mergers involved prolonged review, and several of these were not challenged. Most involved hospitals operating in different geographies or in ones with numerous competitors. According to former FTC Chairman Jon Leibowitz, less than two percent of all hospital mergers reviewed between 2007 and 2011 were challenged in court.
- These trends are more supportive of a conclusion that the majority of transactions enhance value or are competitively benign.
- These trends also reveal high concentration, high market shares and the number of competitors are not predictive of either hospital merger challenges or of predicted or actual anticompetitive effects: Both retrospective and prospective hospital merger analyses in highly concentrated markets show that many hospital mergers, even in concentrated markets, either did not result in or were not predicted to result in substantial increases in prices.

Fundamental Realignment Changes Are Underway within the Context of A Historic Slowdown in the Rate of Healthcare Spending.

- Overall healthcare spending growth is slowing, as reflected by the hospital Producer Price Index (PPI). Some of the key factors behind this trend involve changes in the healthcare delivery system including greater provider efficiency, increased cost sharing, as well as a reduction in imaging technology proliferation, and the advent of new pharmaceuticals. This slowing in the rate of growth of healthcare spending and in hospital PPI, on balance, suggests some benefit from changes in the healthcare delivery system.

This slowing in the rate of growth of healthcare spending and in hospital PPI, on balance, suggests some benefit from changes in the healthcare delivery system.

Methodology

The Center for Healthcare Economics and Policy was commissioned by the Federation of American Hospitals (FAH) to contribute to understanding the likely benefits or competitive risks of hospital consolidation by undertaking research on trends influencing transactions and healthcare delivery, and to assess the literature on the price, value (cost and quality) and access effects of hospital merger transactions. We were tasked to evaluate these research findings for today's dynamic environment of major systemic change in healthcare delivery in the US with its increasing demands for both integrated care and reduction in healthcare costs along with fundamental changes in payment methodologies (i.e., the transition to value and risk-based from fee-for-service models). We evaluate research on the expected and actual benefits and competitive risks of hospital transactions and the circumstances in which they occur. We examine studies of price effects of mergers, and study the specifics of antitrust review of hospital mergers. We limit our analysis to focus on only those studies and articles examining US data and trends. Sources included in the study were identified based on literature searches conducted as of September 2013.

I. Introduction and Overview

A. Objectives and Approach

Recent press and academic articles convey divergent views about the key drivers and likely impact of hospital merger and acquisition activity on value (costs, quality), access and price. Most agree that government policies including healthcare reform initiatives, market conditions, and hospital-specific factors create incentives for significant realignment of healthcare delivery whether by mergers and acquisitions of hospitals – particularly smaller stand-alone hospitals – or by development and expansion of integrated delivery systems. There is little agreement, however, about both the drivers and impacts of transactions.

Most agree that government policies including healthcare reform initiatives, market conditions, and hospital-specific factors create incentives for significant realignment of healthcare delivery whether by mergers and acquisitions of hospitals – particularly smaller stand-alone hospitals – or by development and expansion of integrated delivery systems. There is little agreement, however, about both the drivers and impacts of transactions.

- A recent news article suggests dramatic consolidation yields substantial cost increases: *"Hospitals across the nation are being swept up in the biggest wave of mergers since the 1990s, a development that is creating giant hospital systems that could one day dominate American health care and drive up costs."*[1]
- Yet, a recent academic article views the trends as efficiency-enhancing and necessary to improve cost, quality and access: *"Our healthcare system is fragmented, with a misalignment of incentives, or lack of coordination, that spawns inefficient allocation of resources. Fragmentation adversely impacts quality, cost, and outcomes. Eliminating waste from unnecessary, unsafe care is crucial for improving quality and reducing costs–and making the system financially sustainable. Many believe this can be achieved through greater integration of healthcare delivery, more specifically via integrated delivery systems (IDSs)."*[2]

Specifically, the sharpest disagreement is over what is likely realized from hospital transactions –whether current and anticipated hospital transactions will yield important consumer and community benefits in improved value, efficiency, and access or instead result in anticompetitive pricing without offsetting benefits.[3] The latter perspective often relies on selected academic studies or modeling of price effects of mergers in the 1990s or in highly concentrated markets to draw their more general inferences about market power impact and motivations for current and future transactions.[4] Importantly, this reliance on past (and in some cases quite distant past) data or studies reveals the imperative for a more comprehensive understanding of *current* market conditions, *current* merger motivations and more rigorous examination of merger effects to evaluate the likely benefits or competitive risks of current and future hospital transactions.

Reliance on findings from past studies including ones evaluated under possibly fundamentally different market conditions points to some potentially critical gaps in and issues with using past research to inform current understanding of merger effects. In turn, this has precipitated calls for more careful review and re-focused research to better understand current merger trends and their

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1 Julie Cresswell and Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, THE NEW YORK TIMES (August 12, 2013), available online at http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?pagewanted=all&_r=0. See also: Anemona Hartocollis, *2 Hospital Networks Agree to Merge, Raising Specter of Costlier Care*, THE NEW YORK TIMES (July 16, 2013), available online at http://www.nytimes.com/2013/07/17/nyregion/2-hospital-networks-agree-to-merge-raising-specter-of-costlier-care.html, and Eduardo Porter, *Health Care's Overlooked Cost Factor*, THE NEW YORK TIMES (June 11, 2013), available online at http://www.nytimes.com/2013/06/12/business/examinations-of-health-costs-overlook-mergers.html?_r=1&.

2 Alain C. Enthoven, *Integrated Delivery Systems: The Cure for Fragmentation*, 15 AMERICAN JOURNAL OF MANAGED CARE 10S (2009): S284-S290 at S284.

3 Recent Congressional testimony highlights these different perspectives. For example "The health care field is undergoing a period of fundamental transformation in which the very model of health care delivery is being changed in order to improve quality and lower costs. The reasons for such change are varied, but chief among them are expectations [for]...greater value. Meeting these expectations requires building a continuum of care to replace the current fragmented system of health care. In addition, hospitals are facing enormous pressure to raise capital to invest in new technologies and facility upgrades. Mergers or acquisitions are often essential to make these goals a reality." Sharis Pozen, *The Patient Protection and Affordable Care Act, Consolidation, and the Consequent Impact on Competition in Healthcare*, Statement of the American Hospital Association, U.S. CONGRESS, HOUSE JUDICIARY COMMITTEE, SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW (September 19, 2013). Testimony indicating concerns about mergers includes: Joe Miller, *Competition and Consolidation in the U.S. Health Care System*, U.S. CONGRESS, HOUSE JUDICIARY COMMITTEE, SUBCOMMITTEE ON REGULATORY REFORM, COMMERCIAL AND ANTITRUST LAW (September 19, 2013). Several news article reference economist statements on inferences drawn from prior studies on merger price effects or price variation such as Martin Gaynor. Hartocollis (2013); and Paul Ginsburg: Robert Weisman, *Hospital Mergers May Drive up Costs*, THE BOSTON GLOBE (October 3, 2013), available online at http://www.bostonglobe.com/business/2013/10/02/health-care-leaders-warn-that-hospital-consolidation-could-drive-costs/ZAg3WyOtomHOPK3UNiHwOJ/story.html and articles such as Robert A. Berenson, Paul B. Ginsburg and Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFFAIRS 4 (2010): 699-70 [The latter is critiqued in Margaret E. Guerin-Calvert and Guillermo Israilevich, *Assessment of Cost Trends and Price Differences for U.S. Hospitals* (March 2011)]. These same press articles, however, highlight the many pressures facing hospitals and the benefits from acquisitions or system affiliation and potential gains from transactions [See, Weisman (2013)].

4 As noted in the discussion below of antitrust review of hospital mergers, concentration alone is not predictive of anticompetitive effects or challenge to a merger. While hospital mergers have been challenged, these represent a small proportion of those subject to review and scrutiny by the antitrust agencies. Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation – Update*, THE SYNTHESIS PROJECT (June 2012), available online at http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/the-impact-of-hospital-consolidation.html or David M. Cutler and Fiona Scott Morton, *Hospitals, Market Share, and Consolidation* 310 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 18 (2013): 1954-1970

impacts and implications for future mergers, and to take into consideration the dynamic effects and impacts of mergers on non-price competition. For example: "There is disagreement about whether the current trend toward provider consolidation is a desirable development, but many think continued horizontal and vertical integration based around hospitals is inevitable... Whatever the merits of consolidation, *there is a need to understand the effect of that consolidation on prices, service use, access and quality...*" (Emphasis added.)[5]

Importantly, this reliance on past (and in some cases quite distant past) data or studies reveals the imperative for a more comprehensive understanding of current market conditions, current merger motivations and more rigorous examination of merger effects to evaluate the likely benefits or competitive risks of current and future hospital transactions.

The Federation of American Hospitals (FAH) commissioned The Center for Healthcare Economics and Policy to contribute to this understanding by undertaking research on trends influencing transactions and healthcare delivery and to assess the literature and empirical studies on the price, value (cost and quality) and access effects of hospital merger transactions. We were tasked to evaluate these research findings for today's dynamic environment of major systemic change in healthcare delivery in the US.

In this study, we examine the role played by and the effects of hospital realignment. Specifically, we seek to identify and evaluate research on the factors that lead to hospital transactions and examine studies on the attributes and realization of expected benefits. We also document current merger and acquisition activity and other marketplace changes. To do so, we perform a comprehensive assessment of the literature and review 75 studies and 36 primary sources.

In reaching the findings presented in this report and summarized in the Overview, we examined studies about hospital realignment to identify how it may provide a means for hospitals to adapt to changes in the industry as well as to address current challenges (Sections I and II). **For example, acquisitions or system affiliation can facilitate access to needed capital and speedier implementation of essential technology (such as electronic medical records).**

To understand the effects of hospital realignment, we turn to an extensive review of the existing literature on access, cost and efficiency, and quality (Section III). We also provide a review of key factors and trends facing healthcare delivery today to provide context.

As much of the discussion surrounding hospital mergers and acquisitions pertains to expected price effects, we conduct an exhaustive survey and analysis of pricing studies. In addition, we report and discuss findings from antitrust reviews and retrospectives to put mergers that may pose significant competitive risks (*e.g.*, those receiving close scrutiny or challenge) into context (Section IV). We end our analysis with a review of macro developments and cover, in particular, recent healthcare expenditure and price growth trends (Section V).

Consolidation can lead to better coordinated care and enhance delivery points of care to patients. Mergers can also reduce operating costs or improve outcomes through economies of scale, realignment, or expansion of services.

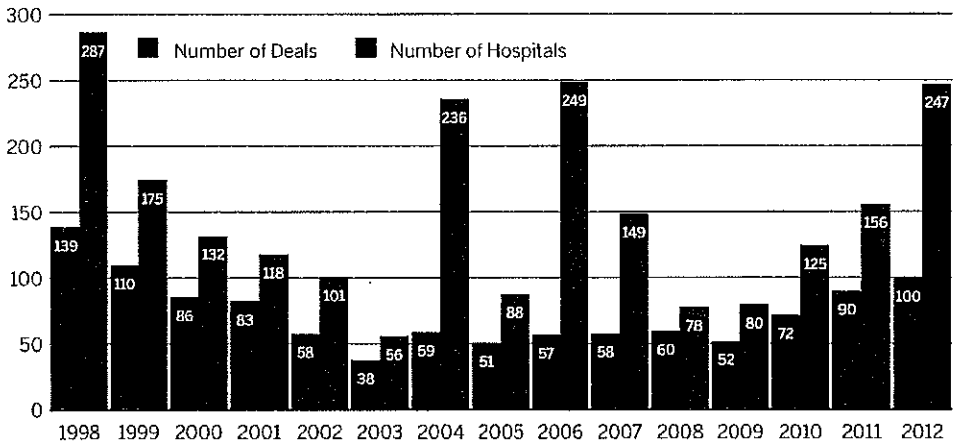
In today's challenging environment, mergers provide an opportunity to realign the healthcare delivery system to the benefit of patients and communities. Consolidation can lead to better coordinated care and enhance delivery points of care to patients. Mergers can also reduce operating costs or improve outcomes through economies of scale, realignment, or expansion of services.

5 Co-Chair G. William Hoagland quoted in a press release for a National Academy of Social Insurance project evaluating policy options that address the trend towards provider consolidation and its impact on health care spending. *Study Panel Announced for NASI Project to Address Pricing Power in Health Care Markets*, NATIONAL ACADEMY OF SOCIAL INSURANCE (July 18, 2013), available online at http://www.nasi.org/press/releases/2013/07/press-release-study-panel-announced-project-address-prici. Quoted in another press release on this project, he states that the study will "...explore the role of health plan consolidation on prices and quality and consider the role of factors besides consolidation on prices and quality." *NASI Announces New Project on Addressing Pricing Power in Health Care Markets*, NATIONAL ACADEMY OF SOCIAL INSURANCE (August 8, 2013), available online at http://www.nasi.org/press/releases/2013/06/press-release-announces-new-project-addressing-pricing-po.

B. Review of Hospital Merger and Acquisition Trends During the Past 20 Years

Facts about hospital consolidation activity over the last 20 years show some activity in each year—mergers are not uncommon but economic and financial factors likely play an important role in overall transaction activity. Figure 1 shows a steady baseline of mergers in each year; there have been 50 or more deals in every year but one (2003) since 1998. The graphic shows some variation in number of transactions and acquired hospitals per year – there generally have been more transactions in years of economic and financial pressures (e.g., after 2008); these factors are also relevant in the mid-to-late 1990s. For example, the number of hospitals involved in transactions has increased in the last 3 years relative to the preceding years – similar trends are found leading up to 1998. Data on individual transactions reveals that more than half of acquired hospitals in recent years had fewer than 150 beds, suggesting financial and economic pressures and/or effects of healthcare reform may be significant factors for this category of hospitals. [6]

Figure 1: Announced Hospital Mergers and Acquisitions, 1998 – 2012



Source: AHA TrendWatch Chartbook 2013, Chart 2.9 Announced Hospital Mergers and Acquisitions, 1998 – 2012

In fact, merger activity is characterized largely by single firm acquisition rather than "mega-mergers" – the majority of hospitals involved in transactions since 2007 were stand-alone hospitals; and many of these combined via mergers or acquisitions with just one or two other hospitals.[7] System acquisitions tended to involve expansion into new geographies and acquisitions of stand-alone hospitals, whether in the same or different geographies.[8] While the number of hospitals in systems has increased over time, there remain a very large number (almost 2,000) of independent hospitals (Figure 2) — many of which are smaller hospitals in rural or smaller urban areas.[9]

...merger activity is characterized largely by single firm acquisition rather than "mega-mergers" — the majority of hospitals involved in transactions since 2007 were stand-alone hospitals; and many of these combined via mergers or acquisitions with just one or two other hospitals.

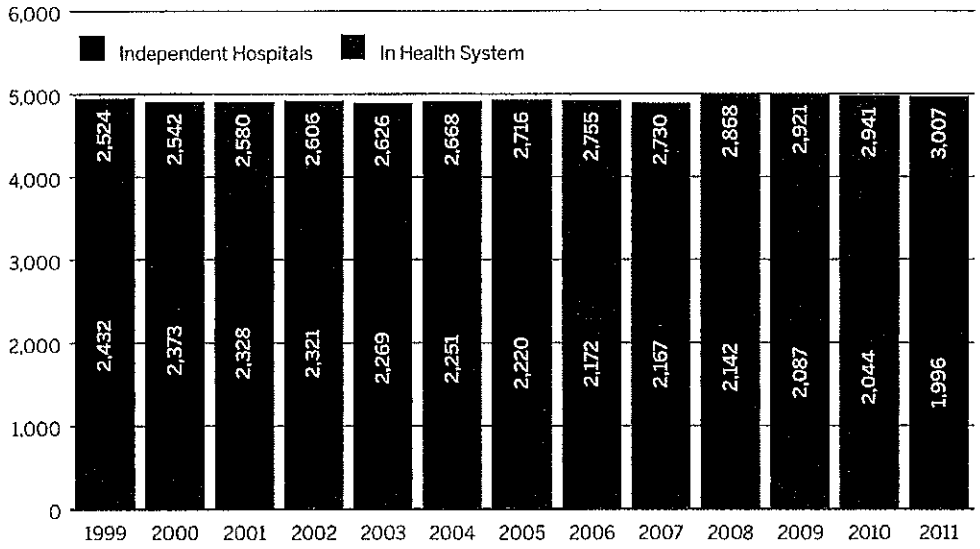
6 *AHA TrendWatch Chartbook 2013*, AMERICAN HOSPITAL ASSOCIATION (2013) Chart 2.9: Announced Hospital Mergers and Acquisitions, 1998 – 2012, available online at http://www.aha.org/research/reports/tw/chartbook/ch2.shtml. See also, *The Health Care Acquisition Report: Eighteenth Edition*, IRVING LEVIN ASSOCIATES, INC. (2012) at 3. The number of hospitals involved in mergers and number of transactions is affected by individual large transactions, such as HCA in 2006. Data from the mid-1990s also showed an increasing number of transactions and associated hospitals in the years leading up to 1998. For transactions before 1998 see AHA data reported in Allison E. Cuellar and Paul J. Gertler, *Trends in Hospital Consolidation: the Formation of Local Systems*, 22 HEALTH AFFAIRS 6 (2003): 677-687.

7 The Center for Healthcare Economics and Policy conducted an extensive study of hospital merger and acquisition activity for the period 2007 through June 2013; the study was commissioned by AHA. The study found that the average transaction size was small (on average one or two acquired hospitals), and a large proportion involved acquired hospitals with 150 or fewer beds, many of which were not previously affiliated with systems. The study also found that about half of all transactions involved hospitals in separate geographies (e.g., non-overlapping) and overlap transactions predominantly occurred in metropolitan areas with 5 or more competitors. Metropolitan areas were defined using MSAs. See *How Hospital Mergers and Acquisitions Benefit Communities: Updated Study by the Center for Healthcare Economics and Policy*, CENTER FOR HEALTHCARE ECONOMICS AND POLICY AND THE AMERICAN HOSPITAL ASSOCIATION (September 2013), available online at http://www.aha.org/content/13/13mergebenefitcommty.pdf for detail and methodology.

8 Based on data referenced in footnote 8.

9 And, the average size of hospital systems is relatively small with just over 3 hospitals. See, Cutler and Scott Morton (2013) at 1965.

Figure 2: Number of Independent Hospitals and Hospitals in Health Systems in the US, 1999-2011



Source: AHA TrendWatch Chartbook 2013, Table 2.1: Number of Community Hospitals, 1991 – 2011

About half of transactions occurred between organizations located in separate geographies and of those that involved overlaps in the same geography, the majority occurred in metropolitan areas with five or more independent competitors. Indeed, a large proportion of transactions occurred in metropolitan areas with multiple independent competitors[10] that are characterized as moderately concentrated or unconcentrated in the 2010 US Department of Justice and FTC Horizontal Merger Guidelines.[11] A recent study estimates concentration measures ("HHIs") for over 300 geographies using hospital referral regions ("HRRs") as the geographic unit in which to measure shares and 2011 data.[12] Interestingly, the study finds that *over half* of these 306 geographic areas are unconcentrated or moderately concentrated (suggesting that mergers in such areas would be less likely to raise a challenge under the 2010 Merger Guidelines on structural grounds).[13] These areas include many of the major metropolitan areas in the country such as Boston, Chicago, Los Angeles and New York, which account for a substantial proportion of US population.[14] Indeed, a population-adjusted map in the study shows that many of the moderately or low concentrated areas are geographies with larger populations and include large numbers of hospital competitors implying substantial alternatives for merging parties.[15]

10 See footnote 8 for detail. Competitors may also include other firms than those physically located in an area.

11 The 2010 Horizontal Merger Guidelines use the Herfindahl Hirschman Index (HHI) as a measure of concentration, and establish thresholds for unconcentrated (<1000), moderately concentrated (1000-2500) and highly concentrated (>2500) markets, and indicate the levels of HHI and change in concentration due to merger likely to precipitate more extensive scrutiny or possible challenge. *See Horizontal Merger Guidelines*, U.S. DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION (2010) available online at http://ftc.gov/os/2010/08/100819hmg.pdf. Market shares and concentration involve assessment of relevant markets and are just one part of merger review, which involves substantial analyses.

12 David M. Cutler and Fiona Scott Morton, *Hospitals, Market Share, and Consolidation*, 310 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 18 (2013): 1964-70. HRRs are derived based on hospital service areas of hospitals and use methodologies based on Medicare data; these are developed by Dartmouth Atlas. *Appendix on the Geography of Health Care in the United States*, THE DARTMOUTH ATLAS OF CARE 1999, The Dartmouth Institute for Health Policy and Clinical Practice: Lebanon, New Hampshire (1999). HRRs tend to be relatively broad areas often encompassing a MSA and surrounding areas

13 This assumes HRRs as proxies for "markets" in estimating HHIs. *See* Cutler and Scott Morton (2013) at 1966. The study also refers to changes in concentration from mid-1980s

14 *See, e.g.*, HHI measures and areas from Cutler and Scott Morton (2013) measuring concentration using hospital referral regions (HRRs).

15 Cutler and Scott Morton (2013) at 1966.

II. Key Policy, Demographic and Economic Factors Shaping Healthcare Delivery and Realignment

Major systemic changes are underway in the healthcare sector driven by government policy changes as well as economic conditions and demographics. The challenges facing the healthcare industry include the slow economic recovery, reduced reimbursements, difficulty in obtaining capital, a changing infrastructure for coordination of care, and an essential investment in and implementation of costly healthcare IT systems. Lower occupancy and excess or misaligned capacity are pressing concerns in many areas. The economic literature shows that these types of factors have been drivers of past mergers and of current ones.

Hospitals and health systems are under increasing pressure to deliver high quality, cost-effective healthcare that is integrated and coordinated across the delivery system in a community.

Hospitals and health systems are under increasing pressure to deliver high quality, cost-effective healthcare that is integrated and coordinated across the delivery system in a community. Pressures affect virtually all hospitals and geographies, albeit in varying degrees and have significant implications for mergers and realignment of healthcare delivery capacity. How these changes affect individual hospitals can vary considerably, depending on local market conditions, the specific situation of the hospital, and the healthcare needs of its community. Among important hospital-specific factors are: payor and service mix, age of plant and need for investments in plant or new technologies, patient volumes and occupancy rates, and financial circumstances including access to capital.[16]

Case in Point: *In an effort to increase efficiency and improve quality of care, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 developed both financial incentives (and penalties) designed to encourage hospitals to implement EMR technology. However, adopting this technology requires significant investment and may be prohibitively expensive for some hospitals. Recent studies show a large proportion of hospitals, particularly smaller hospitals, face significant challenges in meeting these requirements.* ***DesRoches et al. (2013)*** *explores hospital EMR uptake.[17] They find that while 42.2 percent of hospitals have adopted EMR in 2012, the vast majority of their systems are very basic ones.[18] The authors note differences in uptake by hospital characteristics: small hospitals are much less likely to have even a basic system than large hospitals and rural hospitals were also less likely to have a system in place compared to urban hospitals.[19] Both types of hospitals often face financial and human resource constraints to purchase and implement technology, and they may fall behind the more able institutions. If EMR prove not only to increase efficiency and quality of care,[20] but stave off penalties and garner incentives, failing to implement this technology could result in significant, long term costs and relative cost differences among hospitals, and may adversely affect a hospital's ability to compete in the future.*

These legislative and policy changes occur in the context of a broader set of economic, demographic, and patient care pressures.[21]

Key factors shaping healthcare delivery and realignment are: (1) Efforts to achieve "Triple Aim" goals of enhanced patient care, improved health of population, and reduction in rate of increase in per capita costs. These aims are accomplished by a broader

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16 There are many major changes confronting hospitals including actual and expected changes in reimbursements and modes of care delivery: reduced Medicare reimbursements and new payment models (e.g., global risk and value-based reimbursement), and penalties for avoidable readmissions and hospital-acquired conditions; potential expansion of Medicaid and expanded coverage of currently uninsured, required investments in technologies such as electronic health records; and new forms of care delivery such as Accountable Care Organizations, or "ACOs." See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684-89 (2010). See also, *The Affordable Care Act Three Years Post-Enactment*, THE HENRY J. KAISER FAMILY FOUNDATION (March 2013), available online at http://kaiserfamilyfoundation.files.wordpress.com/2013/04/84291.pdf; and Douglas W. Elmendorf, Dir., Cong. Budget Office, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, US CONGRESS, COMMITTEE ON ENERGY AND COMMERCE, SUBCOMMITTEE ON HEALTH (March 30, 2011), available online at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf.

17 The study uses data from the American Hospital Association (AHA) 2012 health IT supplement. Catherine DesRoches, Dustin Charles, Michael Furukawa, Maulik S. Joshi, *et al.*, *Adoption of Electronic Health Records Grows Rapidly, But Fewer than Half of US Hospitals had at least a Basic System in 2012*, 32 HEALTH AFFAIRS 8 (2013):1-9.

18 While they are compliant with the stage 1 guidelines which require compliance as of July 1, 2014, only 5.1 percent would comply with the stage 2 federal requirements. As more advanced systems (i.e., those that meet stage 2 requirements) are thought to provide a larger benefit, there is still substantial improvement which has yet to be realized. DesRoches *et al.* (2013) at 1.

19 Of the 2,796 survey respondents, 483 reported having a comprehensive EMR system, 792 had a basic system, and 1,521 had no system at all. There are marked differences in system type adoption among small, medium and large hospitals: 61.7 percent of small hospitals reported having no EHR system in 2012, while 25.3 percent had a basic system and 13.0 percent had a comprehensive system. For large hospitals, 38.1 percent had no system, 33.6 percent had a basic system and 28.3 percent had a comprehensive system. There also appears to be an urban/rural divide as 66.5 percent of rural hospitals reported having no system, 23.1 percent had a basic system and 10.4 percent had a comprehensive system. Among urban hospitals, 52.3 percent reported having no system, 28.8 had a basic system, and 18.9 percent had a comprehensive system. DesRoches *et al.* (2013) at 4, Exhibit 2.

20 Because EMR technology is a precursor to full participation in a regional health information organization (a facilitator of information sharing among stakeholders), the disadvantage the hospitals which fail to adopt the technology may be further compounded. Similar to the findings presented for EMR adoption, Furukawa *et al.* (2013) studies regional health information organization activity and finds that providers in rural locations had lower levels of exchange activity than did their urban counterparts. Michael F. Furukawa, Vaishali Patel, Dustin Charles, Matthew Swain and Farzad Mostashari, *Hospital Electronic Health Information Exchange Grew Substantially in 2008-12*, 32 HEALTH AFFAIRS 8 (2013):1346-1354.

21 Hospitals in the US have experienced a decline in inpatient admissions over the past several years, due in part to shifts to outpatient care (discussed in more detail below) as well as economic conditions. *AHA TrendWatch Chartbook 2013*, AMERICAN HOSPITAL ASSOCIATION, (2013) Table 3.1, available online at http://www.aha.org/research/reports/tw/chartbook/2013/table3-1.pdf, and Moody's Investor Services, *U.S. NOT-FOR-PROFIT HEALTHCARE OUTLOOK REMAINS NEGATIVE FOR 2012*, OUTLOOK (2012).

focus on coordinated care delivery for populations rather than episodes of care, and through more efficient delivery systems of integrated and coordinated care.[22] Shifting from individual patient episodes and fee-for-service to managing population health effectively requires significant movement from unaligned and fragmented entities toward systems of healthcare providers.[23] In turn, this may result in increased restructuring of care delivery with increased coordination or ownership change, and is likely to implicate more transactions involving hospitals given the large number of hospitals that are stand-alone facilities.[24] (2) Shifts from inpatient to outpatient care and excess inpatient capacity. Improvements in technologies enabling less invasive procedures and shorter stays have resulted in a significant increase in outpatient care and a reduction in inpatient care. Outpatient care now accounts for about 60 percent of patient care, and an increasing proportion of that care is delivered in free standing facilities rather than in hospital-owned facilities.[25] The number of such facilities has increased significantly in the last decade.[26] And (3) Development of integrated delivery systems or integrated delivery networks (IDS or IDN) is expanding considerably with systems of hospitals (community and tertiary) and physicians, and in some cases with insurance plans, to deliver a full spectrum of care to a community. This has been accomplished by adding hospitals or providers to a system, or by expansion and outreach efforts of a health system to serve a wider community and population with outpatient or physician offices.[27]

Key factors shaping healthcare delivery and realignment are ...Efforts to achieve "Triple Aim" goals of enhanced patient care, improved health of population, and reduction in rate of increase in per capita costs.

The net effect of economic factors (including decline in employment, shifts of industries from one area to another) and population shifts, along with the shift in location of care from inpatient to outpatient already has resulted in significant under-utilized inpatient capacity at many hospitals and financial pressures.[28] We turn to these factors specifically in the following and examine in detail the implications for access to capital and hospital executive perceptions of the impact of economic and financial conditions, as well as the impact of capacity on costs.

Financial trends and implications for hospitals' operations, access to and cost of capital in 2013 and beyond: Reductions in the healthcare spending trend along with other factors exert pressure on hospital profit margins. Moody's Investors Service (2012) revised its not-for-profit hospital industry outlook to negative (from stable) in 2008 and reports in 2012 that the outlook is expected to remain negative for the foreseeable future.[29] The slow economic recovery has resulted in a reduction in inpatient volume and a weakening in payor mix (i.e., there is an increased proportion of revenue derived from Medicaid and Medicare which offer less generous reimbursement than do commercial payors), both of which lead to increased financial pressures.[30] Moody's

22 *See*, Atul Gawande, *The Cost Conundrum*, THE NEW YORKER (June 1, 2009), available online at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande and and Donald M. Berwick, Thomas W. Nolan and John Whittington, *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFFAIRS 759 (2008): 759-769.

23 *See*, Berwick (2008) at 763-64 (noting that the integrator has the ability to take a defined population and coordinate services to address care, health, and costs).

24 As shown in Figure 2 above, about 1,900 hospitals in the US are stand-alone hospitals. This number is down by about 450 since 2010 due to affiliations with systems or formation of systems, as well as some closures. *AHA TrendWatch Chartbook 2013* at Table 2.1, available online at http://www.aha.org/research/reports/tw/chartbook/2013/table2-1.pdf. Many are smaller hospitals. *See, Hospital Statistics by State*, AMERICAN HOSPITAL DIRECTORY (2012), available online at http://www.ahd.com/state_statistics.html.

25 For statistics on inpatient care changes including decline in rate of admissions as well as change in acuity of care provided at hospitals *see, Report to the Congress: Medicare Payment Policy*, MEDICARE PAYMENT ADVISORY COMMISSION (March 2013); *Ambulatory Surgery in US Hospitals*, U.S. DEP'T OF HEALTH & HUMAN SERV., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, AHRQ Publication No. 07-0007 (2007): 26-40 available online at http://archive.ahrq.gov/data/hcup/factbk9/factbk9.pdf; and Beth Kutscher, *Outpatient Care Takes the Inside Track*, MODERNHEALTHCARE.COM (AUG. 4, 2012) available online at http://www.modernhealthcare.com/article/20120804/MAGAZINE/308049929. There are also significant changes in payment methodologies and contracting. *See, e.g.*, Zirui Song, Dana G. Safran, Bruce E. Landon, Mary Beth Landrum, *et al.*, *"The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality* 31 Health Affairs 9 (2012):1-10.

26 Between 2006-2008 the number of Medicare approved Ambulatory Surgical Centers increased at an average rate of 5.1 percent per year. *Report to the Congress: Medicare Payment Policy*, MEDICARE PAYMENT ADVISORY COMMISSION (March 2013) at 111.

27 *See*, Emily R. Carrier, Marisa Dowling and Robert A. Berenson, *Hospitals' Geographic Expansion In Quest Of Well-Insured Patients: Will The Outcome Be Better Care, More Cost, Or Both?*, 31 HEALTH AFFAIRS 827 (2012)827-835; Douglas McCarthy, and Kimberly Mueller, *Organizing for Higher Performance: Case Studies of Organized Delivery Systems*, THE COMMONWEALTH FUND (2009); McCarthy, Douglas, Kimberly Mueller and Ingrid Tillmann, *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda*, THE COMMONWEALTH FUND (2009); Douglas McCarthy, Kimberly Mueller, and Jennifer Wrenn, *Geisinger Health System: Achieving the Potential of System Integration through Innovation, Leadership, Measurement, and Incentives*, THE COMMONWEALTH FUND (2009); and Kathleen H. McCarthy and Alan M. Zuckerman, *Realizing the Full Financial Benefits of True Integration*, 64 HEALTHCARE FINANCIAL MANAGEMENT 11 (Nov 2010): 78-82, 84, 86 *passim*, available online at http://www.hfma.org/Content.aspx?id=2740.

28 Trends in occupancy rates are provided in *Health, United States, 2010*, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, CENTERS FOR DISEASE CONTROL & PREVENTION, (2010) available online at http://www.cdc.gov/nchs/data/hus/hus10.pdf (listing trends in occupancy). Significant excess capacity can result in higher operating costs per patient; reduction or elimination of excess capacity may be difficult to achieve absent mergers or consolidation. *See, e.g.*, Kathleen Carey, *Stochastic Demand for Hospitals and Optimizing "Excess" Bed Capacity*, 14 JOURNAL OF REGULATORY ECONOMICS 2 (1998):165-187; and Esther Gal-Or, *Excessive Investment in Hospital Capacities*, 3 JOURNAL OF ECONOMICS & MANAGEMENT STRATEGY 1 (1994):53-70.

29 Moody's Investor Services, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, OUTLOOK (2012). Hospital credit ratings by state are listed on pages 18-32.

30 In part, revenue growth reduction can be attributed to reductions in reimbursement in Medicare and Medicaid which represent 43 percent and 11 percent of a hospital's net revenue, respectively. For the federal fiscal years 2011 and 2012, Medicare payments were reduced by 2.9 percent per year, for a total reduction of 5.8 percent, and a number of states are implementing reductions in Medicaid reimbursement. *Ibid.*, at 4.

notes: **"Hospitals are faced with an unprecedented threat to revenues...we expect revenue growth to continue to be weak and not able to keep pace with normal spending inflation."**[31]

A second 2012 Moody's report states that: "Consolidation offers the promise of greater operating efficiency and risk diversification across larger organizations, likely leading to stronger and more stable bond ratings for affected hospitals."[32] The economic logic underlying these statements is that size and scale can play a role in spreading semi-fixed and fixed costs, a significant portion of overall hospital costs, over a greater volume of business, as well as in providing variable cost efficiencies.[33] Transactions or affiliations with systems can provide access to capital that may otherwise be unavailable or prohibitively expensive.[34] A recent study estimates that less than 20 percent of almost 500 hospitals' debt rated by Moody's had a high bond rating, implying higher costs of capital or greater difficulty in accessing capital.[35]

Perspectives from hospital executives: Surveys of industry executives provide perspectives on the implications of these financial, regulatory and economic trends. A recent survey about capital constraints fielded to non-federal hospital CEOs revealed that nearly half of the hospitals surveyed reported putting capital projects on hold (including stopping ones currently in progress).[36] Projects included facility upgrades, acquisition of clinical technology and the acquisition of health information technology. Various surveys of hospital executives echo these concerns and indicate that the current healthcare environment is exceptionally challenging, with pressure coming for all angles.[37] A Deloitte (2011) study reported that many hospital CEOs believe that navigating the current healthcare environment poses the biggest challenge of their professional careers. Their responses suggest that significant realignment may be necessary for long-term survival.[38] Mergers may provide a means to address these concerns as transactions can include cash transfusions to the acquired party, allowing stalled projects to continue. In addition, mergers allow the potential for realignment which can lead to decreased costs. This reduction in cost would ameliorate some of the financial pressures these firms currently face.

Utilization Trends and "Excess" Capacity: Analyses of bed capacity for U.S. major metropolitan areas show that potentially higher available capacity at the MSA level is a widespread phenomenon: Many cities have above average bed capacity – and in some cases substantial capacity relative to expected usage.[39] Statistics on inpatient utilization trends show an overall decline in inpatient utilization which are likely to be exacerbated where Triple Aim efforts succeed in shifting more patients to preventive care or reduce inpatient

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31 *Ibid.*, at 2.

32 Moody's Investor Services, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, OUTLOOK (2012) at 1.

33 John Commins, *Pace of Hospital M&As Likely to Accelerate*, HEALTHLEADERS MEDIA (March 19, 2012) available online at http://www.healthleadersmedia.com/print/FIN-277847/Pace-of-Hospita.

34 Capital and scale issues have a disproportionate effect on smaller hospitals. Smaller stand-alone hospitals are more vulnerable to changes and may struggle to cope with new regulations stemming from the ACA. They may find implementing IT features such as electric medical records (EMR) would create excessive financial burden. *See, US Hospital M&A Generally Positive for Bondholders*, FITCHRATINGS (July 2012) available online at http://www.fitchratings.com/gws/en/fitchwire/fitchwirearticle/US-Hospital-M%26A?pr_id=754425; Ryan S. Gish and Kit A. Kamholz, *To Stand Alone or to Seek a Partner: A question ..or an imperative?* TRUSTEE (September 2009): 23-26; Daniel M. Grauman, John M. Harris and Christine Martin, *Access to Capital: Implications for Hospital Consolidation*, 65 HEALTHCARE FINANCIAL MANAGEMENT 4 (April 2010)57-66; Frederick A. Hessler, *The Capital Challenge: Think Outside the Box*, HEALTH AND HEALTH NETWORKS DAILY (May 2012); and *Financing the Future II: Report 6: The Outlook for Capital Access and Spending*, 60 HEALTHCARE FINANCIAL MANAGEMENT 8 (2006):40-41

35 Cutler and Scott Morton (2013) at 1965

36 *AHA Report on the Capital Crisis: Impact on Hospitals*, AMERICAN HOSPITAL ASSOCIATION (January 2009) at 3, available online at www.aha.org/content/00-10/090122capitalcrisisreport.pdf. Specifically, 82 percent report putting facilities projects on hold, 65 percent have put clinical technology projects on hold and 62 percent have put information technology projects on hold.

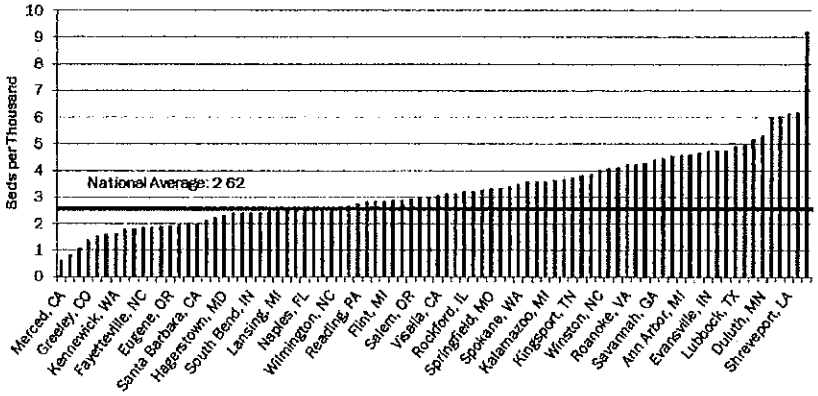
37 Collectively, the survey responses indicate that the current healthcare environment presents significant challenges and that the business model hospitals employed in the past is no longer relevant. Many of the respondents plan to explore consolidation possibilities within the near future (one study found that half of respondents believed that it was extremely likely that their organization would be absorb or be absorbed by another hospital system [U.S. News, 2011]). Findings from a Huron Healthcare (2013) report highlight the perceived benefits from consolidation. Specifically: "CEOs recognize that spreading fixed costs through consolidation or collaboration is one way to create efficiencies in process and pricing. This approach can also help organizations quickly acquire new capabilities at a lower cost structure. In the long term, CEOs are considering how consolidation may help provide more effective population health management." *Inventing the Future of Healthcare: Top CEOs on the Real Work of Transforming the Healthcare Industry*, HURON HEALTHCARE (2013) at11-12. available online at http://healthcareceoforum.com/report/. *See, Issue Brief: A look Around the Corner: Healthcare CEO's Perspective's on the Future*, DELOITTE (June 2012), available online at http://www.deloitte.com/view/en_US/us/Industries/life-sciences/28714218f4108310VgnVCM2000001b56f00aRCRD.htm#; *Annual Executive Survey*, CRANEWARE (February 2012), available online at http://www.craneware.com/stoptheleakage/blog/post/The-results-are-in-Cranewares-Annual-Executive-Industry-Survey.aspx; *Top Issues Confronting Hospitals: 2012*, AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES (January 2013), available online at http://www.ache.org/PUBS/research/ceoissues.cfm; *Eighty-Eight Percent of Healthcare Services Execs Will Pursue M&A in the Next Year, Shows GE Capital Healthcare Survey*, GE CAPITAL (September 2013), available online at http://www.genewscenter.com/Press-Releases/Eighty-Eight-Percent-of-Healthcare-Services-Execs-Will-Pursue-M-A-in-the-Next-Year-Shows-GE-Capital-42b5.aspx#downloads; *Hospital Executives Survey*, U.S. NEWS (July 2011), available online at http://health.usnews.com/health-news/best-practices-in-health/articles/2011/07/18/healthsurveytables; and *CEO Report: Optimism on the Upswing*, HEALTHLEADERS MEDIA, 2013, available online at http://www.healthleadersmedia.com/intelligence/detail.cfm?content_id=287883&year=2013

38 "The bottom line: Many hospital CEOs stated that the new normal represents the biggest test thus far in their professional career. They anticipate two eventualities for their organization: it will be paid less for the entirety of services provided; and its portfolio of acute clinical services is likely to become a cost center in a bigger, more complex organization that is focused on care for the healthy, not just the sick." Deloitte (2012) at 2

39 Bed capacity per capita serves as a rough proxy for available capacity (total bed capacity may also be a useful measure). Above average bed capacity is determined by using the average number of hospital beds per thousand population for MSAs in the country. Other capacity or available capacity measures used include utilization or occupancy rates.

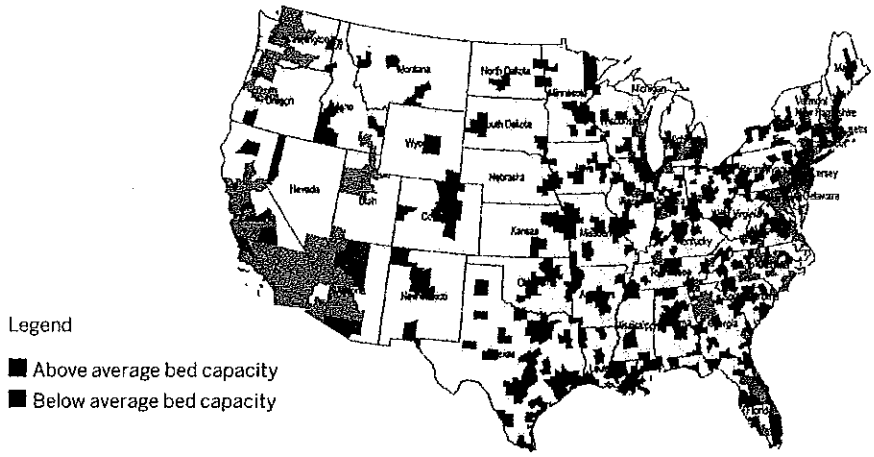
utilization, or where there are increased pressures to reduce readmissions.[40] The following graphics (Figures 3 and 4) depict estimates of bed capacity by MSA. The first graphic presents bed-capacity for small to medium-sized MSAs and demonstrates that many of these areas are likely to have excess bed capacity at least as measured by this proxy of beds per thousand. Our focus on smaller cities comes from the fact that these include cities with a number of stand-alone hospitals.[41] To get a national perspective, the map depicts MSAs (regardless of population size) with above or below average capacity across the US. This provides a perspective on the location of geographies where *current* configuration of capacity may well exceed needed capacity in the future. These figures present geographies where consolidation or realignment may be relevant as a means to improve costs and quality of care.[42]

Figure 3: Estimated Bed Capacity by Metropolitan Statistical Area (MSA) for Selected MSAs
(Limited to MSAs with a population of 250,000 to 500,000)



Source: Author's Calculations using 2011 AHA Survey data
Notes: Bed count presented in this graph is not limited to general acute care (GAC) facilities only but represents beds in all hospital facilities located within the specified MSA

Figure 4: Estimated Bed Capacity by Metropolitan Statistical Area (Map)



Dartmouth Atlas of Health Care, DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICES (2009) at 2-3. The map and graphic show regional variation at the MSA level in capacity per capita; above average capacity per capita may be indicative of overall potential excess of capacity relative to demand at the MSA level; individual hospitals within an MSA may have higher utilization.

40 Over the past two decades there has been a shift from inpatient to outpatient care. Inpatient admissions per 1,000 have declined since 1991 from 123.2 to 111.8 in 2011. Inpatient Days per 1,000 have similarly declined from 883.9 in 1991 to 600.4 in 2011. From 1991-2011, the average length of stay has declined from 7.2 to 5.4 days. Conversely, outpatient visits per 1,000 have risen from 1,273.4 to 2,105.6 over that time period. The change is more pronounced in recent years. From 2006 – 2011, inpatient admissions have declined by 5.4 percent while outpatient visits have risen by 5.2 percent. *AHA TrendWatch Chartbook 2013*, AMERICAN HOSPITAL ASSOCIATION (2013): Table 3.1 Trends in Inpatient Utilization in Community Hospitals, 1991 – 2011, available online at http://www.aha.org/research/reports/tw/chartbook/2013/table3-1.pdf. *AHA TrendWatch Chartbook 2013*, AMERICAN HOSPITAL ASSOCIATION (2013): Table 3.4. Outpatient Utilization in Community Hospitals available online at http://www.aha.org/research/reports/tw/chartbook/2013/table3-4.pdf.

41 The table depicts hospital bed capacity per capita for those 83 MSAs with a population between 250,000 and 500,000 as of 2011

42 Average bed capacity is about 2.6 beds per thousand people for metro MSA areas in the US. *See* also, David C. Goodman, Elliott S. Fisher, and Kristen K. Bronner, *Hospital and Physician Capacity Update: A Brief Report from the Dartmouth Atlas of Health Care*, DARTMOUTH INST. FOR HEALTH POLICY & CLINICAL PRACTICES (2009) at 2-3. The map and graphic show regional variation at the MSA level in capacity per capita, above average capacity per capita may be indicative of overall potential excess of capacity relative to demand at the MSA level; individual hospitals within an MSA may have higher utilization.

Reduction in *actual* excess capacity at the hospital level or at the city level could result in significant operational cost savings; realignment and restructuring through mergers may provide a means to accomplish cost reduction. A study of capacity utilization by US hospitals determined there was potentially significant excess capacity measured at the hospital level. Where substantial excess capacity was present and could be reduced, it has been estimated that operating costs could be reduced.[43] Restructuring (i.e., turning general acute care beds into other uses) that can be accomplished by merger may be an effective tool to address excess capacity. Mergers and acquisitions may provide an effective market mechanism to yield better alignment of capacity with demand. Studies of hospital decision-making suggest that independent decision-making, while beneficial in many respects, can lead to over-investment and excess capacity relative to market demand, and that mechanisms for joint investments or decision making may lead to closer alignment of capacity with market demand.[44] Taking unnecessary costs out of a hospital system frees up funds to invest in unmet healthcare needs or to use in reducing overall healthcare costs.

Reduction in actual excess capacity at the hospital level or at the city level could result in significant operational cost savings; realignment and restructuring through mergers may provide a means to accomplish cost reduction.

III. Review of Literature on Merger Rationale and Effects: Value (Cost, Quality) and Access

A. Overview

In this section, we review the economic literature regarding the role that mergers and acquisitions play in responding to financial and policy pressures, changing demographic and economic conditions, and changes in demand or supply conditions in healthcare. One key driver of mergers has been the ability to maintain services in a community that might otherwise be reduced or eliminated through downsizing or closure of hospitals.[45] Studies show that financial circumstances, reduction in redundant services, efficient realignment and improved access to capital have all contributed to the trend. Many hospitals anticipated and made significant changes in service offerings post-merger, including re-organization. The alternative to merger or acquisitions is shown by some studies to be hospital closures, downsizing, or reduction in service mix such as elimination of maternity services or lower volume tertiary services. Hospital closures can reduce access to care and can result in substantial welfare effects for the local community; the literature shows some impact on mortality rates.

One key driver of mergers has been the ability to maintain services in a community that might otherwise be reduced or eliminated through downsizing or closure of hospitals.... Hospital closures can reduce access to care and can result in substantial welfare effects for the local community....

The literature identifies a number of potential benefits from mergers that fall into the categories of value (cost, quality) and access. Among the benefits identified in the literature are:

- Administrative and overhead savings
- Reduced costs or reduced rate of cost/expense growth through improved operating efficiency or reduction/elimination of redundant services
- Improved overall operations and efficiency
- Realignment of services to achieve greater scale of operations or to improve quality of care delivered
- Reduction of excess capacity
- Access to capital and improved ability to make necessary investments such as technology and update facilities or services
- Ability to maintain or expand services in a community (and thereby maintain quality of services or care and/or access to care)

43 Carey (1998) uses data from the AHA and the Hospital Cost Reporting Information System (HCRIS) for the period 1987-1992 in order to determine the optimal number of excess beds a facility should hold. Carey defines the optimal level of bed capacity as occurring "where the ratio of the hospital s cost of staffing the last bed to the cost of not having the bed available is equal to the probability that the hospital is full." Carey (1998) at 179.

44 Gal-Or (1994).

45 Realignment resulting from a merger may reduce service line duplication which could have a negative impact on access.

These benefits provide the ability to respond to the pressures and challenges facing stand-alone hospitals.

In the following section, we examine the literature on price effects of mergers. The majority of this empirical literature on hospital transactions is based on studies of mergers from the 1990s and early 2000s. We start our review by examining the economic literature on both the drivers and consequences of hospital mergers. For comparative purposes, we also survey the literature on outcomes for hospitals that faced comparable challenges but did not merge. We review numerous studies addressing a very diverse set of market conditions, transactions, and sources of benefits. Many studies involve large numbers of transactions as well as hospitals (including those not involved in transactions) from the 1990s; many are recent studies and trends. This review spans decades of data and information on transactions often not studied in detail–predominantly because the vast majority of mergers raise no significant competitive risks, and their benefits may not be scrutinized or quantified expressly. We are not predicting that specific benefits found in studies from the 1990s will be replicated in each merger in the future, but believe they are informative of the types of benefits achievable by many mergers in the future, particularly where assessment of the current environment suggests increased demand for improvements in quality, access, and costs. Moreover, these studies provide insight into the gains from addressing those contemporaneous challenges.

B. The Role of Mergers and Acquisitions in Realigning the Healthcare Delivery System

As in any industry, a firm will remain viable in the long run only if it is able to adapt to changes in both supply and demand as well as adjust to overall changes in the environment. The hospital industry, in particular, currently faces many challenges that adversely impact hospitals' operations and ability to operate in their original configuration and capacity. The previous section enumerated myriad challenges facing the healthcare industry including slow economic recovery, reduced reimbursements, difficulty in obtaining capital, and a changing infrastructure that stresses the coordination of care and requires the use and implementation of expensive healthcare IT systems. In addition to these challenges, lower occupancy and excess capacity remain pressing concerns. These environmental factors and trends can drive consolidation activity.

Studies on restructuring through consolidation show that mergers and acquisitions can prove an effective means to deal with excess capacity/lower occupancy and financial pressures. ***Bazzoli et al.* (2002)** examine reasons for hospital restructuring and reorganization during 1989-1996.[46] In comparing the acquired and acquiring hospitals, the authors found that the acquired hospitals had lower occupancy rates, on average, than did the acquiring hospitals.[47] Self-reported reasons for merging demonstrate the importance of several factors, among which the desire to improve operating efficiency emerges as a primary objective.[48] Expansion was also indicated as an important reason to merge. 54.4 percent stated that the desire to expand market share was an important consideration, as was the desire to expand access to care (53.2 percent), and to expand the scope of services provided (44.3 percent).[49]

The hospital industry, in particular, faces many challenges that adversely impact operations and the organization's ability to operate in its original configuration and capacity.... Studies on restructuring through consolidation show that mergers and acquisitions can prove an effective means to deal with excess capacity/lower occupancy and financial pressures.

The reasons that motivate consolidation indicate that hospitals perceive growth through merger as an effective way to meet current demand and adjust to the changing healthcare environment. Realignment of services can lead to an organization that is better able to meet the needs of the community and maintain service offerings in challenging times – factors which contribute to hospital survival. Review of the literature suggests that many transactions in the 1990s actually resulted in significant realignment and provides some evidence of administrative and other savings due to consolidation. Bazzoli *et al.* (2002) explore actual changes in service mix among hospitals both pre and post-merger and provide useful insights into what many mergers actually accomplished in

46 Gloria J. Bazzoli, Anthony LoSasso, Richard Arnould and Madeline Shalowitz, *Hospital Reorganization and Restructuring Achieved through Merger*, 27 HEALTH CARE MANAGEMENT REVIEW 1 (Winter 2002) 7-20. Using AHA annual hospital survey data, they identified mergers occurring during the specified time period. They further limited their sample to those mergers which involved only two hospitals. Of the 153 mergers which met their selection criteria, 80 (52.3 percent) responded to a survey developed by the study authors.

47 The reported average occupancy rate of the acquired hospitals during the 1989-1996 period was 57.3 percent while the occupancy rate of the acquirer during this same time period averaged 62.5 percent. Occupancy rates post-transaction were not reported. *Ibid.*, at 11

48 Respondents were asked to rate a given set of reasons in matter of importance using a Likert-type scale, where 1 indicates "not important" and 7 indicates "very important." The top three reasons were to strengthen financial performance (83.5 percent), to achieve operating economies (79.7%) and to consolidate services (70.9). *Ibid.*, at 11.

49 Less commonly reported reasons include expanding the size of the system (22.8 percent), reducing bed capacity (17.7 percent), and expanding bed capacity (8.9 percent). *Ibid*

terms of reorganization during the 1990s.[50] The results they present suggest significant realignment of services occurred, primarily through reduction in service duplication.

To explore the magnitude of realignment resulting from mergers, the study reports the percentage of hospitals where both hospitals offered a service prior to merger and the percentage where both offered that same service post-merger. During the period 1989-1996 (the pre-merger period), 82.7 percent of hospitals offered both inpatient medical service and emergency care. Post-merger, only 42.7 percent of the pairs both retained inpatient medical services and 49.3 percent retained emergency medical care at both facilities.[51] Bazzoli notes that the significant reduction is likely related to the fact that many hospitals were located nearby one another.[52] Nearby hospitals that consolidate provide a greater opportunity for service realignment and repurposing.

In addition to service mix realignment, the authors note that many of the merging pairs report administrative downsizing. The parties reported significant reductions in CEO/COO staffing as well as reductions in order of 12 to 37 percent of general administrative staff. The declines highlight the potential for economies of scale and the associated reduction in cost which may result from a merger. These savings are particularly relevant as labor comprises a significant portion of a hospital's operating costs.[53]

...hospitals perceive growth through merger as an effective way to meet current demand and adjust to the changing healthcare environment (Bazzoli et al. (2002)). Realignment of services can lead to an organization that is better able to meet the needs of the community and maintain service offerings in challenging times — factors which contribute to hospital survival.

***Spetz et al.* (1999)** studied hospitals in California to examine the characteristics of merging hospitals.[54] Of 296 ownership changes between 1986 and 1996, 13 included conversions from not-for-profit to for-profit, and 12 switched from for-profit to nonprofit. Approximately 80 percent of the changes did not include any changes in profit status. Most of the ownership changes during this time were the result of consolidations and mergers between hospital corporations. Multi-hospital systems grew during the period under review with more than half of all hospitals in California affiliated with multi-site hospital corporations. Less than 10% of merger activity during this period occurred in rural areas.

Mergers can be an effective tool in responding to marketplace needs and can help ameliorate resource constraints. Benefits from affiliations include gaining access to personnel, expertise, and/or capital. *Bazzoli et al.* (2006) employs a case study design to explore both the reason for and response to demand and supply conditions in local healthcare geographies.[55] Hospital executives reported that expected population growth or changes in insurance coverage lead to an increase in perceived demand and estimates of the required level of capacity to meet future needs.[56] However, results suggest that there may be several constraints facing hospitals in their ability to respond to marketplace conditions, including physical space, regulation, capital, and personnel. Merger and acquisitions may provide a means for hospitals to overcome these constraints.

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50 This and related studies provide insights into the role that realignment plays in the hospital sector both in form and in the types of benefits, suggesting benefits that likely occurred during the period under their study that may not be captured in other studies.

51 Changes among other service lines were reported as well. Pre-merger, 40.0 percent of the hospital pairs had inpatient OB-GYB, 38.7 had inpatient pediatrics, and 23.0 percent had inpatient rehabilitation. In the post-merger period, the percentage in which both hospitals offered the service line dropped with 8.0 percent retaining inpatient OB-GYN, 9.3 retaining inpatient pediatric services, and 12.2 percent retaining inpatient rehabilitation at both facilities. The authors find that consolidation of departments was a very common occurrence. Among similar hospitals (those having common services), 96.4 percent report consolidating or merging two or more departments or programs compared with 86.1 percent at dissimilar hospitals. Similar hospitals as defined as those hospitals that offered 50 percent or more of the same major services. *Ibid.*, at 15.

52 The merging hospitals tended to be located near to one another. The average distance between urban hospital merging pairs was 4.91 miles, while the distance between rural hospital merger pairs was 11.14 miles (Bazzoli 2002, page 11). Among the hospitals in the sample, 5 percent of rural hospitals and 8 percent of urban hospitals closed. 52 percent of rural hospitals retained acute care services as did 61 percent of urban hospitals. Significant realignment occurred as a result of the merger as 43 percent of rural and 31 percent of urban hospitals were converted to other uses. *Ibid.*, at 14.

53 The study did not report changes in outcome measures or improvements resulting from realignment/consolidation or staffing changes.

54 Joanne Spetz, Jean Ann Seago and Shannon Mitchell, *Changes in Hospital Ownership in California*, PUBLIC POLICY INSTITUTE OF CALIFORNIA (1999).

55 The study uses data collected during 1995-2003 for the Community Tracking Study (CTS), a study which collects data on health system change for a randomly selected, nationally representative sample of 60 communities. The CTS is a study directed by the Center for Studying Health System Change. The randomly selected communities are defined as MSAs with populations of 200,000 or more. Although the CTS includes in-depth interviews in 12 of the 60 sites, four cities (Boston, Cleveland, Miami, and Phoenix) were selected for inclusion in the study as they are located in major metropolitan areas and had diverse hospital resources. The survey questions developed to elicit information regarding capacity constraints are as follows: To what extent has your hospital (or the hospitals in your system) experienced capacity constraints in the past year? In what specific service lines, units, or patient care departments has your hospital (or hospitals in your system) experienced capacity problems? What are the major factors that have caused capacity problems in your hospital (or hospitals in your system)? How is your hospital currently responding to capacity problems? Have there been any community-led efforts to address capacity problems? Gloria J. Bazzoli, Linda R. Brewster, Jessica H. May and Sylvia Kyo, *The Transition from Excess Capacity to Strained Capacity in U.S. Hospitals*, 84 THE MILBANK QUARTERLY 2 (2006): 273-304.

56 However, estimated service demand may not be well aligned with actual future demand.

In the sections below, we highlight findings from key studies that contribute significantly to the literature on access, efficiency, and value (quality).[57]

C. Evaluation of Outcome Measures from Mergers and Acquisitions

1. Access

Studies of hospital mergers generally explore mergers' impact on cost, efficiency, quality, and price. These outcomes focus on what happens in the event of a merger. However, it is as useful to consider what might happen if a merger does not take place since the status quo often is not an alternative, *e.g.*, a merger may prevent a hospital from entering into bankruptcy.

Becker and Dunn (2010) note that during 2000-2010, there were approximately 70 hospital bankruptcies.[58] They identify seven factors that drive bankruptcy including high levels of competition, an aging physical plant, poor physician alignment (resulting in low patient referrals), coping with a dominant commercial payor or an especially large percentage of Medicare/Medicaid reimbursement, poor cost structure, poor management, and poor quality. **Yarbrough and Landry (2009)** explore the precursors to poor financial performance and identify factors related to bankruptcy.[59] They investigate the 36 urban bankruptcies that occurred during 2000-2006. They find that reimbursement challenges including reductions in Medicare and Medicaid payments led to poor financial performance. In exploring characteristics of those firms that file for bankruptcy, they find that both smaller hospitals and independent hospitals are more vulnerable.[60]

Unstable or poor financial health are often times precursors to merger activity as the firm may need financial assistance and merging with another firm provides a means to access that capital and cash flow. Actual merger activity bears this theory out as many mergers and acquisitions result in a cash infusion for the target. If not for the financial support, many of these institutions would be at risk of bankruptcy and closure. Many studies indicate that hospital closure can have disruptive effects on the local community. Hospital closure potentially reduces access to care at least in the short to medium term and vulnerable populations (*e.g.*, the elderly or those with low-income) are more likely to be adversely impacted. Not only can a closure negatively impact access, it may influence health outcomes as well; with literature suggesting a link between hospital closure and increased mortality.[61] Although cost savings may occur from a closure, the savings are not shared equally by stakeholders. The literature suggests that the local community loses while government parties and the payors absorb gains.[62]

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Kirby *et al.* (2005) analyze the hospital industry in California, uncovering trends that highlight challenges facing hospitals and their responses to these challenges.[63] The hospital industry in California has faced both income reductions and increased expenses.[64]

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57 We note that this listing is not exhaustive; several of the reviewed studies have extensive bibliographies of related research.

58 Scott Becker and Lindsey Dunn, *7 Factors to Assess the Sustainability of a Hospitals: Assessing a Hospital's Viability, Its Financial Situation and the Severity of the Threats it Faces*, BECKER'S HOSPITAL REVIEW (September 30, 2013), available online at http://www.beckershospitalreview.com/hospital-management-administration/7-factors-to-assess-the-sustainability-of-a-hospital-assessing-a-hospitals-viability-its-financial-situation-and-the-severity-of-the-threats-it-faces.html.

59 Amy Yarbrough and Robert J. Landry III, *Factors Associated with Hospital Bankruptcies: A Political and Economic Framework* 54 JOURNAL OF HEALTHCARE MANAGEMENT 4 (2009): 252-272.

60 The mean bed size of the filing hospitals was 148 compared to 226 for the non-filing hospitals. Only 14 percent of filing hospitals were part of a system. *Ibid.*, at 263.

61 Thomas C. Buchmueller, Mireille Jacobson and Cheryl Wold, *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, 25 JOURNAL OF HEALTH ECONOMICS 4 (Jul 2006): 740-761.

62 *See*, Corey Capps, David Dranove and Richard Lindrooth, *Hospital Closure and Economic Efficiency* 29 JOURNAL OF HEALTH ECONOMICS 1 (Jan 2010): 87-109.

63 Paul B. Kirby, Joanne Spetz, Lisa S. Mauro and Richard M. Scheffler, *Hospital Service Changes in California: Trends, Community Impacts and Implications for Policy*, THE NICHOLAS C. PETRIS CENTER ON HEALTH CARE MARKETS AND CONSUMER WELFARE (2005).

64 Reimbursement rates from public sector payors such and Medi-Cal and Medicare have declined and the high managed care penetration and cost containment practices they employ (i.e., utilization management such as restrictions on covered procedures, etc.) further reduce revenue from these payors. Meanwhile, operating expenses are high as California hospitals have to contend with some of the highest wages in the country, comply with nurse-to-patient staffing requirement, and implement seismic retrofitting for hospital buildings. *Ibid.*, at 10.

The authors find that in an effort to re-align and improve financial performance, struggling hospitals eliminate unprofitable service lines. During the 1995-2002 study period, approximately half of all hospitals made a change in their service offerings and one-fourth dropped one or more services.[65] Hospitals that closed four or more services tended to be financially troubled, rural, and small. Hospitals that closed completely tended to be small and less efficient. Scott-Morton and Cutler (2013) note that about 15% of hospitals in the US closed over the period 1981 to 2011.[66]

Hospital closure would reduce access and may negatively impact local community-level health and wellbeing. Studies that explore the relationship between reduced access and health highlight the impact hospital closure may have on community welfare. **Buchmuellar *et al.* (2006)** explore the impact of urban hospital closure on healthcare access and outcomes.[67] The impact of a hospital closure increases not just travel time for those residents located near the closed facility, but may increase demand at remaining hospitals and result in reduced access to care. Waiting time may increase and this may cause some to delay receiving care initially (when more easily treatable), and instead seek care once the illness is more severe. The authors explore a rash of hospitals closures in LA County during the late 1980's and early 1990's. Due to financial pressures, 10 percent of the total 131 LA county hospitals were closed between 1997 and 2002.[68] To explore the impact of hospital closure, the authors use Los Angeles County Health Surveys (LACHS) for the period 1997-2003 and California's Department of Health Services cause-specific mortality data for the period 1997-2001. Hospital closures do appear to increase utilization of usual source of care for some populations.[69] However, for those individuals over age 65, a one-mile increase in the distance to the hospital reduces perceived ease of access by four percentage points. This may lead some individuals to postpone preventative care.

As hospital closure without offsetting changes in the existing healthcare infrastructure could increase the distance some residents will have to travel to obtain care, the authors focus on events for which timely treatment is crucial to achieving positive outcomes. Specifically, they examine death from heart attack (AMI) and unintentional injury sustained from home.[70] They find that a one-mile increase in distance to the nearest hospital leads to a 6.5 percent increase in AMI deaths. For unintentional injuries, the effect of an increase in distance is even more extreme. A one-mile increase in distance to the nearest hospital leads to an 11-20 percent increase in deaths due to unintentional injuries. The results presented in this paper provide evidence that hospital closures can have significant negative social welfare effects.

Capps *et al.* (2010) explore the change in social welfare due to a local hospital closing.[71] Using data from the State Inpatient Database of Healthcare Cost and Utilization for two states in the mid- to late-1990s,[72] they study five hospital closures. Their findings suggest that the local community experiences large losses from a hospital closure and that the equivalent utility of the loss ranges from $270,000 to $3.9 million.[73] However, if it is the inefficient hospitals that close, their closure would result in cost savings to payors (Medicaid, Medicare, and commercial payors). The authors find that at the national level, these cost savings overwhelm the decline in local level utility.

The set of available studies, while informative, is based on historical data and has a narrow geographic focus. Expanding the sample size and using current data especially on service offerings and impacts would prove to be directly relevant to the current discussion regarding the cost and benefits of some proposed hospital mergers and acquisitions. Changes in the healthcare environment in which hospitals operate today is significantly more challenging than in the period when the vast majority of these studies took place.

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65 The most common type of service closure was for those lines related to labor and delivery. Surprisingly, the authors note that there was little negative impact resulting from the closure of obstetrics services as the average incremental increase in travel time to the next nearest hospital was a only two-tenths of a mile. However low-income expectant mothers may have been adversely impacted by increased travel time. *Ibid.*, at 8-9

66 Cutler and Scott Morton (2013) at 1965.

67 Thomas C. Buchmueller, Mireille Jacobson and Cheryl Wold, *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, 25 JOURNAL OF HEALTH ECONOMICS 4 (Jul 2006): 740-761

68 The authors include three Orange County hospitals in the analysis as they were the closest general acute care facility for some LA County residents. Four hospitals closed in 1998, eight in 1999, one in 2000, and two in 2002. Of the 15 hospitals that closed, 12 hospitals were for-profit and all but five had an emergency department. *Ibid.*, at 742.

69 This may be through redirecting individuals from the local emergency room to their primary care provider.

70 As a specification check, the authors test the relationship between deaths from two causes which should not be influenced by an increase in travel time: cancer and chronic ischemic heart disease. Their findings show that the mortality rate for either of these conditions does not appear to be sensitive to changes in distance. Buchmueller *et al.* (2006) at 744.

71 Corey Capps, David Dranove and Richard Lindrooth, *Hospital Closure and Economic Efficiency* 29 JOURNAL OF HEALTH ECONOMICS 1 (Jan 2010): 87-109

72 The authors study the Tampa market in 1995 and 1996, the Tucson market in 1998, and the Phoenix market in 1997. They narrow their analysis to focus on the data required for the analysis is available from HCUP and because each area has a well-defined geographic market and contains small to medium sized MSAs. Reasons for each of the hospital closures are not provided.

73 The loss is measured using a consumer discrete choice model that captures the extra distance an individual will have to drive when his "first choice" hospital is no longer an option. The model measures willingness to pay (WTP) and the authors convert this to dollars using two estimates of the average value of travel time (low end: $16/hour, high end: $20/hour). Travel time is calculated not as actual travel time but effective travel time (this is the calculated as expected length of stay times actual travel time). Assuming that only one person travels round trip to the hospital per day, and time is valued at $16.00 per hour, the low end estimate of the utility loss from closure is $270,000. The high end estimate, $3.9 million is calculated assuming that travel time is valued at $20 per hour and two people visit the patient each day. Capps *et al.* (2010) at 94

As noted elsewhere in this report, significant differences in the operating environment include technology advances, different reimbursement frameworks and payor mix, technological changes such as the drive to increase adoption of electronic medical records, and a shift from inpatient to outpatient care. As access to care is a fundamental component of achieving the Triple Aim, more studies along these lines of those presented here should be undertaken that consider the challenges of today's hospital operating environment, including financial challenges, and the impact of hospital transaction activity.

2. Cost and Efficiency

As evidenced in studies about views of hospital industry executives and financial experts, many believe consolidation can lead to substantial value creation. Consolidation provides the opportunity to realize operating efficiencies, including consolidation of operations, and operating expense reductions. Studies find that consolidation may lead to realignment of services and a reduction in excess capacity as well as slower cost growth and increases in economies of scale and scope.[74]

Studies find that consolidation may lead to realignment of services and a reduction in excess capacity as well as slower cost growth and increases in economies of scale and scope.

Alexander *et al.* (1996) analyze 92 hospital mergers that occurred between 1982 and 1989 to explore the short-term effects of a merger on scale of activity, staffing, and operating efficiency.[75] Their empirical findings indicate that although the occupancy rate declines during the study period, the decline is significantly less drastic among the merging sample than among those in the control group of non-merging hospitals. A similar result emerges in cost growth. Costs increased for both merging and non-merging hospitals, but the observed increases were more modest among the former. The study finds evidence of reorganization and realignment as a result of mergers with changes occurring primarily within operating areas. However, these changes are not equally distributed among all hospitals within the sample and are instead a function of the characteristics of the merging organizations and conditions of the respective transaction. For example, mergers that occurred later in the period tended to have larger efficiency impacts than did those occurring earlier. Mergers between similarly sized hospitals resulted in the largest change in operating characteristics.

"...merging hospitals experience significantly lower cost growth, 10.1 percentage points lower than that of non-merging hospitals. They find similar results for price growth and noted that it was 7.9 percentage points lower than among non-merging hospitals, Spang et al. (2001).

Several studies find that consolidation leads to significantly slower cost growth. Spang *et al.* (2001) explore this topic by examining how cost and price growth over an extended period of time differ between firms that merge and those that do not.[76] They find that merging hospitals experience significantly lower cost growth, 10.1 percentage points lower than that of non-merging hospitals. They find similar results for price growth and noted that it was 7.9 percentage points lower than among non-merging hospitals.[77] **Dranove and Lindrooth (2003)** undertake a study to determine if hospital consolidation leads to cost savings.[78] The analysis includes both hospital mergers and system consolidation and compares the estimated differential effects between the two. **The results suggest that the median hospital merger resulted in a cost reduction of 14 percent and that these cost savings persist.** The savings were evident in the follow-up period extending two, three, and four years following the consummation of the transaction. They note that having significant service overlap appears to be a driver of the observed cost reduction. However, among the system acquisition sample, they do not find statistically significant cost reductions during the four-year period following the merger event. [79]

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74 For example, a recent study by Cutler and Scott Morton reference "robust" findings of studies with regard to benefits such as the ability of larger health systems to undertake more costly investments; while noting that empirical findings on other benefits are mixed, the authors note the prospect of improved efficiency from more efficient care coordination, citing this as one of the rationales for ACOs. Cutler and Scott Morton (2013). In a 2009 study, Fisher *et al.* examine opportunities for cost savings and note that increases in efficiency and reductions in cost may be possible through coordinated/integrated care. Elliot S. Fisher, Mark B. McClellan, John Bertko *et al.*, *Fostering Accountable Health Care: Moving Forward in Medicare* 28 HEALTH AFFAIRS 2 (2009):w219-w231.

75 Jeffrey Alexander, Michael T. Halpern and Shoou-Yih D. Lee, *The Short-Term Effects of Merger on Hospital Operations* 30 HSR: HEALTH SERVICES RESEARCH 6 (February 1996):827-847.

76 Heather R. Spang, Richard J. Arnould and Gloria J. Bazzoli, *The Effect of Non-Rural Hospital Mergers and Acquisitions: An Examination of Cost and Price Outcomes*, 49 QUARTERLY REVIEW OF ECONOMICS & FINANCE 2 (2009) 323-342

77 Spang *et al.* (2001) at 154.

78 David Dranove and Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22 JOURNAL OF HEALTH ECONOMICS 6 (2003):983-97

79 *Ibid.*, at 991-993.

Contrary to the findings of Dranove and Lindrooth (2003), **Spang *et al.* (2009)** do find significant cost savings resulting from system acquisition.[80] Their results suggest that pre-consolidation, hospitals in their sample had both higher costs and higher prices than the average hospital in the comparison group. They postulate that these factors may have driven these firms toward consolidation in an effort to become more efficient and competitive by reducing costs and lowering price. In testing for differential effects by ownership status, the authors find that the observed cost and price savings which resulted from the merger were present for for-profit hospitals only.

Economies of scale are one vehicle through which consolidation may lead to efficiency gains. **Harrison (2011)** employs a novel approach that disentangles cost savings occurring from changes in output mix with savings that occur from actual economies of scale.[81] She finds that cost savings due to achieving economies of scale amount to a two percent reduction in pre-merger costs and that hospitals experience these costs savings almost immediately. However, Harrison notes that savings due to economies of scale may not persist over time. Long term cost saving is likely due to changes in output levels.

Available empirical evidence on recent mergers supports findings of improvement in performance (*e.g.* patient volumes) for merged hospitals. Although the vast majority of studies focus on merger activity during the mid-1990s, **Deloitte (2013)** recently released a study analyzing a set of transactions occurring in 2007-2008.[82] The report provides some useful basic insights about the outcomes of more recent hospital transactions. Analyzing 101 hospital transactions consummated during this time period, the study evaluates basic performance measures of merging hospitals over time, and relative to a comparison group. Although the report finds that the hospitals involved in a transaction typically track below those in the comparison group on some measures, they find that over the 2008-2010 period, acquired hospitals, as a group, realized substantial increases in patient volumes. This is a significant finding suggesting that these hospitals not only remained in operation, but may have improved quality or altered service mix to attract these higher volumes. More comprehensive controls and econometric estimation of these and other metrics for acquired and control hospitals could provide greater insights into benefits for consolidation generally and as compared to the status quo of no transaction.

The literature reviewed in this section presents strong evidence that hospital mergers can lead to increased efficiency and reduced cost, particularly where they permit economies of scale or realignment of services. The costs savings that result from mergers appear to be persistent and are not limited to a level drop, but produce slower cost growth overtime. Economies of scale resulting from hospital mergers could amount to a cost savings of two percent operating expenses. Another benefit is that merging hospitals have improved occupancy rates compared to non-merging hospitals. In addition, poor performing or inefficient hospitals (hospitals with high price and high costs) are able to benefit from consolidation by reducing costs and prices, becoming more competitive. The findings from these studies combine to provide strong evidence that hospital mergers and acquisitions result in significant efficiency improvements and cost declines.

3. Quality

Mergers and system acquisitions have the potential to impact quality through many different mechanisms. Consolidated operations may be able to increase the volume of certain types of procedures, thereby increasing the experience level (and performance) of the physicians as well as increase utilization of other hospital resources and technologies.[83] This is an important consideration as seemingly modest improvements in hospital quality can have a significant effect on patient welfare. As Section III points out, access to capital is a growing concern as many planned or in-progress projects are forced to be put on hold for lack of funds. An acquired struggling hospital may benefit from a capital infusion which permits increased investment in staff, technology, or facilities, all of which may lead to increased quality of service. **Another benefit of consolidation is that successful operating practices and procedures established at one location may be adopted by the other party in the transaction, thereby offering an opportunity for improvement.**

Cuellar and Gertler (2005) explore the effects of system consolidation on quality as measured by inpatient mortality, overuse of procedures, and patient safety indicators.[84] They find that the rate of overused procedures declines by 1.2 percent following a system consolidation, but that this finding applies to managed care patients only. They fail to find any other change among the quality

80 Heather R. Spang, Richard J. Arnould and Gloria J. Bazzoli, *The Effect of Non-Rural Hospital Mergers and Acquisitions: An Examination of Cost and Price Outcomes*. 49 QUARTERLY REVIEW OF ECONOMICS & FINANCE 2 (2009):323-342

81 Theresa D. Harrison, *Do Mergers Really Reduce Costs? Evidence from Hospitals*, 49 ECONOMIC INQUIRY 4 (2011):1054-1069

82 *Hospital Consolidation: Analysis of Acute Sector M&A Activity*, DELOITTE (2013), available online at http://www.deloitte.com/view/en_US/us/Insights/centers/center-for-health-solutions/3db1433c081de310VgnVCM1000003256f70aRCRD.htm?id=us_furl_hosconsol_052413

83 Volume impacts are recognized for example in a recent study on mergers by Cutler and Scott Morton (2013) at 1967 citing to Birkmeyer *et al.* (2002 and 2003).

84 Allison E. Cuellar and Paul J. Gertler, *How the Expansion of Hospital Systems Has Affected Consumers* 24 HEALTH AFFAIRS 1 (Jan-Feb 2005): 213-219 [2]. They restrict their analysis to hospitals in four states: Arizona, Florida, Massachusetts, and Wisconsin. They utilize patient-level discharge data, hospital financial data (obtained from the state), and AHA survey data for period 1995-2000.

measures selected for the analysis and conclude that there is little effect from system acquisition on quality. In interpreting these results, it is important to note that their study has several limitations. The authors note that the effects of implementing change that will materially improve hospital level quality takes time to show up in quality metrics. The relatively short duration of the observation period may not have allowed enough time for meaningful change to be observed. They also note that it may be that some changes which impact quality had been successfully implemented, but these factors may not have been captured by the outcome measures investigated in the study. In addition, the study focuses only on four states and the results presented may not be representative of transactions occurring in other states.

Mutter *et al.* (2011) perform a pre-post analysis of hospital consolidations in 16 states that occurred in 1999 and 2000.[85] Their findings indicate that evaluating the quality effects of a merger or acquisition is complex and that the results vary depending upon the entities' role in the transaction (acquirer or target) and the type of transaction (system acquisition or two-to-one merger). The authors find that hospital consolidation is associated with some increases in quality measures as well as some that suggest decreased quality.[86] In comparing the difference in quality effects between the target and acquirer, the authors find that acquiring hospitals experience some improvement for procedures with a likely volume-outcome relationship. However they note that overall, hospital consolidation did not appear to have a significant effect on the vast majority of quality indicators considered in the study.[87] General literature also addresses the volume-quality relationship and finds some strong relationships.[88] **Town (2011)** raises important considerations regarding Mutter's (2011) paper.[89] He notes that although Mutter concludes that there is no consistent impact on quality due to mergers, an alternative interpretation of his findings is that there was no observed impact for the *average* hospital in the sample. As the ability to improve quality depends upon many factors (market structure and patient characteristics, etc.), the effect of mergers on quality is expected to be heterogeneous. As such, the impact may not be detected using a linear framework.[90] In addition, Town points out that even relatively small changes in a quality measure could have a significant effect on patient welfare.[91]

Romano and Balan (2010) measure quality changes due to a merger by using Inpatient Quality Indicators (IQIs) and Patient Safety Indicators (PSIs) as well as risk-adjusted mortality for heart attacks, neonatal mortality, and obstetric trauma.[92] This study differs from those presented in this section as it focuses on a single transaction (the acquisition of Highland Park by Evanston Northwestern Healthcare) and attempts to identify changes that occurred in patient quality as a result of acquisition.[93] The results from these analyses do find some improvements at both Highland Park and Evanston. Several nursing sensitive PSIs at Highland Park Hospital indicate statistically significant improvements, however, risk adjusted obstetric PSI measures show some deteriorations post-merger. At Evanston, the authors find a post-merger decreased risk of adjusted pneumonia and stroke mortality. All other indicators are of mixed sign and are statistically insignificant.[94]

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85 Ryan L. Mutter, Patrick S Romano and Herbert S Wong, *The Effects of Us Hospital Consolidations on Hospital Quality* 18 INTERNATIONAL JOURNAL OF THE ECONOMICS OF BUSINESS 1 (2011): 109-26. They employ the use of Healthcare Cost and Utilization Project (HCUP) data and measure patient quality using 25 of the Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQIs) and Patient Safety Indicators (PSIs)

86 The authors find that hospital consolidation is associated with decreased rates of failure to rescue and in-hospital mortality for pneumonia, increased rates of incidental appendectomy (for the elderly only), and increased rates of bloodstream infections *ibid*., at 119.

87 The research design the authors implement presents advancement over the methodology used in many other studies as it considers both parties separately, and specifically seeks to find the ways in which the acquirer may itself individually benefit. This is an important consideration as consolidating services may result in one party experiencing improvement in a selected outcome because they are able to benefit from the volume-outcome relationship. However, if quality measures selected for analysis in studies are those for which volume is not an influencing factor; the studies may not detect actual improvements in quality.

88 Birkmeyer *et al.* (2002) find an inverse relationship between hospital surgical volume and mortality (operative death) for each of the 14 inpatient procedures (six types of cardiovascular procedures and eight types of major cancer resections) they investigate. They note that the relative importance of surgical volume varies depending on procedure type and ranges between a difference of 12 percent (for pancreatic resection) at the high end of the range and a difference of 0.2 percent (for carotid endarterectomy) at the low end of the range. John D. Birkmeyer, Andrea E. Siewers, Emily V.A. Finlayson, *et al*., *Hospital Volume and Surgical Mortality in the United States*, 346 NEW ENGLAND JOURNAL OF MEDICINE 15 (2002):1128-1137. Birkmeyer *et al.* (2003) find that surgeon volume and operative mortality are inversely related for each of the eight procedures they investigate (cardiovascular procedures and cancer resections). They note that although hospital volume appears initially to be the driver of this volume-outcome relationship, surgeon volume that accounts for a large proportion of the effect they identify. For aortic-valve replacement, surgeon volume accounts for 100 percent of the effect (the high end of the range), while 24 percent of the effect (the low end of the range) is due to surgeon volume for lung resection. John D. Birkmeyer, Therese A. Stukel, Andrea E. Siewers *et al*., *Surgeon Volume and Operative Mortality in the United States*, 349 NEW ENGLAND JOURNAL OF MEDICINE 2 (2003): 2117-2127.

89 Robert Town, *The Effects of Us Hospital Consolidations on Hospital Quality: A Comment*, 18 INTERNATIONAL JOURNAL OF THE ECONOMICS OF BUSINESS 1 (2011): 127-131.

90 A linear framework refers to the commonly utilized methodology relied upon to test for the effect of a merger by comparing observed rates pre-merger with observed rates post-merger for the sample under review.

91 Town presents a simple calculation under which a five percent decline in in-patient mortality would save 255 lives at a hypothetical hospital, representing an increase in consumer benefit of $127.5 million. Town (2011) at 128.

92 Patrick S. Romano and David J. Balan., *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, FTC BUREAU OF ECONOMICS WORKING PAPERS (2010).

93 The transaction of interest occurred in 2000 and the authors use data from 1998-2003

94 Romano and Balan (2010) at 55.

Ho and Hamilton (2000) explore the quality effects of hospital mergers occurring in California.[95] Results both for patients as a whole and patients grouped by insurance type indicate that there was no change for inpatient mortality. However, patients receiving treatment in a merged hospital experienced a 1.7 percentage point increase in the probability of readmission compared to a 0.9 percentage points increase for those receiving treatment in a hospital acquired by a system. The probability of early discharge (for newborns) increased by 3.2 percentage points in those hospitals acquired by another system. Although this study is often cited when addressing the quality effects of mergers and acquisitions, it has several limitations.[96]

The literature reviewed in this section demonstrates that a fairly narrow range of outcomes are generally explored when attempting to identify the quality effects of hospital mergers and acquisitions. While most studies focus on readmission and mortality, some include IQIs and PSI. Although readmission and mortality have the advantage of being discrete events that are readily identified, they can present measurement challenges. Readmission can be used as a measure of quality with the justification that if a patient receives appropriate care, the probability of readmission should be lower. However, it is unclear over what length of time readmission should be measured. Additionally, ill patients may seek care at a different facility if they perceive the quality of care at their original institution as being suboptimal. Or at the extreme, critically ill patients may experience increased mortality preventing readmission from occurring. Most quality studies suffer from a significant limitation in that they fail to identify an appropriate control group. This is important as hospitals that merge (or are acquired) may be fundamentally different from those that do not. Identifying quality effects due to consolidation is difficult as the time period under review may be too brief to detect change. A longer time span would allow for implementation/adoption of new processes and procedures that may produce meaningful improvements in quality. In general, the results presented in this section highlight the need for caution when interpreting results and demonstrate the need for more research within this area of study.[97]

IV. Insights from Antitrust Review of Hospital Transactions: There is More to Hospital Merger Impact Assessment than Market Concentration and Share

A. Overview

Much of the popular press on hospital mergers and antitrust concerns focuses primarily on aggregate market share and concentration trends by city as the basis for competition concerns about future mergers – that is, that local metropolitan areas (*e.g.*, MSAs) may have fewer competitors or have experienced increased market shares of top hospitals or concentration today as compared to some point in the past.[98] This approach, however, does not connect the dots between concentration trends and the actual merger activity that has occurred – or is likely to occur in the future. Moreover, predictions about adverse effects on competition from this "trend" toward concentration typically are not based on any specific or fact-intensive inquiry into the effects of *recent* mergers, their

Moreover, predictions about adverse effects on competition from this "trend" toward concentration typically are not based on any specific or fact-intensive inquiry into the effects of recent mergers, their effects or motivations, but largely by reference to academic research evaluating price effects or studies examining relationships between price and structure conducted predominantly on data from the 1990s.

95 Vivian Ho and Barton H. Hamilton. *Hospital Mergers and Acquisitions: Does Market Consolidation Harm Patients?* 19 JOURNAL OF HEALTH ECONOMICS 5 (2000): 767-91. To investigate the effect of hospital mergers and acquisitions on quality, they identify 21 independent hospitals involved in a merger and 54 hospitals acquired by a system in California during 1992-1995. They use patient-level data from the California Office of Statewide Health Planning and Development (OSHPD) and AHA survey data. The outcomes measures of interest are inpatient mortality for heart attack and stroke patients, 90 day readmission rates for heart attack patients, and early discharge of newborns. The authors believe that quality effects may be due to changes in market power. If mergers and acquisitions increase market power by reducing competition, the hospitals within these markets may face less pressure to maintain or improve quality in order to stay competitive. They hypothesize that since a hospital may have little opportunity to exert market power to influence price, they may instead attempt to improve their bottom line by reducing cost via offering lower quality of care. The authors note that hospitals may have very limited ability to utilize increases in market power gained via mergers or acquisitions to influence price. This is because a large proportion of the hospital's volume stems from Medicare patients and the prices Medicare offers are essentially fixed. In addition, private insurers may use Medicare prices as a benchmark, so if Medicare prices remain steady, private payer prices may remain fixed as well.

96 The most significant limitation is in the failure to identify a better matched control group as hospitals that merge (or are acquired) may be fundamentally different from those that do not. In addition, the explanation for what drives the observed outcomes is at odds with findings from many other studies. Even if the findings were accurate for transactions which occurred in the early 1990s, results may not be applicable in today's operating environment. 20 years later. Information sharing and the availability of hospital performance measures along with financial penalties for poor performance (which are based on factors such as readmission and safety indicators) would moderate any desire to cut quality in order to reduce costs. Furthermore, the authors do not attempt to explain the mechanism through which quality reduction occurs.

97 For a more detailed review of the issues associated measuring quality in the empirical literature, see Guerin-Calvert and Israilevich (2011).

98 We note that this is sometimes portrayed as the increase in *average* concentration which can obscure the many cities that have lower concentration. For example, one study cites the increase in the average MSA level HHI from 2,440 in 1992 to 3,261 in 2006. Martin Gaynor, *The Three Ws of Consolidation and Competition in US Health Care*, Presentation to BIG HEALTH: CONSOLIDATION AND COMPETITION UNDER THE AFFORDABLE CARE ACT, The American Enterprise Institute, Washington, DC (March 1, 2013), slide 10, available online at www.aei.org/files/2013/03/05/-gaynor-slides_102018805600.pptx. Other studies that show concentration measures by geography reveal that many of the largest cities in the country are unconcentrated or moderately concentrated. *See, e.g.*, Cutler and Scott Morton (2003) who compare concentration in the mid-1980s to today (at 1966).

effects or motivations, but largely by reference to academic research evaluating price effects or studies examining relationships between price and structure conducted predominantly on data from the 1990s.[99] Few conduct systematic examination using data on actual transactions *in the past decade* or place mergers that were the subject to challenge in the context of overall merger activity.

This section provides a summary of antitrust review of hospital transactions to provide insights into whether recent transaction trends are consistent with concerns about anticompetitive effects across a large population of mergers – and also to assess the findings from the empirical literature on merger competitive effects:

- **Only a small proportion of actual hospital transactions raise significant risks of substantial lessening of competition. The vast majority of transactions occurred in separate geographies or in ones with numerous competitors. Only a minority of mergers involved prolonged review by the antitrust agencies and of those several were not challenged.**
- **These trends are more supportive of a conclusion that the majority of transactions are competitively benign or value-enhancing transactions.**
- **High concentration, high market shares and the number of competitors are not predictive of either hospital merger challenges or predicted or actual anticompetitive effects: Both retrospective and prospective hospital merger analyses in highly concentrated markets show that mergers even in concentrated markets were not predicted to bring about, nor resulted in, substantial increases in prices.**

- **There were approximately 333 hospital mergers from 2007-2011**
- **Approximately 111 of those were reported to the FTC under Hart-Scott-Rodino**
- **Approximately less than 1/10 of these triggered Second Requests**
- **Only four were challenged in court – less than two percent of all hospital mergers over the last five years**

Leibowitz (2012)

B. Summary of Recent Antitrust Review of Hospital Mergers

In evaluating the impact of hospital mergers on competition and pricing it is useful to turn first to some statistics regarding antitrust review of recent hospital mergers. Government statistics suggest that only a small proportion of actual hospital transactions raise any risk of substantial lessening of competition. This finding is consistent with overall merger review statistics, which show that the vast majority of transactions reviewed by the federal agencies are found to be unlikely to result in a substantial lessening of competition.[100] The FTC has handled the prospective review of the vast majority of hospital transactions in recent years.[101] According to Former FTC Chairman Leibowitz: "Let me pause here lest you get the impression that we never see a hospital merger we like. These are rough numbers, but according to public sources, 2007 to 2011 witnessed approximately 333 hospital mergers nationwide. About one third of those, approximately 111, were reported to the FTC under Hart-Scott-Rodino. Of those, approximately one tenth triggered Second Requests. We challenged only four in court – less than two percent of all hospital mergers over the last five years."[102]

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99 Moreover much of this research focuses on highly concentrated "markets" or on mergers of geographically proximate competitors with few rivals. *See, e.g.*, William B. Vogt and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* THE SYNTHESIS PROJECT. 9 (Feb 2006) available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1

100 "Mergers between competing firms, i.e., "horizontal" mergers, are a significant dynamic force in the American economy. The vast majority of mergers pose no harm to consumers, and many produce efficiencies that benefit consumers in the form of lower prices, higher quality goods or services, or investments in innovation. . (Forward) The core concern of the antitrust laws, including as they pertain to mergers between rivals, is the creation or enhancement of market power...Most mergers between rivals do not create or enhance market power. .However, the Agencies challenge mergers that are likely to create or enhance the merged firm's ability--either unilaterally or through coordination with rivals--to exercise market power .The Agencies focus their attention on quickly identifying those transactions that could violate the antitrust laws, subjecting those mergers to greater scrutiny...For more than 95% of the transactions reported under HSR, the Agencies promptly determine...that a substantial lessening of competition is unlikely." US DOJ/ FTC Commentary on the Horizontal Merger Guidelines. March 2006 at Forward and Introduction. http://www.justice.gov/atr/public/guidelines/215247.htm.

101 The FTC reviews transactions under the Hart-Scott-Rodino Act, and has also reviewed hospital transactions that do not meet HSR criteria.

102 Jon Leibowitz, Chairman, Federal Trade Commission, *Are Titanic Health Care Costs Sinking Us? What the FTC is Doing to Keep Patients Afloat*, Remarks at the ANTITRUST IN HEALTHCARE CONFERENCE, American Bar Association/American Health Lawyers Association, Arlington, VA (May 3, 2012)(emphasis added), available online at http://www.ftc.gov/speeches/leibowitz/120503antitrusthealthcare.pdf. This speech and Maureen Ohlhausen provide a summary of the challenged transactions. Maureen K. Ohlhausen, *Protecting Consumer Welfare in the U.S. Health Care Sector*, Remarks at the FORUM FOR EU-US LEGAL-ECONOMIC AFFAIRS, the Mentor Group (September 13, 2013). See also Jeffrey W. Brennan and Margaret E. Guerin-Calvert, *Assessing Hospital Mergers and Rivalry in an Era of Health Care Reform*, 27 ANTITRUST 3 (Summer 2013).

Although about half of all transactions between 2007 and 2012 occurred within the same geography, statistics show that the vast majority of hospital merger transactions passed antitrust review without need for extensive additional information. Moreover, not all of the healthcare transactions that triggered Second Requests led to challenges or threatened challenges (and/or abandonment) even though the alleged geographic markets were highly concentrated and had few hospital competitors in each of these transactions. This suggests other factors provided sufficient evidence of post-merger competitive discipline or consumer and community benefits from these specific transactions, including the absence of "customer complaints."[103]

...the absence of antitrust action for the vast majority of hospital transactions is inconsistent with concern that hospital mergers routinely implicate anticompetitive behavior, triggering higher prices.

While the challenges indicate that some mergers were regarded as posing significant risks to competition, the absence of antitrust action for the vast majority of hospital transactions is inconsistent with concern that hospital mergers *routinely* implicate anticompetitive behavior, triggering higher prices. First, the statistics suggest that the market structure in which many of the mergers occurred were not likely to raise competitive concerns. As noted previously, a large proportion of the acquisitions in the last six years did not involve overlapping geographies or, where there was an overlap, involved hospitals in areas with numerous competitors.[104] The transactions data also confirm that system acquisitions or formations infrequently have resulted in antitrust challenges, even though there have been a number of such transactions in the past two decades. Many of the larger healthcare systems in the US have facilities in a number of states, and acquisitions often have involved geographic expansion into new areas or states.[105]

The transactions data also confirm that system acquisitions or formations infrequently have resulted in antitrust challenges, even though there have been a number of such transactions in the past two decades.

Second, the overview of hospital antitrust review highlights the fact-intensive nature of the inquiry involved in assessing the likely competitive effects and expected benefits of transactions. Merger review in the hospital sector as in other industries examines whether the specific transaction is likely to result in a substantial lessening of competition, or alternatively be pro-competitive with benefits manifested in efficiencies or quality.[106] The record from antitrust review and merger retrospectives (discussed below) makes clear that market structure alone is not a sufficient basis from which to infer competitive effects. In assessing the relative merit of a merger transaction, several factors are considered including:

- The sufficiency of competitive alternatives (hospital rivals for the merging firms) and rivalry among hospitals
- The factors that promote or limit the ability of payors to negotiate competitive rates post-merger (including the importance of payors to hospitals and mechanisms that encourage use of higher value/lower cost alternatives)
- The rationale for the transaction and its quality and access benefits in the form of improved value relative to the "status quo."

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103 See, Darren Tucker, *A Survey of Evidence Leading to Second Requests at the FTC*, 78 ANTITRUST LAW JOURNAL 3 (2013):591-617 at Table 4, which shows 11 hospital transactions received Second Requests and most were in markets that FTC staff considered to be highly concentrated with few competitors. While there were no closing statements issued, other tables in the Tucker article suggest that reasons for conclusions that the transactions would not substantially lessen competition or warrant challenge could be absence of customer complaints or other factors with offsetting benefits or lower risks of competitive concerns (such as financial condition, capacity, or efficiencies). See also, closing statement on one FTC retrospective discussed below. For a discussion of possible efficiencies or benefits from transactions that could meet staff's concerns see, e.g., Jeffrey H. Perry and Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets*, 27 ANTITRUST (Spring 2013):43-47.

104 See, discussion above in Section I. See, *The Hospital Acquisition Report*, IRVING LEVIN ASSOCIATES INC (2012) at 15-228 and *How Hospital Mergers and Acquisitions Benefit Communities: Updated Study by the Center for Healthcare Economics and Policy*, CENTER FOR HEALTHCARE ECONOMICS AND POLICY AND THE AMERICAN HOSPITAL ASSOCIATION (September 2013), available online at http://www.aha.org/content/13/13mergebenefitcommty.pdf. The largest cities (as measured by Metropolitan Statistical Areas or MSAs) tend to be unconcentrated; based on measures of hospital systems and bed counts. See, *AHA Hospital Statistics*, AMERICAN HOSPITAL ASSOCIATION (2013) for bed counts and hospital affiliations, and for population and definition of MSAs, *Metropolitan and Micropolitan Statistical Areas*, U.S. CENSUS BUREAU, POPULATION DIV., available online at http://www.census.gov/popest/data/metro/totals/2011. See also, Thomas C. Brown, Jr., *et al.*, *Current Trends in Hospital Mergers and Acquisitions*, 66 HEALTHCARE FINANCIAL MANAGEMENT 114 (2012).

105 See, *The Hospital Acquisition Report*, IRVING LEVIN ASSOCIATES, INC. (2012) at 6 for listing of transactions involving systems. Antitrust concerns raised in system transactions are infrequent and tend to involve overlaps in specific geographies. See, e.g., In the Matter of Inova Health System Foundation, and Prince William Health System, Inc., File No.: 061 0166, which was abandoned after FTC challenge. Some of the litigated hospital cases have involved systems, such as FTC and State of Missouri v. Tenet Healthcare Corporation and Poplar Bluff Physicians Group, File No. 971 0090; US v. Long Island Jewish Medical Center and North Shore Health System, Inc; and California v. Sutter Health System, No. C99-03803 MMC. These were cases where the Courts ultimately concluded that there were sufficient competitors even within the local area, and that payors had the ability to discipline pricing post-merger by making increased use of these alternatives.

106 As noted herein, there are many potential sources of pro-competitive efficiencies from mergers, including quality and cost-savings; see, Joseph Farrell, David J. Balan, Keith Brand and Brett W. Wendling, *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 REVIEW OF INDUSTRIAL ORGANIZATION 4 (2011): 271-296 for discussion in hospital industry. Assessment of these effects form a fundamental part of evaluating horizontal merger effects. See, Robert D. Willig, *Incremental Consumer's Surplus and Hedonic Price Adjustment*, 17 JOURNAL OF ECONOMIC THEORY 2 (1978):227-253 and *Unilateral Competitive Effects of Mergers: Upward Pricing Pressure, Product Quality, and Other Extensions* 39 REVIEW OF INDUSTRIAL ORGANIZATION 1 (2011):19-38. For examples in other industries see, Heyer, Ken, Carl Shapiro and Jeffrey Wilder, *The Year in Review: Economics at the Antitrust Division, 2008–2009*, 35 REVIEW OF INDUSTRIAL ORGANIZATION 4 (2009):349-367 and Mark, Israel, Bryan Keating, Daniel Rubinfeld and Robert Willig, *Airline Network Effects and Consumer Welfare: A Preliminary Overview of Methodology and Findings*, Unpublished Working Paper (2011).

Value and access benefits may be firm-specific – *e.g.*, improving the operation and performance of a given hospital, or market-specific – *e.g.*, enabling restructuring that aligns capacity more efficiently or enables hospitals and providers to better meet needs of a community in a more cost effective way. Moreover, benefits may be significant relative to what the hospital would do absent a merger; as discussed below, hospitals that do not merge may be forced to close or to downsize in staffing or in service lines.

Finally, **the statistics and review suggest that measures of share and concentration in local geographies are not necessarily a good predictor of competitive concerns in *prospective* merger review or indicative of anticompetitive results from actual transactions.** The variability in findings in FTC economists' studies of FTC hospital merger retrospectives provides insights. These reports are based on actual consummated mergers where the merging firms were two of relatively few competitors in what are alleged to have been highly concentrated markets. Only one of these cases (Evanston) was ultimately challenged by the FTC, and the investigation in one was actually affirmatively closed based, in part, on the majority of the Commission's assessment that the transaction had *not* resulted in significant price impact or other adverse impact for payors or consumers despite high shares and high concentration.[107] The other two cases examined in the FTC retrospective studies (Sutter, New Hanover) involved mixed evidence of estimated price impacts in the FTC authors' analyses, and countervailing factors or explanations such as failing firm, efficiencies, or quality effects offered by the authors or other commentators.[108]

These retrospectives, however, are frequently cited as the primary basis for concern about the likely anticompetitive effects of hospital mergers and for the magnitude of possible price effects. For example, Cutler and Scott Morton (2013) refer to Martin Gaynor's 2011 Congressional testimony about two of these studies (on the Evanston and Sutter-Summit mergers) as a primary basis for concern about merger price effects. Gaynor and Town refer to these two retrospectives as well as one in North Carolina (Cape Fear-New Hanover) as bases for concern that hospital mergers could lead to 20-40 percent price increases.[109]

These specific case studies and related hospital merger literature (such as that referenced in Gaynor and Town 2012) appear to have influenced perceptions of likely price impact of mergers and concerns that structural change in concentrated markets would routinely lead to higher prices. The following section provides a brief overview and assessment of these studies.

C. Review of Studies on the Estimated Price Effects from Hospital Mergers

A commonly voiced concern about hospital consolidation is that it leads to higher prices.... Many studies examine changes in concentration over time – not discrete events (i.e., merger transactions). No consistent quantified relationship is found, however, between changes in market concentration and observed hospital price increases across studies.

A commonly voiced concern about hospital consolidation is that it leads to higher prices. Mergers and acquisitions are thought to increase market concentration by reducing alternatives available to payors. Fewer competitors, it is argued, equates to increased bargaining power for both the newly consolidated firm and those within the same market. This change in market concentration may ultimately influence price negotiations. Support for the assessment that mergers are likely to result in enhanced market power reference selected academic studies of price effects of mergers in the 1990s or early 2000s to draw inferences about market power impact and motivations for current and future transactions. As discussed below, some of the studies rely on payor negotiation models based on conditions more prevalent in the late 1990s – namely, broad and all inclusive networks where bargaining tended to be characterized as inclusion (or exclusion) of hospitals from a network.

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107 Statement of the Federal Trade Commission in re: Victory Memorial Hospital/Provena St. Therese Medical Center. File No. 011 0225. FTC economists conducted a retrospective analysis of the pricing impact of this transaction using a difference-in-difference (DID) approach, and concluded that the transaction did not resulted in statistically significant increases in prices to payors relative to chosen cohorts. See, Deborah Haas-Wilson and Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INTERNATIONAL JOURNAL OF THE ECONOMICS OF BUSINESS 17 (2011):17-32.

108 While the methodology used to estimate relative price increases at merged hospitals relative to cohorts has been critiqued, these studies show mixed results about the effects of transactions in seemingly similar market structures. In the Cape Fear-New Hanover merger (Thompson), for example, there are mixed findings for three payors studied. In Sutter-Summit (Tenn), there was no finding of statistically significant increase for the acquiring firm (Sutter Alta Bates) but only for the acquired firm (which may be explained by adjustments due to its financial condition, or as suggested by Gowrisankaran in his comment due to quality increases). The Vista transaction found little evidence of significant increases instead finding statistically significant decreases for some payors. See, Haas-Wilson and Garmon (2011) for an overview. *See also*, Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction*, 18 INTERNATIONAL JOURNAL OF THE ECONOMICS OF BUSINESS 17 (2011): 65-82; Gautam Gowrisankaran, *Evaluating the Impact of a Hospital Merger Using the Difference-in-Difference of Prices (Comment on article by Steven Tenn.)* (October 2010); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction*, 18 INTERNATIONAL JOURNAL OF THE ECONOMICS OF BUSINESS (2011):91-101, and Decision, California v Sutter Health System, No. C99-03803 MMC for discussion of the financial condition of Summit and the finding that Summit met the failing firm defense.

109 *See, e.g.*, Martin Gaynor, *Health Care Industry Consolidation*, Statement before THE U.S. CONGRESS, HOUSE COMMITTEE ON WAYS AND MEANS HEALTH SUBCOMMITTEE Congress, (September 9, 2011) Gaynor references other studies based on simulations, price-concentration studies, and other methodologies, which are discussed below.

Fundamentally different market conditions could imply that this past research is ill-suited – if not misleading – to inform current understanding of likely merger effects. Past research may not capture dramatic changes ongoing in the healthcare industry....

Importantly, this reliance on past (and in some cases quite distant past) merger activity and assumptions reveals the imperative for a more comprehensive understanding of *current* market conditions, *current* merger motivations and more rigorous examination of merger effects to evaluate the likely benefits or competitive risks of current and future hospital transactions. Fundamentally different market conditions could imply that this past research is ill-suited – if not misleading – to inform current understanding of likely merger effects. Past research may not capture dramatic changes ongoing in the healthcare industry, including transformative changes on the provider and insurer side, and the pressures and results of healthcare reform – particularly requirements for new technologies, new business models, and reduced reimbursements. **Most of the oft-cited studies are based on mergers or data from the 1990s, under substantially different market conditions than current conditions.** As importantly, the studies should be kept in perspective as to their ability to inform prospective merger review across all mergers and for likely price impacts of actual mergers.

In an effort to consolidate the many pricing studies and draw together common themes and findings, Gaynor and Town (2012) and Vogt and Town (2006) prepared synthesis reports on effects of hospital consolidation.[110] They summarize the findings of a number of studies examining merger effects and changes in concentration, including price-concentration studies, merger retrospectives, studies assessing specific mergers or sets of mergers and merger simulations using hypothetical mergers or actual mergers and specific econometric models.

They conclude from their review of selected merger retrospectives and a study by Leemore Dafny (addressed below) that "price increases exceeded 20% when mergers occurred in concentrated markets" (Gaynor and Town, 2012). As a starting point, it is important to note that the studies they reference are *specific cases* involving selected transactions or data from mergers in highly concentrated markets and thus are not generalizable to all mergers and acquisitions or even to *all* mergers in highly concentrated markets: (1) The majority of hospital acquisitions occur between firms located in different markets and would not be subject to the same market forces that study authors hypothesize drove price increases. (2) Many "in-market" mergers occur in the largest metropolitan areas with many competitors and do not involve material changes in concentration. (3) Even the selected case studies show mixed results – concentrated markets alone did not yield significant price increases.

- **Many studies examine changes in concentration over time – not discrete events (i.e., merger transactions). No consistent quantified relationship is found, however, between changes in market concentration and observed hospital price increases across studies.[111]**

We review here some of the most frequently cited concentration studies and their findings. The studies attempt not only to determine if a relationship exists, but to quantify the impact increases in market concentration may have on the price level. **Vogt and Town (2006)** provide a summary of many of these studies and, importantly, report mixed findings. According to the authors, Structure-Conduct-Performance Studies find estimated price effects with findings ranging from negative to positive (a price change of *negative* three percent to positive 17 percent) while selected event studies also find price increases, including one study which finds increases of 40 percent.[112] These studies they review are based on data from the late 1980s and 1990s and utilize a range of methodologies.

Additional studies that are somewhat more current but largely based on historical data include **Antwi *et al.* (2009)**. They explore price and market concentration changes in California during the period 1992-2006.[113] They find that hospital prices almost doubled[114] and market concentration increased significantly during this period.[115] However, when disaggregating by market area, they do not find any correlation between the rate of hospital price growth and HHI. This result suggests that changes in market concentration did *not* cause

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110 William B. Vogt and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* THE SYNTHESIS PROJECT, 9 (Feb 2006) available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1; Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation – Update*, THE SYNTHESIS PROJECT (June 2012), available online at http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/the-impact-of-hospital-consolidation.html. Gaynor's 2011 Congressional testimony refers to eight of these studies, and summarizes additional literature on price variation and simulations.

111 *See*, Gaynor and Town (2012) at Table 1 for a summary of results.

112 *See*, Vogt and Town (2006) at 6-8 for a detailed summary of several structure-performance studies, and their review and critique of them.

113 Yaa Akosa Antwi, Martin Gaynor and William Vogt, *A Bargain at Twice the Price? California Hospital Prices in the New Millenium*, 12 FORUM FOR HEALTH ECONOMICS AND POLICY 1 (2009).

114 Price is measured by net revenue per discharge.

115 During 1992-2003, market concentration in the average county in California increased from 2,046 to 2,824. This change is consistent with the nationwide increase in HHI during this period. Antwi *et al.* (2009) at 8.

increases in hospital price. The authors mention increased costs[116] and HMO backlash as potential contributing factors, but are not able to identify the cause of the price increases they find. **Moriya *et al.* (2010)** analyze the relationship between insurer and hospital market concentration and hospital prices.[117] Using commercial claims data covering 11 million commercially insured lives during 2001-2003, their findings suggest that hospital concentration is *not* significantly associated with price increases.[118] However, the authors do find that insurer market concentration is associated with a statistically significant reduction in hospital prices.[119] **Dranove *et al.* (2008)** examine whether the market concentration-hospital price relationship began to weaken during the 1990's through early 2000's.[120] To do so, they use data from California and Florida for the years 1990-2003.[121] This study presents results about the hospital price-market concentration relationship; review of the study suggests that it declined and possibly reversed after peaking in 2001.[122] Although not specifically addressed in their study, it may be that the recent shift in payor concentration and changes in payment mechanisms may have played a role in the results they find. Payment mechanisms that encourage consumers or physicians to take relative costs of care into account may increase the ability of payors to discipline pricing in geographies.[123]

- **It is difficult to generalize about merger effects from some studies due to methodology and approach; several are based on simulations or models that either have not been validated against actual mergers or whose key assumptions may no longer be consistent with market realities. Price predictions may thus be overstated – possibly substantially.**

One frequently cited study regarding the price effects of hospital mergers is the 2009 study by **Dafny.**[124] This study is characterized as an "event study" by Town and Vogt. To address the concern of selection, namely that firms that merge tend to be different than firms that do not, Dafny instruments for rival mergers using rival co-located pairs.[125] The author's main results are based on the particular estimation technique used, *i.e.*, instrumental variable analysis.[126] The author compares the results obtained using the instrumental variable approach with the results obtained from using actual mergers.[127] While the former indicate large and statistically significant price changes, the latter, *finds no price increase*. This highlights the fact that the results presented as main findings are highly sensitive to the methodology employed.[128] Finally, the analysis focuses only on markets with co-located merging hospital pairs and may have limited external validity. The author notes "Caution must be exercised, however, when extrapolating these conclusions to hospital mergers in general. The estimates I obtain rely on responses to mergers of co-located hospitals, which likely enjoy especially strong post-merger increases in market power."

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116 Two items which could have contributed to cost increases during this time are the newly adopted mandatory nurse-patient staffing levels and the seismic retrofitting mandate for hospital buildings.

117 Asako Moriya, William Vogt and Martin Gaynor, *Hospital Prices and Market Structure in the Hospital and Insurance Industries* 5 HEALTH ECONOMICS, POLICY AND LAW 4 (2010): 459-479.

118 Price is measured by actual transaction price. Although the coefficient on hospital concentration was positive, it was imprecisely measured as evidenced by the large standard errors. In a sensitivity test using different subset of states, the correlation between prices and hospital HHI remained statistically insignificant in every specification and was of varying sign. The hospital market was defined using Hospital Services Areas which consists of several counties.

119 It is unclear whether this is associated with monopsony power or other effects.

120 David Dranove, Richard Lindrooth, William White and Jack Zwanziger, *Is the Impact of Managed Care on Hospital Prices Decreasing?* 27 JOURNAL OF HEALTH ECONOMICS 2 (2008): 362-367.

121 Hospital financial data and patient-level discharger from California Office of State Health Planning and Development (OSHPD) and Florida State Center for health Statistics (SCHS) was obtained for: 1990, 1995, 1999, 2001, and 2003. Price is the weighted average of the net revenues received by the hospital for 10 common DRGs.

122 Both OLS and IV estimates demonstrate a statistically significant negative relationship between market concentration and hospital price. However, in estimating the relationship for each year individually, the estimates are positive, statistically significant, and increase through 2001, after which point they decline. Dranove *et al.* (2008) at Table 2.

123 See discussion below with regard to changes in marketplace changes.

124 Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 JOURNAL OF LAW AND ECONOMICS 3 (August 2009): 523-550.

125 The instrument, co-located pairs, is defined as hospitals located within 0.3 miles from each other and no more than 5 blocks apart. This produces a set of 191 pairs, of which 10 actually merged during the period under review. AHA annual survey and Medicare Cost Reports data are used in the analysis. Dafny used data for the time period 1989-1996 and limited her analysis to MSAs or counties with populations greater than 100,000. As there are factors that influence both the probability of merging and outcome measures, failing to control for these factors introduces bias. For example, a hospital suffering from poor management may be financially distressed and not able to maintain adequate staffing levels. This may lead to both sub-optimal outcomes as insufficient staff reduces the quality of care, as well as an increase in the probability of a merger since financially distressed firms may be more inclined to merge than healthy, self-sustaining organizations. However, since poor management (an unobservable factor) affects both the probability of merging and the quality of care (the outcome of interest), conventional techniques would produce biased estimates. In general, bias estimates result whenever an omitted factor is correlated with both the outcome of interest and the probability of merging. The author justifies the use of co-located pairs as an appropriate instrument because she reasons that the number of co-located pairs should be correlated with the probability of merging but should not influence any outcome measure. While the author does test the first assumption and finds that it holds, the second assumption, that the number of co-located pairs should not influence the outcome measure, is more suspect (especially since concerns regarding market concentration and price are so prevalent). To further address the concern of selection, Dafny looks not at the effect of a merger on the firm's own price, but on that of rival firms located within the same market.

126 As the number of co-located pairs likely experiences little variation over time, her identification is primarily based upon cross-market variation. This approach implicitly assumes that different geographic markets are very similar and remain so over an extended period of time. The main results are based on a ratio of estimates. This calculation is based on the first stage estimation of the relationship between the number of co-located pairs and number of rival mergers: 0.119 (this value is presented in Table 2, column 3, row 2) and the relationship between price growth and rival colocation: 0.045 (this value is presented in Table 3, column 3, row 1). The resulting IV value is obtained by dividing the two estimates and can be interpreted as representing a 46% increase (0.045/0.119 = 0.376; e.376 = 1.46).

127 Table 4 in the paper compares the value obtained using the instrumental variable (columns 1 and 2) with those obtained using actual mergers (columns 3 and 4).

128 In specific, the estimated effect found relies heavily on the validity of the instrument.

Several studies rely on merger simulation or similar methodologies to test the likely impact of mergers. The economic models of hospital mergers that are referenced in the "simulation" or "event" studies cited by Town and Gaynor, Town and Vogt, and Cutler and Scott Morton and that suggest significant price predictions for mergers do not take into account current realities of new network structures and benefit designs.[129] These new network structures involve greater cost accountability by consumers (higher co-pays, deductibles, co-insurance, or premiums for choices involving broader networks or use of specific providers) that can influence consumer choice and are increasingly prevalent even in marketplaces with relatively few hospital systems, but especially in larger cities with substantial hospital alternatives. These networks provide increased flexibility for insurers to make use of alternatives and to respond to pricing or other conditions by changes in offerings – whether benefit or tier design.

An increasing proportion of consumers with private insurance are enrolled in plans with higher deductibles and co-pays, as well as in narrower or tiered networks.[130] Narrower or tiered networks typically provide lower premiums than broader or more inclusive networks at time of choosing plans and offer lower co-pays, deductibles or co-insurance for choice of specific providers by consumers. Narrow or limited networks are those that include a subset of hospitals offering the full range of hospital services while tiered networks are those that place hospitals on lower tiers based on meeting quality standards at lower relative "cost" to consumers in the form of out-of-pocket costs, and typically lower costs for services. These provide the ability to use out-of-pocket costs or premiums to encourage consumers to choose specific plans, or once a plan is chosen to motivate use of lower cost providers.

The omission of these important current real-world market facts that differ substantially from the all-inclusive networks prevalent in the late 1990s after backlash from HMOs means that critical elements of current competitive dynamics are not well accounted for in reported merger simulations based on older models. These network and benefit designs change a key assumption in prior models, which largely assumed all-inclusive networks. The omission is critical not just for the potential disconnect with real world conditions but for the impact on price predictions: models that do not take into account these realities may overstate predicted price increases from mergers where the ability of insurers to be responsive to pricing by use of new tools for network reconfiguration and for enhanced in-network steering impacts model predictions.[131]

This section has focused primarily on the price effects of mergers. Antitrust review of mergers, however, consider the impact on both price and non-price competition, and attempts to take into account many dynamic factors including entry and reposition, customer alternatives and potential benefits such as discussed above with regard to access, value and efficiency. As noted above, a comprehensive evaluation of the welfare effects of mergers takes these into account.[132] Current simulation models for hospitals do not take into account these more dynamic factors and benefits.

Despite the role market concentration is thought to play in price increases, transactions between firms in disparate markets may also be subject to claims that such a transaction will result

The omission of these important current real-world market facts that differ substantially from the all-inclusive networks prevalent in the late 1990s after backlash from HMOs means that critical elements of current competitive dynamics are not well accounted for in reported merger simulations based on older models...The omission is critical not just for the potential disconnect with real world conditions but for the impact on price predictions....

129 For convenience we summarize from Gaynor Congressional testimony the most frequently cited studies, which are based on econometric models based on specific assumptions: "Last, a few research papers have estimated the impacts of hospital mergers using simulation. These papers estimate models of hospital competition, then use the estimated parameters of those models to simulate the impacts of mergers (Town and Vistnes, 2001; Capps *et al.*, 2003; Gaynor and Vogt, 2003; Brand *et al.*, 2011). These papers find estimated impacts of mergers ranging from 5 to 53 percent increases in price. Town and Vistnes (2001) examine mergers among hospitals in Los Angeles and Orange Counties, California, where there are more than 120 hospitals between the two counties. They find that many of the mergers they examine would result in price increases of 5 percent or greater, in spite of the large number of hospitals in these counties. Capps *et al.* (2003) examine a three hospital merger in the southern suburbs of San Diego County, California, and find a price increase due to the merger of over 10 percent. Gaynor and Vogt (2003) find that a three-to-two hospital merger in San Luis Obispo, California (which was attempted, but blocked by the FTC) would have raised prices by over 50 percent. Brand *et al.* (2011) consider the recent proposed acquisition of Prince William hospital in Manassas, Virginia by Inova health system in Northern Virginia. They estimate that the acquisition would have led to price increases at Prince William hospital of anywhere from 19 to 33 percent." At 7.

130 *Employer Health Benefits: 2013 Annual Survey*, THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH AND EDUCATIONAL TRUST (2013).

131 Authors and reviewers of simulation studies note the assumptions made in many models and possible impact: For example "The exclusion of any hospital from the [managed care organization] MCO may lead to changes in the negotiated prices and/or network inclusion status of other hospitals." Farrell *et al.* (2011) at note 10; "[T]he [FTC] model does not take into account the sophisticated bargaining strategies and contractual solutions often adopted by MCOs and hospitals. These bargaining strategies may (and increasingly do) include an MCO's *ex ante* commitment to limited or tiered networks in order to extract better terms from hospitals by inducing them to compete for membership in the network or for placement in the most attractive network tiers, both of which are likely to bring a larger volume of patients to hospitals in the network by restricting the number of other, competing hospitals in the network." See Bryan Keating, Paolo Ramezzana, Robert Willig, Margaret Guerin-Calvert and Nauman Ilias, *Comment on Farrell, Balan, Brand and Wendling (2011), 'Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets'* (2012) at 4-5; *See, also:* Kate Ho and Robin S. Lee, *Insurer Competition and Negotiated Hospital Prices*, NBER Working Paper 19401 (2013) at 7; Robert Town and Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 Journal of Health Economics 5 (2001): 733–753 at 734; and Gautam Gowrisankaran, Aviv Nevo and Robert Town, *Mergers When Prices Are Negotiated: Evidence from the Hospital Industry*, National Bureau of Economic Research, Working Paper No. 18875 (2013).

132 See, Robert D. Willig, *Incremental Consumer's Surplus and Hedonic Price Adjustment*, 17 JOURNAL OF ECONOMIC THEORY 2 (1978):227-253 and *Unilateral Competitive Effects of Mergers: Upward Pricing Pressure, Product Quality, and Other Extensions* 39 REVIEW OF INDUSTRIAL ORGANIZATION 1 (2011):19-38.

in price increases. This bias is particularly troubling as the majority of merger and acquisition transactions that take place occur in different markets and have no direct impact on market concentration.[133] **Melnick and Keeler (2007)** undertake a study to investigate whether system affiliation alone can influence hospital price.[134] Using financial data and patient-level discharge data from California Office of State Health Planning and Development (OSHPD) for the years 1998-2003, they find that hospitals in large systems appear to be able to increase prices significantly more than those in small systems.[135] These differential price increases hold for both system-affiliated hospitals with and *without* local hospitals in the same system. The authors hypothesize that systems obtain this favorable pricing through their ability to negotiate. Specifically, they theorize a multi-hospital system could exert leverage even if they have only one hospital in a local market by threatening to pull out all member hospitals from the insurer's plan. Alternatively, the authors note that it may be that system affiliated hospitals provide greater quality and observed differential pricing is a reflection of the quality differences, which would be a more pro-competitive explanation. Either explanation would be consistent with their reported results.

The Wall Street Journal notes that medical prices are rising at the lowest rate of the past half century. According to the Altarum Institute's Health Care Price Index, the rate of health care price growth is at an all-time low.

- **Price variation studies tend to be based on limited data or methodology. Empirical research demonstrates many factors account for price variation, including cost of patient care, severity of care, and health of populations served. Price variation is neither necessary nor sufficient to demonstrate market power exercise in differentiated products industries such as healthcare and differences in price levels are not indicative of market power.**

Moreover, empirical research demonstrates that a wide variety of factors account for price variation, including cost of patient care, the severity of illness, and the health of the populations served. ...price variation in and of itself is neither necessary nor sufficient to demonstrate market power exercise in differentiated products – indeed, FTC economists have noted that price levels and comparisons of levels are not indicative of market power in hospital services.

Price variation studies that address concerns about market power or anticompetitive pricing by payors are another relevant subsection of the pricing literature. These studies attempt to reconcile observed geographic variation in prices paid by private insurers or Medicare and often attribute any residual or unexplained portion as indicative of market power. For example, economists Paul Ginsburg and Robert Berenson have conducted interviews of executives or examine price variation across geographic markets and concluded that there is substantial price variation among hospitals. They conclude that such price variation is supportive of market power concerns, but they do not control for factors that could explain price variation.[136] Taking a more rigorous approach, **Guerin-Calvert and Israilevich (2011)**[137] explore geographic variation in hospital prices across the US and find that 72 percent of the observed difference can be explained by regional costs, case mix, hospital investments in capital, and other factors. They find that the remaining difference is likely due to differences in quality of care, cost due to complying with state regulations, and errors in the data. Based on their study findings, they conclude that there is no basis to assume that price variation is due to provider market power.

Some price variation studies estimate the variation in prices for private insurers versus Medicare. **White *et al.* (2013)**[138] compare an estimated actual price paid for medical services by private insurers to an estimate of what Medicare would have paid for a comparable service in order to assess the magnitude of geographic variation in price. The study authors assume that Medicare represents an

133 *How Hospital Mergers and Acquisitions Benefit Communities: Updated Study by the Center for Healthcare Economics and Policy*, CENTER FOR HEALTHCARE ECONOMICS AND POLICY AND THE AMERICAN HOSPITAL ASSOCIATION (September 2013), available online at http://www.aha.org/content/13/13mergebenefitcommty.pdf.

134 Price is measured as average net price index per inpatient day for private pay patients. Multi-system hospitals referenced in the study include affiliated hospitals with and without local hospitals in the same system. Glenn Melnick and Emmett Keeler, *The Effects of Multi-Hospital Systems on Hospital Prices* 26 JOURNAL OF HEALTH ECONOMICS 2 (2007): 400-413.

135 The authors report a 34 percent increase in price growth for large systems and 17 percent for small systems. Market concentration was not correlated with the effect of hospital system affiliation on price. *Ibid.*, at 400.

136 *See, e.g.*, Berenson *et al.* (2010).

137 Margaret E. Guerin-Calvert and Guillermo Israilevich, *Assessment of Cost Trends and Price Differences for U.S. Hospitals* (March 2011).

138 Chapin White, Amelia M. Bond and James D. Reschovsky, *High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power*, RESEARCH BRIEF; FINDINGS FROM HSC 27 (September 2013).

appropriate benchmark for evaluation of commercial reimbursements and can be used as an indicator of competitive "price." The study concludes that market power, leverage, and "must-have hospital status" are responsible for estimated high prices and/or observed price variation. However, this conclusion is not supported by any standard economic analysis that relates "price" or "price" variation to market structure or competitive conditions (concentration, number of competitors, share, etc.). The paper excludes critical details that would allow for a thorough assessment of the methodological approach employed. The authors do not disclose sample size or service mix in any city included in their analysis. Nor do they account for the fact that the variation present could be due to comparing different types of physicians and hospitals with potentially widely varying services within and across cities. In addition, the policy recommendations presented in the study concerning price caps (such as setting commercial rates to be equal to Medicare) are unsupported by any analyses of whether medical services and access are sustainable at those rates.

As market conditions including financial pressures, excess capacity, the nature of hospital-insurer bargaining, the types of payment systems including shifts from fee-for-service, and other healthcare reform are changing over time, findings from these studies are ill-suited for inferring likely price impacts of transactions in 2013.

While the recent focus in price variation is attracting attention, studies that attempt to explain the source of the variation tend to be suggestive at best and do not provide conclusive evidence to support their findings. Moreover, empirical research demonstrates that a wide variety of factors account for price variation, including cost of patient care, the severity of illness, and the health of the populations served. Finally, price variation in and of itself is neither necessary nor sufficient to demonstrate market power exercise in differentiated products – indeed, FTC economists have noted that price levels and comparisons of levels are not indicative of market power in hospital services.[139]

The articles presented in this section highlight the fact that the relationship between market concentration and price is complex. **Mergers and acquisitions are thought to increase hospital prices through gains in market power (evidenced by increased concentration), but review of recent studies finds no consistent quantified statistical relationship between concentration and price.** Academic studies cited as supporting the concern that consolidation leads to increased prices tend to examine specific subsamples of hospitals. As such, the findings in these studies are not necessarily applicable or relevant for the broader sample of hospital mergers and acquisitions. Finally, many studies are based on transactions that occurred in the 1990s. As market conditions including financial pressures, excess capacity, the nature of hospital-insurer bargaining, the types of payment systems including shifts from fee-for-service, and other healthcare reform are changing over time, findings from these studies are ill-suited for inferring likely price impacts of transactions in 2013. These results suggest that the ultimate impact of consolidation on hospital prices is far from established and that the discussion would benefit from additional research on this topic.

V. "Price" Trends and Slowing of Rate of Growth

Changes in health care costs and prices attract significant attention and are among the most highly scrutinized trends in the health-care industry. Recent data indicate that increases in the price of health care are at record lows.[140] *The Wall Street Journal* notes that medical prices are rising at the lowest rate of the past half century. According to the Altarum Institute's Health Care Price Index,[141] the rate of health care price growth is at an all-time low.[142] Hospital prices, a key driver of the index, experienced 1.5 percent year over year growth. This growth rate held steady from the August levels and is the lowest since 1998. Prices for physician and clinical services grew by only 0.2 percent while home health care prices fell by 0.4 percent. Data from the Bureau of Labor and Statistics tell a similar story. The September 2013 hospital Producer Price Index (PPI) increased 0.1 percent from the previous month.[143] For the 12-month period ending September 2013, annual hospital PPI increased 1.5 percent, significantly less than the 2.4 percent increase

139 See, Haas-Wilson and Garmon (2011).

140 Eric Morath and Louise Radnofsky. *Medical-Price Inflation is at Slowest Pace in 50 Years*. THE WALL STREET JOURNAL (September 17, 2013).

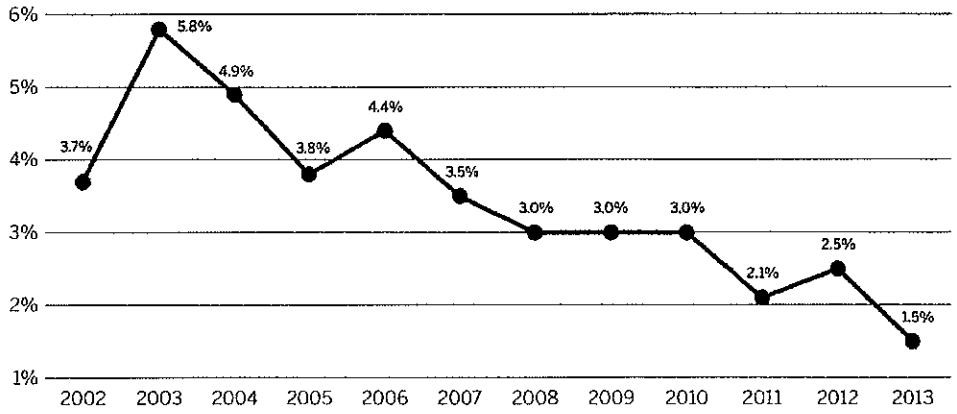
141 *Health Sector Economic Indicators' Insights from Monthly Price Indices through October 2013*. 13 ALTARUM INSTITUTE PRICE BRIEF 11 (November 13, 2013)

142 This represents a 23 year low as the data have been tracked since January of 1990.

143 The PPI is an industry-specific index that tracks price growth for that sector over time by measuring changes in price. The Consumer Price Index (CPI) calculates price growth for all items and is used as a measure of general inflation. Both measures are calculated by the Bureau of Labor Statistics (BLS). http://www.bls.gov/home.htm. The American Hospital Association routinely issues briefs reporting changes in hospital price growth. http://www.ahanews.com/ahanews/jsp/display.jsp?dcrpath=AHANEWS/AHANewsNowArticle/data/ann_103013_PPI&domain=AHANEWS

observed in the preceding 12 month period. This trend can have a significant impact on the government's finances as healthcare represents one of the biggest components of the federal deficit. Figure 5 presents the change in hospital PPI for 2002-2012 and depicts a downward trend in rate of change hospital prices over time a sustained period of time.

Figure 5: Annual Percent Change in Hospital Prices



Source: Bureau of Labor Statistics, Producer Price Index data, 2002-2012 for Hospitals

In a recent paper, Cutler and Shani (2013) indicate that overall healthcare spending growth is slowing and identify several reasons including improved efficiency in the delivery of healthcare. Both the Centers for Medicare & Medicaid Services (CMS) and the Congressional Budget Offices (CBO) have reduced their spending forecasts as projected healthcare spending exceeded actual spending by a large margin. The CMS budget for the period 2003-2012 projected an annual per capita health care spending increase of 3.9 percent. However, real per capita health care spending increased 1.9 percent, on average during this period. Accordingly, CMS reduced its 2018 forecast by eight percent and the CBO reduced its 2020 forecast by seven percent.[144]

Although the 2007 – 2009 recession is credited with a one-time decrease in the spending growth rate, Cutler and Shani find that this accounted for only 37 percent of the overall reduction in healthcare spending observed during the 2003-2012 period. A reduction in Medicare payment rates and a decline in commercial insurance coverage account for another eight percent of the observed decline.

They estimate that the remaining 55 percent of the reduction in spending is due to changes in the healthcare delivery system including greater provider efficiency and increased cost sharing, as well as a reduction in imaging technology proliferation and the advent of new pharmaceuticals.[145] **This slowing in the rate of growth of healthcare spending and in hospital PPI, on balance, suggests some benefit from changes in the healthcare delivery system.**

Both the Centers for Medicare & Medicaid Services (CMS) and the Congressional Budget Offices (CBO) have reduced their spending forecasts as projected healthcare spending exceeded actual spending by a large margin.

VI. Conclusions

To contribute to the understanding of the likely effects of hospital mergers, we surveyed the literature (including both studies and articles in the press) to assess the competitive risks and benefits of consolidation. We focused on trends influencing transactions and healthcare delivery as well as literature on price, value, and quality effects. We find that the effects and in particular the benefits

144 David M. Cutler and Nikhil R. Sahni, *If Slow Rate of Health Care Spending Growth Persists, Projections may be off by $770 Billion*. 32 HEALTH AFFAIRS 5 (2013): 841-850. Slowdown in the rate of growth of healthcare spend is a positive development; the imperatives to strive for "Triple Aim" goals of enhanced patient care, improved population health, and reduction in rate of increase in per-capita costs in healthcare remain strong.

145 Efficiency gains refer to the reduction in hospital acquired infections and reduced readmissions. The percentage of workers with high deductible health insurance plans has increased by 24 percentage points since 2006 and copayments for doctors office visits have increased 1.9 percent annually (in real terms) between 2006-2012. Magnetic resonance imaging and computed tomography use growth rate leveled off in 2006 after growing rapidly during 1996-2005. Prescription drug spending growth was 10.1 percent annually during 1993-2003, but slowed to an annual rate 2.3 percent during 2003-2012. *Ibid.*, at 845-846. For an additional empirical analysis of factors accounting for these trends, see: Henry J. Kaiser Family Foundation, Assessing the Effects of the Economy on the Recent Slowdown in Health Spending (Apr 22, 2013) available online at http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending

of hospital mergers are identifiable but broad-based current studies demonstrating these benefits are lacking. Academic studies and retrospective reviews, especially on price effects, present conflicting evidence and often rely on outdated data or assumptions about market realities. **There is considerable misinformation regarding the drivers of consolidation and the benefits due to realignment which include improvements in access, value, and efficiency. Despite significant concern that most mergers can unilaterally result in increased prices, FTC/DOJ reviews and enforcement actions suggest otherwise.** In addition, hospital price growth has been slowing and is at a record low, a fact that suggests that healthcare system redesign and realignment is yielding some benefits.

Realignment of services can achieve economies of scale and scope, improve quality of care and maintain or enhance access to care. Access to capital made possible by consolidation can enable facility and/or technology upgrades and investments.

Economic conditions and major systematic changes including the slow economic recovery, reduced reimbursements, increased demand for coordinated delivery of care, and implementation of costly healthcare IT systems (*i.e.*, electronic medical records) present significant challenges to the hospital industry as a whole. Mergers provide a means to face these challenges and adapt to the changing landscape. Consolidation allows for realignment of services which can be used to address issues of excess capacity and may lead to cost savings and increases in efficiency. Realignment of services can achieve economies of scale and scope, improve quality of care and maintain or enhance access to care. Access to capital made possible by consolidation can enable facility and/or technology upgrades and investments.

Despite concerns that mergers lead to anti-competitive pricing, FTC/DOJ reviews suggest that the risk of a substantial lessening of competition is not pervasive as only a handful of hospital mergers were actually challenged. High concentration or market share alone do not equate to anticompetitive effects. Prospective and retrospective merger analysis show that even in highly concentrated markets, the estimated effects on price often is mixed. In addition, although hospital mergers and acquisitions have not slowed, spending and price measures for the hospital industry indicate that price growth is slowing. The reliance on past (and in some cases quite distant past) merger activity and assumptions about market conditions to inform current policy reveals the imperative for a more comprehensive understanding of *current* market conditions, *current* merger motivations and more rigorous examination of merger effects to evaluate the likely benefits or competitive risks of current and future hospital transactions. **Fundamentally different market conditions could and do imply that past research is ill-suited – if not misleading – to inform current understanding of likely merger effects.** Past research may not capture dramatic changes ongoing in the healthcare industry, including pressures and results of healthcare reform – particularly requirements for new technologies, new business models, new benefit and network designs, and reduced reimbursements. Moreover, most of the oft-cited price-effect studies are based on mergers or data from the 1990s, under substantially different market conditions than current conditions, and using models that do not fully capture current conditions, thereby overstating merger effects potentially significantly. Further empirical study would be constructive to assess more fully the relevance of prior findings for today – such as the benefits from sustained operations and avoidance of service disruption or closure, and also to assess more completely the effects of mergers in this more complex environment.

...although hospital mergers and acquisitions have not slowed, spending and price measures for the hospital industry indicate that price growth is slowing.

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Authors

Margaret E. Guerin-Calvert is President and Senior Managing Director, The Center for Healthcare Economics and Policy ("Center"), a separate business unit in the Economics Practice of FTI Consulting, Inc. She is also Senior Consultant, Compass Lexecon, a wholly owned subsidiary of FTI Consulting, Inc.

Jen Maki is Director, The Center for Healthcare Economics and Policy. The report benefited from substantial assistance of our colleagues at the Center. *The views and opinions presented are solely those of the authors and the Center and do not necessarily reflect the views of FTI Consulting, Inc. or other organizations with which the authors are or have been affiliated.* The co-authors have worked on healthcare matters for a variety of healthcare entities, including providers, health plans, government, and associations.

FTI CONSULTING

Margaret E. Guerin-Calvert
202.589.3451
Meg.Guerin-Calvert@fticonsulting.com

Jen Maki
202.589.3456
Jen.Maki@fticonsulting.com

Exhibit D
(see attached)

S&P Global
Ratings

RatingsDirect®

Connecticut Health & Educational Facilities Authority
Lawrence + Memorial Hospital Inc.; Hospital

Primary Credit Analyst:
Jessica H Goldman, New York (1) 212-438-6484; jessica.goldman@spglobal.com

Secondary Contact:
Cynthia S Keller, New York (1) 212-438-2035; cynthia.keller@spglobal.com

Table Of Contents

Connecticut Health & Educational Facilities Authority
Lawrence + Memorial Hospital Inc.; Hospital

Credit Profile

Connecticut Hlth & Educl Facs Auth, Connecticut
Lawrence + Memorial Hospital, Inc., Connecticut

Series 2011F

Long Term Rating	BBB+/Developing	Downgraded

Rationale

S&P Global Ratings lowered its rating on the Connecticut Health & Educational Facilities Authority's series F bonds, issued for Lawrence + Memorial Hospital Inc. (L+M), to 'BBB+' from 'A-'. The outlook is developing.

The lower rating reflects weaker-than-expected system operating performance in the most recent period generating less than 1x debt service coverage based on S&P Global Ratings' calculations and a continued weakening of balance sheet metrics. (S&P Global Ratings' debt service coverage calculation differs from the obligated group calculation.)

Operating performance is weaker in part due to the increasing burden of the Connecticut state hospital tax but also volume issues and ongoing losses in the physician group. We assess the enterprise profile as strong with dominant market share. We assess the financial profile as adequate characterized by challenged financial performance with operating losses and debt service coverage weaker than medians but solid reserves relative to long-term debt. Combined, we think these credit factors lead to an indicative rating level of 'bbb+' and final rating of 'BBB+'.

The rating reflects our assessment of L+M's weaknesses, including:

- A sharp decrease in operating profitability in the last three fiscal years from historical levels;
- Pressure from the Connecticut state hospital tax, the impact of which has been increasing;
- Continued inpatient volume softness in fiscal 2016 with some shift of care to the outpatient setting; and
- A weakened balance-sheet position with less financial flexibility than when we assigned our rating.

The rating reflects our assessment of L+M's following strengths:

- Dominant business position in the primary service area with about 66% market share;
- Significant focus on expense-control measures and potential for some additional reimbursement from the state that is not factored into performance or projections; and
- Healthy reserves relative to debt, which are above median levels.

Our rating is based on our view of L+M's group credit profile (GCP) and the obligated group's core status. Accordingly, the long-term rating is at the level of the GCP. A pledge of gross receipts of the obligated group, which includes the parent Lawrence + Memorial Corp. and Lawrence + Memorial Hospital Inc., secures the bonds. Entities outside the

obligated group include Westerly Hospital, a foundation, physicians, a home health agency, a captive insurance company, and other joint ventures. The financial figures in this report refer to the system as a whole, unless otherwise noted.

L+M includes the 198 staffed bed Lawrence + Memorial Hospital and 75-staffed beds at the Westerly Hospital, primarily serving 10 towns in southeastern Connecticut and Westerly, R.I.

Outlook

The developing outlook reflects our opinion that there are credit factors that could determine upward or downward rating potential. We believe that there is potential for benefits from an increased relationship with Yale New Haven Health System, expected improvement in operating performance, and maintenance of the strong business position based on management's initiatives. While cash flow, margins, and coverage should improve based on management's projections to be more in line with the rating, there are external factors that we believe could limit the organization's ability to generate profitability sufficient for the rating.

Downside scenario

A lower rating is possible if the balance sheet deteriorates, coverage is not improved to be more in line with the rating, and cash flow doesn't improve to be more in line with the rating level.

Upside scenario

There's upward rating potential if the integration with Yale New Haven Health System (which includes Yale New Haven Hospital) comes to fruition and provides immediate lift to financial performance and stability to the balance sheet and our group rating methodology would then apply.

Enterprise Profile

Industry risk

Industry risk addresses the health care sector's overall cyclicality and competitive risk and growth by applying various stress scenarios and evaluating barriers to entry; the level and trend of industry profit margins; risk from secular change and substitution of products, services, and technologies; and risk in growth trends. We believe the health care services industry represents an intermediate credit risk when compared with other industries and sectors.

Economic fundamentals

The primary service area includes: New London, East Lyme, Groton, Ledyard, Lyme, Montville, North Stonington, Old Lyme, Stonington, and Waterford. New London County's population has grown over the past five years, though we expect minimal population growth over the next five. New London County's major employers include two local casinos; local universities; a U.S. naval submarine base; and Electric Boat, a submarine manufacturer that plans to increase hiring in the near term. We expect increasing employment and income levels over the next five years.

Market position

L+M maintains about a 66% market position in the primary service area, which is down from 68% reported at the last

review. Some of the decline may be due to some service line changes at Westerly, which are part of efficiency goals and therefore expected. Competition in the Connecticut portion of the service area is limited to two main hospitals: William W. Backus Hospital (part of Hartford Health) and Yale New Haven Hospital. Within 60 miles of L+M are two additional tertiary providers: Hartford Hospital and Rhode Island Hospital. In June 2013, L+M acquired the assets of Westerly Hospital, a 125-bed general acute-care hospital in Westerly, R.I whose main competitor is South County. As part of the transaction, L+M agreed to fund $30 million in capital for Westerly Hospital over five years, more than half of which is already committed there. While the Westerly acquisition allows L+M to extend its geographic reach, though market share benefit has not be realized to date.

L+M employs about 87 physicians (both primary care physicians and specialists) and also has exclusive service arrangements with other physicians. Management hopes to extend its reach in the market with growth in the employed-physician group and believes this alignment better prepares the system for health care reform initiatives. The employed group is dilutive to the system and management expects that support will continue in a significant way, though we believe the strategy will likely benefit the organization over time. With regard to other staff, L+M is in labor contracts with three unions representing over 1,200 full-time equivalents. Following a strike (which lasted four days) and lock-out in November-December 2013, all three unions are currently under contract, with a three-year renewal agreement achieved in March 2016.

L+M is working toward an affiliation with Yale New Haven Health Services. The affiliation has already passed FTC and is pending certificate of need (CON) approval. Our understanding from management is that the Connecticut application is complete and a public hearing is scheduled for June 2016 and the Rhode Island CON is still pending. There was an executive order in Connecticut that could delay this process but management feels that an integration is possible with a one year time frame. In our opinion, L+M's operations and recruitment efforts could benefit from a more formal partnership with YNHHS.

Management and governance

There have been no changes in senior management since the last review when the CFO and physician leadership changed. We believe there are challenges still facing L+M, including volumes, reimbursement, and expense management. The organization's operating performance did not meet expectations for fiscal 2016 and the rating hinges on L+M's ability to execute cost-containment initiatives, partnerships, physician alignment strategies to boost performance and generate debt service coverage in line with the rating while offsetting the impact of the Connecticut state hospital tax and other operating challenges.

Table 1

Lawrence + Memorial Corp. And Subsidiaries Enterprise Statistics

	--Fiscal year ended Sept. 30--		
	2015	**2014**	**2013**
PSA population	174,004	173,728	173,452
PSA market share %	66.1	67.0	67.9
Inpatient admissions	14,499	14,492	15,177
Equivalent inpatient admissions	38,970	38,951	37,922
Emergency visits	107,937	107,770	107,781
Inpatient surgeries	3,159	3,268	3,297

Table 1

Lawrence + Memorial Corp. And Subsidiaries Enterprise Statistics (cont.)

	--Fiscal year ended Sept. 30--		
	2015	**2014**	**2013**
Outpatient surgeries	8,264	8,265	8,975
Medicare case mix index	1.457	1.457	1.359
FTE employees	2,300	2,379	2,429
Active physicians	349	349	361
Based on net/gross revenues	Net	Net	Net
Medicare %	35.3	34.7	33.3
Medicaid %	12.0	11.0	11.9
Commercial / Blues %	49.9	51.1	51.2

*Inpatient admissions exclude newborns, psychiatric, and rehabilitation admissions. N.A.--not available. N/A--not applicable. MNR—median not reported.

Financial Profile

Financial policies

The financial policies assessment is neutral reflecting our opinion that, while there may be some areas of risk, the organization's overall financial policies are not likely to negatively affect its future ability to pay debt service. Our analysis of financial policies includes a review of the organization's financial reporting and disclosure, investment allocation and liquidity, debt profile, contingent liabilities, and legal structure and a comparison of these policies to comparable providers.

Financial performance

L+M has posted operating losses in the last three fiscal years and the interim period of fiscal 2016. While we expected an operating loss in fiscal 2015 based on guidance from management at the last review, results were weaker than expected with a loss of $16.6 million (negative 3.7% margin) compared with a budgeted loss of 1.2%. Performance in the most recent periods was weaker due to the Connecticut state hospital tax volume issues and reduced revenues associated with the shift to outpatient, and some physician competition and departures. The pressure from the tax has been increasing each year and the negative net impact of the tax on operations (the hospital tax less the supplemental payments received) increased from $4 million in fiscal 2014 to $9 million in fiscal 2015, and then following a budget rescission in fiscal 2016, could reach $18 million. However, $5.2 million was approved for restoration by legislative special session with the net impact forecasted at $13 million for the full fiscal year. For the first six months of fiscal 2016, the system is reporting that operating results remain negative and weaker than budgets. While S+P calculates coverage for the system below 1x, management's calculation of coverage for the obligated remains ahead of covenant requirements. Management's projection is for a loss close to $16 million for the full fiscal year in 2016 with a return to breakeven in fiscal 2017 and then a 2% gain in fiscal 2018. These projections include the expected pressure from the hospital tax, continued reimbursement pressures, service line enhancements, significant expense savings, and successful integration with Yale New Haven Health System.

Liquidity and financial flexibility

Historically, the balance sheet has been a credit strength, with solid reserves relative to debt and relatively low leverage levels. At the current rating, these metrics remain ahead of median levels and offset the weaker cash flows and performance. Operating liquidity as measured by days' cash on hand is below median levels but sufficient for the rating and has decreased significantly in recent years due to operating losses and weak investment market performance. We do not expect any additional debt and reserves should be stable to improving if cash flows improve as indicated by the projections.

Debt and contingent liabilities

The obligor has contingent liability risk exposures from financial instruments with payment provisions that change on the occurrence of certain events, but we consider the risk manageable at the current rating level. In October 2013, L+M issued $30 million in long-term fixed-rate debt (series G), which was a direct purchase arrangement with Bank of America Merrill Lynch. In November 2013, L+M issued the series H bonds to refinance the series E bonds—the bonds are secured by a TD Bank letter of credit. L+M has almost 80% fixed-rate debt versus about 20% variable-rate debt, though contingent debt (the series G and H) is equal to $49.8 million. Our understanding is that the direct purchase agreement documents contain covenants, including requirements to maintain 75 days' cash on hand, debt to capitalization not more than between 0.5x and 1x, and debt service coverage of not less than 1.25x to 1.0x. Related to the series G, we understand that there is a 30-day cure period for certain covenants, which we feel mitigates some of the acceleration risk. In addition, the organization's solid unrestricted reserves to contingent liabilities somewhat mitigates the risks associated with the contingent debt. $72 million of unrestricted reserves are available on a daily basis and more than $120 million available in 30 days—the liquidity is sufficient to cover the contingent debt.

Table 2

Lawrence + Memorial Corp. And Subsidiaries Financial Statistics

	--Six months ended--	--Fiscal year ended--		Medians for 'A-' rated stand-alone hospitals	Medians for 'BBB+' rated stand-alone hospitals
	2016	2015	2014	2014	2014
Financial performance					
Net patient revenue ($000s)	212,213	438,783	433,231	316,518	214,356
Total operating revenue ($000s)	219,964	453,734	451,704	MNR	MNR
Total operating expenses ($000s)	233,105	470,287	473,588	MNR	MNR
Operating income ($000s)	(13,141)	(16,553)	(21,884)	MNR	MNR
Operating margin (%)	(5.97)	(3.65)	(4.84)	3.00	1.80
Net non-operating income ($000s)	1,504	18,090	13,210	MNR	MNR
Excess income ($000s)	(11,637)	1,537	(8,674)	MNR	MNR
Excess margin (%)	(5.25)	0.33	(1.87)	5.10	4.00
Operating EBIDA margin (%)	1.27	3.52	2.03	9.80	8.70
EBIDA margin (%)	1.94	7.22	4.81	11.50	11.60
Net available for debt service ($000s)	4,288	34,045	22,360	40,411	24,117
Maximum annual debt service ($000s)	9,569	9,569	9,569	MNR	MNR
Maximum annual debt service coverage (x)	0.90	3.56	2.34	3.80	3.30
Operating lease-adjusted coverage (x)	0.90	3.56	1.85	3.20	2.80

Table 2

Lawrence + Memorial Corp. And Subsidiaries Financial Statistics (cont.)

	--Six months ended--	--Fiscal year ended--		Medians for 'A-' rated stand-alone hospitals	Medians for 'BBB+' rated stand-alone hospitals
	2016	2015	2014	2014	2014
Liquidity and financial flexibility					
Unrestricted reserves ($000s)	195,842	200,225	220,011	189,915	107,562
Unrestricted days' cash on hand	163.3	165.6	180.0	202.60	207.90
Unrestricted reserves/long-term debt (%)	196.6	194.5	202.6	149.90	157.40
Unrestricted reserves/contingent liabilities (%)	393.4	402.2	434.8	MNR	MNR
Average age of plant (years)	N.A.	10.3	10.0	10.80	12.20
Capital expenditures/depreciation and amortization (%)	N.A.	60.9	93.6	119.00	106.10
Debt and liabilities					
Long-term debt ($000s)	99,633	102,939	108,588	MNR	MNR
Long-term debt/capitalization (%)	32.1	33.0	31.0	32.60	31.80
Contingent liabilities ($000s)	49,780	49,780	50,605	MNR	MNR
Contingent liabilities/long-term debt (%)	50.0	48.4	46.6	MNR	MNR
Debt burden (%)	2.16	2.02	2.06	3.10	3.40
Defined benefit plan funded status (%)	N.A.	68.49	73.51	81.90	83.20

N.A.--not available. N/A--not applicable.

Related Criteria And Research

Related Criteria

- USPF Criteria: U.S. Not-For-Profit Acute-Care Stand-Alone Hospitals, Dec. 15, 2014
- USPF Criteria: Contingent Liquidity Risks, March 5, 2012
- General Criteria: Methodology: Industry Risk, Nov. 20, 2013
- General Criteria: Group Rating Methodology, Nov. 19, 2013
- USPF Criteria: Assigning Issue Credit Ratings Of Operating Entities, May 20, 2015
- Criteria: Use of CreditWatch And Outlooks, Sept. 14, 2009

Related Research

- Glossary: Not-For-Profit Health Care Ratios, Oct. 26, 2011
- U.S. Not-For-Profit Health Care Sector Outlook Revised To Stable From Negative, Though Uncertainties Persist, Sept. 9 , 2015
- U.S. Not-For-Profit Health Care Stand-Alone Ratios Signal Continued Stability Through Next Year Despite Industry Pressures, Sept. 1, 2015
- Health Care Providers And Insurers Pursue Value Initiatives Despite Reform Uncertainties, May 9, 2013
- Standard & Poor's Assigns Industry Risk Assessments To 38 Nonfinancial Corporate Industries, Nov. 20, 2013
- Alternative Financing: Disclosure Is Critical To Credit Analysis In Public Finance, Feb. 18, 2014
- Health Care Organizations See Integration And Greater Transparency As Prescriptions For Success, May 19, 2014
- U.S. Not-For-Profit Health Care: Competition And Reform Continue To Spur Mergers, Oct. 24, 2014

Exhibit E
(see attached)

hospitals in pursuit of excellence

Sig's Leadership Series on Population Health

The Second Curve of Population Health

March 2014

Association for Community Health Improvement

HRET
HEALTH RESEARCH & EDUCATIONAL TRUST
In Partnership with AHA

15-32033 07/01/16 0977

Resources: For information related to population health, visit www.hpoe.org and www.healthycommunities.org.

Suggested Citation: Health Research & Educational Trust. (2014, March). *The second curve of population health.* Chicago, IL: Health Research & Educational Trust.

Accessible at: www.hpoe.org/pophealthsecondcurve

Contact: hpoe@aha.org

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Table of Contents

Executive Summary

As hospitals and care systems transform, they are increasingly prioritizing population health as a platform to improve the health of patients and communities. Myriad forces are driving these health care organizations to actively address a broad array of socioeconomic and environmental factors and provide preventive care, particularly for populations who lack access to care or engage the system at the wrong place and time. Building on health care futurist Ian Morrison's idea of health care transformation as a shift from a fee-for-service first curve to a value-based second curve, the second curve of population health depicts an integrated approach to improving patient and community health. For many hospitals, thriving in the second-curve environment will necessitate making challenging organizational and cultural changes to support new goals and initiatives.

This guide builds upon prior American Hospital Association reports that outline a road map for hospitals and care systems to use as they transition to the second curve of population health. Though the rate and extent to which hospitals and care systems engage in population health initiatives may vary, a significant shift toward population health is anticipated in the next three to five years. The tactics described in this guide provide a framework for initiatives that hospitals and care systems could pursue to develop an institutional infrastructure that supports population health. These tactics are:

- Value-based reimbursement
- Seamless care across all settings
- Proactive and systematic patient education
- Workplace competencies and education on population health
- Integrated, comprehensive HIT that supports risk stratification of patients with real-time accessibility
- Mature community partnerships to collaborate on community-based solutions

Hospitals and care systems transitioning to the second curve of population health evaluate process and outcomes metrics to measure their progress in improving patient and community health. Aligning the needs and assets of the hospital and community with metrics allows for meaningful and significant analysis. Possible metrics include but are not limited to:

- Summary measures
- Inequality measures
- Health status
- Psychological state
- Ability to function
- Access to health care
- Clinical preventive services
- Cost of care

As established community stakeholders with extensive knowledge and resources, hospitals are in a unique position to lead population health transformation. Hospitals should challenge themselves to reach beyond their walls and partner with community organizations to implement innovative approaches that sustainably improve total population health.

Driving the Change

As the U.S. health care system transforms, hospitals are expanding their scope to include population health as a model to improve the health of their patients and surrounding communities. Though population health is not traditionally considered a major focus of hospitals and care systems, myriad forces are driving these organizations to address both the medical and nonmedical factors that determine health status. Driving forces include:

- Shift in financial arrangements away from fee-for-service to value-based payments that incentivize positive outcomes
- Increase in provider accountability for the cost and quality of health care
- Increased access to care for underserved and vulnerable populations through the Affordable Care Act
- Constant demand to reduce fragmentation and improve efficiency by redesigning care delivery
- Increased transparency of financial, quality and community benefit data
- Economic and legislative pressures to curb increases in health care spending
- Demographic changes in the patient population that will increase demand for health care services, along with projected shortages of primary care providers
- Recognition that acute medical care is only one aspect of maintaining and improving health

Population health is commonly described as "the health outcomes of a group of individuals including the distribution of outcomes within the group."[1] By integrating preventive principles into care delivery, the ultimate goal of population health is to improve the overall health of a given population while also reducing health disparities.[2] A population health approach aims to improve health outcomes, particularly for individuals who lack access to care or engage the system at the wrong place and time, and complements the Triple Aim goals of improving the patient experience of care, improving population health and reducing per capita cost.

The American Hospital Association published two guides, "Managing Population Health: The Hospital's Role" (available at http://www.hpoe.org/population-health) and "The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships" (available at http://www.hpoe.org/small-rural-partnerships), that outline how population health can serve as a strategic platform to improve health outcomes by focusing on three interrelated approaches:

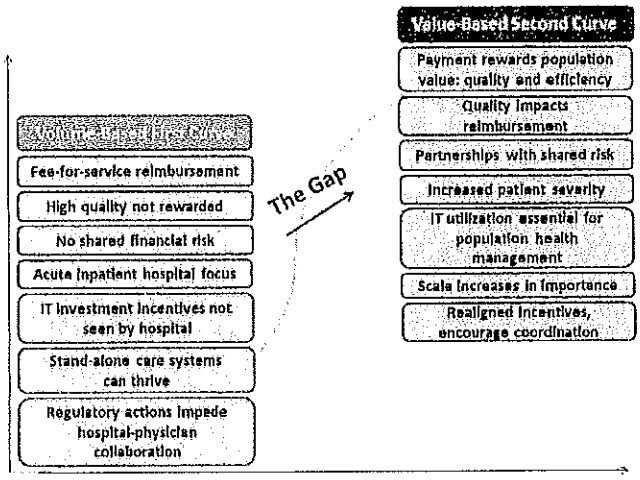
1. Identifying and analyzing the distribution of specific health statuses and outcomes within a population
2. Identifying and evaluating factors that cause the health outcomes
3. Identifying and implementing interventions that modify determinants of health outcomes

Population health resides at the intersection of three distinct health care mechanisms: (1) increasing the prevalence of evidence-based preventive health services and behaviors, (2) improving care quality and patient safety and (3) advancing care coordination across the health care continuum. Health status is influenced by personal behaviors, environmental and social forces, and family history and genetics, while only a small percentage of health status is attributable to medical care.[3] This ecological model of health points to the importance of proactively addressing the upstream factors that affect health to sustainably improve the health of any population. Achieving improved population health will ultimately decrease medical costs and allow hospitals to invest in prevention.

First and Second Curves of Health Care

Economic futurist Ian Morrison suggests that as payment incentives shift, health care providers will modify their core models for business and service delivery. He calls this a first curve to second curve shift.[4] Morrison describes the *first curve* as an economic paradigm driven by the volume of services provided and fee-for-service reimbursement. The *second curve* is concerned with value: the cost and quantity of care necessary to produce desired health outcomes within a particular population. Figure 1 details the first and second curves of health care.

Figure 1. First Curve to Second Curve of Health Care



Source: Adapted from Ian Morrison, 2011.

As hospitals and care systems shift from the volume-based first curve to the value-based second curve, they must transform their business and health care delivery models to balance quality, cost, patient preferences and health status to achieve real value and improved health outcomes. Hospitals and care systems moving to the second curve use performance metrics to identify clinical, financial and process improvements; incorporate the appropriate incentives; and evaluate results. The AHA "Hospitals and Care Systems of the Future" report (available at http://www.aha.org/about/org/hospitals-care-systems-future.shtml) outlines 10 must-do strategies to be successful in the transformation from the first curve to the second curve:

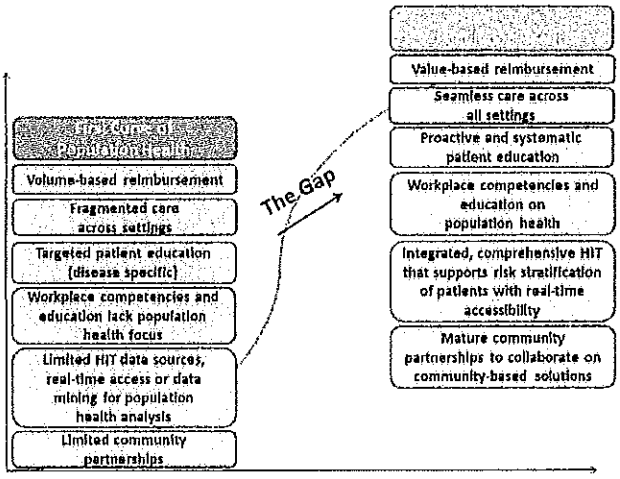
1. Aligning hospitals, physicians and other clinical providers across the continuum of care
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate reinvestment and innovation
8. Partnering with payers
9. Advancing an organization through scenario-based strategic, financial and operational planning
10. Seeking population health improvement through pursuit of the Triple Aim

The Second Curve of Population Health

As health care organizations transition to the second curve, population health approaches must also change to align with new goals and processes aimed at improving patient and community health. Applying the curve concept to population health provides a road map to guide hospitals and care systems as they integrate population health into their organizations.

Adopting a second-curve population health approach will require hospitals and care systems to make major systemic and cultural shifts. They will need to develop a formalized care delivery system that addresses disease prevention and management of the patient population and reaches outside hospital walls to improve community health (see Figure 2).

Figure 2. Second Curve of Population Health



Source: Health Research & Educational Trust, 2014.

The rate and extent of transitioning to the second curve may be dependent on each hospital's or care system's marketplace and influence, other hospitals and care systems in the community, other providers and available resources. Significant transformation across the field is expected to occur in the next three to five years. Some markets are moving more quickly toward the second curve, based on payer, competitor and other market pressures, while others remain in a fee-for-service model.

The tactics described here contribute to an organizational infrastructure that supports population health and the 10 must-do strategies for transitioning to the second curve of health care. Each organization should select the tactics that are best aligned with its mission, goals and resources.

Value-based reimbursement:

- Hospitals and care systems deliver defined services to a specific population at a predetermined price and quality level.
- Large hospitals and care systems provide or contract for a full continuum of services across acuity levels for regional populations.
- Providers link payment contracts and compensation models to performance results.
- Hospitals and care systems participate in an accountable care organization or patient-centered medical home model across a significant population.

- Smaller providers deliver specified services to target populations, working under contract or in partnership within networks that are managed by larger entities functioning as population health managers.
- Care delivery systems align with the Triple Aim to improve the patient experience of care, improve population health and reduce per capita cost.

Seamless care across all settings:

- Preventive services are integrated into all care settings.
- Care transition programs support seamless patient handoffs and excellent communication to reduce readmissions or complications, ensure treatment compliance and engage patients and families as they transition to new settings of care.
- Care teams or navigators are widely used to assist in managing complicated patient cases across the care continuum.
- Hospitals and care systems provide care or develop partnerships for care delivery in a community-based setting, such as community clinics or patients' homes.
- Small and rural hospitals may utilize telemedicine to connect with remote patients and remote specialty or emergency services.

Proactive and systematic patient education:

- All patients receive holistic education about disease management and prevention.
- Education and chronic disease management initiatives target at-risk groups and include medical and behavioral approaches to preventing illness.
- Multidisciplinary teams of case managers, health coaches and nurses coordinate chronic disease cases, set goals and track progress, and follow up after transitions.
- Providers use patient-engagement strategies, such as shared decision-making aids, shift-change reports at the bedside, patient and family advisory councils, and health and wellness programs.
- Providers regularly measure or report on patient and family engagement, with positive results.
- Hospitals lead community outreach screening or health education programs.

Workplace competencies and education on population health:

- Hospitals have leadership and staff dedicated to population health.
- Existing staff and clinicians are trained in population health competencies, including working across sectors, aggregating data and identifying systemic issues, and developing policy and environmental solutions.[5]
- Staff have defined roles within the population health management process.
- Staff receive ongoing training on population health as it relates to their specific job duties.
- Hospitals employ care coordinators, community health workers and health educators and augment population health staff as necessary.

Integrated, comprehensive HIT that supports risk stratification of patients with real-time accessibility:

- HIT possesses capacity for sophisticated analytics for prospective and predictive modeling to support clinical and business decisions.
- Data warehouse is fully integrated and interoperable, incorporating multiple data types for a variety of care settings (e.g., clinical, financial, demographic, patient experience, participating and nonparticipating providers).
- Data from multiple community partners are combined in regional health information exchanges and data registries to comprehensively address the needs of patients and communities.
- Timely and local data that identify the health issues in a community are accessible by clinical staff in real time to guide the care of individuals.

Mature community partnerships to collaborate on community-based solutions:

- Hospitals and care systems engage the community by exchanging resources, sharing knowledge and developing relationships and skills to manage communitywide challenges and leverage collective advantages.
- Extensive and diverse partnerships between hospitals and local organizations use collective impact approaches to address specific and general health needs of the community.
- Hospitals and care systems partner with the community and public health departments to address gaps and limitations in health care delivery and to target community health needs.
- Hospitals and care systems provide balanced leadership that recognizes the resources and contributions of community partners, and they include community representatives in their leadership structure.
- Hospital-led initiatives address community issues such as environmental hazards, poverty, unemployment, housing and other socioeconomic factors.
- Community partners collaborate to develop relevant health metrics to measure progress and community needs.

Bridging the Gap

Every hospital and care system approaches population health differently depending on organizational priorities, resources and population needs. A survey by the American Hospital Association and the Association for Community Health Improvement confirmed anecdotal evidence that implementation of population health initiatives varies widely across hospitals.[6] To move to the second curve of population health, hospitals and care systems will need to align their mission, organizational culture and services with a population health approach that addresses the needs of the community. Each organization's alignment is unique because the hospital's or care system's structure and resources, along with the surrounding community, influence and shape the transformation.

Many hospitals and care systems are taking steps toward the second curve by incorporating population health initiatives into their operations. A common impetus for initially engaging in population health is community benefit regulations that require not-for-profit hospitals to demonstrate their positive impact. Hospitals can achieve their community benefit requirement through community health promotion, education, charity care or other activities.

Part of this regulation mandates hospitals to conduct community health needs assessments at least once every three years and develop implementation plans to address identified needs in the population. By bringing together stakeholders from across the health care system and local community, the community health needs assessment process encourages collaboration between organizations to address the health issues unique to their community.

Some hospitals and care systems take a narrow approach to population health by focusing improvement efforts on their patient population. Many are developing accountable care organizations and patient-centered medical homes to manage care across the continuum for a specific population of patients. While these pilot programs are showing promising results for patient health and cost savings, these approaches do not address the needs of the greater community, particularly those individuals who do not have access to care.

Second-curve organizations go beyond community benefit regulations and accountable care organizations to develop a culture that integrates a population health approach into all facets of the organization. Because hospitals and care systems have different care services and organizational structures, leaders should define the target population and associated health goals. As health care moves to the second curve, hospitals and care systems may be challenged to expand their defined population into the broader community to address growing health issues.

As established stakeholders and leaders, hospitals and care systems should play a significant role in population health transformation. Hospitals can leverage their clinical expertise and extensive resources to promote wellness and support a variety of external collaborative relationships to achieve their population health goals. As the public health and provider sectors become better aligned, hospitals will need to engage in challenging but necessary changes to improve the health of the patient and community population as well as the organization's financial bottom line.

Measuring Transformation to the Second Curve of Population Health

Hospitals and care systems that move toward the second curve of population health should evaluate process metrics but prioritize outcomes measures. For example, success is not the number of people who attend a wellness event; rather, success is the impact that the wellness event has on specific health outcomes.

Hospital and care system leaders can collaborate with their clinical staff and community leaders to develop metrics that are mutually acceptable and attainable. Aligning the needs and assets of the hospital and community with the metrics allows for more significant analysis. Choosing the appropriate metrics to measure transformation to the second the curve of population health involves identifying metrics that are:

- Simple, robust, credible, impartial, actionable and reflective of community values
- Valid and reliable, easily understood, and accepted by those using them and being measured by them
- Useful over time and for specific geographic, membership or demographically defined populations
- Verifiable, independently from the entity being measured
- Responsive to factors that may influence population health during the time that inducement is offered
- Sensitive to the level and distribution of disease in a population

Table 1 outlines possible outcome metrics for assessing the impact of population health initiatives. The metrics can be applied at the patient or community level.

Table 1. Sample Population Health Metrics

Metric Area	Description
Summary measures	• Health-adjusted life expectancy at birth (years) • Quality-adjusted life expectancy • Years of healthy life • Disability-adjusted life years • Quality-adjusted years
Inequality measures	• Geographic variation in age-adjusted mortality rate (AAMR) among counties in a state (standard deviation of county AAMR/state AAMR) • Mortality rate stratified by sex, ethnicity, income, education level, social class or wealth • Life expectancy stratified by sex, ethnicity, income, education level, social class or wealth
Health status	• Percentage of adults who self-report fair or poor health • Percentage of children reported by their parents to be in fair or poor health • Percentage of children aged 3–11 years exposed to secondhand smoke
Psychological state	• Percentage of adults with serious psychological distress (score ≥13 on the K6 scale) • Percentage of adults who report joint pain during the past 30 days (adults self-report) • Percentage of adults who are satisfied with their lives
Ability to function	• Percentage of adults who report a disability (for example, limitations of vision or hearing, cognitive impairment, lack of mobility) • Mean number of days in the past 30 days with limited activity due to poor mental or physical health (adults self-report)
Access to health care	• Percentage of population that is insured • Percentage of the population that has a designated primary care physician
Clinical preventive services	• Adults who receive a cancer screening based on the most recent guidelines • Adults with hypertension whose blood pressure is under control • Adult diabetic population with controlled hemoglobin A1c values • Children aged 19–35 months who receive the recommended vaccines
Cost of care	• Percentage of unnecessary ER visits • Percentage decrease in ER costs • Percentage decrease in cost of care per patient, per year

Source: Adapted from R. Gibson Parrish, 2010 and Healthy People 2020, 2013.

15-32033 07/01/16 0988

Conclusion

To improve the health of a population, hospitals and care systems need to provide high-quality patient care and proactively address the environmental and social factors that affect health status. Hospitals and care systems have the opportunity to redesign their care delivery models to achieve long-term outcomes and cut costs. While most hospitals and care systems do not have the resources or desire to assume all of the health needs of their community, they can leverage their resources and influence to lead community health transformation. Some hospitals are well situated to lead transformation in their communities by strengthening their mission to improve health and investing in capital and collaborations that bind them to their communities.[7]

Specific tactics to operate in the second curve of population health are:

- Value-based reimbursement
- Seamless care across all settings
- Proactive and systematic patient education
- Workplace competencies and education on population health
- Integrated, comprehensive HIT that supports risk stratification of patients with real-time accessibility
- Mature community partnerships to collaborate on community-based solutions

Measuring and evaluating the process and outcomes of population health initiatives are critical to identify gaps and opportunities for improvement. Each tactic can be measured with metrics that allow a hospital or care system to assess its progress to the second curve of population health.

Moving to the second curve of population health will require challenging cultural and systemic shifts alongside buy-in and commitment from hospital leadership. Transformation will not occur over night; forward-thinking hospitals and care systems should engage their leadership, staff and community to develop a road map to the second curve that is congruent with the hospital's and community's needs, resources and priorities. Innovative approaches can be implemented not only to address rising costs and an increased demand for health services, but also to improve the patient experience of care and improve population health.

Case Example 1: Michigan Stroke Network

Background: While many of Michigan's hospitals have neuroendovascular specialists on staff, others cannot support a dedicated stroke expert available around the clock. St. Joseph Mercy Oakland is the first Certified Primary Stroke Center in Michigan.

Intervention: Addressing the need to increase access, in October 2006 Trinity Health launched the Michigan Stroke Network, a collaborative of 30 hospitals. Member hospitals have around-the-clock access to telemedicine services and stroke specialists.

Using Remote Presence™ Robotics, a remotely controlled mobile teleconferencing system, the Michigan Stroke Network ensures that every hospital has the ability to offer all patients the most advanced stroke care available. Initially, the Michigan Stroke Network deployed nearly two dozen RP-7 robots to hospitals throughout the state. The Michigan Stroke Network is funded by SJMO, so participating hospitals received the remote presence robots at minimal cost.

Participating hospitals pay no fee to join the network and there are no additional consultation fees. Stroke patients who are transferred to SJMO receive treatment and are returned to the member hospital for further care. Along with clinical support, the Michigan Stroke Network reaches out to member hospitals and surrounding communities to educate them about identifying strokes. Network representatives visit health fairs and conduct preventive screenings.

Results: As a result of the Michigan Stroke Network, remote presence robots are deployed across Michigan. Since 2006, network staff has seen a considerable increase in calls from partner hospitals requesting a referral for treatment. Additionally, patients who are referred to SJMO for stroke intervention have seen improvement in their NIH stroke assessment score. For example, patients who are admitted with a stroke assessment score between 11–14 are transferred back to their community hospital after treatment with an assessment score of 6–9.

Lessons Learned: Key learnings from the Michigan Stroke Network's experience include:

- Set up electronic communication and reporting between member hospitals and a primary stroke center at the beginning of the project to facilitate transfer of information
- Incorporate a community-based approach to enhance outreach and preventive services

Contact:
Connie Parliament
Clinical Program Director of Neuroscience Services
Michigan Stroke Network
(866) 522-8676
parliamc@trinity-health.org or hoermans@trinity-health.org
http://www.michiganstrokenetwork.com

Case Example 2: Banner Health

Background: Banner Health, a large nonprofit health care organization based in Phoenix, provides care for patients in Alaska, Arizona, California, Colorado, Nebraska, Nevada and Wyoming. Banner Health is driven by its mission: "to make a difference in people's lives through excellent patient care."

Intervention: In 2011 Banner Health redefined the aim of its care delivery process by transforming its organizational culture toward population health management. This redefinition began with formation of the Banner Health Network, an organization comprising Banner Health, Arizona Integrated Physicians, Banner Medical Group and Banner Health Physician Hospital Organization.

Banner Health Network is a comprehensive care system that is responsible for the continuum of patient care and accepts financial accountability for those served by the network. By bringing together Banner Health-affiliated physicians, 13 acute-care Banner hospitals and other Banner services in Arizona, Banner Health Network offers patients convenient access to a full range of high-quality health care services, such as acute care, home care, nursing registries and residential care through an accountable care organization model. It is one of a few networks in Arizona serving patients in a population health management model.

Results: Banner Health Network is one of the top five performing Pioneer ACOs in performance year one in terms of shared savings, with more than $19 million saved. Additionally, BHN had the following results in performance year one:

- 8.9 percent fewer hospital admissions
- 14.4 percent reduction in average length of hospital stay
- 6 percent fewer hospital readmissions
- 6.7 percent drop in use of X-rays, MRIs or other imaging services
- 2.5 percent drop in Medicare payments per beneficiary

Lessons Learned: Critical to the success of BHN were:

- Aligning incentive payments with the physicians, e.g., using a software program to determine claims data and patient volume
- Providing robust support and organization for the primary care team
- Engaging the community with a variety of methods, including community representation on BHN boards

Contact:
Kathy Strasser
Senior Director, Managed Care Operations
Banner Health
(602) 747-4479
Kathy.Strasser@bannerhealth.com
http://www.bannerhealth.com

Case Example 3: Yale New Haven Health System

Background: Yale New Haven Health System, based in New Haven, Connecticut, comprises four delivery networks: Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, and Northeast Medical Group, a physician foundation. YNHHS is an academic medical center affiliated with the Yale University School of Medicine.

Intervention: Over the last five years, YNHHS has progressed quickly in its population health approach. At first, YNHHS used clinic settings to provide basic health care services to the community. Community health needs assessments provided the data to develop targeted community health programs such as Project Access, which connects uninsured community members to local social services and health resources. An early intervention was the development of an onsite care management program for YNHHS employees living with chronic disease. This interview-based program provides care coordination, navigation, coaching and goal setting to employees and their adult dependents.

Recognizing the growing need for population health initiatives, YNHHS developed a set of core competencies for its organizational model that includes primary care access, clinical integration, care management, financial management/direct contracting and data analysis. A leadership group was formed to develop an accountable care organization to support population health initiatives. Working with a variety of health care partners, YNHHS is currently developing a clinically integrated health network.

Results: Within one year, the employee health program improved compliance with evidence-based care by 10 percent, brought risk-adjusted, per-member per-month spending in line with the general employee population, resulted in zero readmissions and avoidable admissions and consistently had 95 percent or higher participant satisfaction ratings.

Lessons Learned: As its population health approach has evolved, YNHHS identified several key factors that contributed to its success:

- An electronic medical record that provides data warehousing, actionable analytics and care management support
- Patient engagement and activation
- Local innovation when scaling small programs to the larger community

Contact:
Amanda N. Skinner, MSN, MBA
Executive Director, Clinical Integration and Population Health
Yale New Haven Health System
(203) 384-3614
amanda.skinner@ynhh.org
http://www.yalenewhavenhealth.org/

15-32033 07/01/16 0992

Case Example 4: Mercy and Memorial Hospitals

Background: Mercy Hospital Downtown, Mercy Hospital Southwest and Memorial Hospital, the three Dignity Health hospitals in Bakersfield, California, are the largest health care providers in the southern San Joaquin Valley and serve a diverse population of urban and rural residents. The hospitals' missions are to provide high-quality, compassionate health care to their patients and advocate on behalf of the poor. Created in 1991, the Department of Special Needs and Community Outreach was formed to take hospital resources beyond the walls of the three hospitals and help create a healthier community.

Intervention: Mercy and Memorial Hospitals have greatly expanded their population health initiatives over the last 10 years. They coordinate more than 45 outreach programs and collaborate with several hundred different partners in the community. A central component of the population health effort has been addressing access to care, preventive care, job training, chronic disease management, nutrition services and youth interventions. The programs are expanding with increased hospital support, grant funding and donations. Mercy and Memorial Hospitals continue to coordinate their population health programs through three outreach centers located in the most vulnerable areas of Bakersfield. These centers have become the hub of resources for the underserved. Residents have come to trust the employees, who provide a variety of health- and nonhealth-related services, including:

- Art for Healing
- Breakfast Club
- Breast health program
- Car seat program
- Community fitness classes
- Community Health Initiative
- Dinner Bell program
- Emergency food baskets
- Empowerment (chronic disease self management)
- Health education seminars and classes
- Health screenings
- Healthy Kids in Healthy Homes
- Homemaker Care job training
- In-home health education
- Operation Back to School
- Referrals for basic needs

Results: Of the patients who enter the empowerment seminars for chronic disease and diabetes self-management, 93 percent avoided admissions to the hospital or emergency department for six months following their participation. In the Homemaker Care job training program, 66 percent of participants have gained employment within six months. In 2013, the Community Health Initiative of Kern County enrolled 9,519 children in health insurance programs. The Art for Healing program has become a popular destination for community caseworkers to bring clients suffering from mental illness.

Lessons Learned:

- Collaboration with other providers and partners enables Mercy and Memorial Hospitals to create a network of community members to enroll residents into health insurance programs.
- By offering evidence-based chronic disease management programs, Mercy and Memorial Hospitals are effective in avoiding hospital admissions and readmissions.
- Many program participants become volunteers, leaders and, in some cases, employees.

Contact:
Debbie Hull
Regional Director
Mercy and Memorial Hospitals
(661) 632-5467
debbie.hull@dignityhealth.org
http://www.bakersfieldmemorial.org, http://www.mercybakersfield.org/

15-32033 07/01/16 0993

Case Example 5: Sentara Healthcare

Background: Sentara Healthcare operates more than 100 sites of care, including 11 acute care hospitals in Virginia and North Carolina. Through its insurance plan, Optima Health, Sentara Healthcare provides health insurance to about 450,000 people.

Intervention: To advance its population health efforts, Sentara Healthcare developed core population health competencies for its leaders and staff from existing small-scale population health programs. To strengthen the population health model, primary care delivery was redesigned, a pilot patient-centered medical home was initiated and clinical and technological capabilities were developed. A group of Sentara senior leaders oversaw the transformation process. Sentara leveraged its insurance plan and created new care delivery processes focused on what is best for the patient. For example, care managers were introduced to focus on high-risk and high-utilization patients.

Sentara Healthcare conducted community health needs assessments, which provided a picture of the health status of community residents and helped direct Sentara in developing and providing health services. Through collaboration with community partners, such as health departments, free clinics and community health centers, Sentara works to improve the health of its community. In 2012, Sentara provided more than $282.2 million in community benefits.

Results: The pilot health programs have met their goals and showed great promise for Sentara Healthcare. Pilot programs resulted in:

- 44 percent decrease in average emergency department visits
- 46 percent decrease in hospital all-cause admissions
- 18 percent decrease in hospital all-cause 30 day readmissions
- 87 percent increase in seven day follow-up visits
- 17 percent reduction payments by Sentara's insurance company, Optima Health

Additionally, the various population health programs have reported high patient satisfaction scores.

Lessons Learned: With a more deliberate approach to the development of its population health initiatives, Sentara learned:

- Using multidisciplinary teams for the leadership group and other project groups helped create a comprehensive and flexible program.
- Taking time to determine the exact significance of the results of small-scaled programs is important before expanding programs to the greater population.
- Breaking down silos and having continuity are critical to improving patient outcomes.

Contact:
Grace Hines
Corporate Vice President for System Integration
Sentara Healthcare
(757) 455-7370
kswillia@sentara.com
http://www.sentara.com

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Endnotes

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About HRET

Founded in 1944, the Health Research & Educational Trust (HRET) is the not-for-profit research and education affiliate of the American Hospital Association (AHA). HRET's mission is to transform health care through research and education. HRET's applied research seeks to create new knowledge, tools and assistance in improving the delivery of health care by providers and practitioners within the communities they serve.

About HPOE

Hospitals in Pursuit of Excellence (HPOE) is the American Hospital Association's strategic platform to accelerate performance improvement and support delivery system transformation in the nation's hospitals and health systems. HPOE shares best practices, synthesizes evidence for application, and engages leaders in the health industry through education, research tools and guides, leadership development programs and national engagement projects.

About ACHI

The Association for Community Health Improvement (ACHI) is a personal membership group of the American Hospital Association. ACHI provides education, professional development, resources and engagement opportunities to its members in the fields of population health, community health and community benefit. ACHI is working to cultivate a society of professionals who apply their specialized knowledge and expertise to effectively educate and collaborate with their communities in achieving the highest potential health for community residents.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	**DOCKET NO. 15-32033-CON**
	:	**July 11, 2016**

PRE-FILED TESTIMONY OF ROSS SANFILIPPO, DMD, LAWRENCE + MEMORIAL CORPORATION BOARD OF DIRECTORS

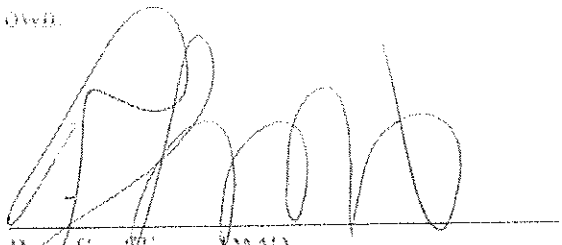
Good afternoon, Attorney Hansted, and staff of the Office of Health Care Access ("OHCA"). My name is Ross Sanfilippo and I am a member of the Board of Directors for Lawrence + Memorial Corporation ("L+M"). I am very appreciative of this opportunity to personally speak with you today and provide, on behalf of the Board of Directors of L+M, our collective reasons for recommending to OHCA that it approve the above-referenced application (the "Application") allowing L+M to affiliate with Yale-New Haven Health Services Corporation ("Yale New Haven Health").

I would like to tell you something about our dedicated L+M Board. The L + M Board is made up of very capable and committed individuals who live and work in the Eastern Connecticut region. These individuals devote significant time to overseeing a vital and important resource to our community. As you heard from Mr. Cummings, the Board engaged in a very deliberate and thoughtful process in arriving at the decision to affiliate with Yale New Haven Health. There were, of course, a number of precipitating factors. Since 2010, the time in which The Patient Protection and Affordable Care Act (the "Act") was passed, it became very clear to the Board that we were in for some very fundamental

changes in health care, and that past assumptions and or approaches to the delivery of health care would no longer serve us well. In fact, it was not long after the passage of the Act that we began seeing reductions in reimbursement at both a State and Federal level. Although we endeavored to counterbalance such reductions by consulting with experts who helped us reduce expenses, we soon realized that cutting expenses was not enough. Given the associated costs relating to data analytics, IT platforms, population health, and care coordination, we knew that enhanced scale would be essential to our success. We also knew that we needed access to capital.

As Mr. Cummings also mentioned, L + M has enjoyed a very positive working relationship with Yale New Haven Health. Quite honestly, we were excited to be associated with their brand. This excitement was not about the name only, but more importantly, it was about their quality, their standards and about being able to recruit the best and brightest physicians to our L + M community. While the changes to the healthcare landscape have left the Board with many uncertainties regarding L+M's future, we are certain that Yale New Haven Health is the most logical partner to support our values and mission going forward. If OHCA either denies or delays the Application, I am here to say that there will be negative consequences for our L + M community; some of which may not be reversible, may result in less access to care, less diversity in providers and even worse, a less healthy community. I urge OHCA to consider our testimony today and allow us to form a relationship on our terms as we are very committed to the future of our L + M.

I adopt this prefiled testimony as my own.



Ross SanFilippo, DMD
Board Member
Lawrence + Memorial Corporation

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	**DOCKET NO. 15-32033-CON**
	:	**July 11, 2016**

PRE-FILED TESTIMONY OF JOSEPH CRESPO, CHAIRMAN OF YALE-NEW HAVEN HEALTH SERVICES CORPORATION BOARD OF TRUSTEES

Good afternoon, Attorney Hansted and members of the staff of the Office of Health Care Access ("OHCA"). My name is Joseph Crespo and I am the Chairman of the Board of Trustees for Yale-New Haven Health Services Corporation ("YNHHSC" known as Yale New Haven Health). I am very appreciative of this opportunity to speak on behalf of our Board of Trustees and present our strong and enthusiastic recommendation to OHCA that it approve the above-referenced application (the "Application") allowing Lawrence + Memorial Corporation ("L+M") to affiliate with Yale New Haven Health.

Yale-New Haven Health is an integrated health care delivery system with a national reputation for high quality patient-centric care and education. One of Yale New Haven Health's many strengths is the diversity of its member hospitals and affiliated providers. Each member of Yale New Haven Health brings unique capabilities and expertise to our system, from Greenwich Hospital's outstanding reputation for patient satisfaction to Yale-New Haven Hospital's position as a preeminent quaternary care and teaching facility.

The boards of our hospitals are composed of community, business and physician leaders from their service area. Our boards are diverse, active and engaged – just last month, we convened a joint board retreat where trustees from each "delivery network" within Yale New Haven Health, including Northeast Medical Group – our physician foundation, came together for two days of meetings and discussion regarding the challenges facing our industry. Yale New Haven Health is strongest when each member hospital learns from and informs the others. We are committed to selecting diverse individuals representative of the local communities they serve, with strong interest in serving as fiduciaries for their respective delivery network. An engaged and committed local fiduciary board with authority and accountability is critical to Yale New Haven Health's success in that these diverse and local perspectives influence both local and system-wide strategy decisions.

As we have outlined in the Application, L+M's board will continue to ensure that the needs of its community are represented and well served when considering both local and system strategy. While Yale New Haven Health will have reserve powers over certain decisions made by the L+M board, as is the case with all hospitals in Yale New Haven Health, decisions regarding major new programs and clinical services or discontinuation or consolidation of any such program will require the approval of the L+M board in all instances. We have followed this process with the boards of other member hospitals, and we find that it allows for an open dialogue between the boards, as the local boards present perspectives tailored to their area and input on system-wide strategies.

Both Bridgeport and Greenwich Hospitals have made tremendous strides as part of Yale New Haven Health, and the integration of the Hospital of St. Raphael into Yale-New Haven Hospital has helped ensure that a vital community resource remains available to the residents of New Haven. It is my strong belief that the addition of L+M to Yale New Haven Health will not only benefit the Eastern Connecticut region, but also will enhance Yale New Haven Health as a whole as we collaborate with and learn from L+M Hospital and Westerly Hospital.

I have met with members of the L+M Board of Directors, and they are remarkably dedicated and talented people. They are excited about what the future holds as part of Yale New Haven Health and as Dr. Sanfilippo has relayed, they are very concerned about the effect on their community if this affiliation is not approved. They have chosen to form a relationship with Yale New Haven Health that will allow us to address community needs, ensure continued access to needed services and enhance the efficiency of the health care system in this state. I urge OHCA to approve the Application, and allow Yale New Haven Health and L+M to forge a partnership that will be truly beneficial for all involved.

I adopt this pre-filed testimony as my own.

Joseph Crespo
Chairman
Yale-New Haven Health Services Corporation

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	**DOCKET NO. 15--32033-CON**
	:	**July 11, 2016**

PRE-FILED TESTIMONY OF THOMAS BALCEZAK, CHIEF MEDICAL OFFICER OF YALE-NEW HAVEN HOSPITAL

Good afternoon, Attorney Hansted, and staff of the Office of Health Care Access ("OHCA"). My name is Thomas Balcezak and I am Chief Medical Officer of Yale-New Haven Hospital ("YNHH"). I appreciate this opportunity to present to you today about the many benefits that will result from approval of the above-referenced application (the "Application").

CURRENT CLINICAL RELATIONSHIP

YNHH has worked with L+M Hospital for a number of years, helping the hospital form an infrastructure for change management, contributing to their pediatric program, and forming an innovative "telestroke" program that addressed the lack of neurologists in their service area, allowing our specialists to provide electronic consultation for stroke patients. Together, we have had significant successes in providing access to certain specialty services, and I think I can confidently state that we have saved lives together. But our current relationship is essentially that of a vendor and customer – we provide a service for which L+M Hospital pays. We cannot integrate L+M into our broader quality improvement program, we cannot extend our efficiencies in purchasing, and we cannot roll out the standardized clinical protocols and evidence-

based practices that we are adopting across Yale New Haven Health and to other Yale New Haven Health hospitals to improve the care that patients receive. And as L+M's financial condition deteriorates, its ability to contract for these services weakens. If this Application is not approved by OHCA, L+M Hospital may be forced to curtail some of these specialty clinical programs, as they may take a backseat to the most basic services.

MAINTAINING LOCAL COMMUNITY HOSPITAL STRENGTH

YNHH's goal here is not to move patients from beds in New London to beds in New Haven. YNHH is at capacity, as is Bridgeport Hospital, and we simply do not have the beds for significant amounts of additional patients. Rather, our intention is to keep patients close to home in New London and in their local communities, transferring only the most complex cases to our campus in New Haven based upon the need to provide services that L+M does not. In fact, we want to enhance the local capabilities, so that our community hospitals are strengthened and can care for the majority of the cases that come in through their doors. This is how we have worked with Bridgeport and Greenwich Hospitals during the years those hospitals have been part of Yale New Haven Health – we have added and helped develop programs in bariatric surgery, gynecologic oncology, cardiac surgery and surgical otolaryngology, just to name a few. However, at the same time when patients in our Yale New Haven Health community hospitals need complex care beyond the expertise or resources of the those hospitals, patients receive access to YNHH in the most seamless, coordinated, efficient and timely manner. It is my opinion that collaboration between our member hospitals and their medical staffs yields many excellent outcomes that would otherwise not be achieved.

INTEGRATING BEST PRACTICES

As a health system, we are seeking to enhance value and reduce costs, and we have found that we need scale to spread costs in order to achieve these aims. By "scale," I am referring not only to the number of beds and size of the hospitals, but also the number of patients that seek care at our institutions and affiliated providers. L+M Hospital and YNHH already share a number of patients, systems and medical staff members – a cardiologist at L+M Hospital trained at and is on the faculty of the Yale School of Medicine, as is the primary neurosurgeon at L+M. By joining Yale New Haven Health, L+M will have access to our sophisticated infrastructure for care management and clinical redesign – and we will have the ability to drive value by spreading the costs of that infrastructure across a wider patient base. Furthermore, by affiliating with a nationally ranked teaching hospital, L+M patients will have access to participate in innovative research studies and potentially life-saving clinical trials. They will also benefit as research findings get integrated into clinical care delivery.

Our goals in rolling out standardized clinical protocols and best practices is not to dictate from New Haven how patients should be cared for at our system member hospitals – instead, we develop protocols and care pathways in conjunction with all hospitals, through a collaborative process that relies on the unique experiences and expertise that each hospital brings to bear. As an example, our Formulary Integration Council, or "FIC," is an integrated group made up of physician and pharmacy representatives from each hospital and from Northeast Medical Group, our medical

foundation. As OHCA is aware, hospital pharmacies face many challenges these days, ranging from drug shortages to drug expense to contamination in compounded pharmaceuticals. The FIC draws on the best practices of each institution to develop a system-level formulary, which is implemented at each hospital and at NEMG. System resources manage the process and support the FIC, and each hospital has a voice in the development of the formulary. We have followed similar processes in developing standardized protocols on infection prevention, prevention of blood clots, improved utilization of telemetry, and other initiatives that have improved care while lowering costs. In some cases, we use the operational expertise of our smaller hospitals to inform how we deliver care at YNHH. For example, Bridgeport Hospital implemented an "Enhanced Recovery After Surgery" program that allowed orthopedic and gynecology patients to have improved pain management, earlier ambulation, and faster return to home. This model is currently being deployed at YNHH. In each case, our approach is the same – draw on the experience and expertise of each hospital, supported by a system-level infrastructure.

In closing, I would like to summarize my key points. Yale New Haven Health does not intend to reduce services or move them to New Haven, and will not weaken the clinical services that are provided in eastern Connecticut. To the contrary, a review of our history with Bridgeport and Greenwich hospitals demonstrates that we have strengthened and enhanced the clinical offerings in these communities. While we have worked closely with L+M for many years, our current contractual relationship is not sufficient to address the many challenges facing L+M at this time, and the only way that L+M can truly benefit from our care management and quality improvement

infrastructure is by affiliating with Yale New Haven Health as a member. OHCA has a unique opportunity here to set eastern Connecticut on a path towards improved access and patient-centered care, and I urge you to approve this Application.

I adopt my pre-filed testimony as my own.

Thomas Balcezak, MD
Chief Medical Officer
Yale-New Haven Hospital

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	**DOCKET NO. 15--32033-CON**
	:	
	:	
	:	**July 11, 2016**

PRE-FILED TESTIMONY OF MONICA NOETHER, PH.D., VICE PRESIDENT OF CHARLES RIVER ASSOCIATES AND EXPERT ON BEHALF OF LAWRENCE + MEMORIAL CORPORATION AND YALE-NEW HAVEN HEALTH SERVICES CORPORATION

I. INTRODUCTION

Good afternoon Attorney Hansted, and staff of the Office of Health Care Access ("OHCA"). My name is Monica Noether. I am a vice president of Charles River Associates, an economic consulting firm. I have over 30 years of experience in evaluating the antitrust issues associated with health care transactions. I have published in peer-reviewed journals on the topic and have also testified to federal and state government agencies and in federal court on several occasions. Previously, I was employed by the Federal Trade Commission ("FTC"). I have a Ph.D. in Economics and an M.B.A in Economics and Finance from the University of Chicago, and a B.A. from Wesleyan University. A copy of my curriculum vitae is attached as Exhibit 1.

II. SUMMARY OF OPINIONS

It is my professional opinion that the proposed affiliation of Yale-New Haven Health Services Corporation (known as "Yale New Haven Health") with Lawrence + Memorial Corporation ("L+M") will benefit the citizens of Connecticut (and Rhode Island) by "improv[ing] quality, accessibility and cost effectiveness of health care delivery in the region."[1] Moreover, "the proposal will not negatively impact the diversity of health care providers and

[1] General Statutes of Connecticut, Office of Health Care Access, Chapter 368z, Section 19a-639. Guideline and Principle 5.

patient choice in the geographic region; and...will not adversely affect health care costs or accessibility to care."[2] My opinion is based on my economic analysis of the transaction and the markets in which Yale New Haven Health and L+M operate, as well as my general experience as a health economist.

As Marna Borgstrom, President and CEO of Yale New Haven Health will testify, as a result of the proposed affiliation, substantial resources will be dedicated to enhancing the health care services delivered by L+M.[3] These resource commitments will upgrade facilities, increase access to services, and facilitate recruitment of additional physicians to the L+M system. In addition, I understand that the parties anticipate cost savings to exceed $30 million over the next five years as operations are streamlined and L+M's currently underutilized capacity is more effectively used. The combined scale of Yale New Haven Health and L+M will enable the newly affiliated entities to engage more effectively in cost-effective population health initiatives that will reduce costs and increase the quality of care. As a result, Connecticut citizens who reside in the area served by L+M will benefit from increased access to higher-quality, lower-cost services close to their homes.

Alan Hunter, Chairman of the Board of Directors of L+M Corporation, and Bruce Cummings, President and CEO of L+M Corporation, have testified that without this affiliation, L+M is unlikely to continue to be able to provide the same level of access to consumers.[4] Like many small systems of community hospitals, L+M faces substantial financial challenges related to its size and lack of access to capital. These problems will only become more severe in the coming years as commercial and government reimbursements decrease and the costs of operating as an independent system increase.

The proposed affiliation between Yale New Haven Health and L+M can achieve these clinical and financial benefits without reducing competition, which is consistent with the fact that

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[2] *Id.*, Guidelines and Principles 11 and 12.

[3] Pre-Filed Testimony of Marna P. Borgstrom, President and Chief Executive Officer of Yale-New Haven Health Services Corporation and Chief Executive Officer of Yale New Haven Hospital. Submitted July 11, 2016 to State of Connecticut Department of Public Health, Office of Health Care Access, Docket No. 15-32033-CON.

[4] Pre-Filed Testimonies of Alan Hunter, Chairman of Lawrence + Memorial Corporation Board of Directors, and Bruce Cummings, President and Chief Executive Officer of Lawrence + Memorial Corporation. Submitted July 11, 2016 to State of Connecticut Department of Public Health, Office of Health Care Access, Docket No. 15-32033-CON.

the proposed affiliation has already received approval from federal antitrust regulators. Because competition will be maintained, the affiliation of Yale New Haven Health and L+M will pass on to consumers the cost savings and clinical benefits that their affiliation will allow them to achieve. As a result, these consumers will benefit directly from the affiliation.

As I discuss below, the proposed affiliation will not reduce competition because Yale New Haven Health and L+M are focused on different patient populations: Yale New Haven Health's flagship hospital is an academic medical center offering complex tertiary and quaternary care that is located in New Haven, while L+M's Connecticut hospital is located nearly 50 miles to the east in New London and is a community hospital offering less complex services. Given their different focuses and the substantial distance between the hospitals, Yale New Haven Health and L+M do not compete directly for many patients. Rather, both face more substantial competition from other health care providers. Similarly, the combination of Yale New Haven Health and L+M's physician groups also does not raise competitive concerns.

While Yale New Haven Health and L+M have developed clinical affiliations over the last several years, they are limited in the extent of financial and clinical integration that they can undertake without regulatory approval. Further advancements will require capital investment and closer alignment of clinical and financial operations, which are only possible through corporate affiliation.

I have reviewed the Intervenors' Petition for Intervenor Status, dated June 17, 2016, submitted by seven interested organizations.[5] As I discuss below, it is my professional opinion that many of the claims made by the Intervenors regarding the extent of overlap and the effect of hospital affiliations are not factually based or have no relevance to the proposed affiliation, given the limited extent to which Yale New Haven Health and L+M currently compete.

I have also reviewed the study coauthored by Yale University economist Dr. Zack Cooper entitled "The Price Ain't Right? Hospital Prices and Health Spending on the Privately

[5] Petition for Appearance by Henry F. Murray, Esq. on behalf of a coalition comprised of AFT Connecticut, Connecticut Citizen Action Group (CCAG), UNITE HERE Connecticut, National Physicians Alliance in Connecticut (NPA-CT), Connecticut Health Policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU [hereinafter "Intervenors' Petition"].

Insured."[6] As I explain below, the study has no relevance to this proposed affiliation. The study focuses on competition between hospitals within a 15-mile radius, while the closest hospitals in the Yale New Haven Health and L+M systems are nearly 50 miles apart.

III. EXPECTED BENEFITS OF THE AFFILIATION

The proposed affiliation between Yale New Haven Health and L+M will allow the systems to achieve both clinical and financial benefits, which will accrue to consumers served by the systems' hospitals. Clinically, the proposed affiliation offers L+M an opportunity to broaden its expertise, thereby providing enhanced local access to cutting-edge, sophisticated services to residents of its service area. The existing clinical programs between the two systems (*e.g.*, heart and vascular, radiation therapy, pediatric hospitalist, and telestroke) will be strengthened and new programs may be developed. As L+M's hospitals are currently underutilized, there is capacity to deploy more clinical resources at its hospitals to enable patients who do not require the most complex services to have better access to high-quality care locally and in a lower-cost setting. The closer affiliation will also facilitate access for residents of L+M service areas who need the tertiary and quaternary services offered by Yale New Haven Hospital. In addition, Yale New Haven Health—which owns the Northeast Medical Group ("NEMG") and is affiliated with the Yale School of Nursing and Yale Medical Group ("YMG")—will assist L+M in recruiting and retaining physicians and other health care professionals to the New London area.

Financially, given L+M's relatively small size and limited access to capital, it lacks the resources needed to maintain its current service offerings, much less achieve the scale necessary to respond to the capital-intensive and risk-bearing demands of health care reform. The financial strength of Yale New Haven Health and its broader scope of services will position L+M to be part of a health care system that is better able to assume the responsibility and the financial risks necessary to achieve quality and service outcomes in value-based contracts with health insurers.

L+M's financial condition as an independent system is worsening. Recently, L+M's bond rating was reduced,[7] which is a sign of its inability to meet the needs of consumers in

[6] Zack Cooper, Stuart Craig, Martin Gaynor, John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" National Bureau of Economic Research Working Paper 21815, December 2015 [hereinafter "*The Price Ain't Right? Study*"].

Connecticut and Rhode Island as an independent entity. As the bond rating memorandum indicated, L+M's "[o]perating performance is weaker in part due to…volume issues and ongoing losses in the physician group."[8] The memorandum also notes "[a] sharp decrease in operating profitability in the last three fiscal years from historical levels."[9] An affiliation with Yale New Haven Health addresses these limitations and provides an immediate benefit to the community.

The access to capital and lower borrowing costs that would result from the affiliation will allow L+M to better maintain and improve state-of-the-art facilities, and to invest in new technologies and diagnostic capabilities. L+M will also be able to access Yale New Haven Health's expertise in population health management and Yale New Haven Health's enhanced and more cost-effective IT platforms (*e.g.*, Epic, which is the gold standard for electronic health record systems).

The parties estimate that they will realize $31 million in cost savings over five years, which will be offset in part by approximately $9 million in implementation costs. Yale New Haven Health has a history of successfully reducing costs as a result of acquiring hospitals: for example, my understanding is that it is well on its way to meeting its five-year goal of achieving $300 million in cost savings from its acquisition of the Hospital of Saint Raphael. In fact, three years after its affiliation with the Hospital of Saint Raphael, it had exceeded its then-current cost savings target.[10]

The cost savings and quality benefits that the affiliation will produce will directly benefit the residents of the New London area. Intervenors express concern over "exploding" insurance premiums and cost-sharing, noting that "New London County's median family income lags the state average."[11] However, absent the affiliation, hospital prices are likely to be higher, as these

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[7] S&P Global Ratings, Connecticut Health &Educational Facilities Authority Lawrence + Memorial Hospital Inc.; Hospital, May 17, 2016.

[8] *Id.*, at 2.

[9] *Id.*

[10] Yale New Haven Hospital, "Saint Raphael Integration: 3 Years Progress Review," September 2015, at 2.

[11] Intervenors' Petition, at 2. While the Intervenors' note that New London County's median family income is less than the Connecticut state average, it exceeds that of New Haven County, where Yale New Haven Hospital is located. (*See* United States Census Bureau, American FactFinder, 2010-2014 American Community Survey 5-Year Estimates, Select Economic Characteristics, available at http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.)

affiliation-specific savings will not be able to be realized. As a result, New London area residents would be worse off.

IV. COMPETITION AMONG HOSPITALS AND THE FRAMEWORK FOR ANTITRUST ANALYSIS

The benefits of the proposed affiliation between L+M and Yale New Haven Health can be achieved without reducing competition. While the criteria that OHCA considers in evaluating whether to grant Certificate of Need ("CON") approval to a proposed transaction do not directly address the transaction's likely effect on competition, maintaining competition guarantees that the enhanced quality and cost-effectiveness resulting from a transaction inure to patients. Moreover, competition also guarantees that the transaction will not negatively affect diversity of choice or health care costs and access. Here, the affiliation will maintain—not reduce—competition.

In order to explain why the affiliation will not reduce competition, I provide some background on how the antitrust agencies, including the FTC, U.S. Department of Justice ("DOJ") and most state attorneys general analyze the competitive effects of hospital affiliations on consumers. This approach is also consistent with economic theory and application. The FTC and DOJ's *Horizontal Merger Guidelines* provide useful guidance regarding this approach.[12]

Hospitals compete for two interrelated sets of customers: patients and the health insurers that insure many of these patients.[13] Therefore, analyses of competition between hospitals must consider what influences the choices of both patients and health insurers. Hospitals compete for health insurer customers by offering favorable price terms that they negotiate in contracts with health insurers to become in-network providers. Insurers then create incentives to encourage their members to utilize the services of in-network hospitals instead of more expensive hospitals that are not included in the insurers' networks.

Hospitals also compete to provide care to members of the insurers' plans. This competition generally focuses more on service and quality than on price, primarily taking the

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[12] U.S. Department of Justice and The Federal Trade Commission, *Horizontal Merger Guidelines*, August 19, 2010 [hereinafter "*Horizontal Merger Guidelines*"].

[13] *See, e.g.*, Gregory Vistnes, "Hospitals, Mergers, and Two-Stage Competition," *Antirust Law Journal*, Vol. 67, No. 3, 671-692 (2000).

form of providing excellent clinical services, having well-regarded physicians on their medical staff, and offering amenities that make the hospital visit more pleasant for the patient.

A variety of factors are considered in determining the extent to which health insurers and patients view hospitals (and other health care providers) as competitors. All hospitals are differentiated based on a myriad of factors, such as the services they provide, the physicians who are affiliated with them, their general reputation, the amenities they offer, and their location. In general, hospitals that offer comparable services, affiliate with the same physicians, and are geographically proximate to each other are more likely to be viewed as close substitutes by their customers than those that provide different services or are located further apart.

With this background, I discuss product and geographic market definition in the next sections.

A. The Relevant Product Market

Within the context of this transaction, I focus on the proposed affiliation's effect on the provision of inpatient general acute care ("GAC") services that are offered by both Yale New Haven Health and L+M. I also discuss the implications of a market limited to GAC services utilized by patients enrolled in commercial health plans to be consistent with the approach typically adopted by the antitrust agencies.[14]

Separate product markets could also be defined and evaluated for outpatient services and for physician services. However, in the case of outpatient services, numerous other free-standing

[14] The antitrust agencies typically focus their analyses on GAC services provided to *commercial* health plans and their members, because they are generally the only customers subject to a potentially anticompetitive price increase. Consumers enrolled in government-funded health insurance such as Medicare or Medicaid pay pre-determined, regulated rates. *See* Complaint, *In the Matter of Inova Health System Foundation, and Prince William Health System, Inc.*, No. 0610166 (F.T.C. May 8, 2008); Complaint, *In the Matter of ProMedica Health System, Inc.*, No. 1010167 (F.T.C. Jan. 6, 2011); Complaint for Temporary Restraining Order and Preliminary Injunction, *Federal Trade Commission v. OSF Healthcare System and Rockford Health System*, No. 111 0102 (F.T.C. Nov. 18, 2011); Complaint, *In the Matter of Reading Health System and Surgical Institute of Reading*, No. 1210155 (F.T.C. Nov. 16, 2012); Complaint for Permanent Injunction, *Federal Trade Commission and State of Idaho v. St. Luke's Health System, LTD and Saltzer Medical Group, P.A.*, No. 121 0069 (F.T.C. Mar. 26, 2013); Complaint, *In the Matter of Cabell Huntington Hospital, Inc.; Pallottine Health Services, Inc.; and St, Mary's Medical Center, Inc.*, No. 141 0218 (F.T.C. Nov. 5, 2015); Complaint, *In the Matter of The Penn State Hershey Medical Center and PinnacleHealth System*, No. 141-0191 (F.T.C. Dec. 7, 2015); Complaint, *In the Matter of Advocate Health Network; Advocate Health and Hospitals Corporation; and NorthShore University Health System*, No. 1410231 (F.T.C. Dec. 17, 2015). The antitrust agencies do recognize that hospitals compete for patients on quality and service dimensions as well as on price; however, they believe that the same factors that determine the extent and nature of price competition affect the quality dimensions of competition as well.

(as well as hospital-based) competitors exist, making the combination of Yale New Haven Health's and L+M's outpatient facilities inconsequential from a competitive perspective. With respect to physician services, as I discuss below, there is little overlap between the physicians employed by Yale New Haven Health and L+M.

B. The Relevant Geographic Market

As I described previously, analyses of competition between hospitals must consider the choices of both patients and the health insurers who insure them. The question of geographic market definition asks what alternative hospitals would patients be willing to travel to if, post-affiliation, the affiliating hospitals raised prices or lowered quality. Generally, a patient's willingness to travel depends on, among other things, the type of care the patient requires and the services offered by the hospital. Health insurers develop hospital networks that provide health plan members with access to relatively local in-network hospitals because their enrollees prefer to stay close to home for certain types of reasonably routine care such as the care that L+M offers.

To define candidate geographic markets in which to assess competition between Yale New Haven Health and L+M, I follow the recent guidance provided by the FTC and DOJ in *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Share Savings Program.*[15] In that statement, the antitrust agencies set forth antitrust safety zones for Accountable Care Organizations ("ACOs") based on ACO-member hospitals' shares in their primary service area ("PSA"). The FTC and DOJ define a PSA as the "lowest number of postal [ZIP C]odes from which [a hospital] draws at least 75 percent of its [patients]."[16] The geographic contours of the PSA reflect consumers' willingness to travel to receive health care services, and can be used to infer the geographic access to care that patients demand.

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[15] Federal Trade Commission and U.S. Department of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, Federal Register Vol. 76, No. 209, Oct. 28, 2011, at 67028.

[16] Similarly, OHCA's 2015 CON application guide, citing Connecticut Statute, defines the primary service area as "the smallest number of [ZIP C]odes from which the [applicant] draws at least seventy-five percent of its patients." State of Connecticut Department of Public Health, Office of Health Care Access, Certificate of Need Application Guide, 2015, at 40.

In several recent challenges to hospital mergers, the FTC has defined geographic markets to include the area from which the merging parties draw approximately 85 to 90 percent of their patients.[17] As such, I also present shares for Yale New Haven Health and L+M in the systems' combined primary and secondary service areas ("PSA/SSA"). This combined area includes the smallest number of ZIP Codes from which the systems draw at least 90 percent of their patients.

V. COMPETITIVE EFFECTS ANALYSIS

A. Yale New Haven Health and L+M Each Have Small Shares in the Other's Service Areas

Exhibit 2 depicts the PSA and SSA for Yale New Haven Health for all patients; this analysis is limited to inpatient GAC services offered by both Yale New Haven Health and L+M.[18] The PSA for Yale New Haven Health extends westward along the Connecticut coast to the New York border, and roughly 20 miles east of New Haven. It also extends to the north about 20 miles, roughly half of the distance to Hartford. The PSA/SSA for Yale New Haven Health is broader, extending past New London almost to the Rhode Island border. It also extends northward to reach areas proximate to Hartford, and includes about a dozen competing hospitals. The breadth of Yale New Haven Health's PSA and PSA/SSA reflects its ownership of

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[17] *See* Complaint for Temporary Restraining Order and Preliminary Injunction, *Federal Trade Commission v. OSF Healthcare System and Rockford Health System*, No. 111 0102 (F.T.C. Nov. 18, 2011), ¶ 37 ("this relevant geographic market accounts for 87% of the inpatient admissions of the merging parties"); Complaint, *In the Matter of Reading Health System and Surgical Institute of Reading,* No. 121 0155 (F.T.C. Nov. 16, 2012), ¶ 51 ("The relevant geographic market in which to analyze the effects of the Acquisition…is the area corresponding to Reading Hospital's primary service area, which is defined by RHS in the ordinary course of business as the set of [ZIP C]odes from which Reading Hospital draws approximately 85 percent of its patients"); Complaint, *In the Matter of Inova Health System Foundation, and Prince William Health System, Inc.*, 061 0166 (F.T.C. May 8, 2008), ¶ 22 ("for the hospitals located in [the relevant geographic market], approximately 90 percent of their patients came from [the relevant geographic market]").

[18] To avoid double-counting inpatients, I exclude newborns and transfers from within or from another short-term acute care facility. I also exclude discharges with invalid patient ZIP Codes and services with invalid or ungroup able DRGs. As explained in the text above, my analysis is also limited to GAC services which exclude services related to behavioral health, rehabilitation and substance use disorder. I also focus on patients categorized into DRGs that are offered by both Yale New Haven Health and L+M as these are the services over which the two systems might compete for patients. I consider a health system to "offer" a DRG if that health system performed the DRG at least once for primary and secondary services and at least three times for tertiary and quaternary services in the last fiscal year. (I define primary and secondary services as medical DRGs with a relative weight of less than 1.3 and surgical DRGs with a relative weight of less than 3 in fiscal year 2015. All other DRGs are considered tertiary and quaternary services.) A "without complications" DRG that does not meet the above criteria for "offered" DRG is still considered to be "offered" if one of the corresponding "with complications" DRGs meets the "offered" DRG criteria.

an academic medical center and its strategy to develop Yale New Haven Hospital into a "destination hospital."

In contrast, L+M draws patients from a relatively narrow area as depicted in Exhibit 3, reflecting its hospitals' status as community hospitals. L+M's PSA is concentrated in areas within a few miles of each of its hospitals, and does not include any other hospitals. The PSA/SSA for L+M is slightly broader, extending along the Connecticut coast from 10-15 miles west of L+M Hospital to 10-15 miles east of Westerly Hospital. The SSA also extends slightly further to the north, including William Backus Hospital in Norwich, which is affiliated with Hartford HealthCare.

It is evident from these maps that a substantial proportion of the residents of the PSAs and PSA/SSAs of Yale New Haven Health and L+M receive care from those facilities, and many also receive care from competing hospital systems, located both within and outside the service areas. In assessing the likely competitive effects of a transaction, competing hospitals that also provide care to service area residents, regardless of whether they are actually located in the PSA or PSA/SSA, should be viewed as alternative hospital choices for residents of the service area.

Service areas defined based only on commercially insured patients are slightly broader than those for all patients, reflecting commercial patients' somewhat greater willingness to travel. These service areas are shown in the maps included in the Appendix as Exhibits A-1 and A-2. (Generally, my conclusions regarding the effects of the proposed affiliation between Yale New Haven Health and L+M do not depend on whether the analysis includes all patients or only those covered by commercial health plans.)

Despite the broad service area of Yale New Haven Health, Yale New Haven Health and L+M largely do not compete for patients residing in the same geographic areas. As Exhibit 4 depicts, a substantial distance exists between the non-overlapping PSAs of the two systems. Moreover, only four ZIP Codes in Yale New Haven Health's extensive SSA are also in L+M's PSA/SSA.

As the table below indicates, L+M treats a high share of the residents of its own service areas: 77 percent of all patients in its own PSA and 60 percent in its own PSA/SSA.

	L+M Service Area		Yale New Haven Health Service Area	
	PSA	PSA/SSA	PSA	PSA/SSA
L+M Share	77%	60%	0%	4%
Yale New Haven Health Share	7%	6%	75%	48%

On the other hand, Yale New Haven Health has a limited presence in L+M's service areas: only 7 percent of residents of L+M's PSA and 6 percent of residents of L+M's PSA/SSA were discharged from Yale New Haven Health. Almost all of these patients received care at Yale New Haven Hospital and a substantial number were admitted in service lines in which there is currently a clinical affiliation between Yale New Haven Health, YMG, and L+M. Hartford HealthCare—largely because of William Backus Hospital, which is the closest competing hospital to L+M Hospital—has a larger presence in L+M's service area than does Yale New Haven Health.

Yale New Haven Health also has a substantial share in its own service area, but L+M has virtually no presence in Yale New Haven Health's PSA, and has a share of only 4 percent in Yale New Haven Health's PSA/SSA. Consistent with the difference in the missions of the two hospital systems, this analysis suggests that L+M is not a significant competitor to Yale New Haven Health.[19]

Intervenors argue that the affiliation will "leave Yale[ ]New Haven [Health] with...more than 80% [share] in L+M's primary service area."[20] While this statement may be true, it is almost entirely attributable to L+M's existing presence in its own primary service area, rather than being the result of combining the significant shares of two existing competitors, which might suggest that meaningful competition between the two systems could be eliminated as a

[19] The shares of commercially insured discharges in these service areas are qualitatively similar to the all-patient shares. Reflecting commercially insured patients' somewhat greater willingness to travel, Yale New Haven Health's share of commercial discharges in L+M's PSA and PSA/SSAs are 12 percent and 11 percent, respectively, while those of L+M are 62 percent and 47 percent. Again, Hartford HealthCare treats more patients from L+M's service area than does Yale New Haven Health.

[20] Intervenors' Petition, at 2.

result of the proposed affiliation. To the contrary, as I discuss in my testimony, current competition between the systems is limited.

B. Yale New Haven Health and L+M Are Not Close Competitors

Yale New Haven Health and L+M focus on different patients. Yale New Haven Health is a nationally recognized health system providing complex care to patients throughout New England and extending into New York State. Yale New Haven Hospital, the system's largest hospital, provides the most complex tertiary and quaternary care to patients in this multi-state area. It is the primary teaching hospital of the Yale School of Medicine and the Yale School of Nursing, and is ranked nationally by U.S. News & World Report.[21] As part of its strategy to become a "destination hospital," Yale New Haven Hospital facilitates transfers of complex cases from community hospitals and coordinates direct admissions to the hospital through its Y Access Line program. The hospital does not actively compete to provide care to patients who can be served at community hospitals like those operated by L+M, but instead competes against other large systems providing highly complex care (*e.g.*, Hartford HealthCare, as well as systems located in Boston and New York City). In contrast, the L+M hospitals are community hospitals, largely offering primary and secondary services.

To the extent that L+M offers some more complex services, it is mostly through clinical affiliations with tertiary hospitals like Yale New Haven Hospital. The difference in the hospitals' missions is reflected in the services they provide. Yale New Haven Health treats patients categorized into more than 700 acute care DRGs, while L+M treats patients in only approximately 500 acute care DRGs. The greater complexity of care that Yale New Haven Health delivers is also reflected in the higher average casemix for inpatient care provided by the system. Excluding obstetric cases, Yale New Haven Health's average casemix for GAC services is 1.70, while the same figure for L+M is 1.44.

Moreover, L+M's community hospitals lack the clinical and financial resources needed to achieve the goals of health care reform and to compete with larger systems in the evolving marketplace. In particular, L+M cannot by itself fully provide integrated care spanning the

[21] U.S. News & World Report, Best Hospitals Rankings: Yale New Haven Hospital, 2015-16. (Available at http://health.usnews.com/best-hospitals/area/ct/yale-new-haven-hospital-6160400.)

continuum of services; it cannot assume the responsibility and accept the financial risk for achieving quality and service outcomes; it cannot invest in the new capabilities necessary to execute on population health initiatives; and it cannot maintain and improve state-of-the-art facilities, technologies and diagnostic capabilities.

Perhaps most importantly, as I noted earlier, Yale New Haven Hospital (the closest Yale New Haven Health hospital to the hospitals operated by L+M) is almost 50 miles away from L+M Hospital and more than 60 miles away from Westerly Hospital. It is one of 14 hospitals and six large health systems with a presence within 50 miles of L+M Hospital. Exhibit 5 contains a map of these hospitals and shows driving times from L+M Hospital.

C. The Proposed Affiliation Will Not Affect Negotiations with Health Insurers

For the reasons described above—especially the distance between the systems' hospitals and differences in service offerings and clinical focus—neither Yale New Haven Health nor L+M is a significant competitive constraint on the other. And because the two systems do not competitively constrain one another, the proposed transaction would not increase the combined entity's leverage in negotiations with insurers. Insurers could not offer a marketable network to residents of the New London area that excluded L+M and instead steered those patients to Yale New Haven Hospital, nor could insurers offer a marketable network to residents of the New Haven area that excluded Yale New Haven Hospital and steered those patients to L+M Hospital. As a result, the proposed affiliation will not affect bargaining dynamics between Yale New Haven Health (including the hospitals now owned by L+M) and health insurers, and Yale New Haven Health will be unable to demand anticompetitive increase in prices from insurers. Moreover, my understanding is that Yale New Haven Health will honor L+M Hospital and Westerly Hospital's existing contracts with health insurers, ensuring that the cost of hospital services will not increase as a result of the affiliation.

In addition, a large number of competing hospitals and hospital systems also provide care to residents of Yale New Haven Health's and L+M's service areas. These competitors include, among others, Hartford HealthCare (William Backus Hospital, MidState Medical Center, and Hartford Hospital, and The Hospital of Central Connecticut), Middlesex Hospital, Ascension Health (St. Vincent's Medical Center), and Trinity Health (Saint Francis Hospital). These competitors will remain after the proposed affiliation.

The Intervenors argue that "[risk-]adjusted prices for the most common diagnoses at L+M are consistently lower than other [Yale New Haven Health] hospitals."[22] However, the Intervenors provide no support for this statement, and it is not clear where they could obtain the data necessary to conduct an analysis that would allow any meaningful conclusions about relative prices. As Yale New Haven Health has explained, a "specific analysis relating to risk-adjusted pricing [is not possible] because there is no such standard industry metric that measures patient acuity or other variables that may affect cost and price."[23] While detailed confidential claims data from different hospital systems would provide information on *unadjusted* prices, the only adjustment that could readily be made to such data would be to control for the specific DRG in which a patient is categorized. Such adjustment, however, would not account for the myriad other factors that affect patient complexity and hospital-specific cost factors (such as Yale New Haven Hospital's substantial teaching mission) and the resulting resources that are required to treat them.

VI. THE PROPOSED AFFILIATION WILL NOT CAUSE ANY REDUCTION IN COMPETITION FOR PHYSICIAN SERVICES

I understand that OHCA is also reviewing a separate CON filing regarding the proposed merger of L&M Physicians Association Inc. ("L&MPA") into NEMG. It is my opinion that there are no competitive concerns associated with this proposed transaction.

I have assessed the overlaps between the two physician groups using the same *Horizontal Merger Guidelines* framework that I applied above in my analysis of the proposed hospital affiliation. While I do not have data to assess directly from where each physician associated with each group draws his or her patients, based on my experience, I believe that geographic markets for most physician services are no broader than, and may be narrower than, those associated with hospital services. Therefore, I focus my assessment on whether the two groups have physician offices that are located in the same county.

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[22] Intervenors' Petition, at 2.

[23] Yale-New Haven Health Services Corporation, Lawrence and Memorial Corporation, "Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation, Docket Number: 15-32033-CON, Responses to Completeness Questions - 2nd Letter," March 30, 2016, at 868.

I perform my analysis at the specialty level. While patients may, on occasion, choose physicians in different specialties to provide care for the same condition, this is relatively uncommon.[24] Moreover, the market conditions affecting different physician specialties may vary considerably.

The only county-level overlap between L&MPA and the physician component of Yale New Haven Health occurs in cardiology in New London County. In this county, L&MPA employs eight cardiologists, while 11 are associated with Yale New Haven Health. The two groups largely complement each other (rather than closely competing with each other) in the cardiology services that they offer. Reflecting the difference in services provided at the respective hospital employers of these physicians, most of the L&MPA cardiologists practice general cardiology, while many of the Yale New Haven Health physicians offer subspecialty cardiology services such as nuclear or interventional cardiology. Moreover, an affiliation already exists between the two cardiology groups. Several of the Yale New Haven Health-affiliated cardiologists see patients in New London and Waterford pursuant to an agreement between Yale New Haven Health and L+M. The combination of the two groups will strengthen this preexisting arrangement, thereby allowing more seamless integration of physician services for patients in New London County.

VII. THE COOPER ET AL. STUDY OF HOSPITAL PRICES IS NOT RELEVANT TO THE ASSESSMENT OF THE PROPOSED AFFILIATION BETWEEN YALE NEW HAVEN HEALTH AND L+M

The Price Ain't Right? Study has received substantial attention since its release in December 2015. For example, Dr. Cooper, one of the study's coauthors, testified to The Connecticut Healthcare Cabinet regarding the study's findings.[25] *The Price Ain't Right? Study*'s most commonly cited finding is that hospitals negotiate higher prices with health plans when they face fewer competitors. However, the authors themselves caution against over-interpretation of their results. Indeed, the authors explicitly note that their "estimates should be

[24] One exception is primary care, where I do consider that patients can choose between internal medicine and family practice physicians to obtain primary care.

[25] Zack Cooper. "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." Testimony to the Connecticut Healthcare Cabinet Meetings, February 9, 2016 [hereinafter "Cooper Testimony"].

interpreted as associations, not causal effects."[26] That is, their finding of an association between hospital market concentration and negotiated prices for hospital services does not imply that hospital market concentration causes higher prices. For example, it would be incorrect to infer from the study's analysis that a hospital merger that increased concentration caused prices to rise in its market.

Regardless of the general significance of *The Price Ain't Right? Study*, it has no relevance to an assessment of the competitive effects of Yale New Haven Health's proposed acquisition of L+M. As I noted earlier, L+M Hospital is almost 50 miles in driving distance from Yale New Haven Hospital. *The Price Ain't Right? Study*, on the other hand, assesses the association between the number of hospitals within a 15-mile radius of a particular hospital and that hospital's prices, *i.e.*, it focuses on hospitals that are more than three times as close as are L+M Hospital and Yale New Haven Hospital.[27] That is, the findings of *The Price Ain't Right? Study* simply have nothing to say about the effect of the proposed affiliation between Yale New Haven Health and L+M, the main and closest hospitals of which are separated by almost 50 miles.

VIII. CONCLUSION

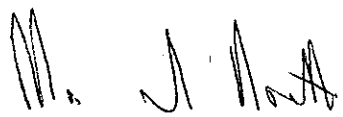
For all of the reasons that I discuss in this pre-filed testimony, it is my opinion that the proposed affiliation of L+M and Yale New Haven Health will benefit the citizens of Connecticut (and Rhode Island) by improving quality, accessibility, and cost effectiveness of health care services. The expected benefits of improving quality of service and achieving cost savings cannot happen absent the proposed transaction. It is also my opinion that the proposed affiliation will not provide Yale New Haven Health with any increase in market power and therefore will not negatively impact the diversity of health care providers, patient choice, health care costs or accessibility to care. As a result, the Intervenors' concerns that the affiliation will lead to higher prices are unfounded. Quite the contrary, it is my opinion that the affiliation will allow health care services to be more affordable. Finally, findings from the study coauthored by Dr. Zack

[26] *The Price Ain't Right? Study*, at 25.

[27] While the study does consider "markets" defined based on alternative radii from a hospital, the largest distance it evaluates is 30 miles, still less than two thirds of the distance between L+M Hospital and Yale New Haven Hospital.

Cooper, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured" have no relevance for the competitive assessment of this transaction.

I adopt this pre-filed testimony as my own.



Monica Noether
Vice President
Charles River Associates

CRA Charles River Associates

Exhibit 1

Monica G. Noether

Vice President

PhD, Economics
University of Chicago
Booth School of Business

MA, Economics
George Washington University

MBA, Finance and Economics
University of Chicago
Booth School of Business

BA, Photography
Wesleyan University

Dr. Noether specializes in antitrust analysis and other competitive issues related to the health care industry for law firms, professional associations, government agencies, and other clients. She has analyzed dozens of hospital and health plan mergers as well as competitive disputes between different players in the health care sector. She is also expert in public and private sector provider reimbursement policies. She has provided expert testimony in antitrust and reimbursement litigation, analyzing class certification, merits, and damages questions. While she is best known for her work in the health care industry, she also has broad general expertise in all aspects of antitrust analyses. She has also worked on matters involving insurance, pharmaceuticals, software, retailing, wholesale, distribution, music, soft drinks, and energy.

Dr. Noether has also served in several senior leadership positions at CRA, including as Chief Operating Officer from 2009 to 2012. Prior to joining CRA 20 years ago, Dr. Noether served as a managing vice president at Abt Associates, where she specialized in federal reimbursement policy for hospitals and physicians and in antitrust issues. She also spent several years at the Federal Trade Commission as a deputy assistant director in the Bureau of Economics and Commissioner Advisor.

Professional experience

Antitrust

Antitrust litigation. Dr. Noether has provided economic analysis to various cases involving allegations of attempted monopolization, supracompetitive pricing and monopsonistic purchasing, exclusive dealing, boycotts, or tying for a variety of healthcare services. Cases have involved physicians, hospitals, ambulatory facilities, health plans, pharmaceutical products, medical devices and clinical laboratories across a variety of health care segments such as radiology, anesthesia, cardiology, dental services, women's health, dialysis, and trauma, among others. Dr. Noether has also assessed similar economic issues in a variety of other industries: retailing, wholesale distribution, software, and chemicals. She has provided deposition and trial testimony in a variety of these matters on class certification, liability, and damages questions.

Hospital mergers. Dr. Noether has analyzed the economic effects of dozens of proposed hospital mergers all over the country, including issues related to market definition, nature of existing competition, ownership structure, scale and scope requirements for hospitals to engage in meaningful risk bearing and delivery of population health, and importance of network development to payment reform initiatives. She has testified in federal district court and/or been deposed in a variety of hospital merger cases in federal district court, including the Federal Trade Commission's challenge of the consummated merger between Evanston Northwestern Healthcare and Highland Park Hospital and the FTC's challenge of the proposed acquisition of Rockford Health System by the OSF Healthcare System (on behalf of the hospitals).

Health plan mergers. Dr. Noether has assessed the likely competitive effects of several health plan consolidations. She has provided expert testimony to state departments of insurance in some of these matters. In some, such as Aetna's purchase of Prudential; United's acquisitions of Oxford, PacifiCare, and Sierra; Humana's acquisition of CHA; and Anthem's acquisition of WellPoint; she has prepared white papers for and made presentations to federal and/or state antitrust authorities. Issues have included definition of the appropriate product and geographic markets for antitrust analysis, assessment of the likelihood and sufficiency of entry or expansion by competitors, and the potential for the exercise of monopsony power over providers. She is familiar with the variety of databases useful to these efforts.

Other mergers. Dr. Noether has evaluated the effects of mergers proposed in a variety of industries, including clinical laboratories, pharmaceuticals, medical devices, physician services, disability insurance, soft drinks, supermarkets, energy, chemicals, recorded music, and building materials. Each of these analyses has required assessment of market definition, entry conditions, and the impact of unique industry conditions on competition among market participants. In some cases, Dr. Noether has been involved in presentations to state or federal antitrust agencies.

Policy issues. Dr. Noether has provided research and analysis on a number of important policy issues in health care. She has developed and evaluated models of bundled payment for health care services, designed physician payment methodologies, and assessed the effects of various innovative payment mechanisms. She estimated the costs of proposed legislation that would have allowed physicians the right to negotiate collectively with health plans, and the results of her analysis were widely disseminated to federal and state legislators. She has also been involved in various Certificate of Need proceedings in which she has provided expert testimony on issues relating to competitive impact.

Other litigation

Class certification. Dr. Noether has addressed the economic questions that relate to the issues of predominance and typicality in class certification matters and has provided expert testimony on these questions. Her analysis has focused on whether common interests and methods of assessing harm pertain to all members of putative classes as well as whether, from an economic perspective, the named class members can adequately represent the interests of the class.

Damages. Dr. Noether has constructed and estimated models of the "but for world" that are well-founded in industry and market specifics to assess potential damages or consumer harm that might have accrued from alleged illegal activity. Cases have involved allegations of attempted monopolization and exclusion, underpayments of health care providers, denials of claims, collusion, and delayed entry of generic pharmaceuticals, among others.

Regulatory issues. Dr. Noether has assessed the economic issues arising from various forms of health care regulation, including fair market value provisions of the fraud and abuse laws, Orphan Drug Act, and Certificate of Need statutes. Analysis has focused on the regulations' effects on the economic incentives and behavior induced by the regulation as well as on their likely impact on market competition. She has provided testimony in a number of these matters.

Hospital and physician payment. Dr. Noether has analyzed the economic issues and, in some cases, testified in various matters relating to hospital and physician reimbursement by private and public payers. These have included issues related to out-of-network reimbursement, appropriate payment by Medicaid risk plans, benchmarking of competitive rates, reimbursement of salaried teaching physicians, and Boren Amendment mandates that rates support efficiently operated hospitals.

Physician studies

Medicare physician fee schedule analyses. Dr. Noether was active in all aspects of the congressionally mandated reform of Medicare's physician payment system to reflect a "resource-based relative value" approach. For the Health Care Financing Administration (now CMS), she directed the design of the data collection strategy for measuring physician practice expenses, which relied on national survey data as well as information obtained from clinical panels. She also conducted a variety of studies and data collection efforts on behalf of specific medical specialties (including cardiothoracic, vascular, orthopedic, otolaryngologic, and general surgeons; gastroenterologists, radiologists, pathologists, and nuclear medicine physicians) to assess the effects of the proposed reforms of practice expense reimbursement as well as of the work and malpractice components of the Medicare Physician Fee Schedule. In other fee-schedule-related work, Dr. Noether also assisted in the development of the methodology used to update and reevaluate the work component of the fee schedule, evaluated the effects of volume performance standards, and assessed the visit patterns associated with global surgical fees.

Forecast of staffing requirements in various specialties. Dr. Noether assessed current utilization of anesthesiology, nephrology, oral, and maxillofacial surgery, critical care staffing in different settings, and projected requirements in future years based on anticipated demographic and technological changes and the influence of health care reform. She compared projected requirements and supply to estimate training needs.

Development of bundled surgical episode payment options. Dr. Noether developed design and implementation options for lump-sum prospective payment of all services associated with a surgical episode. She analyzed particular procedures (cataract extraction, cardiac surgery) to determine options for episode definition, risk stratification, payment mechanisms, and other design and implementation features.

Hospital studies

Development of estimates of effect of new technologies on hospital costs. Dr. Noether developed the annual estimate of the scientific and technological advance allowance presented by the Prospective Payment Assessment Commission (now MedPAC) to Congress as part of its recommendation regarding payment updates for hospitals and dialysis facilities. The project involved collecting cost and diffusion data on cost-increasing, quality-enhancing technologies.

Analysis of factors contributing to growth in outpatient surgery. Dr. Noether evaluated factors that explain switch from inpatient to outpatient setting for five outpatient surgical and diagnostic procedures. Changes in technology, reimbursement, and clinical risk were assessed through literature review and structured interviews with clinicians and medical device manufacturers.

Hospital prospective payment system evaluations. Dr. Noether conducted various economic analyses of the effects of federal and state prospective reimbursement programs on utilization, quality, and cost of hospital services as well as on medical education provided by hospitals. She also designed and evaluated a prospective ambulatory reimbursement system.

Outcomes research

Practice guideline development. Dr. Noether assisted a specialty society coalition in developing an AHCPR-funded guideline on colorectal cancer screening. She coordinated a comprehensive literature review and analysis of the resulting data and convened an expert panel.

Profiling of hospitals and physicians for managed care plan network development. Dr. Noether implemented a scoring system to evaluate hospitals and physicians on the quality and efficiency of care they provide for possible inclusion in a point-of-service managed care plan. The system involved the use of discharge and claims data in scoring algorithm designed to rank medical providers.

Previous professional experience

1987–1996 *Managing Vice President* and *Area Manager of Economic Consulting to Healthcare Organizations*, *Senior Economist*, Abt Associates Inc.

Dr. Noether developed a new practice of health economics consulting to private clients on policy issues. She also directed a variety of publicly funded research initiatives.

1983–1987 *Deputy Assistant Director*, *Staff Economist*, Antitrust Division, Bureau of Economics, Federal Trade Commission

Dr. Noether analyzed economic consequences of various actions subject to antitrust scrutiny, including mergers in various industries, price fixing, group boycotts, and other horizontal restraints. She was particularly active in investigations of competitive practices of various members of the health care industry. She served as lead economist on the Commission's investigation of various acquisitions in the soft drink industry; she also supervised and worked

on investigations of mergers in the oil, polyester, recorded music, and supermarket industries. In addition, she supervised several staff economists.

As part-time economic consultant to Commissioner Azcuenaga, Dr. Noether advised the Commissioner on specific cases before the Commission and on general economic theory. She also advised the Commissioner on acquisitions in chemical, natural gas, and other industries.

1979 — *Research Associate*, Office of Domestic Policy Coordination, US Department of Commerce

Dr. Noether prepared briefings to the Secretary on various policy issues.

1974–1978 — *Administrative Positions*, American Association of Psychiatric Services for Children and the American Psychiatric Association

Dr. Noether was responsible for federal lobbying activities as well as management of Associations' finances, meetings, and newsletter editing.

Papers, publications, and presentations

Publications and reports

"St. Luke's-Saltzer: Where Does the Ninth Circuit Decision Leave Quality-Enhancing Network Integration in Allegedly Concentrated Markets?" *CPI Antitrust Chronicle,* April 2015.

"Unresolved Questions Relating to Market Definition in Hospital Mergers." With Sean May. *Antitrust Bulletin* 59, Fall 2014.

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Presentations

"What Can Economic Research Say about Merger Policy?" Presentation at the 2016 Antitrust in Healthcare Conference sponsored by the ABA Health Law Section, Section of Antitrust Law and the American Health Lawyers Association, May 12, 2016.

Panelist in the "Summation Roundtable: Antitrust Perspectives on Evolving Provider and Payment Models" for Examining Health Care Competition: FTC-DOJ Workshop, February 25, 2015.

"Trust Us, It's Complicated: Antitrust Issues Facing Healthcare in the Affordable Care Act Environment." Presentation to the Los Angeles County Bar Association, May 1, 2014.

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"Physician Practice Mergers: The Key Antitrust Issues." Webinar sponsored by the American Health Lawyers Association, June 6, 2011.

"Economic Analysis of Monopsony Concerns in Health Plan Mergers." Presentation at 2010 Antitrust in Healthcare Conference—Arlington, VA, American Bar Association Health Law Section, ABA Section of Antitrust Law, American Health Lawyers Association, May 25, 2010.

"The Use of Direct Evidence of Competitive Effects" Presentation at Joint Department of Justice—Federal Trade Commission Public Workshops on Revisions to the Horizontal Merger Guidelines, Chicago, IL, December 10, 2009.

"Highmark-IBC Merger Challenge—An Economist's Perspective." American Bar Association Section of Antitrust Law, Teleconference on Insurance Mergers, March 2, 2009.

"Health Care Antitrust Enforcement in the New Administration—An Economist's Perspective." Boston Bar Association, Boston, MA, February 10, 2009.

"Recent Hospital Merger Enforcement Actions: The Case of *FTC v. Evanston Northwestern Healthcare*." American Enterprise Institute Conference on Old and New Forms of Hospital Competition, Washington, DC, November 21, 2008.

"Economic Analysis in Hospital and Health Insurance Mergers." American Health Lawyers Association Annual Meeting, San Francisco, CA, June 30, 2008.

"Merger Remedy Policy: Application to the Evanston Case," ABA Spring Antitrust Meeting, Washington, DC, March, 2008.

"Hospital Turf Wars." American Health Lawyers Association Teleconference, February 13, 2007.

"Health Plan Power and Practice." American Bar Association/American Health Lawyers Association Health Law Conference, Washington, DC, May 12, 2005.

"Review of FTC/DOJ Health Competition Report." American Bar Association Annual Antitrust Meeting, Washington, DC, March 30, 2005.

"Physician Product and Geographic Market Definition." Federal Trade Commission—Department of Justice Joint Hearings on Health Care and Competition Law and Policy, Washington, DC, September 24, 2003.

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"Health Insurance and Providers: Countervailing Market Power." Federal Trade Commission—Department of Justice Joint Hearings on Health Care, Washington, DC, May 7, 2003.

"Experts in Antitrust Litigation." American Bar Association Annual Meeting, Washington, DC, August 11, 2002.

"Exclusive Contracting—Benefit or Evil to Competition?" American Health Lawyers Association Annual Meeting, Antitrust Practice Group, July 1, 2002.

"Use of Economic Experts in Merger Evaluations." American Bar Association Antitrust Section Conference, New York, NY, June 13, 2002.

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"Antitrust Issues in Health Care Restructuring." Practicing Law Institute Program on Health Care Restructuring, New York, NY, April 26, 2001.

"Looking Beyond Managed Care: What's Next?" Health Industry Group Purchasing Association Annual Meeting, Orlando, FL, October 24, 2001.

"Economic Issues in Antitrust Policy Regarding Health Care Mergers." Practicing Law Institute Program on Health Care Mergers and Acquisitions, New York, NY, April 15, 1999.

"Economic Input to Strategies in Merger Litigation." American Bar Association, Section of Antitrust Law, Spring Meeting, Washington, DC, April 14, 1999.

"Issues in Hospital Merger Policy." Dallas Bar Association, Health Section, March 17, 1999.

"Antitrust Considerations in Mergers and Acquisitions." Tax Executive Institute, Needham, MA, January 22, 1999.

"Recent Policy Developments in Hospital Mergers." CRA International Conference on Economists' Perspectives on Antitrust, Boston, MA, April 30, 1998.

"Hospital Merger Policy." New York State Bar Association, January 29, 1998.

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Participation in Robert Wood Johnson working conference on "Defining Competition in Health Care Markets," Reston, VA, November 14–15, 1996.

"A Health Policy Perspective on Market Definition." CRA International Conference on Current Topics in Merger and Antitrust Enforcement, Washington, DC, October 31, 1996.

"New Ways to Think About Market Definition in Health Care as Markets Evolve." American Bar Association Health Antitrust Conference, New Orleans, LA, October 25, 1996.

"Defining Markets for Healthcare Networks." New York City Bar Association, May 20, 1996.

"Reform of Medicare Physician Payment for Practice Expenses." Harvard University course on Coping with the Healthcare Revolution, May 14, 1996.

"Pricing Your Plan's Services." Presented at Physician Sponsored Managed Care Plans conference, Chicago, IL, October 16, 1995.

Briefings to 130 medical specialty societies on Reform of the Physician Practice Expense Reimbursement, June 13 and August 18, 1995.

"Pricing of Bundled Episodes of Care." Presented at Activity Based Costing Conference, Boston, MA, July 12, 1995.

"Medicare Practice Expense Reform." Presented to American Association of Thoracic Surgeons, April 22, 1995.

"Antitrust and Evolving Health Care Markets." Opening remarks and moderator of day-long symposium sponsored by Chicago Bar Association, March 1995.

"Costing of Bundled Service Packages." Massachusetts Health Financial Management Association, March 1995.

"Economic Analysis of Physician Joint Ventures." National Association of Attorneys' General Meeting, September 1994.

"Market Definition in a Hospital Physician Privileges Case." American Bar Association Antitrust Meeting, April 1994.

"Hospital Merger Analysis." Loyola University School of Law, December 1993.

"Resource-Based Approaches to Physician Practice Expense Payment." American College of Surgeons Coalition Meeting, November 1993.

"Issues in RBRVS Refinement." Massachusetts Health Information Management Association Meeting, September 1992.

"Abt Restudy of Vascular Surgery Work Values." Midwestern Vascular Surgery Society Meeting, September 1992.

"Changes in Hospital Competition during the Early 1980s." Annual Health Economics Symposium, May 1991.

"The Effects of RBRVS on Physician Payment—Lessons for Other Payors." Workmen's Compensation Research Institute Annual Meeting, February 1991.

"Results from the Restudy of Work in Cardiothoracic and Vascular Surgery." Society of Thoracic Surgeons (STS) Interim Meeting, September 1990.

"A Method to Identify Inappropriate Cataract Surgeries." International Society of Technology Assessment in Health Care, June 1992; American Medical Review Research Center (AMRRC), August 1990.

"Constructing and Analyzing Episodes of Care Using Claims Data." AMRRC, November 1989.

"Competition among Hospitals." Western Economic Association, July 1986; American Economic Association, December 1986; Association for Health Services Research, June 1987.

"The Magnitude and Effect of Changes in Patient Severity and Hospital Utilization Measured Using MEDISGRPS Data." MediQual's 4th National Symposium, April 1988.

"Readmissions and Transfers: The Effects of PPS." Eastern Economic Association, March 1989; Harvard School of Public Health, April 1989; AMRRC, November 1989.

Memberships

- American Economic Association
- Association for Health Services Research
- American Bar Association
- American Health Lawyers Association, Former Vice Chair, Antitrust Practice Group, 2001–2008

Board affiliations

- Boston Medical Center Trust, 2015–Present
- Dana Farber Cancer Institute Susan F. Smith Center for Women's Cancers Visiting Committee, 2015-Present
- Lahey Health Behavioral Services, 2009–2015
- The Boston Club, 2010–2013
- Wesleyan University President's Advisory Council, 2013–Present

Referee

- *American Economic Review*
- *Antitrust Law Journal*
- *Health Affairs*
- *Health Services Research*
- *International Journal of the Economics of Business*
- *Journal of the American Medical Association*

- *Journal of Political Economy*
- *Journal of Law and Economics*
- *Journal of Labor Economics*
- *Journal of Health Economics*
- *Journal of Industrial Economics*
- *Medical Care*
- *National Science Foundation*
- *RAND Journal of Economics*

Honors

- Charles E. Merrill Fellowship, 1978–1980
- US Department of Health, Education, and Welfare Fellowship, 1979–1980
- University of Chicago Fellowship, 1980–1983
- H. B. Earhart Fellowship, 1981–1983
- Dean's Honor List, University of Chicago Booth School of Business

Exhibit 2

Yale New Haven Health

Combined 75 and 90 Percent Service Areas for All Patients
General Acute Care Services Provided by Both Systems

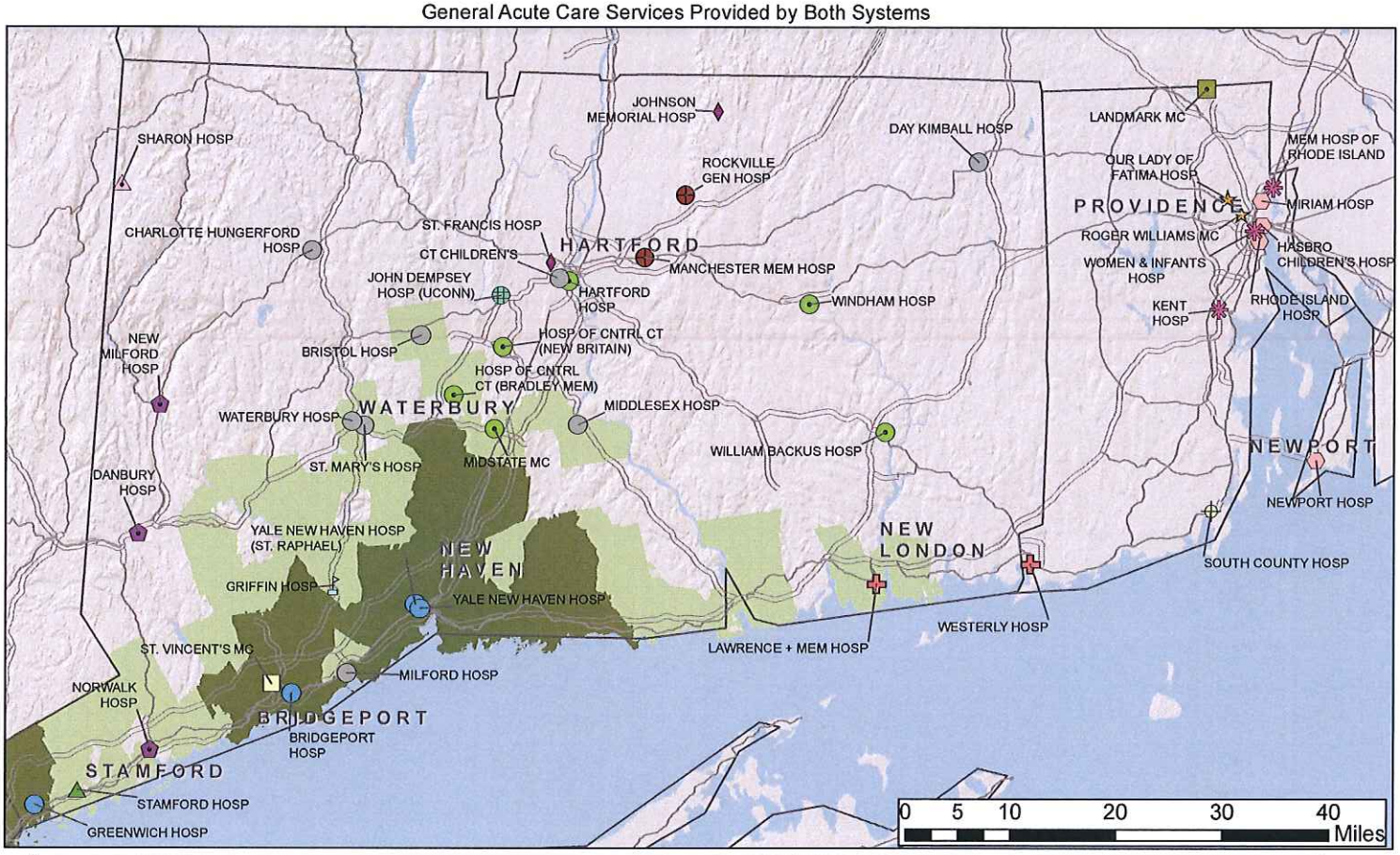


Exhibit 3

Lawrence + Memorial Healthcare

Combined 75 and 90 Percent Service Areas for All Patients

General Acute Care Services Provided by Both Systems

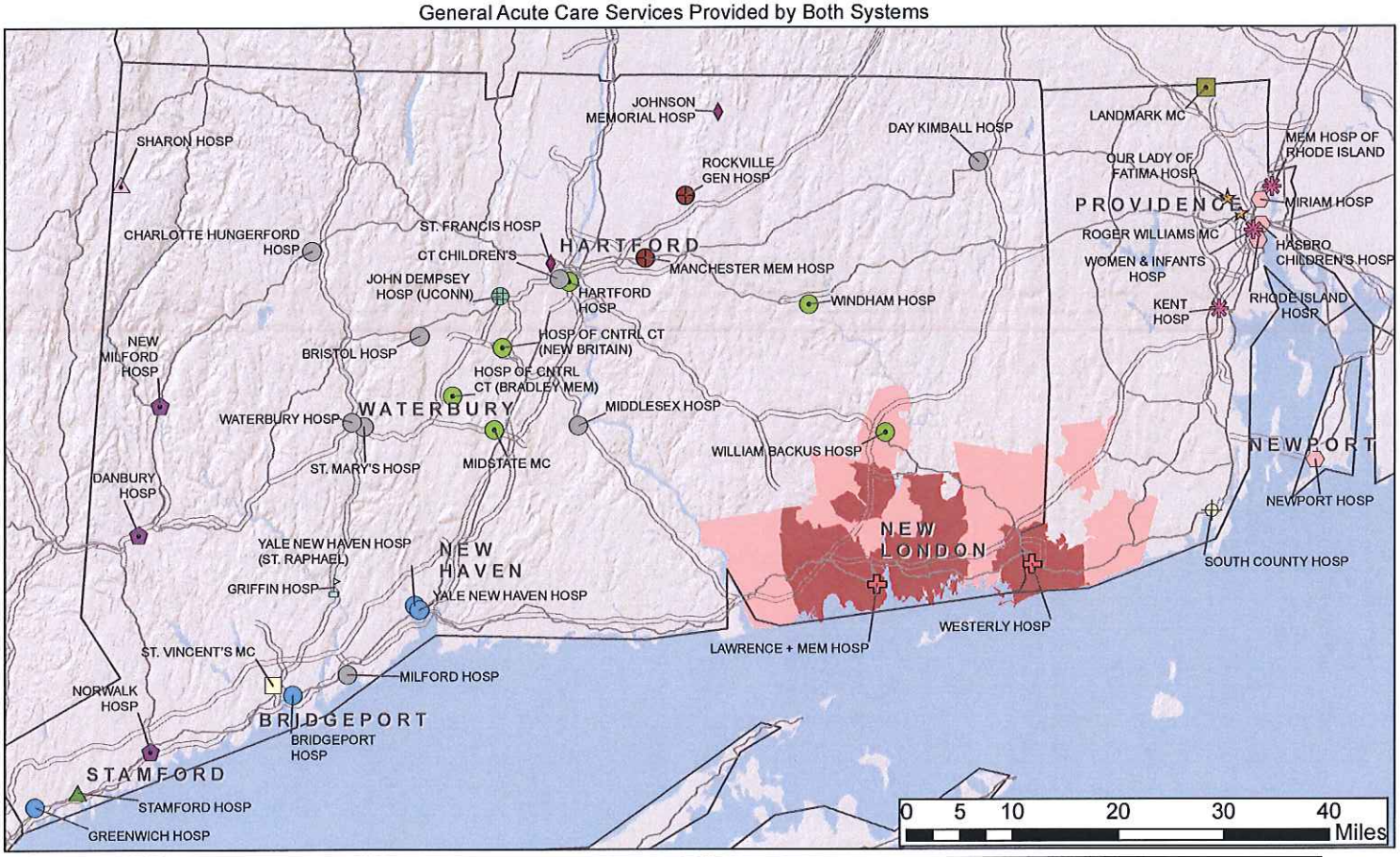


Exhibit 4

Lawrence + Memorial Healthcare and Yale New Haven Health

Combined 75 Percent Service Areas for All Patients

General Acute Care Services Provided by Both Systems

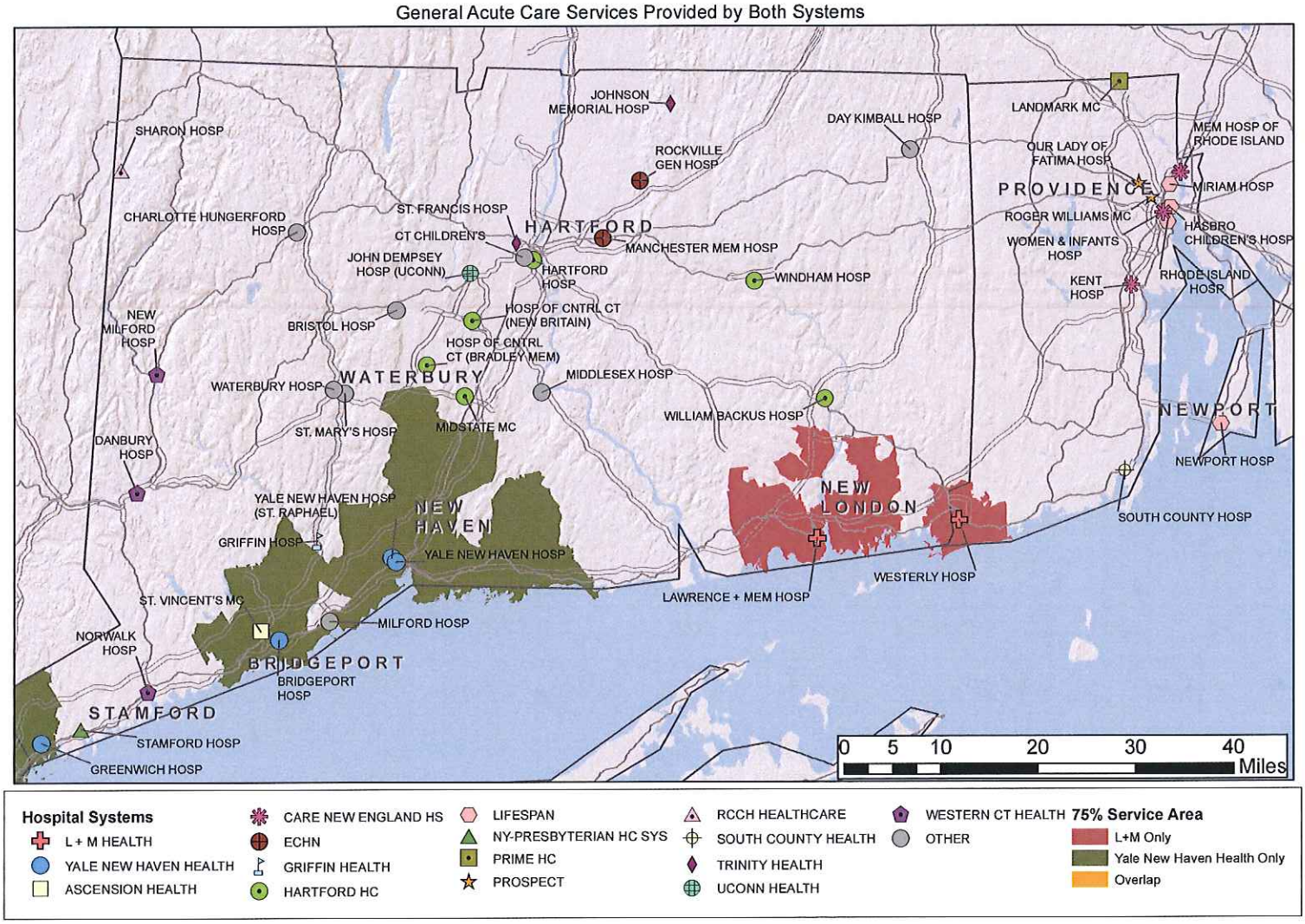


Exhibit 5

Drive Times to Lawrence + Memorial Hospital

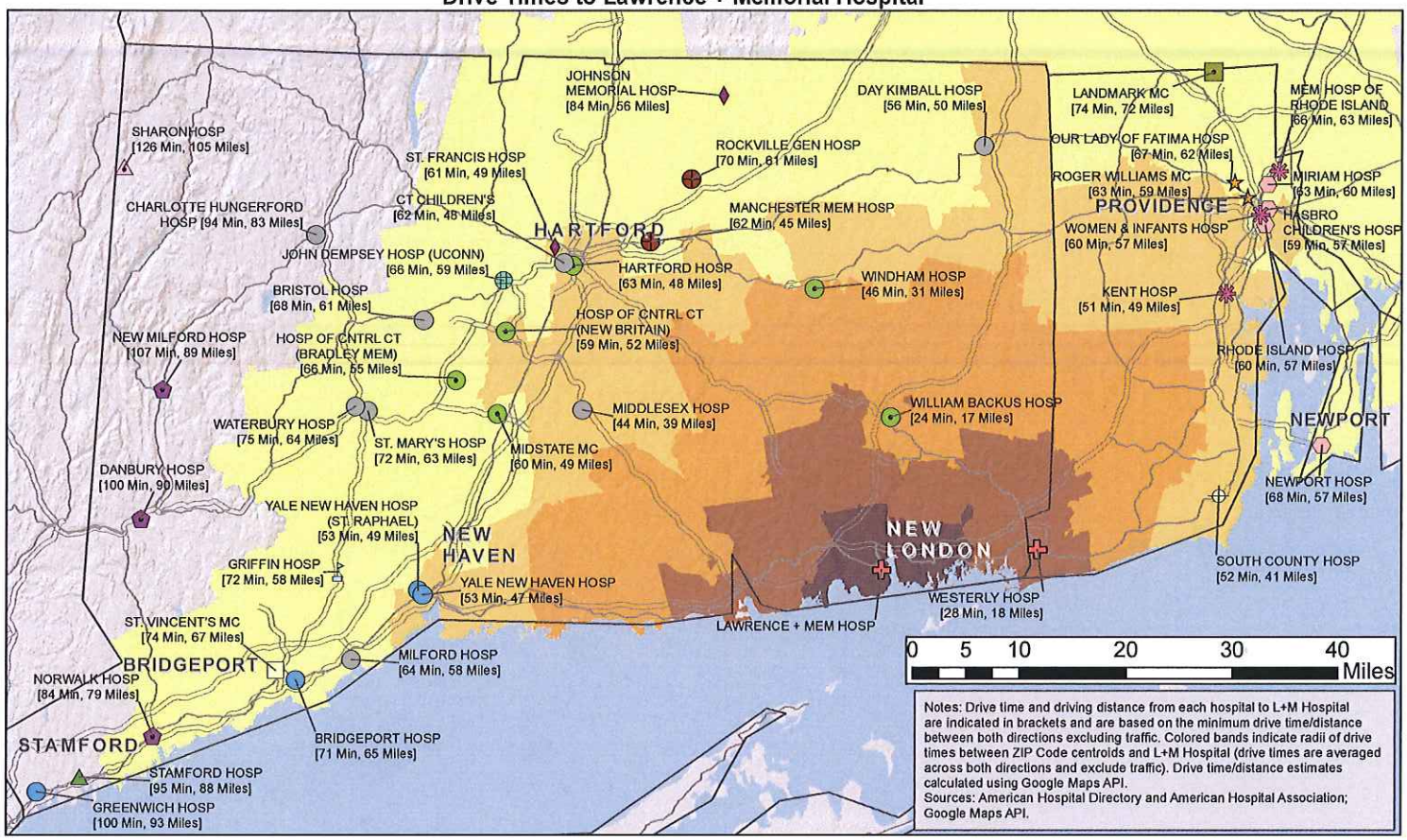
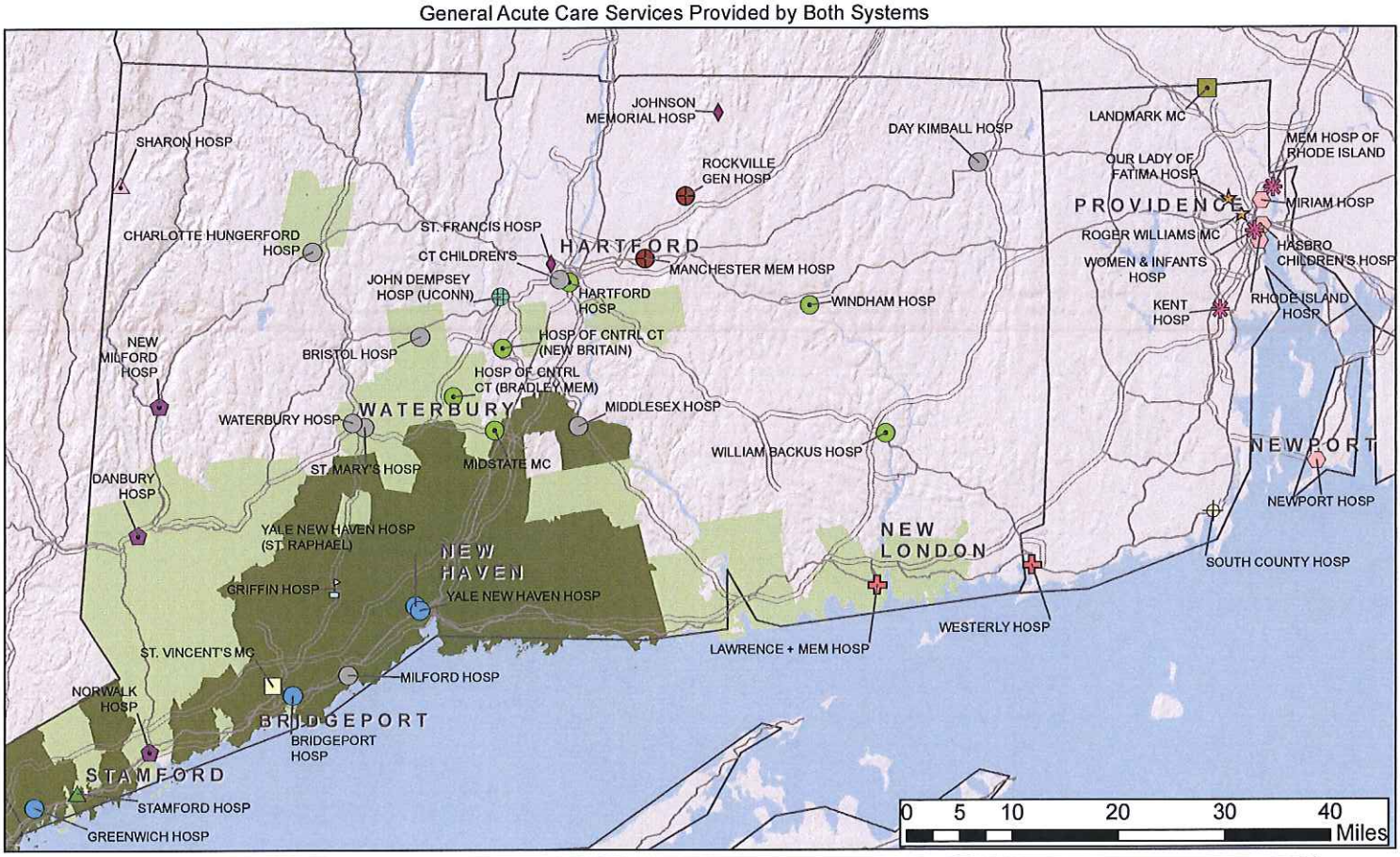


Exhibit A-1

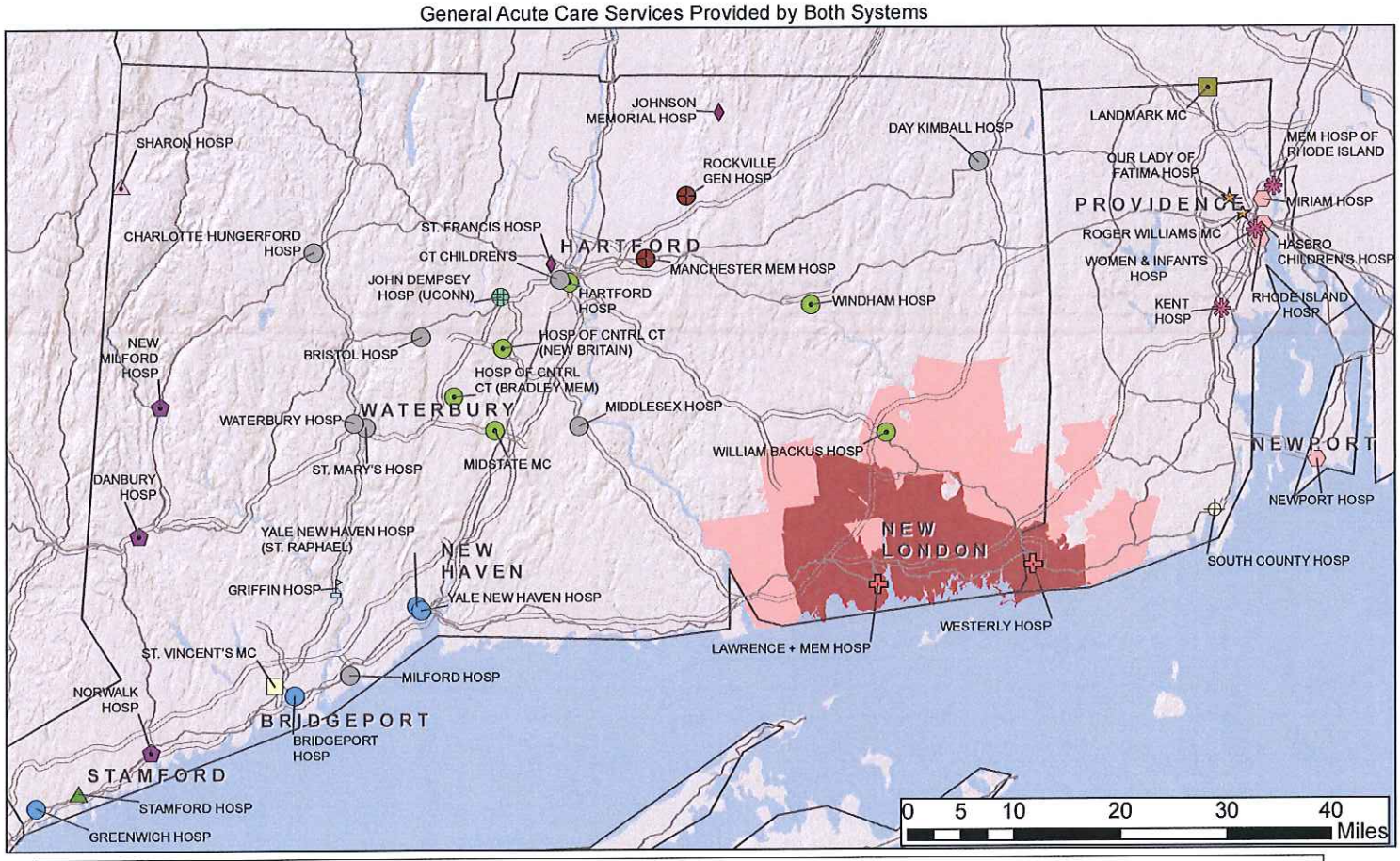
Yale New Haven Health

Combined 75 and 90 Percent Service Areas for Commercially Insured Patients
General Acute Care Services Provided by Both Systems



Lawrence + Memorial Healthcare

Exhibit A-2 Combined 75 and 90 Percent Service Areas for Commercially Insured Patients
General Acute Care Services Provided by Both Systems



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	DOCKET NO. 15-32033-CON
	:	
	:	
	:	July 11, 2016

PRE-FILED TESTIMONY OF MARNA P. BORGSTROM, PRESIDENT AND CHIEF EXECUTIVE OFFICER OF YALE-NEW HAVEN HEALTH SERVICES CORPORATION AND CHIEF EXECUTIVE OFFICER OF YALE-NEW HAVEN HOSPITAL

Good afternoon, Attorney Hansted, and staff of the Office of Health Care Access ("OHCA"). My name is Marna Borgstrom and I am the President and Chief Executive Officer of Yale-New Haven Health Services Corporation and Chief Executive Officer of Yale-New Haven Hospital. I appreciate having this opportunity to speak with you today and convey my many reasons for recommending to OHCA that it approve the above-referenced application to affiliate L+M Corporation ("L+M") with Yale-New Haven Health Services Corporation ("YNHHSC" known as "Yale New Haven Health") (collectively, the "Applicants").

I believe that it is important for OHCA to know and understand that the proposed affiliation between L+M and Yale New Haven Health is a value-driven affiliation designed to improve access to health care, enhance the quality of care, and reduce costs through scale. Quite simply, the objective of the proposed affiliation is to meet policy and consumer expectations for greater value in the delivery of healthcare services.

CULTURE & HISTORY OF SUCCESSFUL AFFILIATIONS

Our culture and philosophy as an integrated healthcare delivery system is neither driven by a desire to grow for growth's sake, nor to reduce healthcare services in the communities served by the affiliated hospitals for the sole purpose of referring patients to Yale-New Haven Hospital. Rather, if one looks at the evolution of our system over the last twenty years, they will observe that our hospital affiliations have yielded very positive results and benefits to its system member hospitals, and most importantly, the communities served by each of our hospitals.

In 1996, Bridgeport Hospital joined Yale New Haven Health, and then two years later in 1998, Greenwich Hospital affiliated with Yale New Haven Health. It was approximately fifteen years later in 2012, that Yale New Haven Hospital acquired the assets of the Hospital of Saint Raphael ("HSR"). Each of these organizations and their communities, as well as the founding hospital – Yale-New Haven Hospital – have benefitted from their participation in Yale New Haven Health.

For example, early on Bridgeport Hospital was a struggling organization that was losing money, losing physicians, losing patients and losing ground. Located in the heart of the City of Bridgeport, it was the primary provider of care to medically indigent patients in that region. With new leadership and support from Yale New Haven Health, Bridgeport Hospital was able to turn things around to become a leader in its service area. It has enhanced the depth and strength of its medical staff, its patient satisfaction rank in the State has improved from being 29th to 12th, its employee engagement has grown from 50% to 90%, physician satisfaction is up to 81% from 20%, cash on hand has

grown from 84 to 110 days, and emergency department visits are over 92,000. In addition, as a member of Yale New Haven Health, Bridgeport Hospital is now home to Yale-New Haven Hospital Children's Hospital, a vibrant heart and vascular center, the Smilow Cancer Hospital, and a number of other innovative clinical programs that have benefitted patients and the surrounding communities tremendously. The same is true of Greenwich Hospital, as it and the surrounding community and patients too have benefitted from greater efficiencies, clinical linkages with Yale-New Haven Hospital and access to our best and most successful programs in the areas of cancer care, heart and vascular care, and pediatric specialists to name a few.

The acquisition of the Hospital of Saint Raphael ("HSR") by Yale-New Haven Hospital in 2012 also has been a success with very positive and measurable outcomes. Specifically, 3,000 HSR employees remained employed with enhanced job security and wages and benefits; an aging physical plant was rejuvenated with more than $100 million in infrastructure investments made (e.g., installment of Epic, replacement of chillers, generators and patient beds, investment in new technologies, innovations on patient care units and in the operating rooms); clinical programs were developed and those already in existence, strengthened; and, $250 million dollars in cost savings (versus the targeted $198 million) were achieved. At the same time, Yale-New Haven Hospital obtained much needed additional inpatient capacity and was able to avoid the $400-700 million dollar cost associated with the construction of a new patient tower. By all standards, the HSR story is a success story, and has been recognized as such by national organizations

such as the Advisory Board.[1] We are confident that L+M can experience similar success.

ADDING VALUE

Yale New Haven Health's goal is to add value to our system members and enhance access to the most vulnerable people in our community, along with becoming a world-class destination healthcare system. Coordination of care and enhanced delivery points of care to patients will help us achieve all of our goals relating to access, reduction in costs and enhancement of value. As to the benefits that this proposed affiliation will have for L+M, I will not waste OHCA's time today by repeating the testimony provided to you by Mr. Bruce Cummings and Dr. Ross Sanfilippo. However, I do want to take this opportunity to stress to OHCA once again that: (1) health care reform requires that hospitals reduce costs, improve value, coordinate care, and manage risk-based payment; and (2) if this Application is not approved, I worry that L+M and the patients and communities it serves will face disruption, instability and reduced access to care.

MISCONCEPTIONS REGARDING OUR AFFILIATION

It is important to note that our approach to governance is community driven and decentralized. In other words, the primary responsibility for services provided by our system members rests with the member hospitals. Our corporate focus is not one of control, but of creating a unified system strategy, enhancing performance, setting standards for quality and value, and achieving cost reductions through economies of scale. Thus, despite assertions to the contrary, our hospitals are governed locally, and their respective fiduciary boards are accountable for their hospital's service and

[1] See Exhibit A attached hereto.

operations, including the provision of high quality and safe clinical services, unique service area strategies, nurturing a high quality medical staff and achieving performance benchmarks commensurate with the Yale New Haven Health brand.

There have been those who have cited our size as a system as a potential concern. Let me address that directly. Nationally speaking, Yale New Haven Health is modest in size. We are not even among the 40 largest systems in the nation. However, our competitors such as New York Presbyterian, Northwell and Partners are all in that group. It is not our goal, interest, desire or objective to drive up costs or increase prices for consumers. We do not negotiate rates as a system, but rather each hospital has its own cost structure and prices that serve as the basis for negotiations. With a commitment to bringing greater value and assuming risk, as stated by Dr. Noether, it is counterintuitive to think that we see logic in raising costs and charges. What we want to raise is the standards for quality, safety and patient experience and through that, we will bring added value, which today is essential for any health care organization to not only survive, but thrive. We will all succeed if L+M is financially stable and vibrant.

OHCA is tasked with the statutory mandate to evaluate proposals against certain statutory guidelines. We believe that this affiliation satisfies all of these guidelines, including advancing everyone's goal of increasing access to high quality care in the most efficient and cost-effective manner possible. Moreover, and given what you have heard from Mr. Bruce Cummings and Dr. Sanfilippo today, I believe that if this Application is delayed or denied, the opportunity for Yale New Haven Health to make a positive difference may be diminished, or worse, lost. Put simply, the alternative to this

Application may be the eventual closure, reduction and or termination of services, lost jobs, and reduced access to care. Accordingly, I urge OHCA to approve this Application.

I adopt this pre-filed testimony as my own.

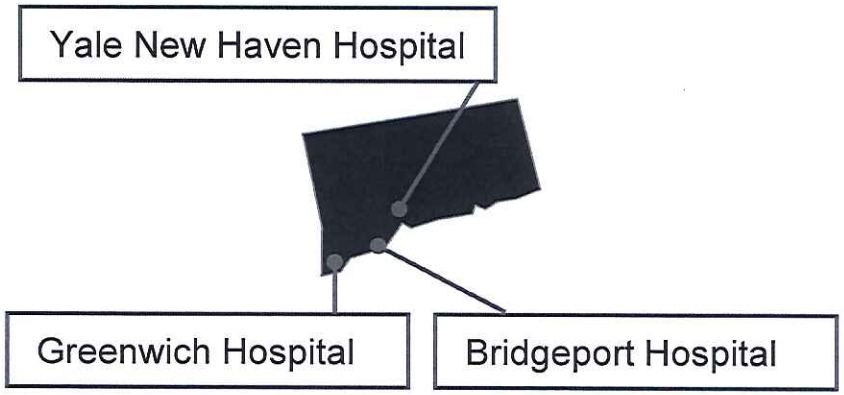
Marna P. Borgstrom

Marna Borgstrom
President & CEO
Yale-New Haven Health Services
Corporation

EXHIBIT A

Structural Advantage: Yale New Haven Health System

Balancing Growth and Service Rationalization



YALE NEW HAVEN HEALTH

System in Brief: Yale New Haven Health System

- Three-hospital system headquartered in New Haven, Connecticut
- Yale New Haven Hospital is teaching hospital for Yale School of Medicine
- After acquisition of Hospital of Saint Raphael, Yale New Haven Hospital now fifth largest hospital in the country with 1,541 beds

3
Hospitals

18K
Employees

$3.3B
Annual revenue

27%
Market share in Connecticut

Source: "Moody's Assigns Aa3 to Yale New Haven Health's (CT) Series A,B,C,D,E & 2014 Revenue Bonds; Outlook Stable," Moody's Investors Service, May 18, 2014, https://www.moodys.com/research/Moodys-assigns-Aa3-to-Yale-New-Haven-Healths-CT-Series--PR_299736; "Yale-New Haven Hospital," Yale University, November 2012, https://www.ynhh.org/vSiteManager/Upload/Docs/ynhhFACT-1112.pdf; Health Care Advisory Board interviews and analysis.

Facing a Familiar Challenge

Balancing Cost Reduction and Market Growth

Financial Challenges Promote Cost Reduction Strategy…

Medicare Forecast Revealed Negative Long-Term Margins

Decrease Cost per Unit for Targeted Cases

Improve Quality, Safety, and Patient Service

…But Market Ambitions Require Growth

Significant Infrastructure Required to Meet Growth Expectations

Increase Access, Expand Capacity

Expand Clinical Breadth & Depth of Services

> "Yale New Haven Health System is not just reducing costs, we're also building value holistically. We need to be dramatically better and are driving ourselves to improve our care while deliberately growing to become a world-class destination health system."
>
> *Richard D'Aquila, EVP*
> *Yale New Haven Health System*

15-32033 07/01/16 1054

Source: Health Care Advisory Board interviews and analysis.

Two-Pronged Strategy Tackles Both Challenges

Focus Lies on Standardization, Smart M&A

Value Creation Strategic Plan Phases

Reducing System-wide Clinical Variation

- Set specific cost per case targets
- Redesign care in areas with clinical variation
- Streamlined service line reporting structures

Acquisition, Integration of Neighboring Hospital

- Standardize operational functions
- Rationalize sites of care between facilities
- Expand services to become care destination

Moving Toward a $1B Cost Reduction Goal

$395M
Total savings from reducing system variation

$300M
Operational savings expected from integration

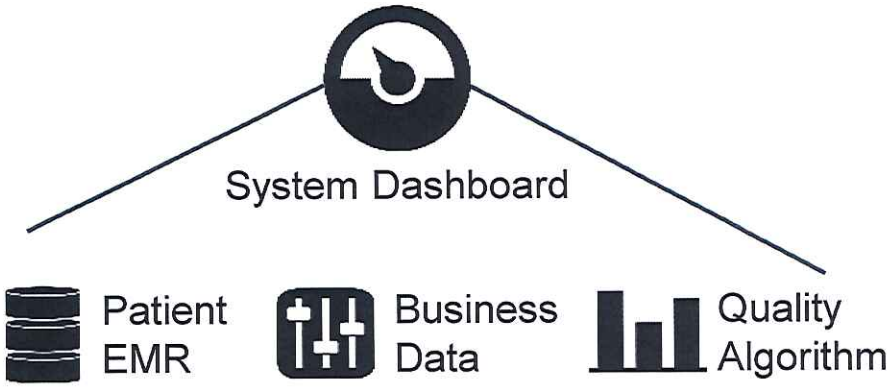
15-32033 07/01/16 1055

Source: Health Care Advisory Board interviews and analysis.

Cost and Value Initiative Targets Clinical Redesign

Opportunities Revealed When Facilities Speak Common Language

System-wide Data Compiled to Identify Quality Variation Indicators (QVIs)



Sample QVI Categories

1. Accidental puncture during procedure
2. Postoperative deep venous thrombus
3. Post-procedural pneumothorax

- 30 QVI categories tracked
- Total cost of cases with QVIs 3-4x more than non-QVI cases
- 8% of cases have QVIs

Reducing Variation in QVIs Through Service Line Structure, Aggregated Data

Finance, clinical leaders use dashboard to identify, implement clinical redesign opportunities

Clinical redesign focused on care management processes, redesign of care protocols

$125M

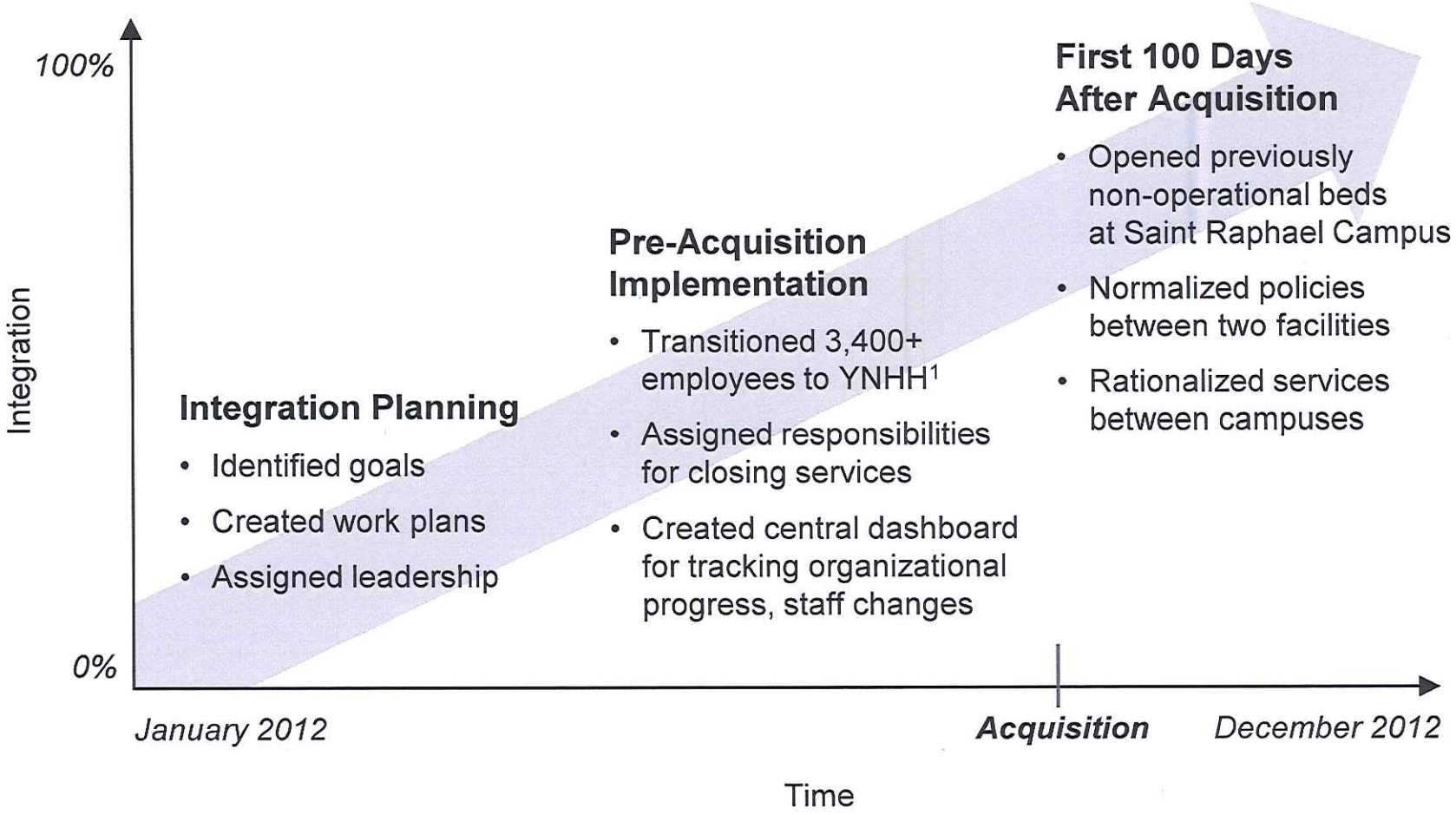
Cost savings from reducing QVIs system-wide

Source: Letourneau R, "$125M Value Initiative Pays Off at Yale New Haven Health System," HealthLeaders Media, March 16, 2015, http://www.healthleadersmedia.com/content/FIN-314329/125M-Value-Initiative-Pays-Off-at-Yale-New-Haven; Health Care Advisory Board interviews and analysis.

Nearby Facility Fully Assimilated into Flagship Hospital

Principled Growth Strategy Prioritizes Goals, Integration Potential

Yale New Haven Health System's Execution of Hospital of Saint Raphael Integration



1) Yale New Haven Hospital.

Source: Health Care Advisory Board interviews and analysis.

Success Built on Strong Planning Foundation

Identifying Leadership, Top Priorities First Step

Integration Leadership Selected from Yale New Haven Hospital

Yale New Haven Hospital President chosen to lead integration efforts

↓

Supported by Leadership Team at YNNH[1] and HSR[2]

↓

Created 12 planning teams to develop 41 specific transition plans

Selected Transition Task Teams

1. Employee Transition
2. Finance/Operations
3. Marketing/Communications
4. Labor Contracts

Top Integration Work Plan Priorities

1. *Uninterrupted Patient Care*
   - ✓ Transporting patients between campuses
   - ✓ Continuing care plans through transition
2. *Benefits & Compensation*
   - ✓ Centralizing payroll system
   - ✓ Enrolling staff in single benefits plan
3. *Supply Chain*
   - ✓ Streamlining supply orders
   - ✓ Centralize receiving process
4. *Billing & Collections*
   - ✓ Combine patient bills from two organizations
   - ✓ Prevent disruptions in reimbursement, denials work

1) Yale New Haven Hospital.
2) Hospital of Saint Raphael.

Source: Health Care Advisory Board interviews and analysis.

15-32033 07/01/16 1058

Hard Work of Integration Started Early

Staff Given Roles for Integration, System Develops Tracking Mechanisms

Assigning Responsibilities

Collaborative workshops solicited input from staff on potential integration issues

3,400 staff transitions from Hospital of Saint Raphael to Yale New Haven employees

Service closure duties delegated to service line leaders

Tracking Progress

Centralized dashboard created to track deadlines and progress on organizational goals

Employee tracker matched existing staff with future roles, identified overlapping duties

Contract management reassigned vendors to central supply chain office

Source: Health Care Advisory Board interviews and analysis.

Each Service Evaluated on Strategic Considerations

Non-negotiable Principle: Zero Tolerance for Redundancy

Strategic Considerations for Rationalization of Services	Rationalization Actions Based on Strategic Considerations
Matching **access and capacity** to historical volumes	Analyzed OR procedural volumes to determine appropriate locations
Opportunity for growth in new and existing service lines	Invested in services with high forecasted demand to create care destinations
Regulatory issues with FTC, State Attorney General, CMS	Required zero duplication of new services or technologies at two sites
Culture of clinical and non-clinical staff constituencies	Created single medical staff, evaluated clinical need at sites
Religious directives for Hospital of Saint Raphael (Catholic Church)	Respected Ethical and Religious Directives for Catholic Health Care at Hospital of Saint Raphael

15-32033 07/01/16 1060

Source: Health Care Advisory Board interviews and analysis.

Something for Each Side

Clinical Campus Configuration of Yale New Haven Hospital

Service Allocation Post-Acquisition of Hospital of Saint Raphael

York Street Campus	Both Campuses	Saint Raphael Campus
Children's Hospital	Behavioral Health	New Musculoskeletal Center
High-Risk Obstetrics	Emergency Services	Low-risk, High Amenities Obstetrics
Major Trauma	General Medicine	Specialty Geriatrics Care
Transplant	Heart & Vascular	Specialty GI Surgery
Cardiac Surgery	Neurosciences	Neurovascular
	Oncology	Medical Heart Failure
	Urology	
	Women's Services	

Source: Health Care Advisory Board interviews and analysis.

Nothing Possible Without Physician Support

Concrete Benefits Bring Physicians on Board

Tactics for Achieving Physician Buy-In During Integration

Facilitated physician focus groups to discuss data-driven decisions on service rationalization

Established new Musculoskeletal and Restorative Care Centers; planning Centers of Excellence for bariatrics and neurovascular services

Renovated facilities and invested in new equipment at Hospital of Saint Raphael to improve quality of care

Offered medical staff membership to all physicians at Hospital of Saint Raphael to join Yale New Haven Hospital staff

4.9%

Percentage decrease in cost per case after acquisition

$80M

Savings after one year as a result of consolidation

$300M

Projected five-year reduction in clinical, operational costs

15-32033 07/01/16 1062

Source: Health Care Advisory Board interviews and analysis.

Structural Advantage: Yale New Haven Health System

Balancing Growth and Service Rationalization

Lessons from Yale New Haven Health System

1. **Asset density creates opportunities for footprint redesign.**

2. **The assignment of responsibility for executive disruptive change should preserve both local and system-wide perspectives and authority.**

3. **Organization-wide information and analytics both reveal opportunity and support implementation.**

4. **Tangible, concrete displays of the benefits of disruptive change signal good faith and engender support among the most disrupted parties.**

Source: Health Care Advisory Board interviews and analysis.

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922
TELEPHONE: (860) 233-9821 • FAX (860) 232-7818
WWW.LAPM.ORG
C-126

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
EMAIL:hfmurray@lapm.org

July 1, 2016

Via Email and Hand Delivery

Kimberly Martone, Director of Operations
Kevin Hansted, Hearing Officer
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, CT 06106

Re: Certificate of Need Applications,
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and Northeast Medical Group, Inc. and,
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation

Dear Ms. Martone and Mr. Hansted:

Attached please find originals and two copies of pre-file testimony submitted by the Intervenors in the above captioned matters. Thank you.

Very truly yours,

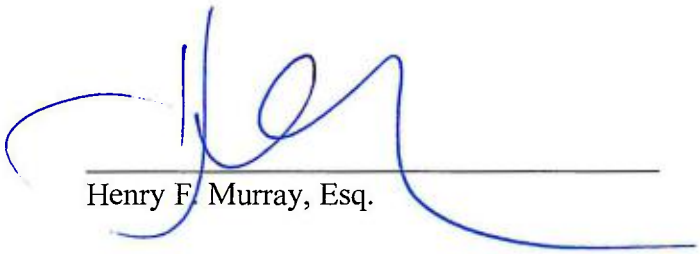
Henry F. Murray

HFM:vds
Enclosure

CERTIFICATION

This certifies that the Intervenors' pre-file testimony was sent via email and First Class Mail, pre-paid on July 1, 2016, to the following counsel of record:

Joan W. Feldman, Esq.
SHIPMAN & GOODWIN LLP
One Constitution Plaza
Hartford, CT 06103-1919
jfeldman@goodwin.com



Henry F. Murray, Esq.

Connecticut Health Policy Project

The Grove, 760 Chapel St., New Haven CT 06510
Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

TESTIMONY to the Office of Health Care Access
July 1, 2016
Re: CON application regarding acquisition of Lawrence & Memorial Hospital and its physicians' group by Yale-New Haven Health System
Ellen Andrews, PhD, Executive Director

My name is Ellen Andrews. I reside at 49 Wilkins St., Hamden Connecticut. I am Executive Director of the Connecticut Health Policy Project. I'm here today to urge OHCA not to approve the application of Yale-New Haven Health System to take over Lawrence and Memorial Health.

We are in the midst of enormous transition in our health care system. The Affordable Care Act has enabled 16 million Americans to gain health insurance coverage, and covered thousands of Connecticut's previously uninsured residents. The ACA offers ongoing incentives and supports to help our state get coverage for the remaining 250,000 uninsured that live in Connecticut.

But not all the news is good. The continued consolidation of providers and insurers is driving an ongoing cost spiral that threatens to undo much of the positive change that we've seen in the past few years. . Dr. Hyde has described the overwhelming body of research demonstrating that as competition is drained from our health care system, costs inevitably go up, and consumers lose choice.

The Connecticut Health Policy Project is particularly concerned about the impact of these trends on low income and underserved communities, the state budget and the growing trend of underinsurance among those with private coverage.

Connecticut has received national recognition for its work reining in Medicaid costs.[1] We are the only state to take back Medicaid recipients from private managed care plans and negotiate provider rates ourselves. That decision and resulting reforms has reduced per member costs, increased the number of physicians participating in the Medicaid program, and reduced emergency room visits. More people covered for less money seen by more providers and better quality care in the appropriate setting. Sounds like a win.

But it hasn't been enough. Underlying provider prices are destroying access to care for many in our state. Due to budget constraints, 11,677 working parents are losing HUSKY coverage at the end of this month. Medicaid beneficiaries in high cost areas like New Haven still struggle to get appointments. HUSKY families "transitioning" to coverage in AccessHealthCT insurance plans, our state's health insurance exchange, are expected to meet a $500 deductible and spend 10-12% of their income on health care. Enrollees in AccessHealthCT plans face enormous

[1] Melinda Beck, "Connecticut Moves Away From Private Insurers to Administer Medicaid Program," *Wall Street Journal*, March 18, 2016. http://www.wsj.com/articles/connecticut-moves-away-from-private-insurers-to-administer-medicaid-program-1458325696

deductibles as subsidies decrease up the income scale. Even workers with decent jobs are increasingly stuck in cost-prohibitive plans. Nearly a quarter of workers are in high deductible plans, up from just 4% in 2006. According to the Kaiser Family Foundation deductibles have increased at nearly seven times the rate of workers' earnings.

Some policymakers insist that high cost sharing is necessary to reduce excess utilization. But utilization isn't really our main problem. Despite progress, Medicaid members, the remaining uninsured and the growing ranks of underinsured state residents still struggle to access recommended care. The US has the highest health care costs by far in the world – we spend twice as much per person on average as the rest of the world, and nobody spends even three quarters as much as we do. Except for Switzerland, we already have the highest out of pocket costs. So if out of pocket costs are the solution, why isn't the problem solved?

As Dr. Hyde's literature review shows, our problem is price, not utilization, and monopoly creates a disaster for prices. Jason Pelletier's testimony contains a shocking fact – workers at a corporate cafeteria run by a global food service company serving food to workers at one of the most profitable companies in the world *are forced to go without health insurance or be covered by state assistance programs because their premium share is too high.* Shame on those employers, but let's not kid ourselves. Employers are fighting with workers over premiums because underlying provider prices are forcing them to.

And when you lose your coverage, or your deductible goes up to five thousand dollars, what happens? You go to the doctor, and, now that the hospitals are buying up all the doctors, you get charged a facility fee for the privilege of seeing a new sign on your doctor's office door. You find yourself choosing between rent, food, and the electric bill for your family or going to the doctor for yourself.

To approve this CON, OHCA must look the public in the eye and say "Yale is different." Unlike all the other giant monopolies, Yale will throw away its monopoly bargaining advantage and keep prices low. Or you must say "New London County is different." For some reason Yale won't buy up all the doctors the way they have in the New Haven area.

No one can take those arguments seriously. One of the few things that Yale's proposed $300 million investment clearly identifies as a specific priority is physician recruitment. To most of us, that suggests recruiting neurologists to move to New London so that telemedicine visits or an hour's drive to New Haven aren't patients' only options. But Yale's past behavior in the New Haven area suggests that money is earmarked for physician practice acquisitions – which means more market power, more facility fees, higher prices and people skipping needed care because of cost.

Perhaps the most telling passage in the CON can be found on page 34. Asked how "low income persons, racial and ethnic minorities, disabled persons and other underserved groups" will benefit from the proposal, YNHHS replies that L+M and YNHHS provide services to the uninsured, underinsured and all patients regardless of race, ethnicity, income or ability to pay. "That will not change as a result of this proposal."

The proposal offers no visions for improvement of services to underserved populations save for the general clinical benefits presumed to accrue to all patients. One must assume that this, like so many other specifics, would be left to the post-acquisition strategic planning process to decide. The rest of us are supposed to wait and hope.

As a member of the Governor's Health Care Cabinet, I view this proposal as the leading example of one of the most dangerous trends in health care, and one of the few key issues we must grapple with to set Connecticut on course

for an accountable 21st Century health care system. I urge you not to rule on this application until my colleagues and I, and our counterparts on the Certificate of Need Task Force have completed our recommendations. If you must rule before that, you must deny the application. Without dramatic changes to address the issues of access, price and quality within a framework of true accountability to the community and protections for underserved and at-risk residents, you must deny it whenever it ripens for decision. There is no public need for this deal and very great risk to state residents and the state's budget.

Pre-file testimony from Stephen R. Smith, M.D., M.P.H.

My name is Stephen R. Smith, M.D. I am a professor emeritus of family medicine at the Warren Alpert Medical School of Brown University. I live in New London.

I am a family physician working at the Community Health Center of New London. I also speak on behalf of the National Physicians Alliance in Connecticut. This group includes physicians from a variety of different specialties who serve on the medical staff and/or work as community-based physicians who refer their patients to either Yale/New Haven Hospital or Lawrence and Memorial (L+M) Hospital.

I am also speaking on behalf of the Universal Health Care Foundation of Connecticut in my capacity as a member of the board of directors of the Connecticut Health Advancement and Research Trust (CHART), the parent organization of the foundation.

I am a lifelong resident of New London residing at 899 Montauk Avenue and have served on the medical staff at Lawrence and Memorial Hospital in the past.

The initial position that the Office of Health Care Access should take when considering any hospital merger or acquisition is that such mergers are not in the best interest of the public and should be denied. As our testimony has previously shown, hospital mergers are, by their very nature, anti-competitive and generally lead to higher prices without concomitant improvements in efficiency, quality, accessibility, or accountability. Mergers and acquisitions should be permitted *only* when convincing evidence has been presented demonstrating that no other means is available to achieve the purported goals of the merger that would serve the community's interests in preserving high-quality, affordable, and accessible health services.

The proposed acquisition of L+M by Yale/New Haven Health Services Corporation does not demonstrate any compelling public interest, or evidence suggesting a public good.

Close clinical coordination and cooperation is already achieved between the two institutions and with health care providers in the community without the benefit of formal acquisition.

As a family physician working in an independent community health center in New London, I already have instant access to the L+M computers to obtain laboratory data, x-ray reports, emergency room reports, and hospital discharge summaries on my patients. If a patient of our health center is seen in the emergency room at L+M, procedures already exist that allow the emergency physician to schedule a visit for the patient with us within 24 hours. Yet our community health center and L+M are separate, independent entities.

I already have excellent relationships with the specialists at Yale/New Haven, many of whom have office hours at L+M for the convenience of our patients. Yale/New Haven specialists have often called me on the telephone to discuss mutual patients with serious vascular problems and pulmonary conditions. At their behest, I have seen the patients and ordered tests and managed their conditions in between visits to the specialists in New Haven. All of this is done without the need for one hospital to "own" the other, especially given all of the bad results from such ownership.

The neonatal intensive care unit at L+M is already staffed by Yale/New Haven neonatologists. The NICU staff already arrange for babies to be seen within 24 hours at our community health center following their discharge. This occurs without the necessity of L+M being owned by Yale/New Haven.

This and other evidence demonstrates that close clinical coordination and cooperation already exists between L+M and Yale/New Haven. This clinical coordination already exists between Yale/New Haven personnel and community health providers in the New London area. The formal acquisition of L+M by Yale/New Haven is neither required nor justified to achieve clinical goals—that is, to serve our patients.

Should the Office of Health Care Access nevertheless consider approval of such an acquisition, it must condition such an acquisition on agreement by both parties to stipulations that would safeguard health care services in Southeastern Connecticut. These stipulations should be in force for at least 10 years and would include:

- Retaining existing health services in the New London community and not outsourcing them to other Yale hospitals or relocating them to more affluent communities in the L+M service area
- Freezing the prices charged and negotiated by L+M to existing levels with annual increases no greater than the Consumer Price Index
- Ensuring help with any transportation for health care that has to be delivered at another hospital
- Expanding health services to Southeastern Connecticut by fully funding and implementing all the recommendations emanating from the 2016 Community Health Needs Assessment conducted by L+M and the Ledge Light Health District
- Requiring that L+M and Yale/New Haven negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs
- Assuring that L+M Hospital remains under the control of a locally controlled and locally elected Board of Directors with decision making authority and accountability to the community.

The Office of Health Care Access must consider this proposed acquisition in the context of the entire state's health care system. Consolidation of the health care system is not in the best interests of patients or communities. Consolidation weakens accountability to the communities these hospitals serve. Consolidation erodes competition and innovation, increase costs, and provides little or no additional benefits in terms of quality, safety, or accessibility.

I urge the Office of Health Care Access to deny the proposals to transfer ownership of L+M to Yale/New Haven Health Services Corporation and the merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.

Stephanie Johnson, RPSGT
President, AFTCT Local 5051 LPN/Technologists
43 Converse Pl.
New London CT
(c) 860-961-1635

Pre-filed Testimony
July 1, 2016
Office of Health Care Access

My name is Stephanie Johnson and I am the president of AFTCT Local 5051 which represents more than 270 LPN's and Technologists at Lawrence Memorial Hospital. I am a 15 year employee, the last 13 years being in my current position as a polysomnographic technologist and a resident of East Lyme. Today I am here to ask you, Office of Health Care Access, to follow Governor Malloy's directive to hold off on this takeover of Lawrence Memorial Hospital by Yale New Haven Hospital.

As a caregiver in the hospital and as president of the union, I have seen many changes and understand that sometimes change is necessary. In this instance I would say that not only is this change for the sake of change but also the changes that are made can be devastating to our community. I have reservations about many things but primarily I am concerned about access to the quality care that we provide. I think it is irresponsible for a community hospital to not be there for the region we are supposed to be here to care for. The story has already played out in Windham, how long before it reaches New London and Westerly?

I was at a meeting held jointly by L&M and Yale recently and heard for myself from Bruce Cummings, CEO of L&M Hospital that Westerly Hospital does not have the physical footprint that the hospital needs to do inpatient and outpatient services. As an employee of the New London hospital, which is also land locked and has constraints that might prevent future growth, how long until we are told that the services we provide are not going to continue. How far will our patients have to travel to receive care? I am not just a care giver but I also utilize the hospital for my care. I was born at Lawrence and Memorial Hospital, gave birth to my son there and have said final good byes to close relatives who died there. I cannot imagine having to drive to Yale to visit a sick family member and more importantly, I cannot imagine how our patients who may not have the benefit of transportation and rely on public transportation will get there.

Decisions about which services will be kept at both campuses will be made by Yale. We are asking for assurances that services for our patients will not be made by a board that seeks to fatten the already large pocket of Yale New Haven's system, as there will no longer be any viable competition which. That means reduced patient's choice to seek care at a lower cost. I have personally read the bylaws changes in the Certificate of Need and have seen the handover of control to Yale. When I asked about it, I was not taken seriously and told "Oh those are just words written in the contract." Luckily, I know how to read contracts.

We were surprised to see Yale and L+M say that L+M lacks the financial and clinical resources to run the programs necessary to take care of our community. We've watched management spend $17 million dollars that could have gone to take care of people in Greater New London on strikebreakers, lawyers

and other expenses to lock their workers out of their jobs. We've watched management spend $35 million dollars to buy an unprofitable hospital out of bankruptcy. We've watched management spend more $78 million of our hospital's profits subsidizing the growth of its physician practice, and now Yale-New Haven says the combined NEMG/LMPA practice will run $70 million a year in losses.

All of that money could have, and should have gone to strengthening our hospital's clinical programs. Instead, we see staffing cuts, the first of what may be many. In the CON, Yale-New Haven says it doesn't have any planned service cuts, but it may reduce "duplicate" services in the future. We are concerned that the duplicate services may simply be the profitable services, which will be extracted from the hospital and placed far from New London, where poorer patients and those who need help with transportation will struggle with access.

When you look at this proposal, make sure you ask what Yale's goals will be. We've already lived under management that thought they were building a small empire. Now the biggest empire in the state wants to take over.

We are asking that services be made available to this community in this community. We are asking that the community be made aware of who will be in control of these services. We are asking that any promises be guaranteed, in writing, with enforcement and oversight by the community. We are asking for you, Office of Healthcare Access to slow down this process. If, after all is said and done, and the bodies that Governor Malloy put in place to look into the laws that govern deals like this find that our concerns are not necessary, we can start a new conversation about the future of L+M, Yale and our health care system. Please allow the process to be followed, and give us time so that all questions can be asked and answered—truthfully.

Pre-filed testimony of Jason Pelletier

Office of Health Care Access

Docket #s 15-30233 CON and 15-30233, Acquisition of L+M Health Care by Yale-New Haven Health Services Corporation and Merger of Lawrence and Memorial Physicians Association into Northeast Medical Group

June 30, 2016

My name is Jason Pelletier. I live at 28 E Street, Groton Connecticut. I am a cook in the cafeteria at Pfizer in Groton, and a shop steward for UNITE HERE Local 217.

I am now almost 49 years old and have always been in great health until last year, when I contracted Lyme disease. After a run of antibiotics, all was well until symptoms started to recur this year.

My health care coverage is very important in order to cover costs of recurring doctor visits and prescriptions. I am also concerned about having adequate health coverage as I get older and have more health issues.

We are in in contract negotiations with our employers. So are 7 other corporate cafeterias in Connecticut that are operated by Compass, including our brothers and sisters at Electric Boat. We pay 20% of our premiums now, and are trying to reduce that percentage at the bargaining table.

The cost of employees' share of the premiums went up by 10% last October. That means that everyone who had coverage had a big bite taken out of the raises that we negotiated with our employer. We have a really good health plan and have fought to keep costs down, but I have coworkers who are uninsured or on state assistance because they can't afford the premiums.

Before I talk about Yale taking over our hospital, I want to tell you how hard our union works on health care costs. Our health plan, UNITE HERE Health, is run jointly by our union and employers in our industries. Workers in our union take leave from their jobs for several weeks to educate their coworkers and help them sign up for a primary care doctor and get their biometric tests so that they can work with our health plan to improve their health and avoid going the hospital. We have run a union-wide education program to educate our coworkers on how to tell the difference between a health care problem and a real emergency, and to use Urgent Care or see their doctors instead of the Emergency Room, unless they really need to go. As a steward, I'm trained to help my coworkers use health care the right way, and to help them connect with our health plan if they have problems.

But that won't matter if prices for hospitals and doctors go up because Yale takes over our hospital. Even if we convince our employer to lower the percentage of the premiums that we pay, if the care itself gets more expensive, premiums will go up and we'll be paying what we paid before. Please stop this takeover, or, if it is approved, make Yale-New Haven guarantee in writing that they won't raise prices.

We don't make a lot of money. As a cook, I make $16.44 an hour, and I'm one of the better paid people in our workplace. I'm fortunate to have full-time hours and a steady paycheck. But none of us can afford

to pay more for health care. Affordable health insurance has always been important to me, but where I'm at in my life now, I can't do without it. Thank you.

Pre-filed Testimony
July 1, 2016

Fred Hyde, M.D.
57 Main Street
Ridgefield, CT 06877

A. General Background

(1) The proposed acquisition of L+M Health Corporation (L+M) by Yale-New Haven Health Services Corporation (YNHHSC) comes at an important moment in the American and Connecticut health care systems.

(2) The Patient Protection and Affordable Care Act (PPACA) has failed to control the ongoing growth of health care costs.

(3) In the five years since passage of the PPACA, private sector health care insurance premiums grew at three times the rate of general inflation, faster in relation to inflation than during the five years prior to passage.

(4) A portion of this increase in health and hospital expense can be *directly attributable to the consolidation of hospitals and health systems*. These consolidations result in:

(a) Higher prices through monopoly market position;

(b) Inflated expenses resulting from more complex and more generously compensated management, with hospital administration now accounting for 1.43% of the nation's Gross Domestic Product; and

(c) Compromise to the integrity of physician judgment when such hospital and health system consolidations include physician practices.

(5) The burden of these costs falls on the patient, the patients' families, and society, through higher health insurance premiums, higher out-of-pocket payments and compromises to choice and freedom. The Kaiser Family Foundation reports that insurance deductibles grew nearly seven times faster than worker earnings in the five years following PPACA passage.

(6) This is the background against which OHCA is called upon to evaluate yet another attempt at monopoly acquisition (another hospital by a health system) and consolidation of institutional control over professional judgment through hospital-sponsored medical groups.

(7) *OHCA's task is non-delegable.* Legal redress opposing or attempting to remedy hospital monopolies has proven to be unreliable: even when "after-the-merger" remedies or checks are in place, inevitable cost increase occurs.

The FTC has allowed the Hart-Scott-Rodino review period to lapse, and the federal government continues to struggle to win cases under antitrust laws.

(8) OHCA awards a Certificate of Need "franchise" to private corporations which are engaged in publicly funded services: the *award must be based on the public good*, not on private gain.

One state with challenges parallel to those of Connecticut is Massachusetts. Testimony is offered on the applicability of findings from that state to the challenge facing OHCA in this and similar Certificate of Need applications.

B. The Applicants assert these arguments in support of Docket No. 15-32033-CON (**affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Corporation**), and Docket No 15-32032, (**merger of L&M Physician Association and Northeast Medical Group**):

(1) Lawrence + Memorial as a system *does "not have the clinical and financial resources" to "integrate service delivery and assume responsibility for achieving specific quality, cost and service outcomes."* [1];

a. Lawrence + Memorial only lacks financial resources as a result of empire building and other imprudent management decisions, including:

(i) Expensive attempts to outsource services, and to "lock out" unionized employees performing those services, about which other members of the coalition will provide more detailed testimony;

(ii) The acquisition of the bankrupt Westerly Hospital for a reported price of $35 million; and

(iii) The extraordinary subsidy of physician practices. The **first attachment** to this document shows the extent to which hospital revenues are generating adequate margins to support operations and maintenance, but are subsidizing physician practice and other "system" losses. Those losses amount to $78 million over the past five years. The combined new NEMG practice is expected to lose $70 million per year.

b. In general, not-for-profit hospitals are doing well financially.[2] In fiscal year 2015 Moody's reports that not-for-profit hospitals had median annual growth rate of 7.4% and median three-year revenue compounded annual growth rate of 5.6%.

(2) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial as a system would *achieve efficiencies through economies of scale*, and patients will receive *"the right care at the right time and in the most cost effective setting."*

a. However, evidence provided here (the **second attachment**, a list of peer-reviewed journal articles provided electronically) shows that such economies have not been achieved in similar health system acquisitions in the past, and that consolidation leads to significant price increases and resulting systemic cost growth. Consider these critical examples from a body of literature that grows daily:

i. A comprehensive study by the Massachusetts Health Policy Commission found that market power is the primary determinant of prices in the state,

[1] OHCA Docket 15-32033-CON, p. 25
[2] Health Care Policies and Trends, *Healthcare Financial Management*, June 2016, Page 18

and that community hospitals provide the same care at much lower price as the dominant system.

ii. Cooper[3] et al studied nearly 4 billion private sector claims nationwide and found that the primary determinant of health care costs is the price of provider services, and that the most powerful determinant of provider price is market power – not quality, not size, not academic status or reputation. Parenthetically, these authors noted that one area of the country with ***both*** high Medicare and high private commercial health insurance costs is New Haven, CT.

iii. Gowrisankaran[4] et al studied data on post-merger pricing and found that separately negotiated prices do not negate the impact of a system's market power. Newly purchased hospitals still gain a price premium.

A new study of leverage in California hospitals[5] indicates that monopolist health systems took active advantage of their status, leading to steadily increasing price differentials, separating them from non-monopolist hospitals by as much as $4,000 per discharge.

iv. The Applicant's own evidence makes this point. The Health Care Cost Institute's report submitted with the application notes that the primary driver of health care cost increases is provider and pharmaceutical pricing.

b. Despite OHCA's request and the urging of legislators, the Applicants flatly refuse to provide comparative price data between L+M and the YNHHS hospitals. However, original analysis of Medicare payments submitted as part of this testimony shows that, almost uniformly, payments for services at Yale-New Haven (including low acuity services) are significantly higher than those at Lawrence + Memorial and much higher than other currently independent hospitals.

The **third attachment** to this testimony is excerpted from 2013 CMS records of billing and payment by DRG by hospital for the top 100 DRGs in Connecticut hospitals.

No evidence has been offered by applicants to demonstrate that past acquisitions or affiliations (Bridgeport, Greenwich) have produced economies similar to those predicted in the current application. To the contrary, these hospitals remain among the most expensive in Connecticut;

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[3] Cooper, Z. et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

[4] Gowrisankaran, G., et al, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *The American Economic Review*, March 2013

[5] Melnick, G. and K. Fonkych, "Hospital Price Increases in California, Especially Among Hospitals in the Largest Multi-hospital Systems," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Volume 53: 1-7, 2016

c. A report by members of the intervenor coalition from December of last year, submitted as the **fourth attachment,** demonstrates that this acquisition will lead to extreme market concentration in the L+M service area, and intensify Yale-New Haven's market power from New York to the Rhode Island border. If this acquisition is consummated, Yale-New Haven Health Systems will account for 83% of discharges in L+M's primary service area, and nearly 60% of all inpatient discharges in the southern half of the state. Using the federal government's standard measure, the growth in market concentration in each of those areas would be presumed to create excessive market power.

d. Consolidation can alter financial and referral relationships to create a "death spiral" for community hospitals. The Massachusetts Health Policy Commission, in its comprehensive study of community hospitals and the effect of monopolist systems, has concluded that the provision of *routine* hospital care at academic medical centers and teaching hospitals leads to lower total and commercial inpatient volume at community hospitals.

   This sequence of events, in turn, leads to lower prices at community hospitals, poor hospital financial performance, limited ability to invest, and barriers to adoption of new technology. This cycle reinforces patient preferences for academic medical centers and teaching hospitals, even for routine hospital care.

   For patients left behind in communities like Windham and New London, especially those (i) without transportation to the central hospital, (ii) good health insurance, or (iii) well-connected doctors, this practice results ***in patient red-lining***, leaving the poor and aged to be served by inferior hospitals, made inferior as their patients are drawn out of local services, and into the central "name-brand" academic medical center.

   The initial and understandable community "rapture" at being part of a larger, more exciting, more capable health system becomes, in short order, the recognition that the community hospital has been "left behind."

e. The Applicants have offered no evidence that the acquisition of Lawrence + Memorial Physicians Association, L+M's 70-physician group medical practice, will create efficiencies with any meaningful return to patients and payers. Extensive bibliographic evidence of studies in academic, professional and public service literature, submitted as the **fifth attachment**, indicates that such efficiencies will not result.

f. For example, Robinson[6] et al, found that physician practices in California that were owned by local community hospitals had costs 10% higher than physician-owned organizations. Practices owned by regional multi-hospital systems generated costs 20% higher than physician-owned practices.

g. **Excessive bureaucracy** will increase expenses, including (a) more layers of management between the physician and the patient, (b) attempts to conform

[6] Robinson, J. and K.Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA*, October 22/29, 2014;312(16):1663-1669

physician behavior to purchasing, referral or other financial direction, (c) hospital-oriented -- that is, institutional and hospital revenue cycle-oriented -- information systems.

h. OHCA should view with skepticism the idea that installation of the EPIC electronic medical record system will generate efficiency or improve quality. The Partners system in Massachusetts spent $1.2 billion to go live in 2015, double the original budgeted $600 million. Auditors for Southcoast Health hospitals in Massachusetts attribute a $30 million 2014 operating loss and 105 layoffs in part to the cost of EPIC.[7] Southcoast (and other Massachusetts hospitals) are attempting to "keep up" with the highest priced system, Partners, as Partners attempts to meet its own budget requirements by electronic steering of patients from distant corners of that State.

   Moreover, "efficiencies" or quality improvements resulting from the use of one or another brand of electronic health record systems are purely speculative. There is no generalizable data showing that EHRs are actually helping control health costs, and EPIC is an extraordinarily expensive product.

(3) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial would achieve *higher quality* in care provided.

a. The recent comprehensive study of all hospitals in Massachusetts by the Health Policy Commission (HPC), cited above, reveals that spending at community hospitals is lower for low acuity inpatients and "is not associated with any difference in quality."

b. In fact, the HPC study showed that "Most community hospitals provide care at a lower cost per discharge, without significant differences in quality," nearly $1,500 less per inpatient according to that study. This HPC study is **the sixth attachment** to this testimony.

c. The **fifth attachment** (as also noted above) is a list of peer-reviewed journal articles that report, among other findings, no evidence that consolidation of large and small hospital systems produces higher quality care. There is, to the contrary, some evidence that care improvements and patient safety both become victims of bureaucratic inertia and indifference.

d. Extensive bibliographic evidence of studies in academic, professional and public service literature indicates that the "quality" of physician services will not increase, and may, in fact, be compromised.

(4) That *access to primary and advanced specialty care will be greatly enhanced* for the citizens of the Lawrence and Memorial hospital service area through the acquisition. This argument is contradicted by:

a. The example of Windham Hospital's acquisition by Hartford HealthCare, to which testimony will be given by others.

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[7] Akanksha Jayanthi, "8 Epic EHR implementations with the biggest price tags in 2015," *Becker's Health IT and CIO Review*, 7/1/2015

b. Compromise to physician resistance achieved through acquisition of medical practices. Doctors will ordinarily be fighting for their patients' rights, with insurance companies, vendors and even with hospitals. When the doctor is owned by the hospital, judgments may be altered concerning necessary services, referrals and costs. See the **fifth attachment** for journal studies in this area;

c. Changing governance and control will render local officials and L+M itself incapable of protecting local services. The hearing notice makes clear that OHCA rejects the notion that this is not an acquisition. Upon consummation, the deal will leave all relevant decision-making authority in the hands of Yale-New Haven Health System.

d. **Patient choice** will be severely compromised, if not eliminated. The Massachusetts Health Policy Commission study indicated that, as the result of consolidation in that state, "Patients often mentioned that they did not feel they had a choice of hospitals because their primary care provider or insurance plan determined where they could go for care."

   In fact, insurance carriers are driven by the financial impact of monopolist pricing to develop narrow networks of providers. This results in limited or non-existent flexibility for the patient and the patient's treating physician. Insurers are compelled to this strategy as a means of attempting to secure discounted prices from price-gouging monopolist systems, in return for assurance of increased volume.

e. **Physician integrity** may be compromised. Since patients rarely evaluate the quality of medical care, instead valuing the recommendations of physicians, those recommendations become very important.

   Contracts involving "owned" physicians reveal requirements for which service to use, what imaging center, what laboratory, what pharmaceutical products have been included in the formulary of the monopolist system, all of these limitations on the ability of the practicing physician to put their patients' interest first.

   Many physicians in independent practice face overwhelming bureaucracy and micro-regulation. These bureaucratic challenges are complicated by the extraordinary difficulty of actually being paid for work done. Many therefore have thrown in this particular "towel," resigned to doing the best they are able under the constraints of monopolist systems. By way of recompense, physicians who have ceded such freedoms now have salaries or practice income guarantees supported by double billing and price-gouging associated with large health systems.

f. Applicants' submission of misleading data about the flow of patients to out-of-state providers, obscuring a potential reduction in the diversity of providers. The applicants break out discharges from New York and Massachusetts providers, but neglect discharges from Rhode Island Hospital. RIH, the affiliated hospital of Brown University Medical School, is the most obvious competitor for subspecialty care to Yale-New Haven Hospital – the two hospitals are exactly equidistant from New London.

   OHCA must ask the Applicants what mechanism they will use to shift patient flows from "distant" competitors. Why should an acquisition change referral patterns? Without reviewing all provider employment, affiliation and practice management

agreements between YNHHS, NEMG and all employed physicians and/or affiliated group practices, OHCA cannot fairly evaluate the impact on access. If doctors are contractually bound to refer to YNHHS, patients – especially those in towns west of the Thames River – will lose choice and will incur higher costs due to monopoly pricing effects.

The cancellation of L+M's affiliation with the Dana Farber Institute offers an ominous foreshadowing of this effect. There is no reason L+M can't allow its doctors and their patients access to two brand-name cancer hospitals. Patients should have their choice of providers when their care requires subspecialty services only available outside New London.

g. The terms of the supposed **$300 million investment** in health in Southeastern Connecticut. The applicants refuse to offer specifics about how much they will really invest, what they will invest in, or where the money will come from.

All of the hypothetical $300 million appears to be contingent on future programs being consistent with the YNHHSC strategic plan, mutually agreed upon (between YNHHS and L+M), and *displaying a positive return on investment.* In other words, there would be no new investment in the Greater New London community's health unless that investment earns Yale-New Haven Health System a profit.

The proposed expenditures for "physician and clinical recruitment" require scrutiny. The system spent $54.5 million in cash to buy PriMed LLC in 2014. If by "recruitment," Yale actually means "buying up the physician practices that L+M hasn't already purchased," patients will not benefit.

In fact some or all of the $300 million is supposed to come from efficiencies that lead to lower expenses in L+M's future operations, or perhaps from the other YNHHS hospitals. The application assumes that L+M will eliminate more than 200 jobs and more than $130 million in wage and benefit expense ***during the first three years.*** (See **attachment seven**, excerpts from the application.) Over seven to ten years, L+M could generate its own $300 million in funds to invest, and have control over how they would be invested. Of course, these may be needed jobs for the delivery of patient services.

h. **Financial pressure on patients** will be increased, perhaps intolerably so, as evidenced by these examples:

There is a well-known history of abusive bill collection practices at Yale-New Haven. These abuses were investigated by the then-Attorney General;

Approximately 35% of the accounts receivable of the nation's hospitals is now categorized as "patient responsibility." Articles in the hospital field call the patient the "new payer." Pressure on hospital revenue cycle performance will, of necessity, be addressed now more directly and forcefully to patients;

Also, narrow networks allow referral only to "approved" doctors, leading to "surprise" bills (for out-of-network services, specialties not covered, services in other parts of Connecticut, other states).

Hospitals Owning Doctors

The shift of physician practices from 70% physician-owned in 2003 to less than 55% physician-owned by the end of 2010 (Mathews, A., "When the Doctor Has a Boss," *The Wall Street Journal*, November 8, 2010) was accompanied by extraordinary increases in the cost of medical care, even by the standards of high prices and inflation in the health care field.

Who benefits? If these proposals before OHCA will not produce efficiency, improvement in quality or control of cost, but will, to the contrary, lead to bureaucratic inefficiency, decline in physician integrity and accountability, and increase in cost, why then do their sponsors put them forward?

Hospitals and the Public Interest

Put simply, executives prosper. At Yale-New Haven, for example, **attachment eight** demonstrates that compensation of the top ten most highly compensated executives has increased by 100% in the time period (2006-2014) when smaller and independent hospitals have had increases of 20 – 25%.

Moreover, the doubling of administrative cost has an impact on the perception of those less handsomely compensated, such as practicing doctors. The surge of doctors seeking to become administrators has spawned extraordinary growth in schools of business, public health and hospital administration. Doctors see the lavish compensation of executives, the unhurried hours, and quickly deduce the market strategy (get bigger, earn more). Of course, all of this affects the patient.

A study published in *Health Affairs* and summarized by the Commonwealth Fund compared hospital administrative costs in eight countries and found that such costs accounted for 25% of hospital spending in the United States, twice the proportion seen in other advanced nations.

The hospital administration share of gross domestic product for the entire country rose from .98% to 1.43% between 2000 and 2011. Moreover, "There was no apparent link between higher administrative costs and better-quality care."

This anomaly—societal concern and even outrage over health prices, yet skyrocketing compensation for hospital administrators—is made possible by the financial insulation enjoyed by members of those hospital boards.

In short, public agencies—not private boards or conflicted executives—will have to "stand in" for governance, if public interests are to be served.

C. Summary

In summary, the applicants have failed to successfully address these issues identified by OHCA:

(1) Public need:

a. There is no "public need" demonstrated for this proposal;

b. To the contrary, the public good (preservation of the lowest possible rates for health services and health insurance; the guarantee of local autonomy concerning decisions involving access to services; measures preserving the independence and integrity of physicians) argues against this proposal;

(2) **Impact on residents**, including how access to services (including specialty care) will be maintained or improved:

a. The applicants have failed to provide evidence that the access to specialty services will be improved. To the contrary, evidence has been presented that in other acquisitions by market-leading health systems in Connecticut (e.g., Hartford HealthCare acquisition of Windham Hospital), services have diminished. In that example, specialty and hospital care has been transferred incrementally to centrally-located specialists with Hartford.

b. Similar migration of specialty services has been demonstrated in a comprehensive study of community hospitals in Massachusetts by the Massachusetts Health Policy Commission.

(3) **Benefits achieved** in the Bridgeport/Greenwich Hospitals service areas:

a. There is no evidence that has been presented that either financial stability or enhanced programs or services have taken place in the Bridgeport and/or Greenwich Hospital services areas, beyond whatever trends and factors have applied to the hospital industry as a whole.

b. Neither OHCA nor the applicants have produced complete records of the "before" and "after" assessment of "financial stability or enhanced programs or services." The submission of incremental and selected information by the applicants more than six months after the beginning of the CoN process indicates that demonstration of the benefits of previous hospital acquisitions has not been a priority.

These applications fail to meet the standards in PA 14-168 Section 7(a)(3), (4), (5), (11) and (12).

(3) Applicants have not demonstrated a clear public need.

(4) By refusing to provide price data, applicants have failed to adequately demonstrate how the proposal will impact the financial strength of the health care system, particularly if one views patients and payers as part of the system.

(5) Applicants have not satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care. Intervenors have presented a large volume of evidence to the contrary.

(11) Applicants have not satisfactorily demonstrated that the proposal will *not* negatively impact the diversity of health care providers and patient choice in the geographic region. This is a new and much higher burden of proof for both OHCA and the Applicants. Intervenors have raised a series of questions about the vague generalities in the application, without answers to which OHCA cannot plausibly certify having met this standard.

(12) Applicants have failed to provide any evidence that the consolidation from the proposal will *not* adversely affect health care costs or accessibility to care. Again, this is a new standard, enacted by the General Assembly specifically to address the circumstances currently under review. When OHCA pressed the applicants to say whether any of the supposed cost savings from the acquisition would be passed on to consumers, they simply refused.

These proposals should not be ruled on until January 15, 2017 or until the Governor's Task Force makes its recommendations. If forced to rule by the statutory calendar, OHCA must deny them. Regardless of Executive Order 51, the applications as written fail the relevant statutory tests and must be denied whenever they ripen for decision.

The only possible scenario under which a proposed takeover of L+M by YNHHS or any other major system could proceed is with permanent, concrete written guarantees on access, cost, quality and workplace standards, all negotiated directly with a representative cross-section of the community and with ongoing enforceable community oversight. We have attached our coalition's "Vision and Values Statement" which includes details of our vision for the future of the Southeastern Connecticut health care system.

Thank you for your attention.

EXHIBIT 1

YNHHS and L+M, Holding Company Profit and Loss, Hospital Profit, Physician Subsidy

	2015	2014	2013	2012	2011
Yale New Haven Health System					
Holding Company Profit (Loss)	$144,091,000	$204,301,000	$168,660,000	$130,416,000	$71,016,000
Hospital/Hosp + Sub Profit	$105,816,000	$160,785,000	$178,722,000	$130,609,000	$67,162,000
Physician Subsidy	$53,931,000	$45,621,000			
Lawrence + Memorial					
Holding Company Profit (Loss)	$1,536,369	($3,388,068)	$2,253,354	$7,721,331	$15,902,773
Hospital Profit	$14,522,752	$5,979,688	$10,767,187	$17,549,573	$16,766,396
Physician Subsidy	$20,061,502	$20,865,372	$15,724,357	$12,069,947	$9,263,443

Source: audited financial statements

EXHIBIT 2

Exhibit One
Monopoly Prices in Health Care, The Result of Hospital Consolidation

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EXHIBIT 3

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Septicemia or Severe Sepsis W MV 96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	81	$310,648	**$85,235**	$74,434	**$10,801**
St. Francis Hospital & Medical Center	29	$158,137	$60,347	$48,067	$12,280
Bridgeport Hospital	15	$158,715	**$57,016**	$53,003	**$4,013**
Hospital of Central Connecticut	28	$124,601	$52,428	$41,063	$11,365
Hartford Hospital	33	$139,676	$52,283	$46,420	$5,863
Manchester Memorial Hospital	16	$174,226	$50,655	$49,772	$883
William W. Backus Hospital	11	$91,957	$48,128	$38,732	$9,396
Saint Mary's Hospital	19	$72,890	$45,681	$42,864	$2,817
Lawrence & Memorial Hospital	15	$93,194	**$44,932**	$44,211	**$721**
Waterbury Hospital	25	$143,911	$43,622	$39,899	$3,723
Middlesex Hospital	16	$161,074	$43,016	$41,385	$1,631
MidState Medical Center	12	$71,954	$38,774	$38,038	$736

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Infectious & Parasitic Diseases W O.R.
Procedure W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	12	$140,156	$68,723	$62,636	$6,087
Yale-New Haven Hospital	120	$202,690	**$63,477**	$56,019	**$7,458**
Norwalk Hospital Association	15	$214,160	$62,501	$56,386	$6,115
Bridgeport Hospital	23	$156,619	**$54,100**	$43,510	**$10,590**
Stamford Hospital	34	$178,845	$51,370	$49,450	$1,920
St. Francis Hospital & Medical Center	34	$128,416	$51,080	$44,622	$6,458
Waterbury Hospital	25	$200,489	$50,593	$46,907	$3,686
Hartford Hospital	98	$114,399	$48,902	$43,311	$5,591
Saint Mary's Hospital	25	$78,892	$44,855	$42,893	$1,962
St. Vincent's Medical Center	22	$108,916	$43,810	$36,102	$7,708
Griffin Hospital	15	$111,374	$41,967	$40,039	$1,928
Lawrence & Memorial Hospital	37	$86,724	**$41,567**	$39,538	**$2,029**
William W. Backus Hospital	37	$83,688	$41,302	$36,969	$4,333
Danbury Hospital	16	$86,609	$40,480	$38,556	$1,924
Middlesex Hospital	27	$152,242	$39,522	$37,910	$1,612
Hospital of Central Connecticut	42	$78,346	$38,158	$34,812	$3,346
Greenwich Hospital Association	11	$123,456	**$38,080**	$36,732	**$1,348**
Manchester Memorial Hospital	30	$112,079	$37,533	$36,745	$788
MidState Medical Center	26	$71,300	$35,872	$33,463	$2,409
Charlotte Hungerford Hospital	17	$53,134	$31,503	$30,075	$1,428

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	11	$130,340	$63,059	$58,620	$4,439
Yale-New Haven Hospital	90	$174,277	**$58,706**	$52,041	**$6,665**
Stamford Hospital	24	$205,005	$50,763	$48,905	$1,858
Norwalk Hospital Association	17	$161,687	$49,798	$46,130	$3,668
Bridgeport Hospital	14	$183,169	**$49,112**	$45,626	**$3,486**
St. Francis Hospital & Medical Center	34	$138,873	$48,929	$45,632	$3,297
Danbury Hospital	26	$122,442	$47,977	$42,206	$5,771
St. Vincent's Medical Center	22	$168,701	$46,987	$43,328	$3,659
Hartford Hospital	42	$99,028	$42,729	$39,399	$3,330
Middlesex Hospital	21	$172,377	$42,616	$41,002	$1,614
Lawrence & Memorial Hospital	12	$96,118	**$40,832**	$35,154	**$5,678**
Saint Mary's Hospital	11	$96,824	$40,716	$38,949	$1,767
Greenwich Hospital Association	12	$125,846	$38,204	$36,592	$1,612
Bristol Hospital	16	$118,331	$37,414	$36,530	$884
Waterbury Hospital	15	$136,953	$37,140	$35,004	$2,136
Hospital of Central Connecticut	27	$88,070	$36,713	$35,055	$1,658
MidState Medical Center	27	$75,716	$36,492	$33,697	$2,795
Manchester Memorial Hospital	13	$89,343	$34,247	$29,579	$4,668
William W. Backus Hospital	14	$61,329	$32,713	$31,709	$1,004
Charlotte Hungerford Hospital	14	$57,485	$31,433	$30,673	$760

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Respiratory System Dx W Ventilator Support
96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	60	$202,775	**$60,818**	$56,656	**$4,162**
Bridgeport Hospital	13	$176,297	**$56,366**	$52,897	**$3,469**
Norwalk Hospital Association	26	$185,081	$54,524	$52,202	$2,322
Hartford Hospital	28	$176,005	$52,351	$47,429	$4,922
Manchester Memorial Hospital	14	$145,965	$52,058	$40,189	$11,869
Danbury Hospital	13	$123,626	$50,969	$36,085	$14,884
St. Francis Hospital & Medical Center	24	$142,835	$50,483	$47,648	$2,835
St. Vincent's Medical Center	12	$169,032	$47,863	$39,396	$8,467
Saint Mary's Hospital	14	$72,570	$42,707	$33,796	$8,911
Lawrence & Memorial Hospital	20	$72,632	**$42,362**	$35,254	**$7,108**
William W. Backus Hospital	14	$94,899	$42,219	$35,684	$6,535
Hospital of Central Connecticut	24	$102,087	$40,720	$38,574	$2,146
Waterbury Hospital	11	$133,217	$38,140	$34,802	$3,338
MidState Medical Center	13	$84,483	$37,188	$36,733	$455
Middlesex Hospital	21	$127,717	$35,824	$34,429	$1,395
Charlotte Hungerford Hospital	13	$58,770	$34,149	$32,069	$2,080

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Spinal Fusion Except Cervical W/O MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	107	$88,003	**$41,497**	$35,917	**$5,580**
John Dempsey Hospital	55	$54,387	$40,845	$37,805	$3,040
Bridgeport Hospital	23	$100,121	**$37,203**	$31,497	**$5,706**
Hartford Hospital	78	$57,900	$34,783	$27,294	$7,489
Norwalk Hospital Association	29	$100,576	$34,032	$32,417	$1,615
Danbury Hospital	54	$72,815	$33,594	$27,322	$6,272
Stamford Hospital	17	$129,246	$32,690	$29,709	$2,981
Saint Mary's Hospital	25	$81,847	$32,119	$25,184	$6,935
St. Vincent's Medical Center	21	$70,481	$32,054	$30,560	$1,494
Greenwich Hospital Association	28	$158,360	**$31,394**	$27,047	**$4,347**
St. Francis Hospital & Medical Center	70	$42,545	$31,302	$27,700	$3,602
Lawrence & Memorial Hospital	16	$75,241	**$30,013**	$28,832	**$1,181**
Waterbury Hospital	26	$144,435	$29,952	$25,218	$4,734
Hospital of Central Connecticut	29	$79,744	$29,488	$28,308	$1,180
New Milford Hospital	13	$36,857	$28,916	$24,487	$4,429
Middlesex Hospital	19	$110,939	$28,693	$25,097	$3,596
MidState Medical Center	12	$72,749	$27,806	$26,627	$1,179
William W. Backus Hospital	72	$47,418	$27,151	$24,440	$2,711
Rockville General Hospital	29	$45,887	$24,461	$22,523	$1,938
Charlotte Hungerford Hospital	33	$21,714	$23,945	$21,278	$2,667

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Other Vascular Procedures With MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Middlesex Hospital	12	$174,250	$38,456	$36,551	$1,905
Yale-New Haven Hospital	79	$135,606	**$38,296**	$35,731	**$2,565**
Stamford Hospital	12	$159,728	$34,254	$32,540	$1,714
Danbury Hospital	22	$96,541	$32,267	$25,353	$6,914
Hartford Hospital	73	$83,857	$29,041	$26,612	$2,429
St. Francis Hospital & Medical Center	30	$83,915	$26,624	$25,165	$1,459
St. Vincent's Medical Center	16	$76,358	$25,618	$24,552	$1,066
Saint Mary's Hospital	13	$52,451	$25,068	$24,006	$1,062

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Hip L& Femur Procedures Except Major Joint
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	41	$138,463	**$38,348**	$33,057	**$5,291**
Stamford Hospital	13	$127,169	$29,561	$28,118	$1,443
Bridgeport Hospital	14	$81,959	**$28,016**	$25,755	**$2,261**
Hartford Hospital	56	$60,199	$25,384	$22,919	$2,465
Norwalk Hospital Association	13	$79,773	$25,255	$23,679	$1,576
St. Vincent's Medical Center	15	$86,790	$25,218	$23,223	$1,995
Lawrence & Memorial Hospital	16	$46,929	**$24,778**	$19,022	**$5,756**
St. Francis Hospital & Medical Center	25	$69,793	$24,706	$23,328	$1,378
Danbury Hospital	25	$57,373	$24,119	$22,871	$1,248
Hospital of Central Connecticut	25	$64,529	$22,876	$21,677	$1,199
Waterbury Hospital	15	$79,965	$22,327	$20,985	$1,342
Greenwich Hospital	14	$101,216	**$22,016**	$20,670	**$1,346**
Middlesex Hospital	20	$78,502	$20,670	$19,232	$1,438
MidState Medical Center	15	$55,966	$20,173	$19,315	$858
Charlotte Hungerford Hospital	12	$37,816	$18,874	$17,996	$878

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W CC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	14	$47,604	$27,884	$25,212	$2,672
Yale-New Haven Hospital	93	$74,952	**$26,205**	$21,802	**$4,403**
Stamford Hospital	24	$124,873	$25,037	$23,465	$1,572
Norwalk Hospital Association	23	$86,327	$24,176	$21,118	$3,058
Bridgeport Hospital	20	$74,235	**$23,887**	$19,380	**$4,507**
Greenwich Hospital Association	42	$78,156	**$23,388**	$17,851	**$5,537**
Waterbury Hospital	19	$106,740	$23,111	$21,013	$2,098
Hartford Hospital	68	$51,502	$22,477	$18,355	$4,122
MidState Medical Center	25	$53,290	$22,143	$13,714	$8,429
St. Francis Hospital & Medical Center	62	$56,193	$21,189	$18,850	$2,339
Danbury Hospital	33	$67,201	$20,728	$18,782	$1,946
St. Vincent's Medical Center	32	$52,380	$20,438	$17,881	$2,557
Hospital of Central Connecticut	33	$43,989	$19,505	$17,296	$2,209
Saint Mary's Hospital	25	$54,208	$19,306	$17,936	$1,370
Griffin Hospital	13	$67,822	$19,135	$17,659	$1,476
Middlesex Hospital	31	$86,394	$18,870	$17,074	$1,796
Lawrence & Memorial Hospital	17	$48,783	**$18,657**	$17,678	**$979**
William W. Backus Hospital	45	$39,831	$17,888	$15,142	$2,746
Manchester Memorial Hospital	21	$50,777	$17,071	$14,998	$2,073
Bristol Hospital	15	$57,521	$16,599	$15,813	$786
Charlotte Hungerford Hospital	21	$31,548	$15,957	$14,889	$1,068

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Circulatory Disorders Except AMI, W Card Cath W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	65	$120,592	**$28,531**	$25,275	**$3,256**
Hartford Hospital	64	$71,032	$21,132	$16,888	$4,244
St. Vincent's Medical Center	26	$79,241	$19,916	$16,494	$3,422
St. Francis Hospital & Medical Center	40	$53,805	$18,661	$16,819	$1,842
Danbury Hospital	12	$48,886	$18,543	$13,047	$5,496
Lawrence & Memorial Hospital	14	$39,395	**$15,344**	$14,496	**$848**
Hospital of Central Connecticut	11	$36,002	$14,949	$13,855	$1,094

Source: FY2013, CM5 Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Intracranial Hemorrhage or Cerebral Infarction
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	138	$94,839	**$24,649**	$21,717	**$2,932**
John Dempsey Hospital	19	$27,682	$20,308	$18,596	$1,712
Bridgeport Hospital	29	$49,352	**$19,343**	$15,691	**$3,652**
Hartford Hospital	143	$55,092	$17,903	$15,145	$2,758
St. Francis Hospital & Medical Center	86	$57,287	$17,058	$15,649	$1,409
Windham Community Memorial Hospital	13	$19,960	$16,147	$15,323	$824
Danbury Hospital	50	$37,247	$15,970	$14,198	$1,772
Norwalk Hospital Association	39	$48,086	$15,837	$13,720	$2,117
St. Vincent's Medical Center	33	$45,394	$15,776	$14,137	$1,639
Stamford Hospital	39	$62,925	$15,021	$13,826	$1,195
Saint Mary's Hospital	29	$25,038	$14,670	$13,448	$1,222
Hospital of Central Connecticut	53	$34,972	$14,643	$12,615	$2,028
Waterbury Hospital	33	$49,025	$14,378	$13,132	$1,246
Griffin Hospital	15	$42,608	$13,961	$12,562	$1,399
Greenwich Hospital Association	37	$47,276	**$13,639**	$12,463	**$1,176**
Lawrence & Memorial Hospital	41	$30,269	**$13,047**	$12,207	**$840**
Middlesex Hospital	36	$55,045	$12,635	$11,568	$1,067
William W. Backus Hospital	19	$26,775	$12,458	$11,657	$801
MidState Medical Center	31	$32,481	$12,041	$11,245	$796
Charlotte Hungerford Hospital	15	$14,539	$11,321	$10,460	$861

Source: FY2013, CMS Data

EXHIBIT 4

HOSPITAL MARKET CONCENTRATION IN CONNECTICUT:

The Impact of Yale-New Haven Health System's Expansion

CCAG
CONNECTICUT CITIZEN ACTION GROUP

Connecticut Health Policy Project

United Action Connecticut

1199NE | SEIUHealthcare. United for Quality Care

Council 4 AFSCME
We Make Connecticut Happen

aft AFT Connecticut
A Union of Professionals

UNITEHERE! Connecticut

EXECUTIVE SUMMARY

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If currently proposed mergers are completed, more than 80% of Connecticut's patients will receive care from hospitals owned by large, powerful multi-hospital systems. Driven in part by new "shared savings" reimbursement policies in the state Medicaid and federal Medicare programs, this trend is accelerating.

Connecticut now has five major acquisitions pending, including the expansion of the state's most powerful health care entity. The Yale-New Haven Health System has proposed to buy Lawrence and Memorial Health, which owns both Lawrence and Memorial Hospital in New London and Westerly Hospital in Rhode Island. At the same time, Milford Hospital was forced to shut down Labor and Delivery services when its leading Obstetrician/Gynecologists defected to Yale-New Haven Hospital. Financially distressed, Milford now leases space to Yale-New Haven Hospital for its regional inpatient rehabilitation services. A slow-motion takeover appears to be in process.

The most recent data available show that Connecticut has the 4th highest health care costs in the United States, but lags in most measures of quality. Numerous academic studies show that as providers take each other over and limit competition, prices go up without service improvement—and the more heavily concentrated the market is to begin with, the higher the price increases.

The co-authors of *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, have worked together on legislative solutions to the challenges of growing hospital monopoly for the past several years. In continuing that work, we have analyzed state inpatient hospital discharge data and mapped the potential changes to the state's health care markets if Yale-New Haven buys L+M and swallows up Milford Hospital. The report examines five geographic areas, from L+M's relatively small self-defined service area, to an area covering the southern half of the state.

The data yield three key metrics: the percentage market share held by Yale-New Haven Health, the score for each area on a standard government measure of market concentration called the Herfindahl-Hirschmann Index, or "HHI", and the amount of change in the concentration of the hospital market in each area. The findings include:

- Though consumers already face a market with limited competitive pressure to protect them, the Milford and L+M takeovers will significantly increase the Yale-New Haven Health System's market share in all five areas. In L+M's primary service area, Yale-New Haven Health System will grow from 14% to 83% of inpatient discharges.
- All five geographic regions studied easily meet the federal government's standard for a "highly concentrated" market even before the two takeovers. Highly concentrated markets lack competition and can lead to artificially excessive prices.
- In the market areas studied, the size of the increase in consolidation caused by YNHHS's expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will "obtain market power," which federal regulatory standards warn against.[1] Studies show that mergers in already highly consolidated markets can often lead to price increases of 20%.
- Although hospitals are consolidating across the state, the shoreline areas dominated by YNHHSC are the most heavily concentrated regions in Connecticut, and thus most vulnerable to price increases. The three-hospital Yale-New Haven system claims a "local service area" comprising nearly half the state's population. Upon full absorption of Milford and L+M, the Yale-New Haven system will account for 59% of discharges in this area.

The report's co-authors urge public officials to take three steps before any decisions are made on whether or not, and under what conditions, the merger should proceed.

- In 2015, Connecticut passed a sweeping health care consumer protection law, SB 811. The law requires a cost and market analysis prior to regulatory action on hospital mergers. Although Yale-New Haven and L+M applied for approval before the new law took effect, state officials should conduct the cost and market analysis prior to any action on the proposed merger.
- In particular, state officials should examine the pricing impact in Greater New Haven of Yale-New Haven Hospital's 2012 takeover of the Hospital of St. Raphael. No data will better illuminate the potential impact of Yale-New Haven's expansion than what happened to prices after this deal, which created the 6th largest hospital in the United States.
- The L+M transaction should not be viewed in isolation. Yale-New Haven's market power on the shoreline is expanding by leasing a wing of Milford Hospital. This adds a small but significant further increase in the extent of Yale-New Haven's market control. State officials should include the potential absorption of Milford in their analyses.

1. GROWING CONCENTRATION IN THE HEALTH CARE MARKETPLACE

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If current proposed mergers are completed, more than 80% of Connecticut's inpatients will pass through hospitals owned by large, powerful multi-hospital systems, with few legal checks on price increases to protect them.

The Affordable Care Act has delivered health insurance to millions of people, a significant policy victory. At the same time, however, changes in reimbursement policies, mandates for technology improvements, and new regulations have tilted the market even further in favor of large, wealthy hospital systems. In Connecticut, the State Innovation Model (SIM) and "shared savings" policies for Medicare and Medicaid are creating incentives for large combinations of hospitals and doctors that can accept risk for broad patient populations. These systems are taking advantage of the new conditions to overrun their smaller competitors and build market power.

Unfortunately, the ACA contains few proven cost control measures. Congress largely left it up to states, employers, payers, municipalities, and individual patients to rein in costs as health care systems undergo rapid consolidation. Academic studies consistently show that the main impact of hospital consolidation is increased prices without improvement in quality.[2] Nationally, ballooning prices threaten newly expanded access. Although increasing numbers of Americans have health insurance, out of pocket costs are rising at 3-4 times the rate of wages.[3] More Americans than ever report delaying needed medical care for cost reasons.[4] Without cost control, the long-overdue expansion of health insurance coverage will not be sustainable.

These challenges have become clear in Connecticut in recent years. Despite a dramatic growth in their market power - which will continue if the combined $91 billion Anthem-Cigna and Aetna-Humana deals are completed - health insurers have done little to restrain costs.[5] Meanwhile, the rise of multi-hospital systems has created concentrated markets in the state, and the Yale-New Haven and Hartford HealthCare systems have developed a dominant grip on health care statewide. The two major health systems account for nearly half the inpatient discharges in the state, and each has even tighter regional control in its respective market. Hospital consolidation and price inflation will continue unless checked at the state level.

Acquisition and Absorption: Yale-New Haven Expands

Yale-New Haven Hospital (YNHH) began the process of industry consolidation in Connecticut in 1995, when YNHH added Bridgeport Hospital to its network. Greenwich Hospital joined the growing system in 1998. In 2010, the health system added Northeast Medical Group, a start-up physician multispecialty group that now employs over 550 doctors and is wholly owned by the Yale-New Haven Health Services Corporation, the parent corporation of the Yale-New Haven Health System (YNHHS).

In 2012, Yale-New Haven Hospital's takeover of the Hospital of St. Raphael created the 6th largest hospital in the country.[6] After the merger, the Yale-New Haven Health System (YNHHS) market share rose to 98% of inpatient discharges among New Haven residents and 76% in Greater New Haven, up from 68% and 48% respectively.[7]

In 2014, Texas-based for-profit hospital operator Tenet Healthcare proposed purchasing five Connecticut hospitals in an equity partnership with YNHHS, with Tenet owning 80% and Yale-New Haven 20%. Adding five of its competitors to Yale-New Haven's existing market share would have meant that 37.5% of all discharges in the state were from the newly merging system, a major expansion of the Yale network. The deal fell through after the Office of Health Care Access imposed unusually strong requirements on the terms of the deal, in the face of concerns about the impact of the transaction on cost, access, services, financial burden on the uninsured, and accountability of the hospitals to local communities.

Now, YNHHS has two impending hospital takeovers that will expand its control over the health care market along Connecticut's coastline.

One is widely known. The Yale-New Haven Health System has announced a deal to purchase Lawrence + Memorial Health, a smaller system that controls: Lawrence + Memorial Hospital in New London; Westerly Hospital in Westerly, Rhode Island; L+M Physicians Association, a 72-member multispecialty physician practice; and several other outpatient facilities.[9]

In a series of less publicized moves, YNHHS seems to be quietly acquiring pieces of financially struggling Milford Hospital.

Milford has reported negative operating margins in each of the last seven years. The hospital's license allows it to operate 118 beds, but due to declining patient volume, only 43 are currently staffed. Documents filed with the state Office of Health Care Access reveal that physician defections to Yale-New Haven Hospital contributed to those losses and inflicted severe competitive damage on Milford's labor and delivery service. According to these documents, in 2012, six OB/GYN doctors who accounted for a majority of Milford Hospital's deliveries told management that they would no longer deliver babies there. One had decided to stop delivering babies altogether, but the other five told Milford management that they were making Yale-New Haven Hospital their "exclusive hospital provider."[10]

Milford subsequently attempted to hire additional obstetricians, but could not keep them. In February of 2015, Milford applied for state approval to terminate its Labor and Delivery service. Milford's family birthing center, which occupies a large portion of the hospital's third floor, will no longer accept patients.[11]

Having expanded its OB/GYN network due to Milford's financial distress, Yale-New Haven Hospital announced last fall that it would open a 24-bed inpatient rehabilitation clinic on one of the three floors of Milford Hospital. The clinic would serve patients suffering from certain neurological, orthopedic, musculoskeletal, and other conditions. These patients typically have received inpatient treatment such as surgery for their conditions, and require extensive nursing care and supervision while undergoing treatments such as physical or occupational therapy.

YNHH's proposal would shift all patients who would have been treated in the current rehab unit at the St. Raphael's campus to Milford. Shortly after, YNHHS-owned Bridgeport Hospital submitted its

own paperwork to terminate its inpatient rehabilitation services as well.[12] In essence, YNHHS is regionalizing its inpatient rehabilitation services at its leased space at Milford Hospital, even as Milford's traditional hospital services decline and close. Taken together, these events suggest that Yale-New Haven Health System's absorption of Milford Hospital is in process. Yet state regulators have treated each submission—Milford's closure of its Labor and Delivery service, the opening of Yale-New Haven's inpatient rehabilitation unit, and the two separate YNHHS inpatient rehabilitation unit closures—as distinct, unrelated events.

In contrast to Milford Hospital, Lawrence + Memorial Hospital is a financially successful 256-bed hospital in New London that recently acquired Westerly Hospital in Rhode Island, pledging to invest $36.5 million over five years in the new acquisition. In September, the parent company of the two hospitals and Yale New Haven Health System filed a Certificate of Need application for YNHHS to take over the L+M system. In the application, YNHHS promises to make a $300 million capital investment in the region.[13] This deal is now in front of state regulators seeking approval.

Connecticut's Growing Monopolies

Hospital consolidation is a recent and rapid phenomenon in Connecticut: twenty years ago, every hospital in the state was independent.

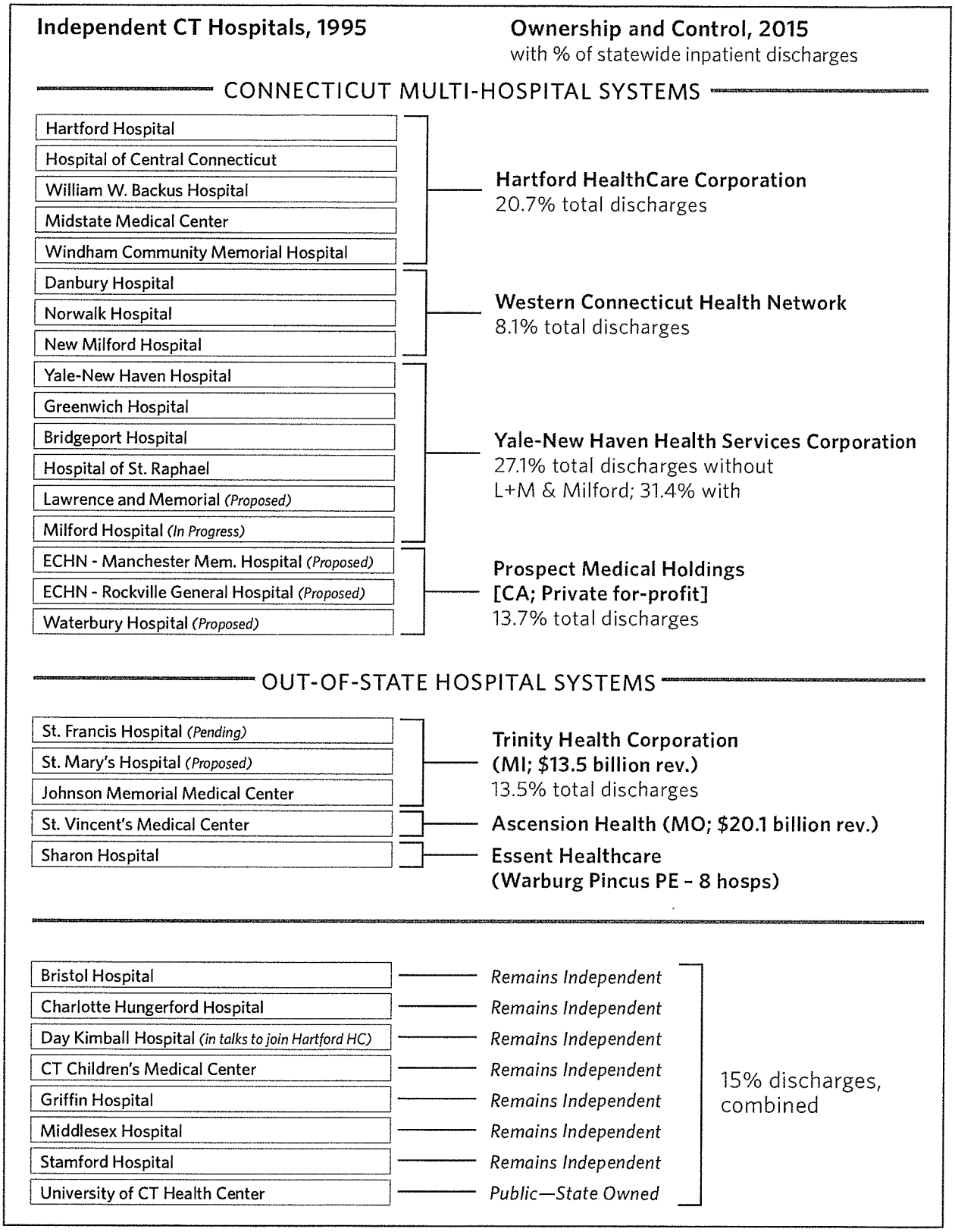
The trend has accelerated recently. A tally of transactions by the Universal Health Care Foundation in December 2014 reported that "between 2009 and 2013 there were thirteen attempted and seven successful hospital consolidations and/or partnerships [in Connecticut], a substantial increase from the four that occurred in the previous decade."[14]

As a result of these consolidations, Hartford HealthCare accounted for 20.7% of inpatient discharges in the state in FY 2013, while Yale-New Haven Health System saw another 27.1%. The two health systems combine for nearly half of the state's discharges, a lopsided market for Connecticut consumers.

In the year since the UHCF report, at least five major hospital affiliations or purchases have been announced or proposed: private for-profit Prospect Medical Holdings has moved to purchase the Eastern Connecticut Health Network and Waterbury Hospital; St. Francis Hospital affiliated with Trinity Health Corporation, a $16 billion national company based in Michigan, has acquired Johnson Memorial Hospital, and has moved to acquire St. Mary's Hospital; and Ascension Health has purchased St. Vincent's Medical Center—all in addition to Yale's proposed acquisition of L+M and progressive annexation of Milford. Today, the eight hospitals that will remain independent if all pending transactions are approved provide only 15% of inpatient discharges in the state.

Unless radical change to reimbursement and support for financially distressed hospitals is on the horizon, some consolidation is inevitable. Unlike many of the other recent and proposed hospital acquisitions, however, the Lawrence + Memorial deal is not spurred by a community hospital's financial crisis. The conditions of this proposal create an opportunity for regulators to take a closer look at the growing monopolies in the state.

Figure 1: Hospital Ownership Changes, 1995-2015



2. THE DATA: YALE-NEW HAVEN'S LATEST MOVES INCREASE CONSOLIDATION

New data make it possible to chart the development of Connecticut's hospital systems, including the expansion of Yale's regional control in the last several years, and to anticipate how such control will grow as hospital networks expand. The authors obtained general acute inpatient care discharge data from the Office of Health Care Access, showing the number of discharges from each hospital by patients' town of residence during fiscal year 2013.

The question of how to define health care markets is highly contested and technically complex. For a detailed discussion, see Appendix A. Courts, hospitals, and regulators have disputed market boundaries for a quarter of a century while hospital systems completed 1,881 mergers.[15]

Recently, economists have developed improved tools to measure market boundaries, but courts are still catching up. Despite an academic consensus that hospital markets are much smaller and therefore more concentrated than courts were willing to accept a decade ago, only a handful of cases have actually seen anti-trust remedies applied to mergers.[16] Meanwhile, mergers are proceeding at a rate of more than 90 per year.[17]

For our initial analysis, we focus on market areas defined by the health systems and hospitals themselves, including concentric areas surrounding different hospitals that define smaller and larger markets. This approach gives a thorough preliminary analysis of market concentration at varying scales. The analysis examines five areas:

- **Yale-New Haven Health System's local service area:** In the Official Statement accompanying its most recent bond offering, YNHHSC defined the "local service area" for its full system as a 55-town region encompassing roughly the southern half of the state. The area includes 1.6 million people, 46% of the state's population.[18]
- **Yale-New Haven Hospital local service area:** A 34-town region also defined in YNHHS bond statements.[19]
- **Greater New Haven Area/Southern Connecticut Region Council of Governments (SCRCOG):** We use the area defined by membership in the Southern Connecticut Regional Council of Governments (SCRCOG) as a definition of Greater New Haven. SCRCOG contains fifteen towns with 16% of the state's population.
- **Lawrence + Memorial Hospital Primary Service Area:** L+M Hospital defines its primary service area as a ten-town region surrounding New London, both in the Official

Statement for its most recent bond issue and in its Certificate of Need application.

- **Lawrence and Memorial Hospital Secondary Service Area:** In the same sources, L+M also identifies as its secondary service area a twenty-town area surrounding New London.[20]

Within these five areas, our analysis focuses on three key metrics:

- The percentage market share for the Yale-New Haven Health System in each area prior to and after the absorption of Milford and the purchase of L+M Health.
- The Herfindahl-Hirschman Index, or "HHI," score for each area pre- and post-acquisitions. HHI measures the degree to which a market is concentrated, and thus how likely consumers are to face anticompetitive practices. It is a standard FTC and DOJ metric, also used by the American Medical Association, Congressional Budget Office, Kaiser Family Foundation, insurance industry, and other economists and regulators for analyses.
- The change in HHI for each area before and after a transaction, a prediction of merging hospitals' gain in market power.

In examining these metrics, we found that:

- Though consumers already face a market with limited competitive pressure to protect them, the ongoing absorption of Milford and the proposed purchase of L+M will significantly increase the Yale-New Haven Health System's market share in all five areas we examined - by a factor of 5 or 6 in the markets surrounding New London - at the further expense of competition.
- All five geographic regions studied easily meet the federal government's standard for a "highly concentrated" market even before the two takeovers. Highly concentrated markets can lead to artificially excessive prices.
- In the market areas studied, the size of the increase in consolidation caused by YNHHS's expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will "obtain market power," which federal regulatory standards warn against.[21]
- Although there is rapid consolidation across the state, the coastline areas dominated by YNHHS are the most heavily concentrated regions of the state and therefore are most vulnerable to price increases.

In each of these areas, the expansion is significant. The ultimate absorption of Milford Hospital and the L+M deal as proposed will leave YNHHS with nearly 60% of inpatient discharges in the Yale-New Haven Health System's local service area, which covers roughly the southern half of the state, including 46% of its population. It will also add the L+M service area to the swath of coastal areas in which YNHHS dominates the market. *[See Figures 3 and 4.]* Yale-New Haven Hospital already treats the second highest volume of patients in L+M's primary service area and third highest in its larger secondary service area. Combining the two hospital networks will leave YNHHS with monopoly pricing power.

When federal and state anti-trust regulators measure the degree to which a market is concentrated, they use a tool called the Herfindahl-Hirschman Index (HHI), which measures market concentration by aggregating measures of firms' market shares.

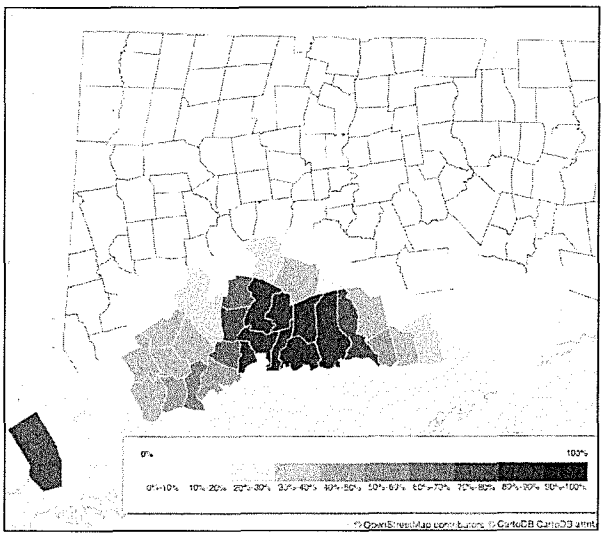
The DOJ and FTC assert that "mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise" because of the threat to competition. When a merger increases the HHI in a highly concentrated market by 100 points, regulators expect that merger to "potentially" raise significant concerns because of an increase in market power. When it increases by 200 points or more, they "presume" that an impermissible market power increase is likely. This presumption can be rebutted only by "persuasive evidence showing that the merger is unlikely to enhance market power."[22] We applied HHI to the discharge data from towns and multi-town areas to determine the health of the state's markets.

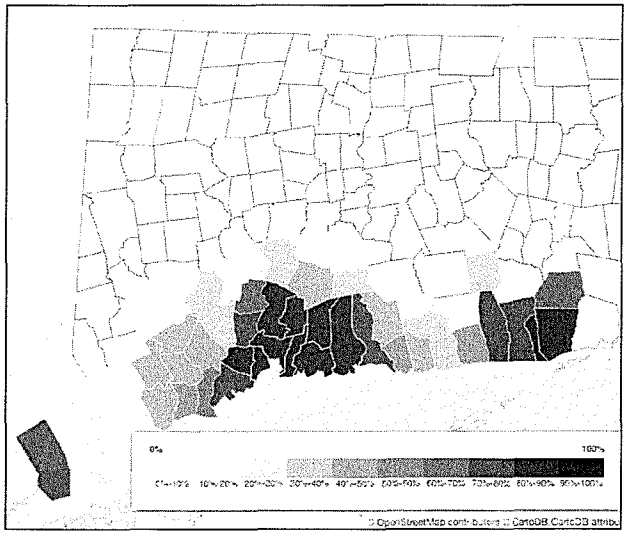
Figure 2: YNHHS inpatient discharge share by region, before and after addition of L+M and Milford

	Population	YNHHS discharge share now	YNHHS discharge share with deals
Statewide	3,570,000	27%	31%
YNHHS local service area	1,650,000	51%	59%
YNHH local service area	1,096,135	60%	65%
GNH/SCRCOG	570,000	74%	83%
L+M primary service area	175,000	14%	83%
L+M secondary service area	362,000	12%	59%

Figures 3 and 4: YNHHS local service area market share, before and after

These maps illustrate the percentage of inpatients from each town within the Yale-New Haven Health System's local service area who were discharged from a hospital in the YNHHS, before and after the addition of L+M and Milford.





Measuring Market Power

To calculate HHI, one adds the squares of the market shares together to get a number on a scale of 100-10,000:

- A region with a pure monopoly on a good or service would score an HHI of 10,000: $(100\%)^2 = 10{,}000$.
- A region with 10 competitors, each with equal market shares of 10% would score 1,000: $(10\%)^2 = 100$ for each competitor. 100 x 10 competitors = 1,000.
- A region with five competitors, one with 50% market share, one with 20% market share, and three with 10% market share would score 3,200 on HHI. $(50\%)^2 = 2{,}500$; $(20\%)^2 = 400$; $(10\%)^2 = 100$ x 3 competitors = 300.

The federal government divides markets into three categories based on HHI scores to assess the risk of monopoly:

- Less than 1,500—unconcentrated market with adequate competition
- Between 1,500 and 2,500—"moderately concentrated" market
- Above 2,500—"highly concentrated" market with an elevated risk of inefficiency and collusion to fix prices.

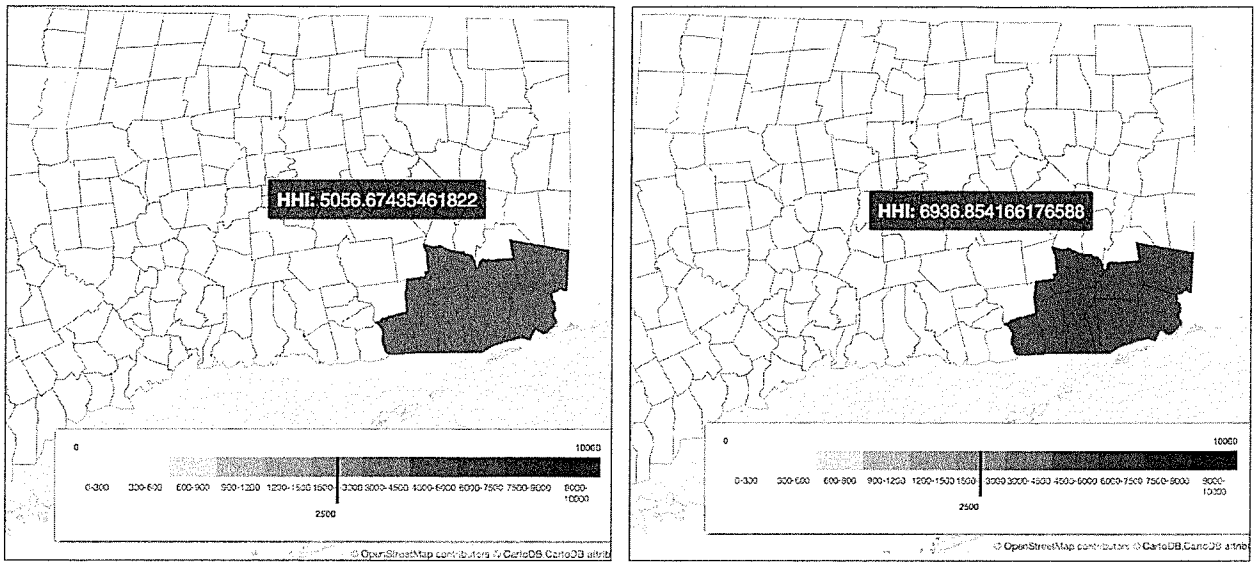
Regulators apply the strictest scrutiny to "highly concentrated" markets with scores of 2,500 or above.[18]

We found that every one of the five regions is already a highly concentrated hospital market to begin with. In every region, the increase in HHI was dramatic. The maps on the opposite page illustrate the HHI increase in the L+M service area. For the full table showing HHI and change in HHI for each geographic area, see Appendix B.

In every relevant local or regional area we examined, the HHI indicates that the market is already highly concentrated. When concentration is already high, increases to HHI are more concerning: federal standards indicate that the strictest scrutiny should be applied to markets like these because of the risk to competition. In every one of these markets, the magnitude of the HHI increase is far higher than the 200-point threshold at which federal regulations presume an impermissible increase to market power. In the L+M primary service area, the increase is over nine times the 200-point standard. In the YNHHS local service area—which encompasses 46% of the state's population—the increase is more than quadruple the standard.

The state of Connecticut is far too large to consider a "market." Even if we did consider Connecticut as a "market" of its own, however, it would already have an HHI of 1412. After these transactions, it would have an HHI of 1716—an increase of 304 points that would move it from the "unconcentrated" category to the "moderately concentrated" category. These two acquisitions constitute a substantial increase to overall market concentration in the state because they bolster the market power of its largest health system.

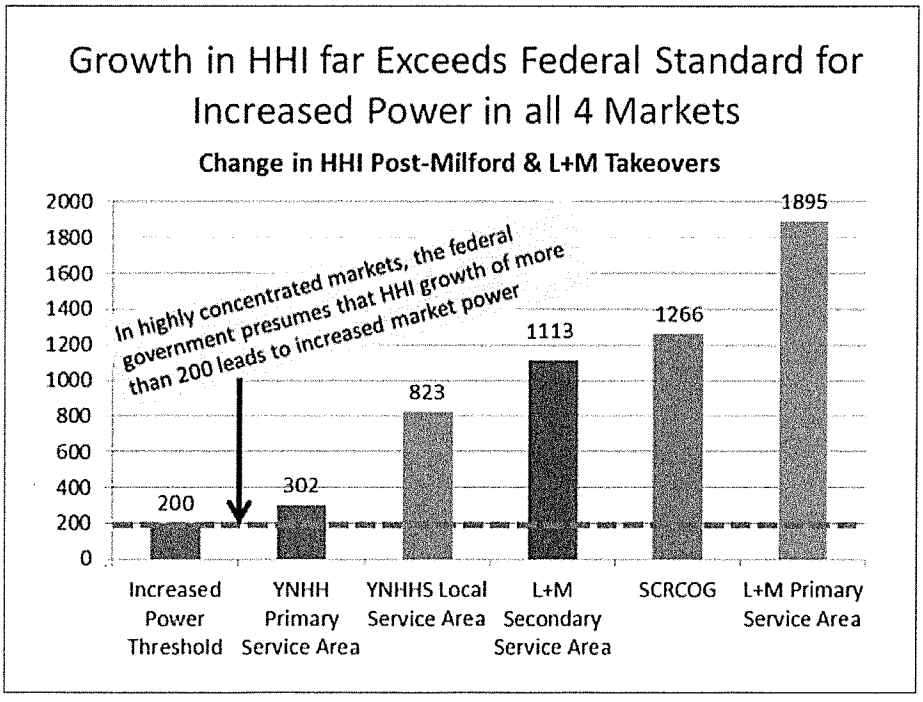
Consolidation is not equally threatening everywhere, however. We also calculated market concentration on a town-by-town basis for the entire state to demonstrate the distribution and comparative level of concentration across regions. Hartford's expansion in northern Connecticut has been more diffuse than Yale-New Haven's southern growth to date. In Hartford, for example, Hartford Hospital continues to face direct competition from St. Francis, which is now aligned with a multi-billion dollar national non-profit chain and is itself seeking to buy two hospitals. In the southern half of the state, highly concentrated multi-town regions clearly show the dominance of the Yale-New Haven Health System.



Figures 5 and 6: L+M Service Area HHI, before and after YNHHS takeover

This map demonstrates the dramatic increase in market concentration for the L+M Primary Service Area that will result from the potential takeovers. Because the market is already highly concentrated before the acquisition, combining YNHHS and L+MH will cause a large spike in market concentration, leaving few alternatives to the newly dominant Yale-New Haven system.

Figure 7



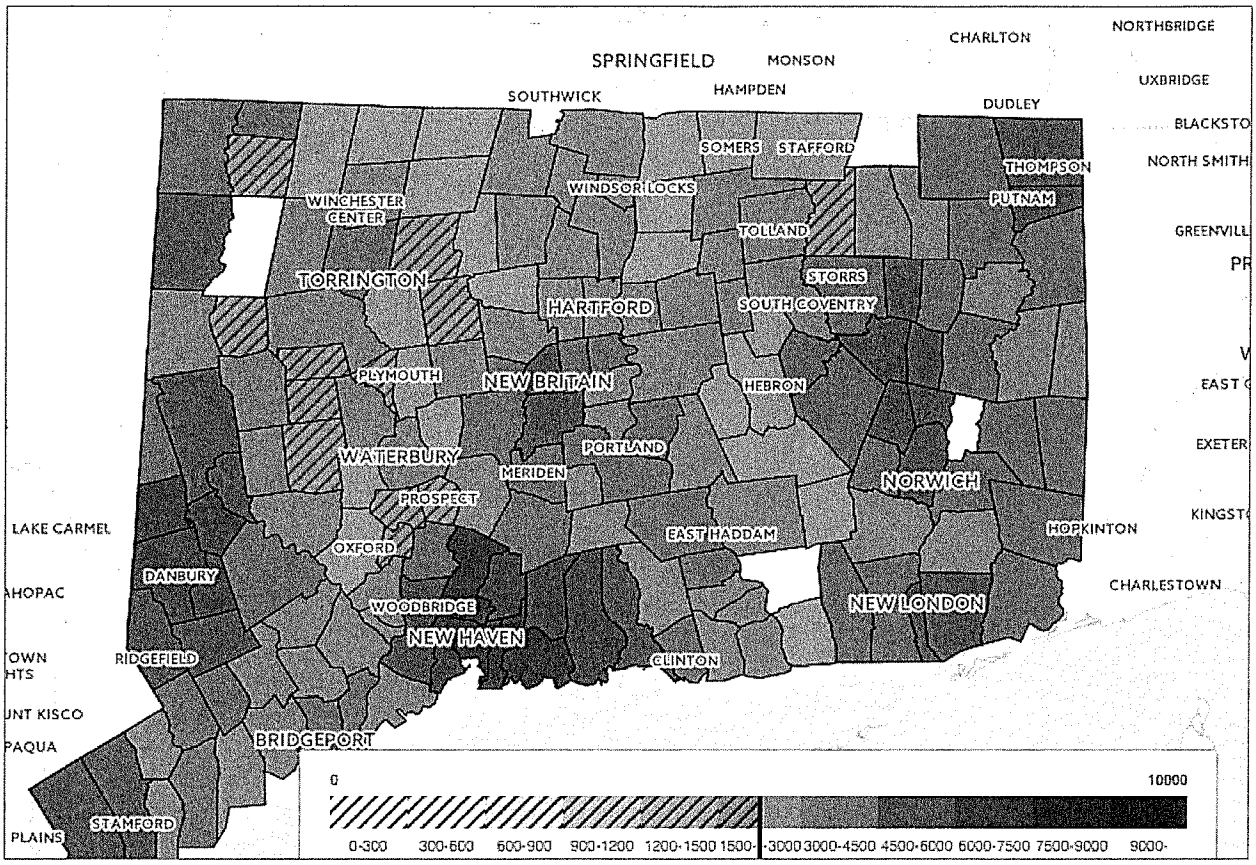


Figure 8: Town-by-town market concentration, Connecticut

This map shows the existing HHI scores for each town in Connecticut. Though discrete towns are not complete health care markets in themselves, the map shows roughly the distribution of highly and extremely concentrated markets throughout the state. Though Hartford HealthCare controls a large number of hospitals statewide, its hospitals are distributed in such a way that most towns in the north of the state exhibit comparatively lower market concentration, although most would still be defined as "highly concentrated" under federal standards. In the Yale-New Haven-controlled southern half, however, we see the highest density of towns with extremely high market concentration—above 6,000, indicating that Yale-New Haven's control of the market is geographically consolidated. Note that the region around New London is already heavily concentrated, and will become even more so if Yale-New Haven takes over L+M.

3. THE UNAFFORDABLE CONSEQUENCES OF MARKET CONCENTRATION

Prices Go Up as Hospitals Gain Market Power

Hospitals often claim that consolidation increases efficiency. There is little evidence to support this claim.

Independent comprehensive reviews of the academic literature have rejected this interpretation. Nationally, the Robert Wood Johnson Foundation reports, based on a review of five independent studies, that when hospitals "merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent."[23] Locally, the Universal Health Care Foundation of Connecticut concluded in its December 2014 review that "almost all retrospective studies suggest that hospital consolidation results in concentration of market power and a rise in the price of care."[24]

In Massachusetts, the Attorney General has documented that monopoly pricing, especially by the non-profit Harvard-affiliated Partners system, is the state's most significant cost driver.[25] In a court ruling this year against a hospital merger involving Partners, the Massachusetts judge found that the system was able to "exercise 'near monopoly power' that allows it to charge prices far in excess of its competitors for the same services."[26]

The fact that the dominant systems in Connecticut are nominally not-for-profit corporations does not protect Connecticut patients. A majority of U.S. acute care hospitals are structured as private, non-profit enterprises. That fact has not prevented a massive wave of mergers and skyrocketing prices.

For years, judges permitted mergers of non-profit hospitals on the theory that they would behave charitably with greater market power. In 2007, the Federal Trade Commission studied the pricing impacts of a non-profit merger in Illinois. It found that, according to the hospitals' own economist, managed care prices increased by 42% over four years, 12% above the market as a whole.[27]

With rising health care costs one of the largest drivers of perennial state budget crises, state officials are increasingly concerned about the long-term cost of consolidation to taxpayers. Comptroller Kevin Lembo, who administers the state employee health plan covering 210,000 people at a cost of $1.4 billion annually, recently testified stating, "We're going to be negotiating potentially with 2 or 3 large systems and that's basically it, if things keep going the way they are going. I don't think you need to be an actuary to know that that's going to be a tough spot for us."[28]

Non-profit hospitals claim they need surplus revenue to serve low income people. But Duke University Professor Clark Havighorst points out that the IRS allows non-profit hospitals "to spend their untaxed surpluses on anything that arguably 'promotes health.' Much of what hospitals count as charitable behavior or community benefit is not spent on lower income people."[29] University of Illinois tax law professor John Colombo adds:

> *"The standard non-profit hospital doesn't act like a charity any more than Microsoft does—they also give some stuff away for free. Hospitals' primary purpose is to deliver high quality health care for a fee, and they're good at that. But don't try to tell me that's charity. They price like a business. They make acquisitions like a business. They are businesses."*[30]

We're Not Getting the Quality Care We're Paying For

Already, Connecticut has the 4th highest per capita health care costs in the nation: we paid 27% more per person than the national average for health care in 2009, the most recent year for which data are available,[31] and what we spend at the hospital annually nearly tripled from 1991 to 2009, from $3.9 billion to $9.3 billion.[32]

The science of measuring hospital quality is still in its infancy. No single set of metrics is backed by a wide consensus. However, we examined several federal and independent evaluations. The available data provide no evidence that Connecticut's high health care costs are correlated to high quality. On several currently available metrics, Connecticut ranks among the states with the lowest scores.

For example, Medicare penalizes hospitals if patients are frequently readmitted within a month of their discharge. Based on these readmission standards, 90% of Connecticut hospitals received penalties for the 2015-2016 fiscal year, the second highest penalty rate for any state.[33] These 28 penalized hospitals included all three in the Yale-New Haven Health System, and Yale-New Haven Hospital itself received the seventh most severe penalty in the state.[34]

Medicare also assesses hospitals based on patient satisfaction across a number of areas like communication, cleanliness, and pain management. In the most recent scores compiled from quarterly Hospital Consumer Assessment of Healthcare Providers and Systems surveys, no Connecticut hospital received the top rating of five stars. Eighteen out of twenty-five hospitals received a three star rating, including YNHHS's Bridgeport and Yale-New Haven hospitals.[35]

The independent Leapfrog Group assesses hospital quality nationally and grades hospitals "A" to "F" based on factors such as safe surgery practices, infection rates, and use of correct staffing and procedures to minimize mistakes.[36] Connecticut ranked 36th in the percentage of hospitals scoring "A" in Fall 2015.[37] Maine and Massachusetts were 1st and 2nd nationally. Yale-New Haven and Greenwich Hospitals received "C" grades, Bridgeport a "D". Three of Hartford HealthCare's five hospitals received "C" grades, one a "B" and one a "D".[38]

As the science of quality measurement improves, and analysts are better able to account for factors such as the severity of patients' conditions across populations, these scorecards may yield different results. However, the Robert Wood Johnson Foundation examined the literature on hospital consolidation in relation to currently available quality indicators, and found that "a slim majority of studies find that, at least for some procedures, increases in hospital concentration reduce quality. The strongest studies confirm this result."[39]

4. CONFRONTING CONNECTICUT'S HOSPITAL MONOPOLIES

The Affordable Care Act and new Connecticut reimbursement policy are accelerating changes in how care is delivered and measured, and how the business of health care is structured. Before our very eyes, Connecticut is being carved up by a few hospital systems. The leader is clearly Yale-New Haven, with a level of control in many areas that easily meets any definition of market power. Meanwhile, our patients and payers are carrying a heavier and heavier financial burden as their health care costs rise.

Fortunately, Connecticut's legislative leaders have acted to curb the threat of consolidation by giving more tools to public consumers and to regulators. Two hospital regulatory bills in the last two years leave Connecticut better prepared to protect its consumers from the ill effects of monopoly. These reforms have put us in the forefront of states asserting the public interest in creating a fair health marketplace that benefits all. State regulators and advocates should use those tools now.

The acquisition of Lawrence + Memorial Health by the Yale-New Haven Health Services Corporation is a pivotal opportunity for stemming the growth of monopoly in Connecticut's health care market and limiting the ill effects of consolidation. The proposal will be reviewed under Public Act 14-168, which passed in 2014. Portions of Public Act 14-168 were quickly superseded by SB 811, which passed in 2015. However, the L+M acquisition application was submitted before the newer law took effect. Nevertheless, PA 14-168 added new standards for the Certificate of Need. In any decision to grant or refuse a CoN, the law requires the Office of Health Care Access to take into account whether the applicants have

> *"satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and [w]hether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care."*[40]

The sale as proposed unquestionably poses a threat to both provider diversity and health care costs along the shoreline.

In light of this threat, state officials should

rigorously examine the likely consequences of the transaction in order to decide whether to allow it to proceed. In particular, we recommend that prior to any approval or rejection, and prior to developing any proposed conditions, regulators take the following steps:

- SB 811 requires the state to undertake a "cost and market analysis" for such mergers. Although SB 811 does not formally apply, the Attorney General retains responsibility to enforce the Connecticut Anti-trust Act, and the Office of Health Care Access now must specifically examine the impact of merger-related consolidation on cost and access. Having public market analysis was critical to the process of public comment to the judge in the case of proposed mergers by Partners Health System in Massachusetts. Accordingly, we urge regulators to conduct the cost and market analysis that our state legislators have deemed appropriate for sales like this one.

- In order to understand the likely results of these acquisitions, we also believe that a thorough analysis of potential consolidation-related cost and access impacts calls for a retrospective look at any price changes following YNHH's acquisition of the Hospital of St. Raphael three years ago. This is a clear test of whether or not YNHHS exercises market power to artificially inflate prices: if St. Raphael's or Yale-New Haven's overall prices increased significantly post-merger, there is no question that the system is flexing monopoly muscle within the SCRCOG region. Understanding any changes in the two hospitals' prices may portend similar behavior in eastern Connecticut.

- We urge OHCA and the Attorney General to view the L+M acquisition in tandem with the unannounced takeover of Milford Hospital. To date, the relationship between YNHHS and Milford Hospital has been viewed as a series of individual transactions.

The changes to the market statewide pose high potential risks to patients. In the interest of quality and affordability in our health care marketplace, regulators must use these tools and more before they decide whether this transaction should proceed.

APPENDIX A: DEFINING AND MEASURING HOSPITAL MARKETS

The authors have chosen to apply HHI to the five geographic areas identified in the report as an initial illustration of the challenges posed by YNHHS's slow-motion consumption of Milford Hospital and proposed acquisition of L+M Health. We are awaiting further data to allow more thorough analysis, and also expect that regulators will apply a more rigorous methodology as full information on the transaction becomes available.

The definition and measurement of hospital markets is a hotly contested legal subject. As noted in the body of the report, for many years courts tended to assume that it was appropriate to entrust not-for-profit entities with market power because of their "charitable" nature. As courts began to take the threat to competition from consolidating non-profit hospitals seriously, the prosecution of anti-trust cases foundered on the use of analytic tools that fail adequately to account for the inelasticity of hospital demand.

In 1982, the FTC and Department of Justice Guidelines adopted a test that sets the boundaries of a monopoly market at the furthest limits at which a potential cartel or monopolist can impose a small but significant non-transitory increase in price ("SSNIP"). A SSNIP is generally assumed to be a 5% increase for a year without losing market share.

To define the SSNIP boundary, economists used two tests. For hospitals, the Elzinga-Hogarty test uses "patient flow" data to determine consumers' ability to enter and exit the market boundaries. Any boundary in which 10% or more patients leave to get care elsewhere is assumed to have enough competition to preclude anti-competitive behavior. "Critical Loss Analysis" examines the ability of firms to withstand profitably the loss of customers expected under a given market definition following a price increase. Once the market was defined, analysts would then apply a measure of market concentration such as the Herfindahl-Hirschman Index (HHI) to determine the anti-trust risk.

E-H and CLA both proved inadequate for hospital mergers. Neither accounts for factors that influence patient choice other than price (3rd party payment, role of the physician, proximity, availability of subspecialty services, etc.). Standard CLA analysis often results in "inconsistent logic and erroneous conclusions." Use of these tools allowed hospital defendants to win a series of cases between 1997 and 2004 in part by successfully defining markets as large geographic areas within which any single combination of hospitals posed a minimal threat to competition.

Gaynor, Kleiner, and Vogt estimate that these older methods overstated the elasticity of hospital demand "by a factor of 2.4 to 3.4 and were likely a contributing factor to the permissive legal environment for hospital mergers." That permissive environment allowed 1,425 mergers and acquisitions to be consummated between 1994 and 2009. Dr. Elzinga himself questioned the value of his own test on hospital markets in 2011.

In the early 2000s, economists developed the "option demand" analysis (Town and Vistnes, 2001; Capps, Dranove, and Satterthwaite, 2003) and the Differentiated Bertrand Oligopoly Model (DB). These models attacked the issue of third party reimbursement by envisioning a hypothetical health plan attempting to construct a provider network in the region of the merging competitors. "This is a reasonable characterization of managed care markets," write Gaynor, et al., of the option demand model.

The new methods yield markets far smaller and closer to economic reality than the older tests, and

lead to clearer pictures of market concentration. According to Gaynor et al, they allow analysts "to assess merger effects without a market definition."

However, they are not yet universally accepted in court, and even though the new methods are capable of assessing merger effects without a market definition, courts expect definitions and FTC guidelines for state Attorneys General insist on them as well. The new tools are powerful, and once we obtain data sufficient to apply them we will attempt to do so.

For our initial analysis, we have chosen to examine markets defined by the hospitals in their public descriptions of themselves. These analyses serve as an adequate preliminary basis for gauging the degree of concentration, and we examine several concentric markets that present analyses at varying scales of market definitions.

However, we recognize that in the policy process, any attempt at market definition will be contentious. Therefore, we urge regulators to heed the words of Kenneth Elzinga closely. In evaluating the usefulness of his original model in the context of hospital mergers, Dr. Elzinga notes "where direct evidence of anticompetitive effects attributable to a merger is available, its use may diminish the need to rely on geographic market definition tools such as the E-H test," writes Dr. Elzinga. "Such direct evidence is most readily available in post-closing merger challenges such as the FTC's Evanston case."

Connecticut patients cannot wait until Milford and L+M are fully in the Yale-New Haven orbit to understand the potential price impact of the deals. Although there is no direct evidence, there is a useful precedent. Yale-New Haven's purchase of the Hospital of St. Raphael resulted in intense market concentration in the Greater New Haven area.

The Certificate of Need filed for that transaction in 2012 states that "YNHH has no plans to raise charges as a result of the HSR acquisition," language similar to that in the Certificate of Need for L+M. If an analysis of the market before and after that merger reveals significant price increases, there will be little question that YNHHS exerts monopoly pricing power.

APPENDIX B:
HHI TABLE, BEFORE AND AFTER BOTH HOSPITAL ACQUISITIONS, BY AREA

Market name	HHI before	HHI after	Change
Lawrence + Memorial Primary Service Area	5087	6982	+1895
Lawrence + Memorial Secondary Service Area	3485	4598	+1113
YNHHS Local Service Area	2911	3735	+823
Greater New Haven (SCRCOG)	5665	6931	+1266
YNHH Primary Service Area	3920	4222	+302

APPENDIX C:
MARKET SHARE AND HHI CALCULATIONS FOR L+M ACQUISITION ONLY, WITHOUT MILFORD HOSPITAL ACQUISITION, BY AREA

Data in this table include YNHHS's proposed acquisition of L+M, but not the addition of Milford Hospital. HHI increase is compared to HHI with the Yale-New Haven system as is.

Market name	YNHHS Discharges	HHI	HHI Increase
State	31%	1667	+254
Lawrence + Memorial Primary Service Area	83%	6972	+1884
Lawrence + Memorial Secondary Service Area	59%	4592	+1107
YNHHS Local Service Area	57%	3539	+628
Greater New Haven (SCRCOG)	79%	6309	+643
YNHH Primary Service Area	61%	3933	+14

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EXHIBIT 5

Exhibit Two
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EXHIBIT 6

Community Hospitals at a Crossroads

Findings from an Examination of the Massachusetts Health Care System

Background of the report: building a path to a thriving, community-based health care system

The need for the report

- Hospitals and health systems across the country are facing **unprecedented impetus to adapt** to new care delivery approaches and value-based payments
- Community hospitals are under particular pressure to change and are uniquely challenged **by current market and utilization trends,** as evidenced by a number of recent consolidations, closures, and conversions in Massachusetts
- The state is pursuing sweeping delivery system transformation to achieve shared cost containment goals, and effective, **action-oriented planning is necessary**

Objectives of the report

- To understand and describe the **current state of and challenges facing community hospitals**
- To examine the implications of **market dynamics** that can lead to elimination or reduction of community hospital services
- **To identify challenges to and opportunities for transformation** in community hospitals
- To **encourage proactive planning** to ensure sustainable access to high-quality and efficient care and catalyze a **multi-stakeholder dialogue** about the future of community health systems

> *"I don't see any future for community hospitals…I think there's a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care]."*
>
> *COMMUNITY HOSPITAL CEO*

Key themes of the report

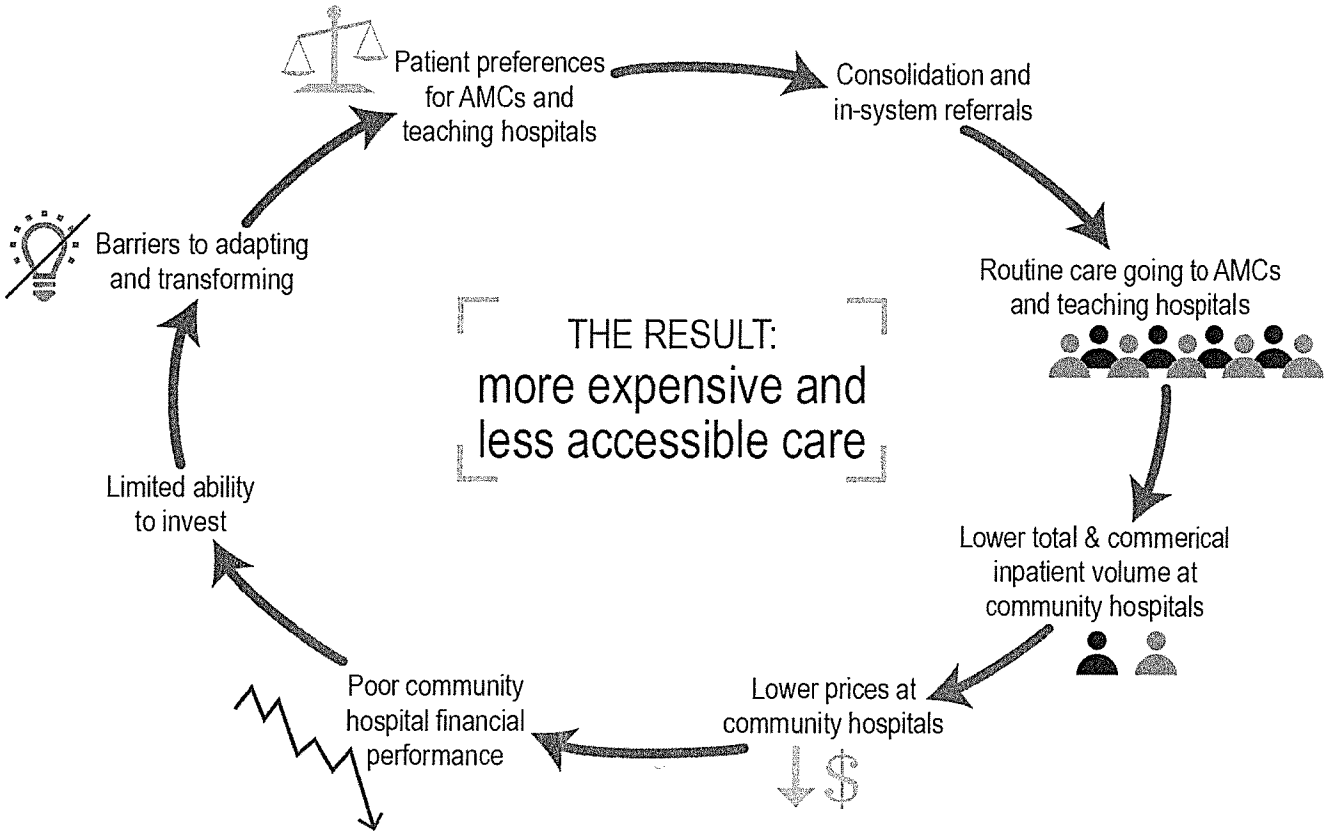
Community hospitals provide a unique value to the Massachusetts health care system

- While individual characteristics vary, as a cohort community hospitals play a critical role in care for publicly insured patients; providing local, community-based access; and, in particular, meeting behavioral health needs
- Community hospitals provide more than half of all inpatient discharges and more than 2/3 of all ED visits statewide
- Community hospitals generally provide high-quality health care at a low-cost, providing a direct benefit to the consumers and employers who ultimately bear the costs of the health care system

The traditional role and operational model for many community hospitals faces tremendous challenges

- Community hospitals generally have worse financial status, older facilities, and lower average occupancy rates than AMCs and teaching hospitals
- Many hospitals face barriers to transformation:
  - Consolidation of acute and physicians services into major health systems
  - Routine care going to AMCs and teaching hospitals
  - Lower commercial volume and prices leading to lack of resources for reinvestment
  - Difficulty participating in current alternative payment models

Community hospitals face self-reinforcing challenges that lead to more expensive and less accessible care

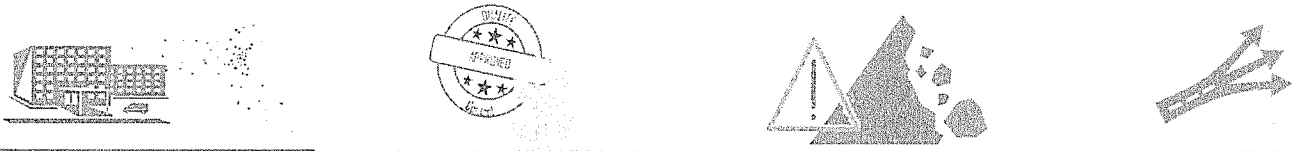


Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System

Overview | **Value** | **Challenges** | **Path Forward**

- An **overview** of community hospitals in Massachusetts
- The **value** of community hospitals to the health care system
- **Challenges** facing community hospitals
- The **path** to a thriving community-based health care system

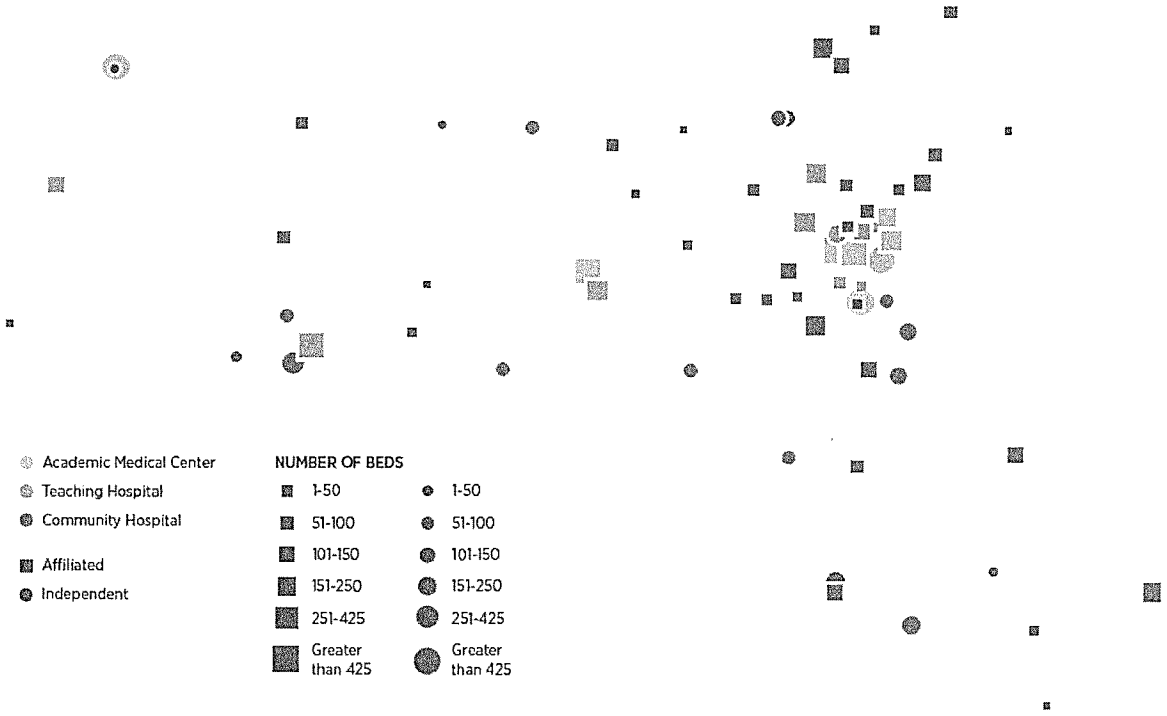
An overview of community hospitals in Massachusetts



Overview

- Key distinguishing features of community hospitals (geographic distribution, patient populations, services, financial condition)
- Key community hospital trends (transitions, consolidation and closure)

Community hospitals serve all parts of the Commonwealth



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Community hospitals at a glance

43
Community Hospitals

27 | 18
DSH | non-DSH

7,518 | 52%
more than half of beds statewide
(19 – 556)

417,275 | 51.3%
more than half of discharges statewide
(556 – 40,303)

5.8 | 42
million | %
outpatient visits

1.9 | 65
million | %
2/3 of ED visits
(10,329 – 155,236)

64% | 84%
community hospitals | AMCs
low occupancy rate
(29% – 74%)

0.8 | 1.33
community hospitals | AMCs
low case mix index
(0.60 – 0.93)

9.3 | +11
minutes | minutes

local patients drive 9.3 minutes on average to community hospitals; they would drive 11 minutes more on average to get to the next closest hospital

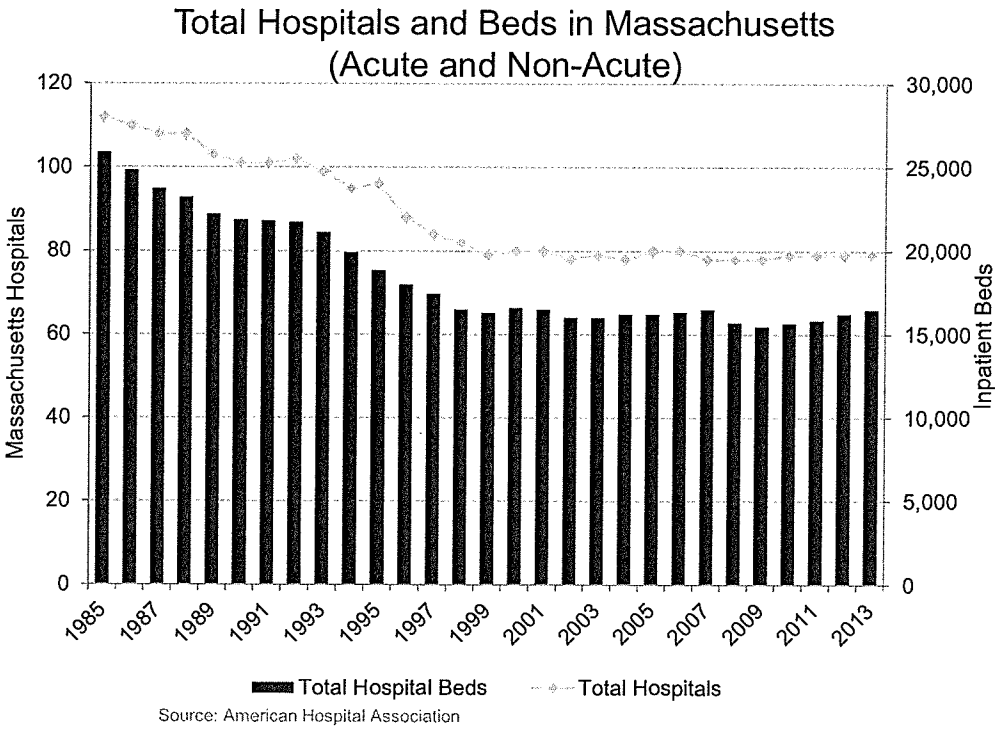
Older age of plant

Community hospitals generally have older physical plants than AMCs or teaching hospitals

Higher public payer mix

Community hospitals generally have disproportionately high shares of Medicaid and Medicare patients

Consolidations and closures over the last 30 years have contributed to a dynamic hospital market in Massachusetts



Source: American Hospital Association

Recent Conversions in Massachusetts Have Had Varied Impact

North Adams Regional Hospital

Steward Quincy Medical Center

Two Conversions Are Being Currently Contemplated

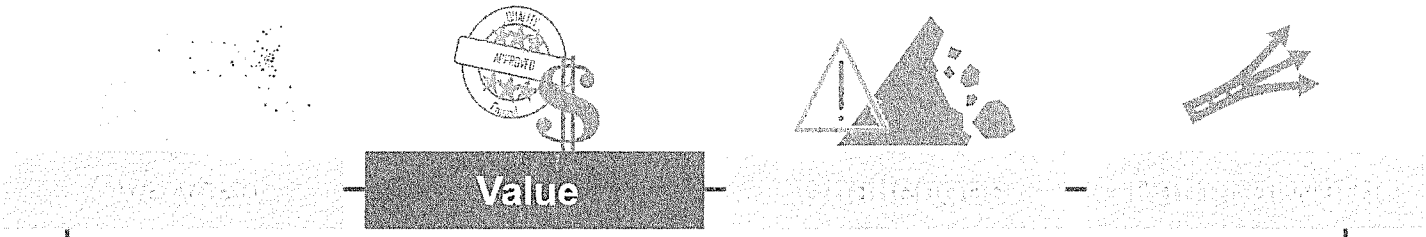
Baystate Mary Lane Hospital

Partners North Shore Medical Center – Union Hospital

Hospital-related Material Change Notices since 2013

11	16	5
mergers or acquisitions of one hospital by another	new contracting or clinical relationships between hospitals	hospitals acquiring physician groups

The value of community hospitals to the health care system



Community-based care and access

- Care close to home / drive time analyses
- Patient populations / payer mix

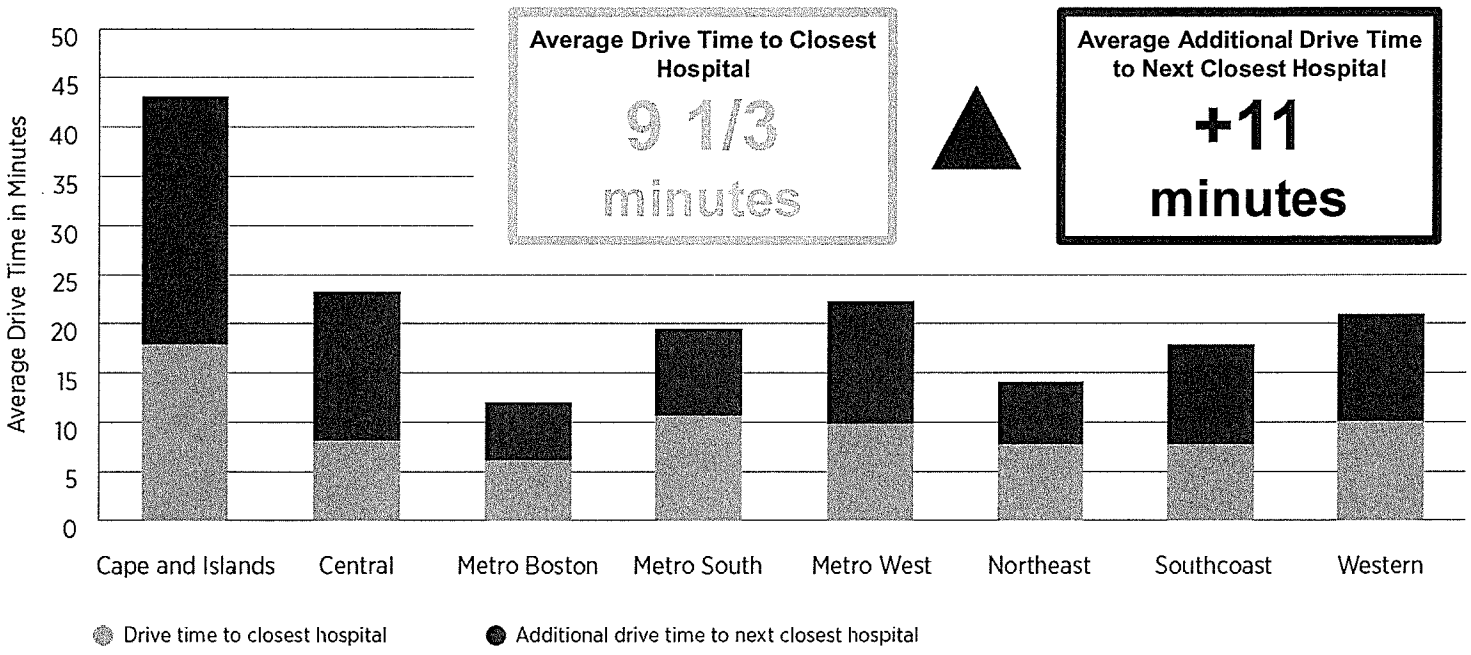
Quality and Efficiency

- Examination of quality performance by community hospitals and patient perception of quality and value
- Variation in spending and costs for community-appropriate care at community vs other hospitals

Community hospitals provide local access for local patients

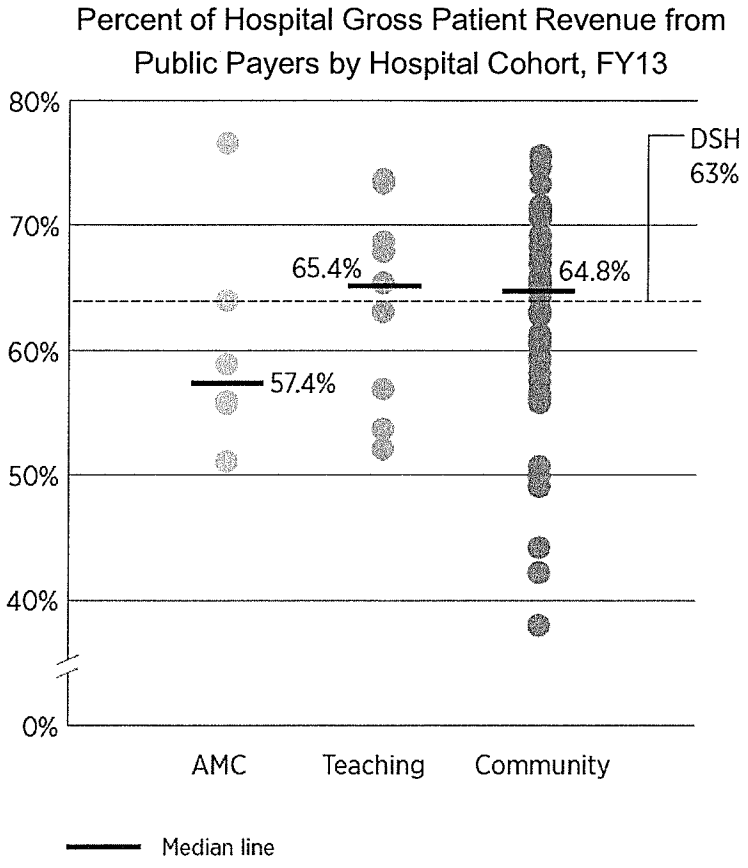
Average Drive Times for Patients Using Their Local Community Hospital

Analysis of patients who use their closest community hospital as a usual site of care



Source: HPC analysis of MHDC 2013 discharge data.
Notes: Drive times may underrepresent travel time and travel time differentials for populations relying on public modes of transportation. The Cape and Islands region includes only Falmouth and Cape Cod Hospital for the purposes of this analysis, since measuring drive times for Hospitals on Nantucket and Martha's Vineyard islands would not be meaningful.

Community hospitals serve a high proportion of vulnerable populations for whom access to care is often difficult, such as elders, individuals with disabilities, and individuals with low incomes



> *The community hospital plays a role as a cultural and social staple for the community that it serves. It's the place you're born at, that you grow up with, and get most of your basic care at…The state should ensure access to community-based, cost-effective care*
>
> *MASSACHUSETTS STATE LEGISLATOR*

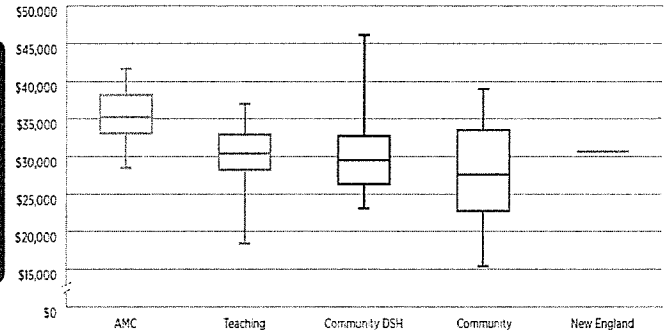
Source: HPC analysis of CHIA Acute Hosp. Databook, supra footnote 11, at Appendix D.
Note: Public payers include Medicare and Medicaid/MassHealth fee for service and managed care plans, Health Safety Net payments, and charges designated by hospitals as "other government."

Spending at community hospitals is generally lower for low-acuity orthopedic and maternity care and is not associated with any difference in quality

Orthopedics

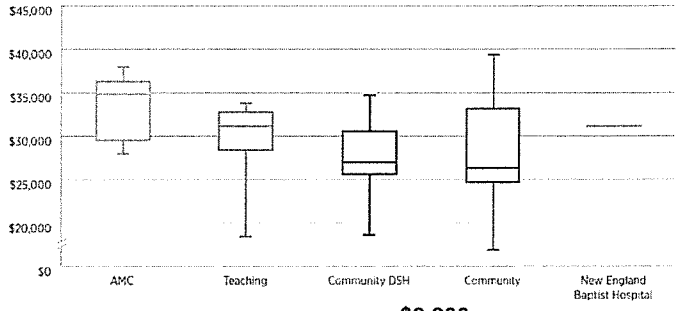
Deliveries

Hip Replacement



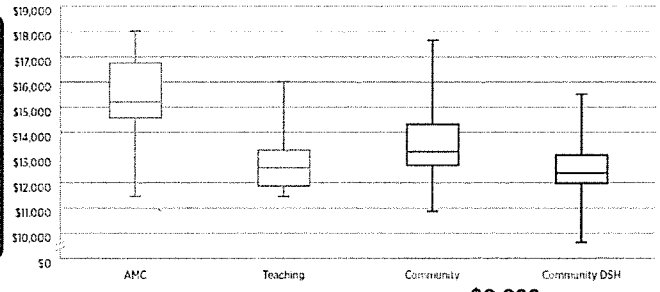
$6,750 less than AMCs

Knee Replacement



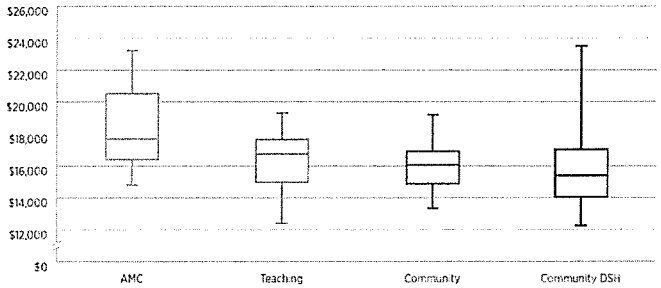
$8,200 less than AMCs

Pregnancy - Vaginal Delivery



$2,200 less than AMCs

Pregnancy - Caesarian Delivery



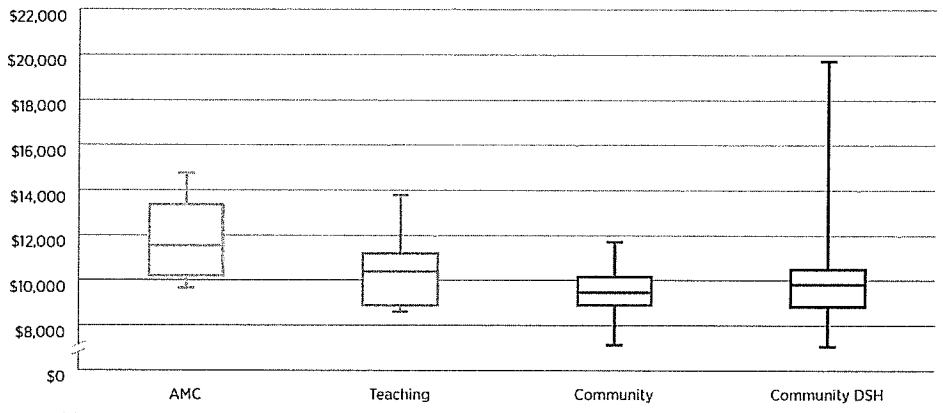
$2,100 less than AMCs

Source: HPC analysis of 2011 and 2012 APCD data for Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Plan patients

We found no correlation between hospital cost and quality. Each group of hospitals has higher and lower quality performers but no cohort outperforms any other overall

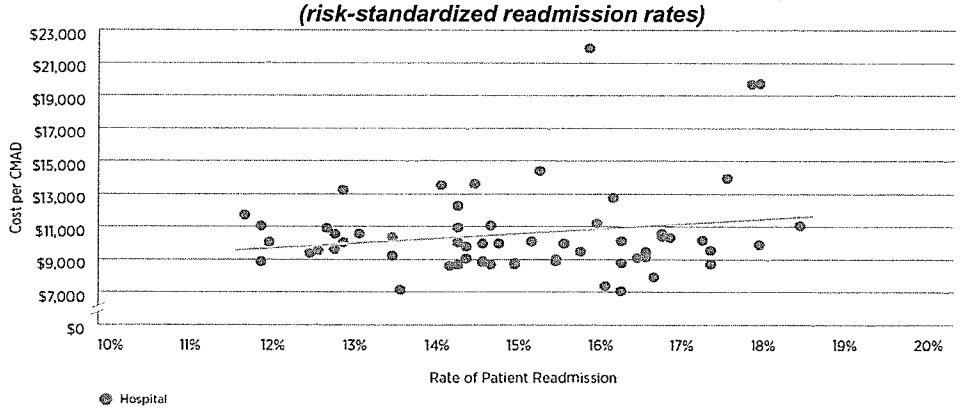
Most community hospitals provide care at a lower cost per discharge, without significant differences in quality

Hospital costs per case mix adjusted discharge, by cohort



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Costs per CMAD are not correlated with lower quality
(risk-standardized readmission rates)



Source: HPC analysis of CHIA Hosp. Profiles, 2013; CHIA Focus on Provider Quality Databook, Jan 2015

On average, **community hospital costs are nearly $1,500 less per inpatient stay** as compared to AMCs, although there is some variation among the hospitals in each group

Although costs per discharge for community hospitals have grown at a slightly higher rate than those for AMCs, the gap between AMC and community hospital costs has not substantially changed

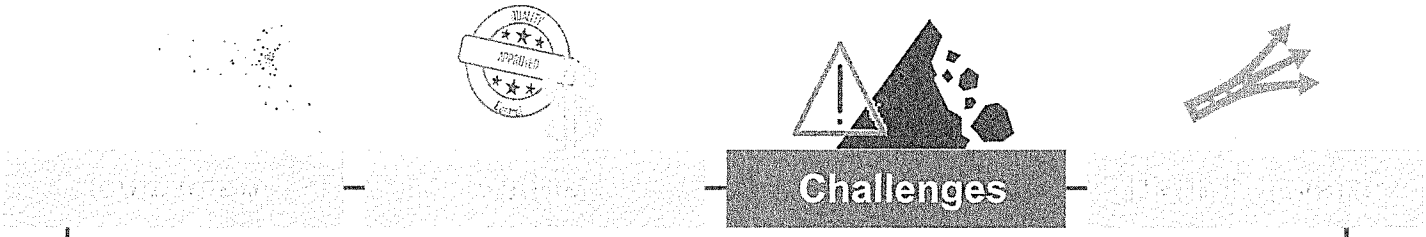
Reasons for differences in efficiency likely vary, and may include service offerings, support for teaching programs, and, particularly for community hospitals, the pressure of tight operating margins

Increases in health care spending on inpatient care would result from the closure of most community hospitals, due to commercial price variation

The HPC modeled where patients would likely seek care if community hospitals were to close and to estimate commercial spending impact.

- In most cases, a community hospital closure would **increase annual spending on inpatient care**
- **The majority of these increases would be less than $4 million**, due to the disproportionately low volume of commercially insured patients at many community hospitals
- Spending would increase by **more than $5 million for seven community hospitals**
    - The closure of **Lowell General Hospital** would cause the greatest increase: **over $16 million**
- Spending would actually **decrease** in the event of the closure of any of eight community hospitals, primarily those with higher relative prices
    - The greatest decreases in spending would result from **South Shore Hospital ($4.2 million annually)** or **Cooley-Dickinson Hospital ($2.8 million annually)** becoming unavailable

Challenges facing community hospitals



- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Competition from non-traditional market entrants
- Implications if current trends continue

Driven by referrals and perceived quality, many patients are choosing AMCs and teaching hospitals over community hospitals for routine care

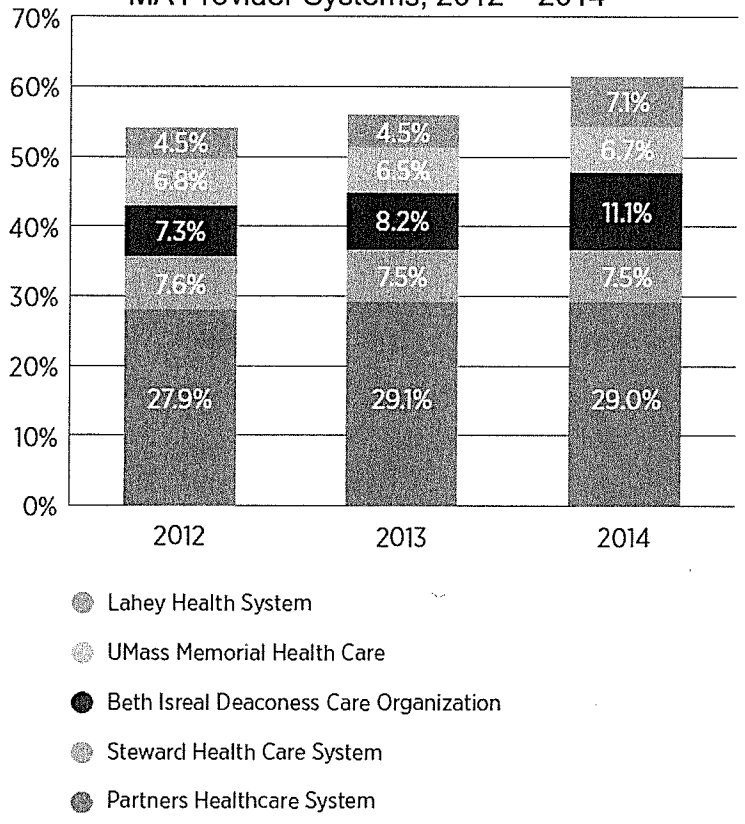
HPC commissioned qualitative analyses (8 focus groups in four regions of the state) by Tufts University to better understand what drives consumer choices of hospitals

> *"I guess it might be something in your psyche because I like brand-name products. So maybe that's what drives me to Boston."*
>
> *FOCUS GROUP PARTICIPANT*

- Patients often mentioned that **they did not feel that they had a choice** of hospitals because their primary care provider or insurance plan determined where they could go for care
- **Two in three Massachusetts adults** have **never sought information** about the safety or quality of medical care, instead valuing the experiences of peers and recommendations of their primary care physicians.
- Many patients stated that they felt that **AMCs and teaching hospitals were better** because they had the best physicians, including doctors who had graduated from medical schools they considered prestigious. Many patients indicated that they **believed AMCs and teaching hospitals had developed reputable brands**
- Some patients stated that the **higher costs of AMCs and teaching hospitals must mean that they provided better quality**, regardless of what quality data showed. Many also said they wanted to "get their money's worth" from the health care system after investing heavily in health insurance coverage. Others reported that **cost is not a factor when it comes to health**

Increased consolidation of providers has driven referrals to large provider systems, including their anchor AMCs and teaching hospitals

Percent of Statewide Inpatient Discharges at the Five Largest MA Provider Systems, 2012 – 2014

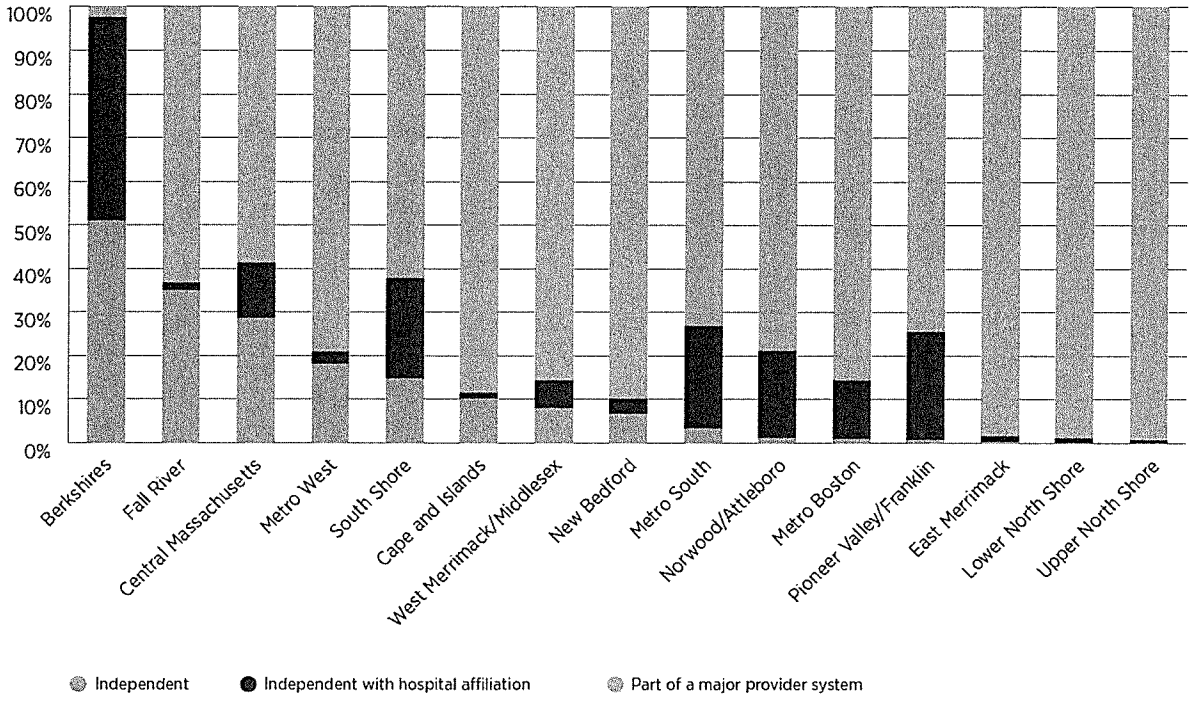


> *"Retaining primary care staff and specialists, 'the gatekeepers to volume' is challenging. Providers continue to leave for big-name systems and AMCs – and patients follow"*
>
> *Synthesis of MASSACHUSETTS PROVIDER INTERVIEWS*

Source: HPC analysis of MHDC discharge data.
Note: Systems shown have the highest total net patient service revenue among providers in the Commonwealth.

Most primary care services are now delivered by physicians affiliated with major provider systems

Percentage of Primary Care Services Delivered by Independent versus Affiliated Physicians by Region, 2012



Percentage of PCPs Affiliated with Eight Largest Systems Grew from

62%

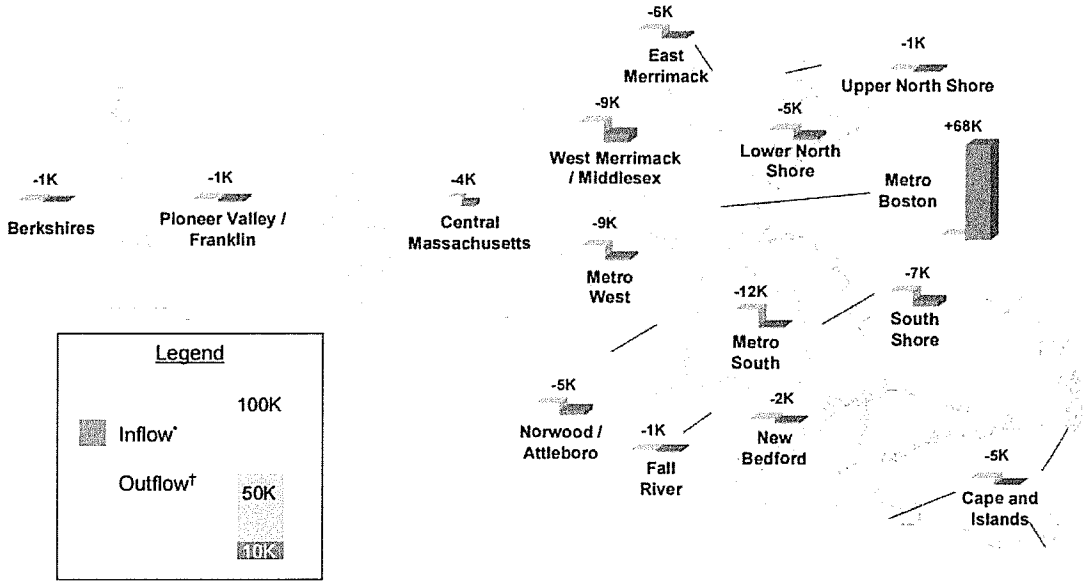
in 2008 to

76%

in 2014

Source: HPC analysis of 2012 APCD claims for BCBS and HPHC ; 2012 MHQP Master Provider Database.
Note: For the purposes of this analysis, major provider systems include Atrius Health, Baycare Health Partners, Beth Israel Deaconess Care Organization, Lahey Health System, New England Quality Alliance, Partners Community Health Care, Steward Health Care Network, and UMass Memorial Health Care. PCPs affiliated with multiple systems are counted as being part of a major provider system.

Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



Commercially insured patients are most likely to outmigrate to Boston

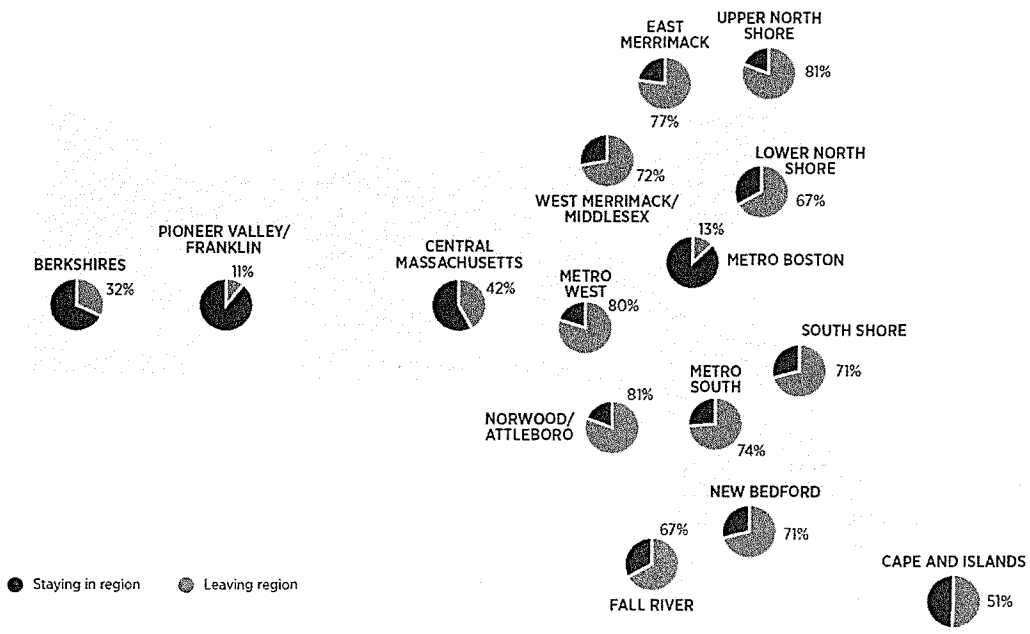
Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
Source: HPC Cost Trends Report, July 2014 Supplement

Large proportions of patients leave their home regions for deliveries

Percentage of Patients Leaving their Home Regions for Community-Appropriate Deliveries, 2013



74%→50%

change in proportion of all births in community hospitals from 1992 – 2012[1]

[1]Healthcare Equality and Affordability League. *Healthcare Inequality in Massachusetts: Breaking the Vicious Cycle*

6 hospitals saw **53%**

of low risk births in 2011-2012. 5 of these hospitals had above average delivery costs.

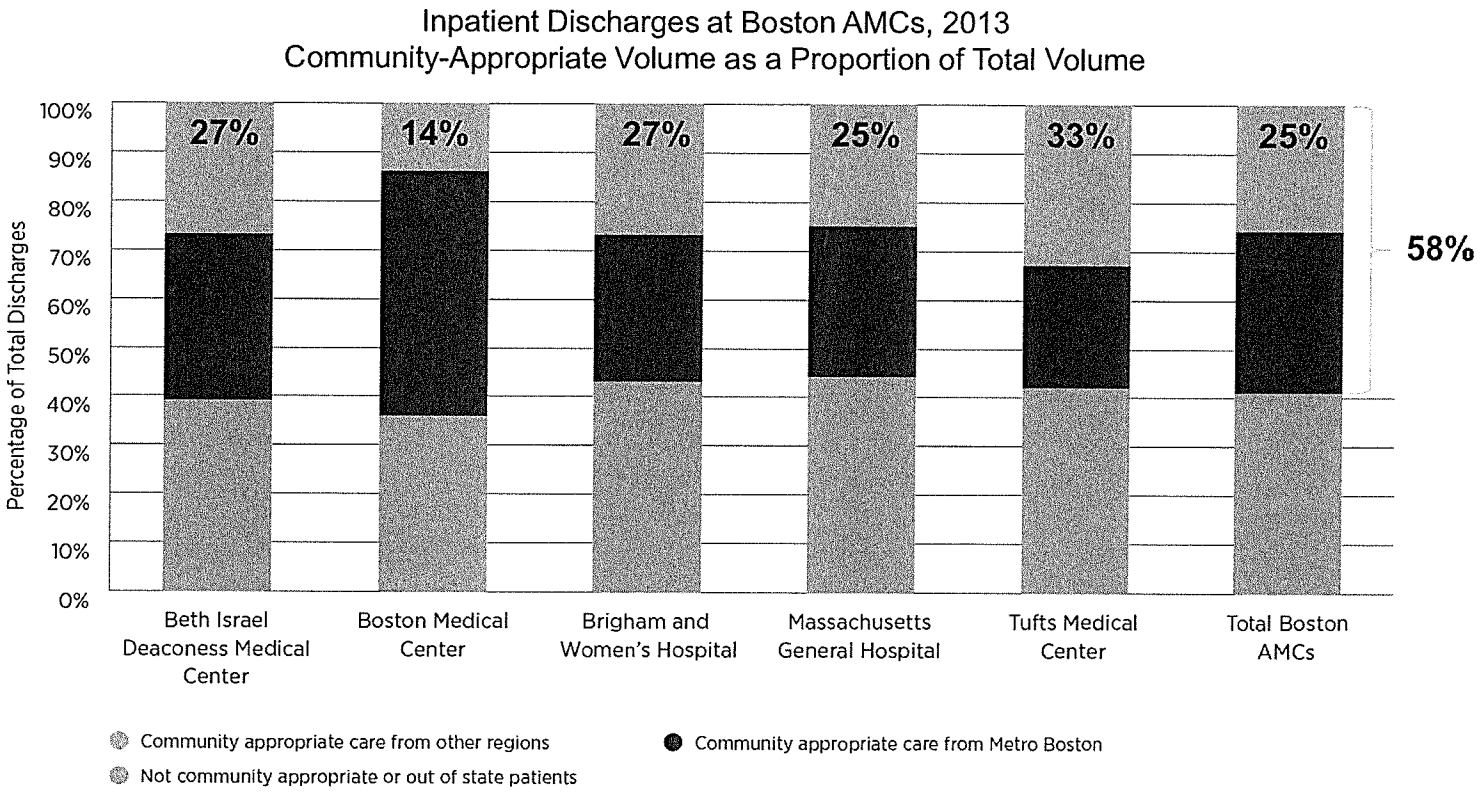
Massachusetts General Hospital and Brigham and Women's Hospital have highest costs statewide for maternity care and saw

20%

of all low-risk births in the state

Source: HPC analysis of MHDC discharge data.

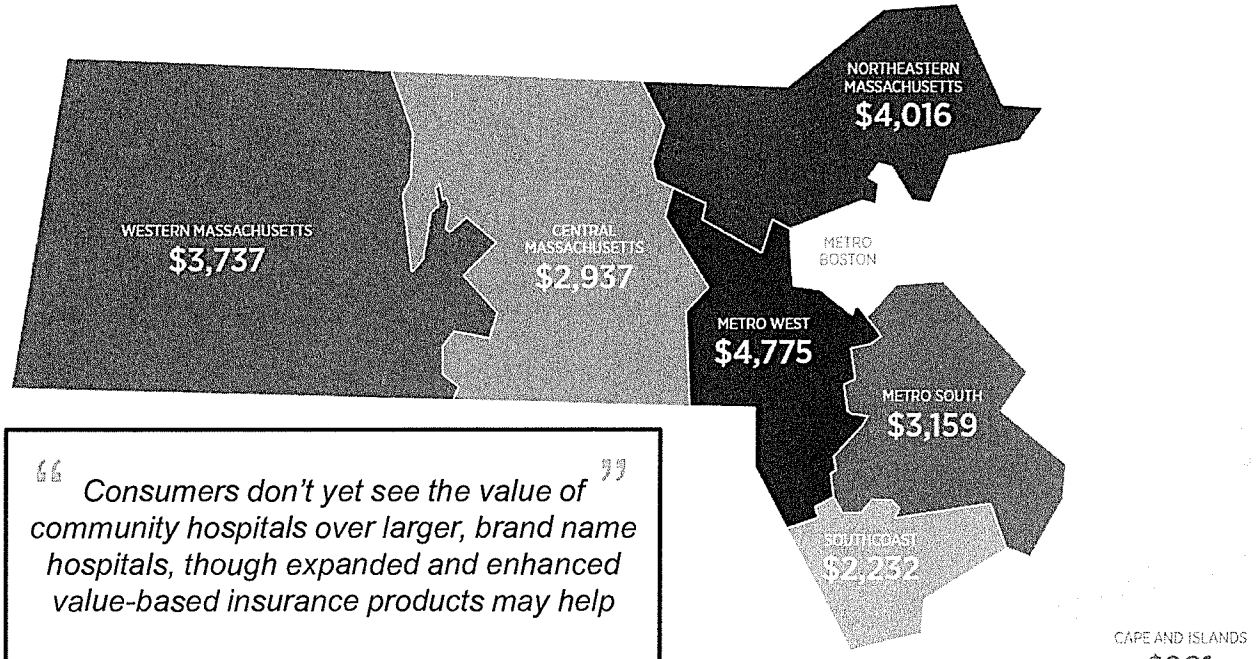
A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting



Source: HPC analysis of MHDC 2013 discharge data.
Note: Figure shows proportion of volume at each hospital, and does not reflect differences in total volume amongst the hospitals shown. Estimates of the volume of community appropriate care provide at AMCs are conservative as community appropriate care is defined to exclude cases which some community hospitals could effectively handle but that many community hospitals could not.

Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

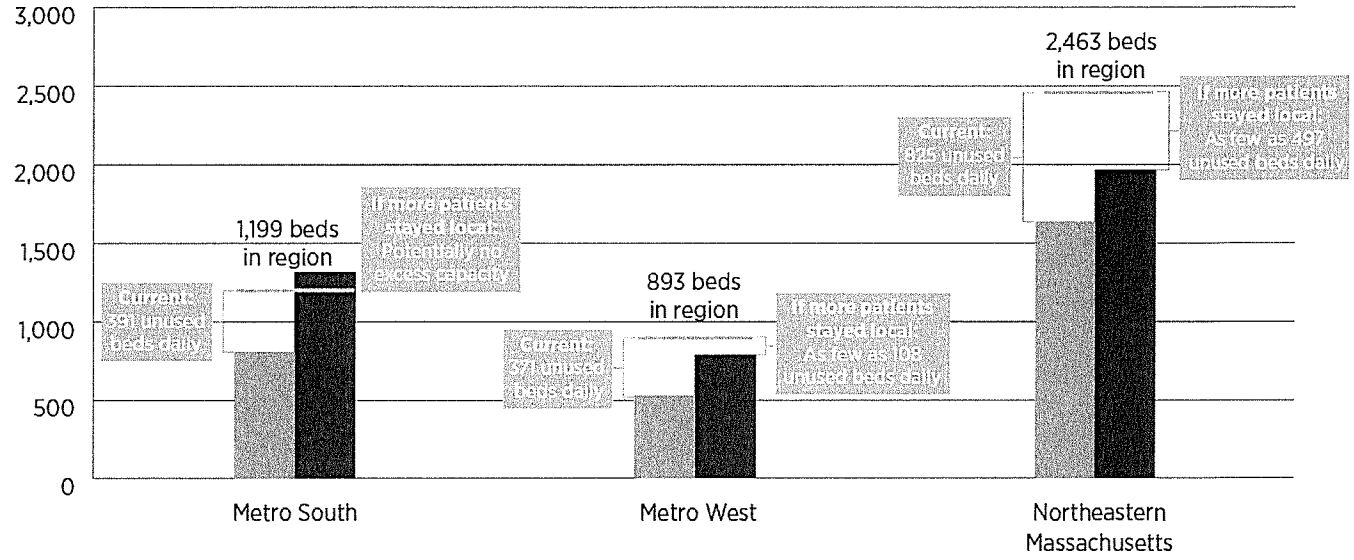


> *"Consumers don't yet see the value of community hospitals over larger, brand name hospitals, though expanded and enhanced value-based insurance products may help"*
>
> *MASSACHUSETTS EMPLOYER GROUP*

Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

In most regions, hospitals have the capacity to treat more patients locally

Average Use of Hospitals in Regions Neighboring Metro Boston
versus Average Use of All Hospitals by Region Residents, 2013



Average daily utilization of hospitals in region by patients in the region

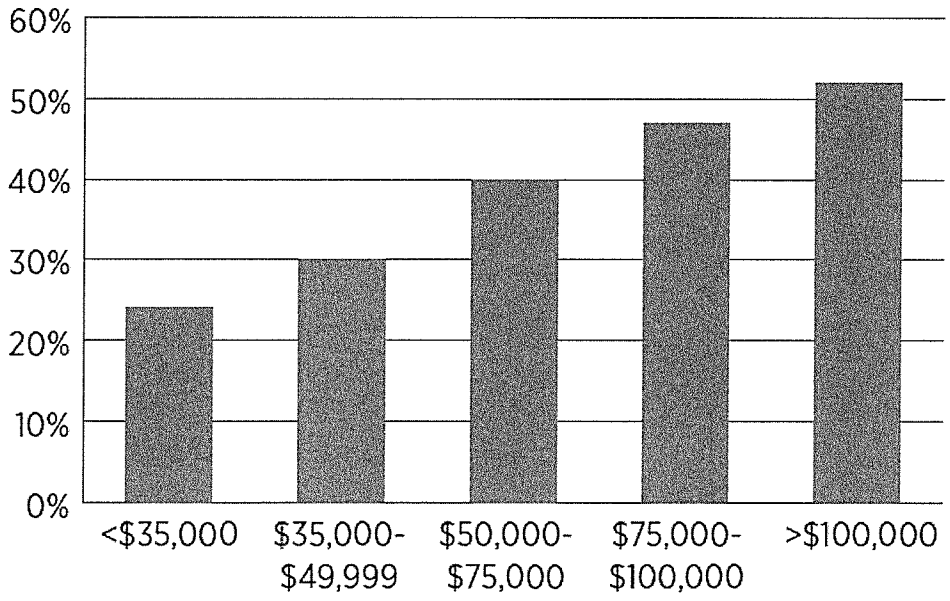
Average daily utilization by all patients from region (at hospitals anywhere in Massachusetts)

The total hospital bed supply in region

Source: HPC analysis of MHDC 2013 discharge data and CHIA hospital 403 reports.

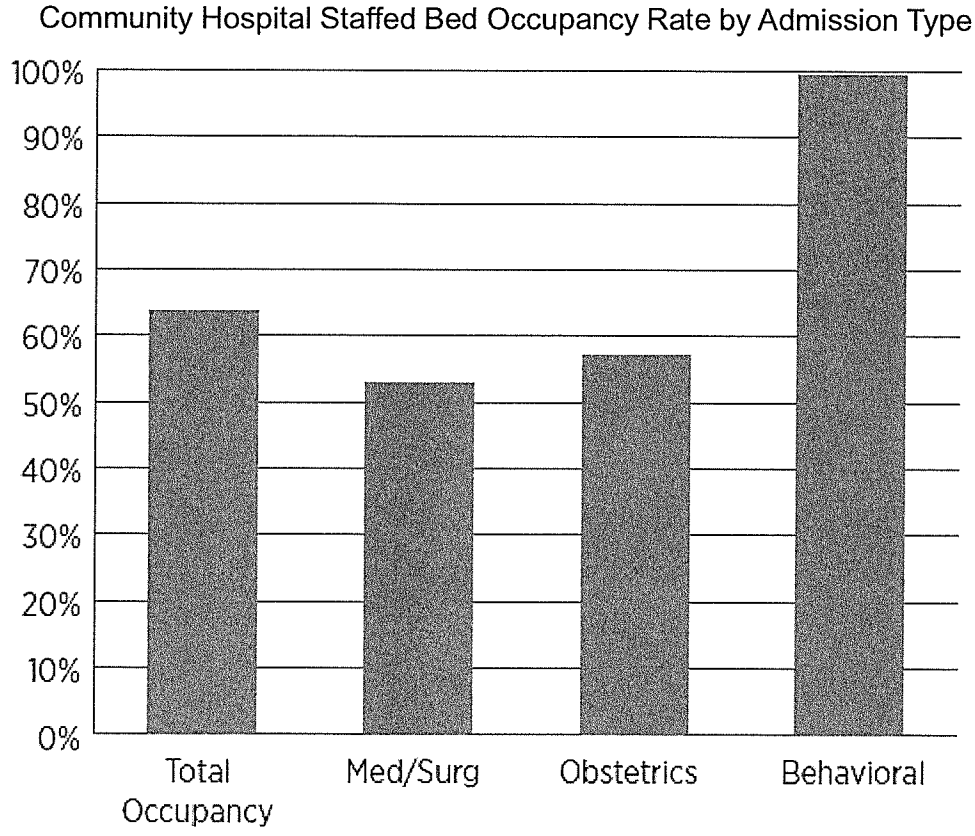
Commercially insured patients and patients from wealthier communities are more likely to migrate to Boston for care

Probability that Patient will Travel Outside of His/Her Home Region for Inpatient Care, Based on Home Community Income



Source: HPC analysis of MHDC 2012 discharge data and U.S. Census Bureau American Community Survey data.

In addition to lowering volume, migration results in community hospitals seeing larger proportions of government payer patients and those seeking low-margin services



Boarding of behavioral health patients in emergency departments increased by

40%

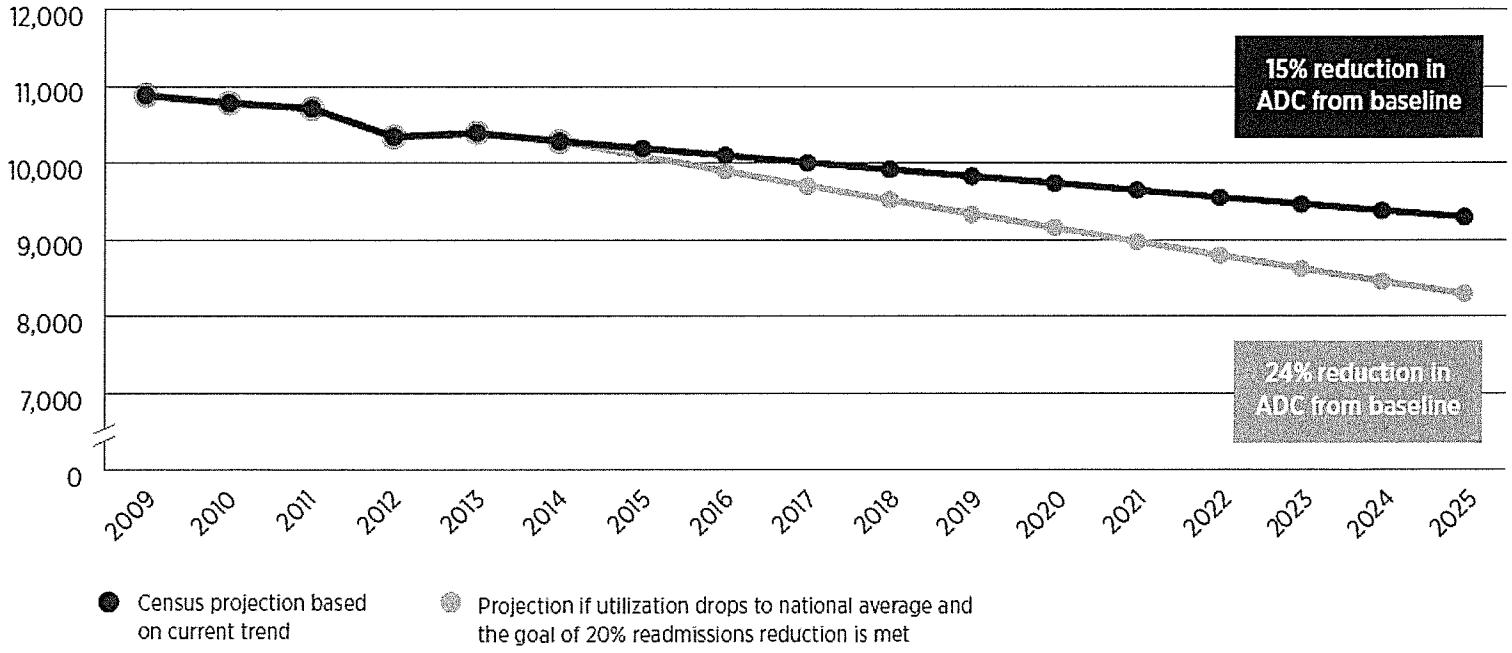
from 2012 - 2014

Source: HPC analysis of Department of Public Health data

Source: HPC analysis of 1Q-3Q 2013 discharge data and CHIA hospital-05 records.

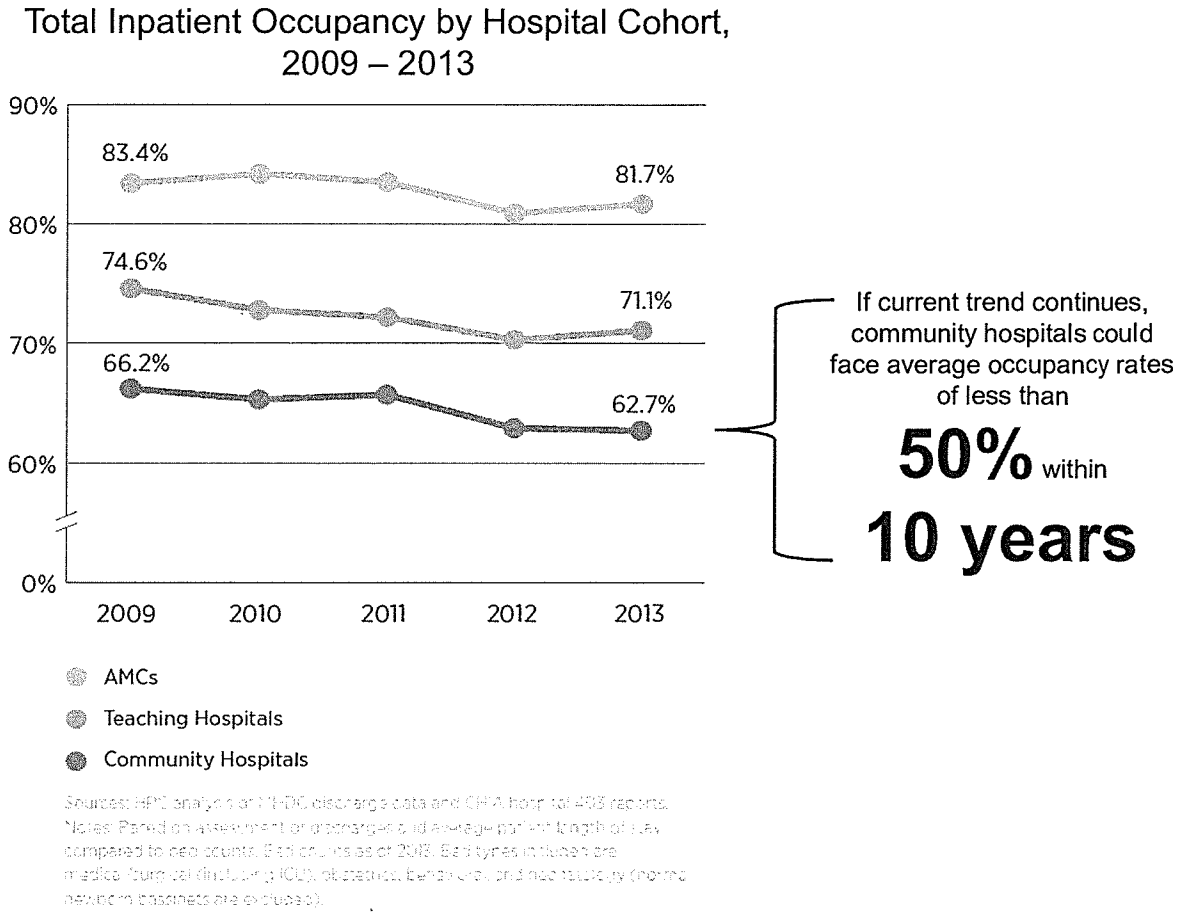
Declining inpatient utilization poses a structural challenge to the traditional community hospital model

Total Average Daily Census Projections for all Massachusetts Hospitals, 2009 - 2025



Sources: HPC analysis of MHDC claims data, CHIA hospital UCD records, CMS National Enrollment, and population data from the Executive Office of Massachusetts Census Data Center.
Notes: Projection based on current trend assumes a continuation of recent utilization trends in major service categories and does not take into account any efforts to implement alternative payment methods or delivery system reforms. Projection assumes a 20% reduction in 30-day readmission rates in line with national hospital initiatives and a 5% reduction in inpatient admissions and lengths of stay, a goal of recent legislative proposals.

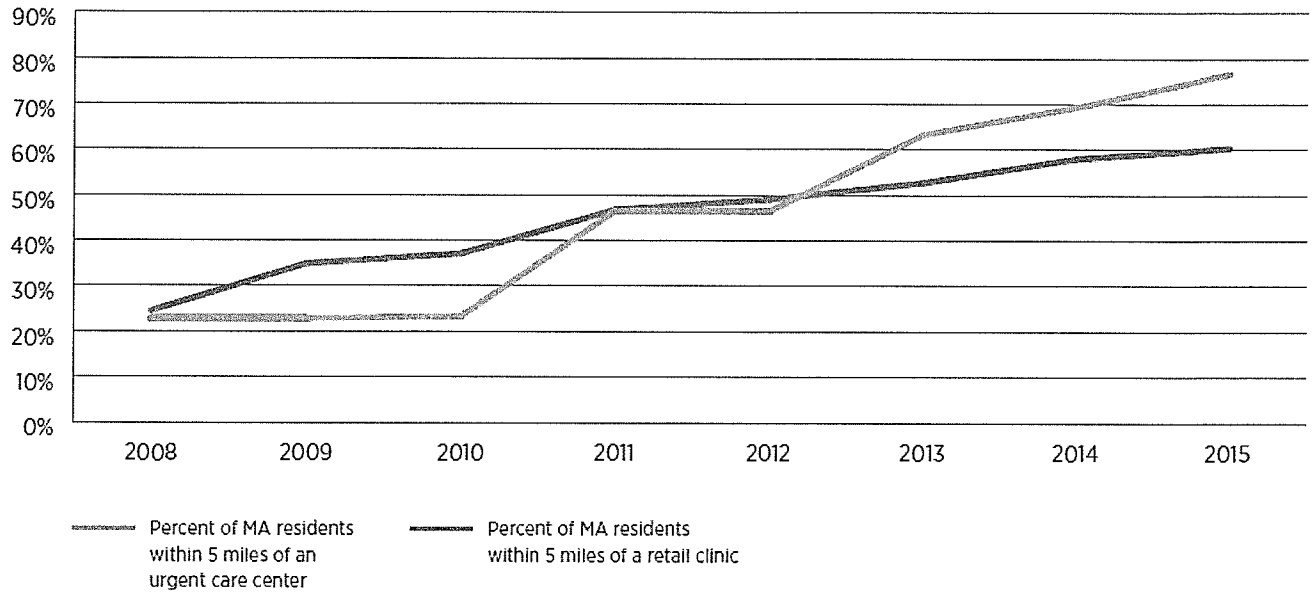
Community hospitals have lower average occupancy, and declining hospital utilization has further impacted occupancy rates



Sources: HPC analysis of CHIA discharge data and CHIA hospital 403 reports.
Notes: Based on assessment of prolonged, adjusted average patient length of stay compared to bed counts. End of June as of 2013. Bed types in cluded are medical, surgical (including ICU), obstetrical, behavioral, and pediatric (normal newborn bassinets are excluded).

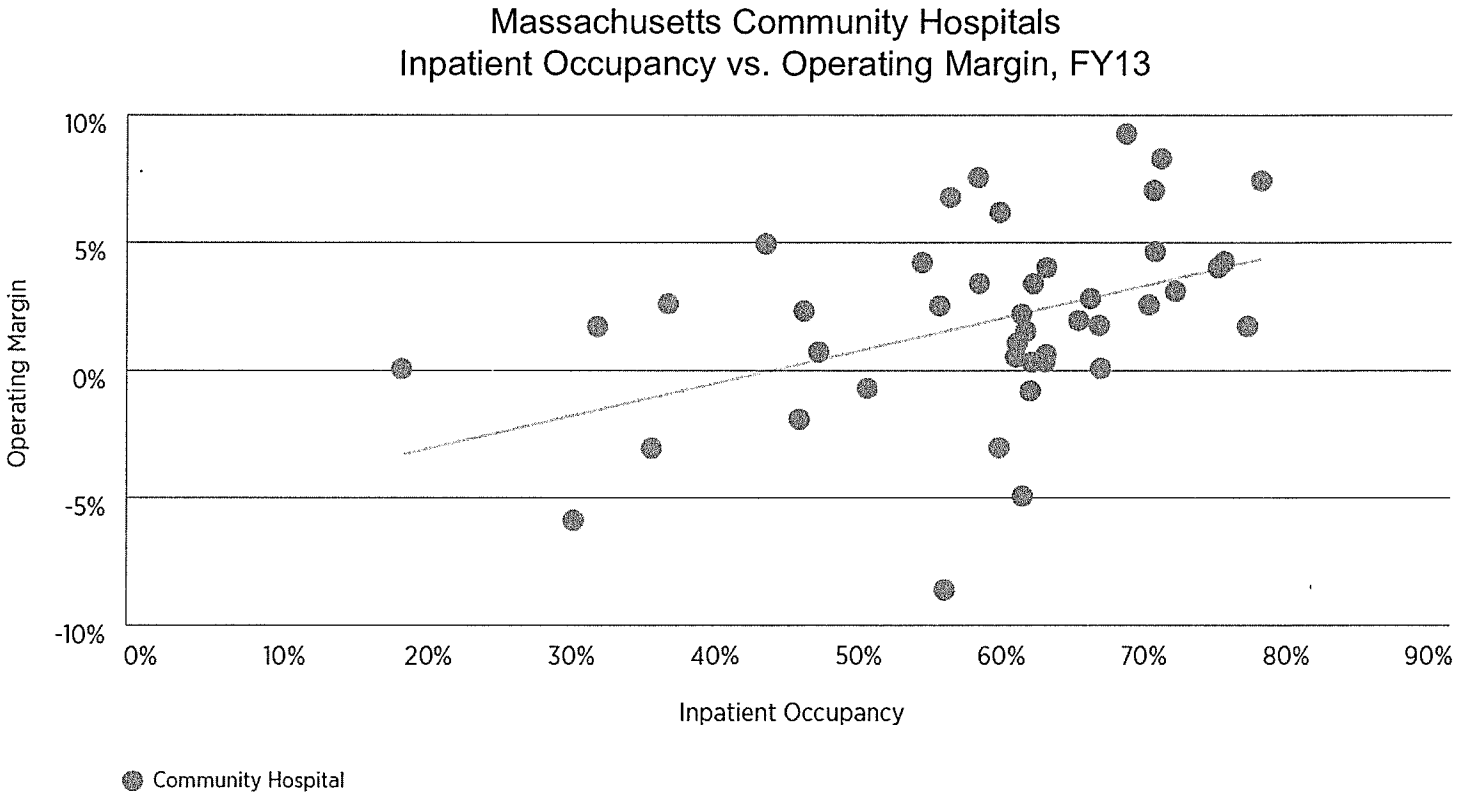
Declining inpatient utilization is driven in part by growing accessibility of non-hospital health care providers

Percent of MA Residents Living Within 5 Miles of Retail Clinics and Urgent Care Centers



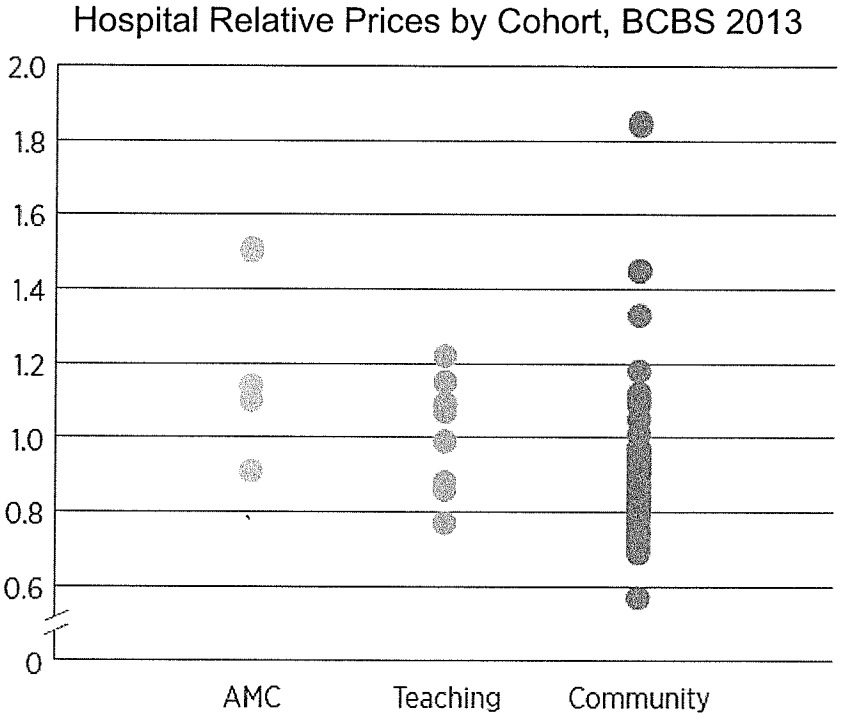
> *"When [they] opened an urgent care center down the block we saw an immediate and precipitous decline in ED volume, especially the commercially insured, non-acute patients. It might be good for costs in the short term, but if we cannot keep our ED open, then what's next?"*
>
> *COMMUNITY HOSPITAL CHIEF STRATEGY OFFICER*

Lower occupancy is associated with lower operating margins for community hospitals, and may threaten their financial stability



Sources: HPC analysis of CHIA Hosp. Profiles, 2013; MHDC 2013 discharge data; CHIA hospital 403 reports

Community hospitals tend to receive lower commercial relative prices than AMCs or teaching hospitals

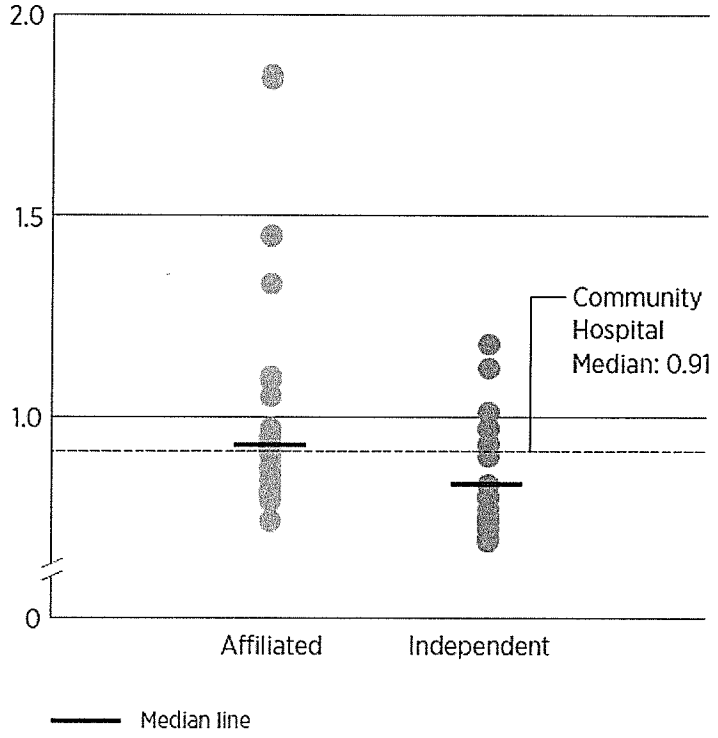


> *"The gap in prices, [which is] a reflection of the market power dynamics in the state, is probably the biggest threat to a lot of the community hospitals"*
>
> *MASSACHUSETTS HEALTH INSURANCE LEADER*

Sources: HPC analysis of Ctr. For Health Info & Analysis, Provider Price Variation in the Massachusetts Health Care Market (calendar year 2013 data), Databook (Feb. 2015), [hereinafter CHIA 2013 RP Databook] available at http://chiamass.gov/assets/Uploads/relative-price-databook-2013.xlsx

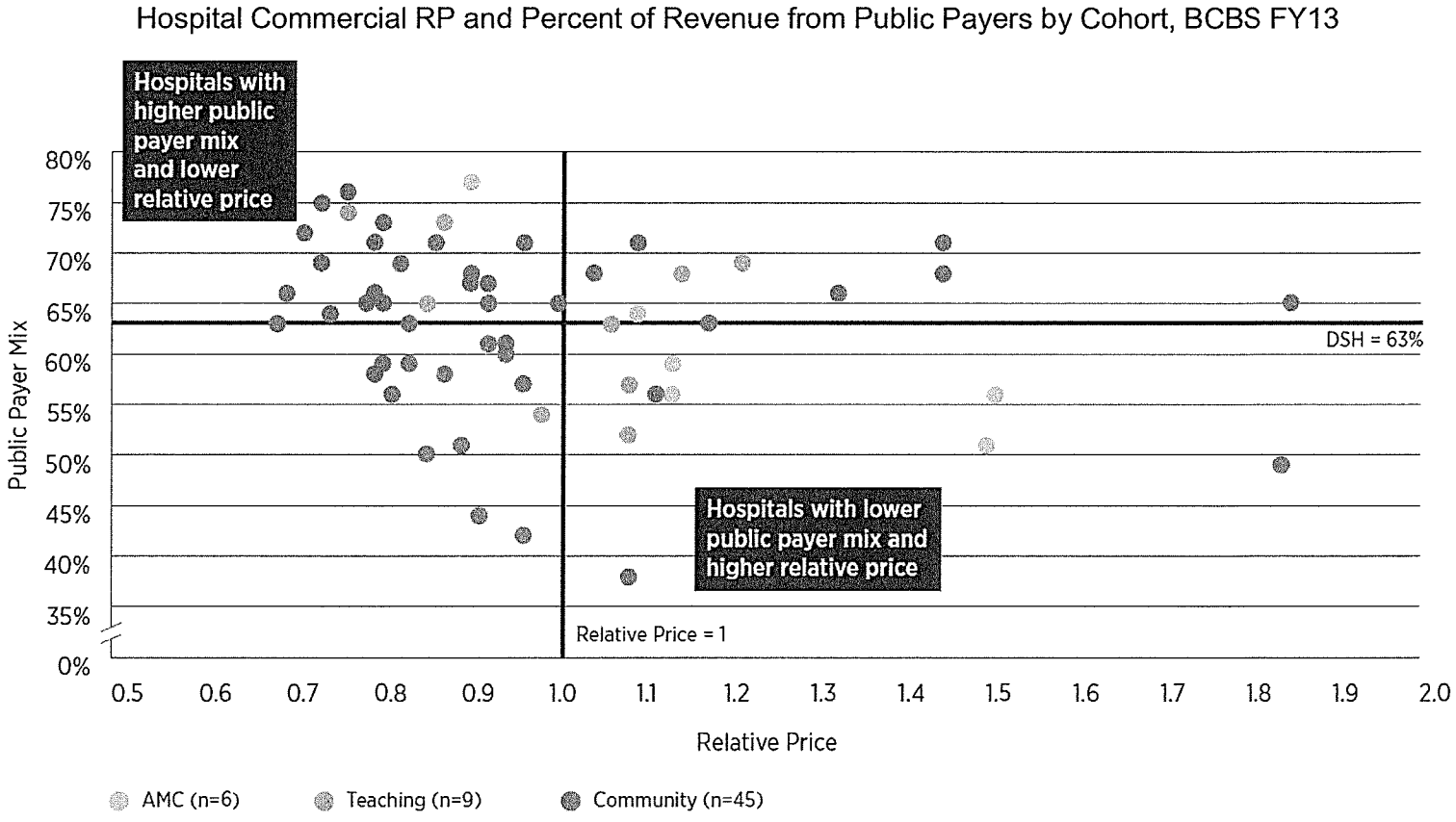
Community hospitals affiliated with systems tend to have higher relative prices

Community Hospital Relative Prices and Affiliation Status, BCBS FY13



Source: HPC analysis of CHIA 2013 RP Databook
Note: While this graph shows relative prices for only one major commercial payer, price and affiliation status are similarly correlated for the other two major commercial payers.

Hospitals with higher public payer mix tend to have lower relative prices, compounding financial stresses; cross-subsidization of higher public payer mix with higher commercial prices is not observed



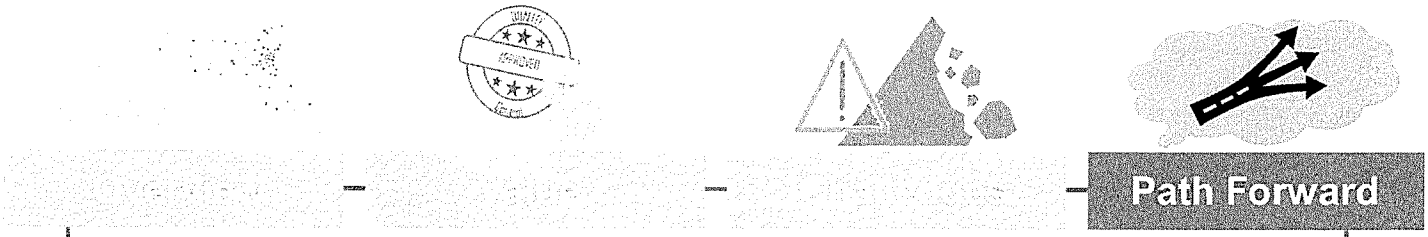
Source: HPC analysis of CHIA 2013 RP Databook and CHIA Hosp. Profiles, 2013

Market participants report facing additional barriers to transformation

To successfully meet challenges and adapt to a changing delivery and payment system, community hospitals must overcome barriers and utilize resources and capabilities that may not be readily available. Barriers reported to the HPC during stakeholder interviews include:

- Lack of **resources**, including financial resources and the ability to attract and retain new staff.
- Lack of needed **data and analytic support** to enable transformation efforts, including a lack of information about health needs and coordinated health planning.
- **Concern about change** by hospital governing bodies and community representatives.
- Challenges **aligning the interests of hospital labor and management** to more effectively pursue transformation efforts.
- Difficulty participating in **alternative payment models**, including challenges under current risk adjustment methodologies for hospitals serving patient populations with socioeconomic disadvantages.
- **Insufficient alignment** among programs designed to fund or assist transformation efforts.
- **Policy or regulatory frameworks** that limit deployment of new structures of care.

The path to a thriving community-based health care system



- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and policies should align to support them
- Call to develop an Action Plan in concert with market participants

Building a path to a thriving community-based health care system

Vision of Community-based Health

A health care system in which patients in Massachusetts are able to get most of their health care in a local, convenient, cost-effective, high-quality setting.

- **The traditional role and operational model for many community hospitals faces tremendous challenges:**
  - evolution in the health care delivery and payment system
  - persistent market dysfunction → resource inequities and overreliance on higher cost care settings
- **A re-envisioning of the role of community hospitals will require:**
  - development of a roadmap for care delivery transformation focused around the community
  - planning and investment for better alignment of providers with community needs
- **Multi-sector dialogue** is necessary to build consensus and identify a series of targeted actions to be taken by providers, payers, consumers, and government

Fostering dialogue and developing an Action Plan

Community Hospitals at a Crossroads:
A Conversation to Foster a Sustainable Community Health System

Developing a successful path to a thriving community-based health care system requires multi-stakeholder engagement and incorporation of many diverse viewpoints.

The report findings are designed to spur market-wide dialogue and support identification of priority actions to be taken by providers, payers, purchasers and government.

March 29, 2016 at 9:00AM at Suffolk University School of Law

The HPC Commissioners and staff will convene industry leaders and stakeholders to discuss findings from the report and its implications for transformation of the Commonwealth's community hospitals. Interested members of the public are invited to attend: register online at www.mass.gov/hpc

In collaboration with stakeholders, HPC will develop an Action Plan to address findings of the report. Action Plan recommendations will be oriented towards providers, payers, purchasers and policymakers

Key themes for further discussion, consensus-building, and action planning

Community Hospitals at a Crossroads: A Conversation to Foster a Sustainable Community Health System

Planning and support for community hospital transformation

Encouraging consumers to use high-value providers for their care

Creating a sustainable, accessible, and value-based payment system

> *"We need to **stop playing defense and start playing offense**. This [challenge of supporting community hospitals] is one of the most complex health policy issues we have, but we cannot keep just relying on short term fixes. These hospitals are the backbones of our communities — we owe it to our communities to come together to develop a plan for their future"*
>
> *MASSACHUSETTS STATE LEGISLATOR*

EXHIBIT 7

NON-PROFIT

Applicant: L+M Health System
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2016 Projected	(3) FY 2016 Projected	(4) FY 2016 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$1,070,627,000	$1,166,643,000	($15,527,000)	$1,151,116,000	$1,213,309,000	($24,164,000)	$1,189,145,000	$1,281,641,000	($9,784,000)	$1,252,057,000	$1,312,915,000	$3,739,000	$1,316,654,000
2	Less: Allowances	$616,857,000	$673,892,000	($6,486,000)	$667,346,000	$717,136,000	($8,305,000)	$708,831,000	$762,089,000	$105,000	$762,194,000	$811,976,000	$8,494,000	$820,472,000
3	Less: Charity Care	$9,783,000	$7,336,000	$38,000	$7,374,000	$7,630,000	$130,000	$7,760,000	$7,935,000	$232,000	$8,167,000	$8,252,000	$328,000	$8,580,000
4	Less: Other Deductions	$32,469,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000
	Net Patient Service Revenue	$463,529,000	$467,273,000	($3,079,000)	$466,194,000	$470,341,000	($16,989,000)	$454,352,000	$473,615,000	($10,121,000)	$463,494,000	$473,683,000	($5,063,000)	$468,800,000
5	Medicare	$161,244,000	$169,569,000	($2,854,000)	$166,705,000	$179,162,000	($4,894,000)	$165,268,000	$171,320,000	($2,848,000)	$168,472,000	$171,415,000	($1,094,000)	$170,321,000
6	Medicaid	$48,110,000	$50,591,000	($1,355,000)	$49,236,000	$50,771,000	($2,496,000)	$48,276,000	$51,119,000	($1,888,000)	$49,230,000	$51,144,000	($1,363,000)	$49,781,000
7	CHAMPUS & TriCare	$12,447,000	$13,089,000	($279,000)	$12,813,000	$13,139,000	($493,000)	$12,645,000	$13,225,000	($330,000)	$12,889,000	$13,232,000	($200,000)	$13,032,000
8	Other	($2,458,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)
	Total Government	$219,343,000	$216,037,000	($4,486,008)	$210,652,000	$216,867,000	($7,883,000)	$207,884,000	$217,459,000	($5,070,000)	$212,389,000	$217,589,000	($2,657,000)	$214,932,000
9	Commercial Insurers	$216,658,000	$226,760,000	($4,072,000)	$222,688,000	$227,567,000	($7,250,000)	$220,317,000	$229,115,900	($4,617,000)	$224,598,000	$229,242,000	($2,170,000)	$227,072,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$9,955,000	$10,489,000	$24,000	$10,403,000	$10,500,000	$100,000	$10,815,000	$10,577,000	$238,000	$10,813,000	$10,583,000	$344,000	$10,927,000
12	Workers Compensation	$8,692,000	$9,035,000	($124,000)	$8,911,000	$9,067,000	($203,000)	$8,864,000	$9,129,000	($94,000)	$9,035,000	$9,134,000	($1,000)	$9,133,000
13	Other	$0	$6,972,000	($422,000)	$6,550,000	$7,334,000	($761,000)	$6,573,000	$7,334,000	($675,000)	$6,659,000	$7,334,000	$1,232,000	$8,566,000
	Total Non-Government	$234,186,000	$252,256,000	($4,594,080)	$247,642,000	$254,474,008	($8,105,000)	$248,369,000	$256,166,000	($5,050,000)	$251,105,000	$256,293,000	($595,000)	$255,698,000
	Net Patient Service Revenue* (Government+Non-Government)	$453,529,000	$467,273,000	($3,079,000)	$466,194,000	$470,341,000	($16,988,000)	$454,353,000	$473,614,000	($10,120,000)	$463,494,080	$473,882,000	($3,252,000)	$470,630,000
14	Less: Provision for Bad Debts	$20,298,000	$17,177,000	($54,000)	$17,123,000	$17,240,000	($289,000)	$16,951,000	$17,359,000	($291,000)	$17,068,088	$17,369,000	($291,000)	$17,070,000
	Net Patient Service Revenue less provision for bad debts	$433,231,000	$450,096,000	($3,025,000)	$441,071,000	$453,101,000	($15,708,000)	$437,401,000	$456,255,000	($9,830,000)	$446,426,088	$456,514,000	($4,792,000)	$461,722,000
15	Other Operating Revenue	$20,795,000	$18,625,000	($4,822,000)	$14,093,000	$18,626,000	($0,243,000)	$9,382,000	$18,625,000	($9,243,000)	$9,382,000	$18,626,000	($9,243,000)	$9,382,000
17	Net Assets Released from Restrictions	$879,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	$454,902,000	$468,721,000	($13,647,000)	$455,074,000	$471,726,000	($24,343,000)	$446,783,000	$474,881,000	($19,073,000)	$455,808,000	$475,138,000	($14,035,000)	$461,104,000
B.	OPERATING EXPENSES													
1	Salaries and Wages	$213,468,000	$221,743,000	($18,504,000)	$206,239,000	$218,732,000	($32,626,000)	$186,106,000	$220,784,000	($33,139,000)	$187,626,000	$223,224,000	($32,879,000)	$190,345,000
2	Fringe Benefits	$59,168,000	$61,336,000	($2,486,000)	$58,850,000	$59,382,000	($4,888,000)	$54,494,000	$59,611,000	($4,866,000)	$54,745,000	$59,980,000	($4,677,000)	$55,303,000
3	Physicians Fees	$54,479,000	$36,263,000	$11,193,000	$47,466,000	$26,552,000	$18,383,000	$45,916,000	$29,231,000	$17,197,000	$46,428,000	$29,015,000	$18,070,000	$47,085,000
4	Supplies and Drugs	$71,950,000	$77,726,000	($1,406,000)	$76,320,000	$78,133,000	($2,333,000)	$75,800,000	$79,256,000	($1,760,000)	$77,496,000	$80,383,000	($1,273,000)	$79,110,000
5	Depreciation and Amortization	$27,479,000	$29,416,000	$41,000	$29,456,000	$30,071,000	$67,000	$30,138,000	$30,346,000	$55,000	$30,413,000	$31,453,000	$55,000	$31,508,000
6	Provision for Bad Debts-Other*	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,556,000	$3,358,000	$0	$3,358,000	$3,188,000	$0	$3,188,000	$2,974,000	$0	$2,974,000	$2,749,000	$0	$2,749,000
8	Malpractice Insurance Cost	$14,513,000	$16,833,000	($1,285,000)	$15,647,000	$16,833,000	($2,571,000)	$14,262,000	$16,833,000	($2,571,000)	$14,262,000	$16,833,000	($2,571,000)	$14,262,000
9	Lease Expense	$6,070,000	$7,954,000	($1,058,000)	$6,896,000	$7,994,000	($2,139,000)	$5,825,000	$7,964,000	($2,138,000)	$5,826,000	$7,964,000	($2,138,000)	$5,826,000
10	Other Operating Expenses	$21,044,000	$23,767,000	($2,057,000)	$21,710,000	$20,618,000	($4,115,000)	$16,503,000	$21,103,000	($4,128,000)	$16,975,000	$21,579,000	($4,137,000)	$17,439,000
	TOTAL OPERATING EXPENSES	$475,588,008	$477,417,000	($13,575,000)	$463,842,000	$464,433,000	($32,219,000)	$432,214,000	$468,046,000	($31,338,000)	$439,748,000	$473,777,000	($28,649,000)	$444,223,000
	INCOME/(LOSS) FROM OPERATIONS	($18,686,000)	($8,696,000)	($72,000)	($9,768,000)	$7,293,008	$7,276,000	$14,569,080	$6,795,000	$12,266,000	$19,060,000	$1,362,000	$15,513,000	$16,875,000
	NON-OPERATING REVENUE	$15,297,000	$8,859,000	$0	$8,859,000	$8,859,000	$0	$8,859,000	$8,859,000	$0	$8,858,000	$8,859,000	$0	$8,859,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	($3,389,000)	$163,000	($72,000)	$91,000	$16,152,000	$7,276,008	$23,428,000	$15,654,000	$12,265,000	$27,919,000	$10,221,000	$15,513,000	$25,734,000
	Principal Payments	$5,153,000	$5,511,000	$0	$5,511,000	$5,726,000	$0	$5,726,008	$5,911,000	$0	$5,911,000	$8,137,000	$0	$8,137,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	-4.1%	-1.9%	0.5%	-1.9%	1.5%	-29.2%	3.3%	1.4%	-64.3%	4.2%	0.3%	-110.5%	3.7%
2	Hospital Non Operating Margin	3.4%	1.9%	0.0%	1.9%	1.9%	0.0%	2.0%	1.9%	0.0%	1.9%	1.9%	0.0%	1.9%
3	Hospital Total Margin	-0.7%	0.0%	0.5%	0.0%	3.4%	-29.2%	5.2%	3.3%	-64.3%	6.1%	2.2%	-110.5%	5.5%
D.	FTEs	2,649	2,821	(181)	2,641	2,711	(325)	2,386	2,701	(323)	2,378	2,691	(313)	2,378
	FTEs associated with the integration of NEMG and LMPA are excluded in the incremental column. Please refer to the Medical Group CON to reference the corresponding additional FTEs													
E.	VOLUME STATISTICS*													
1	Inpatient Discharges	17,286	17,243	211	17,454	17,081	393	17,474	16,900	574	17,474	16,783	755	17,538
2	Outpatient Visits	585,965	618,543	4,554	623,097	620,364	11,080	632,244	621,813	16,830	637,643	621,913	16,556	640,471
	TOTAL VOLUME	603,263	635,786	4,765	640,551	637,445	12,273	649,718	638,813	16,204	655,117	638,695	18,313	657,979

*Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Applicant: L+M Hospital
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual	(2) FY 2015 Projected	(3) FY 2015 Projected	(4) FY 2015 Projected	(5) FY 2017 Projected	(6) FY 2017 Projected	(7) FY 2017 Projected	(8) FY 2018 Projected	(9) FY 2018 Projected	(10) FY 2018 Projected	(11) FY 2019 Projected	(12) FY 2019 Projected	(13) FY 2019 Projected
	Description	Results	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON	W/out CON	Incremental	With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$795,287,000	$860,193,000	$14,084,000	$874,277,000	$894,590,000	$37,460,000	$932,050,000	$930,374,000	$53,320,000	$983,694,000	$967,589,000	$58,908,000	$1,026,497,000
2	Less: Allowances	$456,251,000	$487,244,000	$8,282,000	$495,526,000	$521,292,000	$22,590,000	$543,882,000	$553,773,000	$32,780,000	$586,553,000	$590,538,000	$43,352,000	$633,891,000
3	Less: Charity Care	$5,449,000	$5,894,000	$97,000	$5,991,000	$6,375,000	$267,000	$6,642,000	$6,895,000	$395,000	$7,290,000	$7,457,000	$531,000	$7,988,000
4	Less: Other Deductions	$2,468,000	$16,202,000	$0	$16,202,000	$16,202,000	$0	$16,202,000	$16,202,000	$0	$16,202,000	$16,202,000	$0	$16,202,000
	Net Patient Service Revenue	$337,129,000	$348,843,008	$5,716,008	$354,568,008	$348,721,000	$14,683,000	$363,324,000	$351,504,000	$20,145,000	$371,649,000	$351,391,008	$25,025,000	$376,416,000
5	Medicare	$118,154,000	$123,561,000	$1,924,000	$125,505,000	$123,639,000	$4,816,000	$128,455,000	$124,491,000	$6,783,000	$131,274,000	$124,452,000	$8,426,000	$132,878,000
6	Medicaid	$36,748,000	$39,097,000	$609,000	$39,706,000	$39,064,000	$1,555,000	$40,639,000	$39,385,000	$2,146,000	$41,531,000	$39,373,000	$2,666,000	$42,039,000
7	CHAMPUS & TriCare	$10,981,000	$11,683,000	$182,000	$11,865,000	$11,679,000	$465,000	$12,144,000	$11,769,000	$641,000	$12,410,000	$11,786,000	$797,000	$12,583,000
8	Other*	($2,458,000)	($16,202,000)	$0	($16,202,000)	($16,202,000)	$0	($16,202,000)	($16,202,000)	$0	($16,202,000)	($16,202,000)	$0	($16,202,000)
	Total Government	$161,425,000	$158,159,800	$2,715,800	$160,874,000	$166,100,000	$6,036,008	$163,036,008	$167,443,000	$9,578,088	$167,013,800	$167,389,008	$11,689,088	$169,278,000
9	Commercial Insurers	$163,214,000	$173,849,000	$2,704,000	$176,353,000	$173,591,000	$8,908,000	$180,499,000	$174,928,000	$9,531,000	$184,459,000	$174,873,000	$11,839,000	$185,712,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,132,000	$5,460,000	$85,000	$5,545,000	$5,458,000	$217,000	$5,675,000	$5,500,000	$300,000	$5,800,000	$5,498,000	$372,000	$5,870,000
12	Workers Compensation	$7,358,000	$7,829,000	$122,000	$7,951,000	$7,826,000	$311,000	$8,137,000	$7,886,000	$430,000	$8,316,000	$7,884,000	$534,000	$8,418,000
13	Other	$0	$5,746,000	$89,000	$5,835,000	$5,746,000	$229,000	$5,975,000	$5,748,000	$315,000	$6,061,000	$5,748,000	$392,000	$6,139,000
	Total Non-Government	$176,704,800	$192,884,088	$3,000,008	$195,684,000	$192,621,000	$7,665,000	$200,286,800	$194,068,800	$10,576,000	$204,636,800	$194,001,000	$13,137,800	$207,139,000
	Net Patient Service Revenue* (Government+Non-Government)	$337,129,000	$348,843,008	$5,716,008	$354,568,008	$348,721,000	$14,601,000	$363,322,000	$361,503,008	$20,146,880	$371,649,008	$351,390,008	$26,826,000	$376,416,000
14	Less: Provision for Bad Debts	$14,830,000	$13,603,000	$210,000	$14,813,000	$13,798,000	$537,000	$14,336,000	$13,909,000	$741,000	$14,650,000	$13,904,000	$921,000	$14,826,000
	Net Patient Service Revenue less provision for bad debts	$322,199,000	$335,840,800	$5,505,088	$340,545,000	$334,923,000	$14,066,000	$348,988,000	$337,595,000	$19,404,008	$356,999,008	$337,487,800	$24,104,000	$361,591,008
15	Other Operating Revenue	$28,161,000	$31,186,000	$0	$31,186,000	$31,188,000	$0	$31,188,000	$31,186,000	$0	$31,186,000	$31,186,000	$0	$31,186,880
17	Net Assets Released from Restrictions	$672,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	$351,022,000	$368,226,000	$5,505,008	$371,731,000	$366,109,000	$14,066,000	$380,176,000	$368,781,800	$19,404,000	$388,185,008	$368,673,008	$24,104,008	$392,777,000
B.	OPERATING EXPENSES													
1	Salaries and Wages	$143,838,000	$143,577,000	$804,000	$144,181,000	$140,019,000	$761,000	$140,780,000	$141,973,000	$755,000	$142,728,000	$143,983,000	$1,270,000	$145,253,000
2	Fringe Benefits	$51,045,000	$54,026,000	$848,000	$54,874,000	$52,457,000	$1,229,000	$53,686,000	$52,771,000	$1,255,000	$54,026,000	$53,088,000	$1,408,000	$54,496,000
3	Physicians Fees	$38,649,000	$30,254,000	$2,845,000	$33,099,000	$22,993,000	$4,678,000	$27,671,000	$22,533,000	$4,789,000	$27,322,000	$22,849,000	$4,922,000	$27,771,000
4	Supplies and Drugs	$59,638,000	$64,299,000	$55,000	$64,344,000	$64,810,000	$346,000	$64,956,000	$65,541,000	$652,000	$66,193,000	$66,471,000	$918,000	$67,389,000
5	Depreciation and Amortization	$22,728,000	$26,054,000	$77,000	$26,131,000	$27,572,000	$154,000	$27,726,000	$27,826,000	$154,000	$27,980,000	$28,840,000	$154,000	$28,994,000
6	Provision for Bad Debts-Other*	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,643,000	$3,368,000	$0	$3,368,000	$3,168,000	$0	$3,168,000	$2,974,000	$0	$2,974,000	$2,749,000	$0	$2,749,000
8	Malpractice Insurance Cost	$4,539,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000
9	Lease Expense	$4,619,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000
10	Other Operating Expenses	$25,333,000	$30,491,000	$0	$30,491,000	$30,491,000	$0	$30,491,000	$30,795,000	$0	$30,795,000	$28,256,000	$0	$28,256,000
	TOTAL OPERATING EXPENSES	$353,832,000	$361,724,808	$4,429,000	$366,163,000	$368,975,000	$7,168,808	$376,143,000	$364,076,000	$7,605,000	$361,683,000	$359,901,000	$8,672,000	$385,573,000
	INCOME/(LOSS) FROM OPERATIONS	($2,810,000)	$4,502,000	$1,076,000	$5,578,000	$15,134,000	$6,898,008	$22,032,000	$14,703,000	$11,799,000	$26,502,000	$11,772,000	$16,432,000	$27,204,000
	NON-OPERATING REVENUE	$8,789,000	$8,263,000	$0	$8,263,000	$8,263,000	$0	$8,263,000	$8,263,000	$0	$8,263,000	$8,263,000	$0	$8,263,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$5,979,000	$12,765,800	$1,078,000	$13,841,000	$23,397,000	$6,898,800	$30,295,000	$22,966,000	$11,799,808	$34,765,000	$20,036,000	$15,432,000	$35,467,000
	Principal Payments	$5,153,000	$5,511,000	$0	$5,511,000	$5,726,000	$0	$5,726,000	$5,911,000	$0	$5,911,000	$6,137,000	$0	$6,137,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	-0.8%	1.2%	19.5%	1.5%	4.1%	49.0%	5.8%	4.8%	60.8%	6.8%	3.2%	64.8%	6.9%
2	Hospital Non Operating Margin	2.5%	2.3%	0.0%	2.2%	2.3%	8.0%	2.2%	2.2%	0.0%	2.1%	2.2%	0.0%	2.1%
3	Hospital Total Margin	1.7%	3.5%	19.6%	3.7%	6.4%	49.0%	8.0%	6.2%	60.8%	9.0%	5.4%	64.0%	9.0%
D.	FTEs	1,849	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	VOLUME STATISTICS[c]													
1	Inpatient Discharges	14,151	14,212	179	14,391	14,883	329	14,412	13,940	478	14,418	13,823	627	14,450
2	Outpatient Visits	458,110	455,077	3,462	458,539	466,677	10,936	466,607	465,077	14,489	468,566	455,077	17,407	472,484
	TOTAL VOLUME	472,261	469,289	3,641	472,930	480,180	11,259	480,419	469,017	14,967	483,984	468,900	18,035	486,935

*Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Lawrence + Memorial Health System Affliation with Yale New Haven Health System Assumptions

Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2) Non-Government	0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3) Inpatient Volume	1.1%	0.1%	0.0%	0.2%
4) Outpatient Volume	1.0%	1.5%	0.8%	0.5%

		FY 2016	FY 2017	FY 2018	FY 2019
	EXPENSES				
A.	Salaries and Fringe Benefits	1.5%	1.5%	1.5%	1.5%
B.	Non-Salary				
1)	Supplies and Drugs	2.0%	1.5%	1.5%	1.5%
2)	Professional and Contracted Services	2.0%	1.5%	1.5%	1.5%
3)	Malpractice Insurance and Lease Expense	0.0%	0.0%	0.0%	0.0%
4)	All Other Expenses	1.0%	1.0%	1.0%	1.0%
5)	All Other Expenses				

	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	2,641	2,386	2,378	2,378

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

YALE-NEW HAVEN System
Lawrence + Memorial Affiliation
Assumptions

Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	1.0%	1.0%	1.0%	1.0%
2) Non-Government	1.0%	1.0%	1.0%	1.0%
3) Inpatient Volume	1.0%	1.0%	1.0%	1.0%
4) Outpatient Volume	1.0%	1.0%	1.0%	1.0%

	FY 2016	FY 2017	FY 2018	FY 2019
EXPENSES				
A. **Salaries and Fringe Benefits**	3.0%	3.0%	3.0%	3.0%
B. **Non-Salary**				
1) Supplies and Drugs	3.0%	3.0%	3.0%	3.0%
2) Professional and Contracted Services	3.0%	3.0%	3.0%	3.0%
3) Malpractice Insurance and Lease Expense	3.0%	3.0%	3.0%	3.0%
4) All Other Expenses	3.0%	3.0%	3.0%	3.0%

	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	14,391	14,412	14,418	14,450

EXHIBIT 8

EXHIBIT 9

William W. Backus Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Former President & CEO			$3,357,690	$738,636	$666,118	$925,503	$645,419		
Regional President		$858,680							
President & CEO			$975,550	$664,781	$573,317	$410,672		$627,001	$596,473
Regional VP, Finance		$598,856							
Medical Affairs Regional VP	$410,993	$577,237							
Medical Director, Medicare Care Admin	$552,137								
BPS Physician	$622,339	$558,100		$523,896	$497,357				
Hospitalist Physician	$489,374								
Sr. Vice President & CFO			$659,230	$488,297	$438,868	$494,684	$407,839	$404,988	$382,897
Chief of Emergency Medicine		$495,605							$357,592
Clinical Services Sr. VP & CMO			$587,917						
ER Physician	$424,203	$414,709				$437,095	$415,402	$406,279	$345,324
Medical Director				$479,197	$458,448	$407,519	$380,678	$366,158	
ER Physician	$418,265	$414,453		$469,984	$471,117	$404,362	$379,087	$347,302	$330,183
Vice President & COD						$391,942	$360,153	$345,700	$317,502
BPS Physician		$551,117	$548,961	$400,639	$397,513				
BPS Physician			$504,965	$384,636	$377,448				
ER Physician	$416,812								
ER Physician	$409,255	$405,635	$481,414	$380,816	$382,452	$369,115	$346,575	$339,930	$328,021
ER Physician	$391,415	$396,123	$421,693	$372,326	$380,316	$362,716	$344,000	$336,916	$326,419
ER Physician			$411,993			$358,594	$343,575	$332,063	$322,176
ER Physician			$403,912				$342,098	$326,881	$320,727
Rhuematology Physician	$407,038								
Total	**$4,541,831**	**$5,270,515**	**$8,353,325**	**$4,903,208**	**$4,642,954**	**$4,562,202**	**$3,964,826**	**$3,833,218**	**$3,627,314**

Bridgeport Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$1,447,989	$1,222,022	$1,101,139	$764,779	$1,352,509	$1,702,615	$2,543,047	$1,021,040	$932,810
Chief Financial Officer									$510,450
Physician Chief								$1,222,471	
Sr. VP of Administration	$955,867	$929,905	$885,638						
Senior VP of Finance & CFO	$941,809	$796,077	$741,380	$668,999	$687,985	$646,716	$572,020	$572,249	
VP of Finance	$778,986								
Medical Director			$632,905	$570,304	$571,351	$748,468			
Physician General Surgery								$561,283	
Sr. VP Medical Affairs	$582,014	$516,861					$640,909	$646,930	
Senior VP of Human Resources				$468,241	$494,194	$464,453	$449,781	$445,356	$425,297
Surgeon in Chief & Chairman of Surgery Dept								$518,721	
Senior VP & CDO				$458,001	$529,615	$514,318	$475,065	$477,510	$416,311
Chief, ER Physician									$353,048
Chief, Section of Cardiology								$504,253	
Chief, Maternal Fetal Medicine								$488,249	
VP				$452,611					
Senior VP, Planning & Marketing	$522,220	$487,114	$460,560		$465,508				$328,370
ER Physician	$481,515	$457,886	$455,310		$409,341	$414,117	$386,542		$327,312
ER Physician	$466,707	$433,118		$402,984	$404,703	$375,929	$353,626		$315,697
VP of Performance Management	$436,837								
Sr. VP of Quality Control and Risk Management			$412,762	$397,219	$396,540	$355,398	$331,960		
ER Physician	$393,898	$403,033	$397,495	$391,752	$366,594	$354,567	$337,643		$308,417
ER Physician		$399,524	$393,302	$365,621		$351,726	$334,460		$307,444
ER Physician		$381,032	$392,410						
Total	**$7,007,842**	**$6,026,572**	**$5,872,901**	**$4,940,511**	**$5,678,340**	**$5,928,307**	**$6,425,053**	**$6,458,062**	**$4,225,156**

Bristol Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$756,841	$659,742	$605,526	$495,299	$441,821	$368,985	$358,071	$301,300	$145,757
Interim CEO/CFO									$250,043
Chief Operating Officer									$236,857
Senior Vice President, Chief Medical Officer	$395,340	$375,135	$368,261	$392,474	$353,187	$307,376			
Vice President of Admin Services								$202,603	
Oncology Physician						$327,712	$280,817		
Senior Vice President, Patient Care Services & CNO	$318,668	$308,975	$304,551	$237,201		$212,105			
Senior Vice President/CFO		$328,273	$268,516		$331,856	$287,078		$134,945	
Vice President/CFO	$348,020					$200,460	$186,930		
Vice President, Human Resources and Support Services	$221,100	$207,363	$204,326						
Clinic Physician						$197,383	$202,405	$199,016	
Vice President of Operations					$227,176	$195,850			
Occupational Health Physician	$179,366	$177,125	$176,987			$157,692	$213,798	$216,973	$186,222
Assistant Vice President, Information Services	$215,018	$210,272	$198,613	$197,149	$180,780				
Assistant Vice President/In House Counsel								$166,354	$146,325
Vice President of Patient Care Services				$195,892			$196,267		$143,244
Assistant Vice President, Human Resources & Support				$181,069	$146,022	$142,091			
Director of Physician Recruitment									$140,180
Controller			$168,117	$174,159					
Director of Revenue Cycle		$157,556							
Staff Psychiatrist				$168,640	$206,727		$189,381	$200,513	
Psych Physician								$143,448	$194,500
Psych Physician									$140,095
Assistant Vice President, Chief Development Officer	$193,117	$186,781	$169,549	$168,198	$149,114				
Director, Clinical Operations	$168,848		$165,578	$168,106					
Director, Diagnostic Imaging	$167,114								
Biomedical Technician							$149,554		
Director of Perioperative Services							$148,407		
Manager of Applications & Programming		$156,752			$145,775		$147,965	$139,438	
Psychologist								$138,061	$135,572
Clinical Staff Pharmacist					$143,422				
Total	**$2,963,432**	**$2,767,974**	$2,630,024	**$2,378,187**	**$2,325,880**	**$2,396,732**	**$2,073,595**	**$1,842,651**	**$1,718,795**

Hospital of Central Connecticut

Position Title	2014	2013	2012	2011	2010	2009	2008	2007
President & CEO	$2,325,846	$999,354	$1,499,546	$2,764,505	$609,893	$2,851,220	$1,110,502	$852,338
Physician, Private Practice								$625,058
Executive Vice President and CMO		$849,179	$776,392	$736,855	$603,486			
Senior VP of Medical Affairs						$652,298	$498,636	
Chief of Pediatrics						$563,571	$401,551	$360,656
Hospitalist	$763,388			$568,564				$395,449
Chief Emergency Room Physician	$728,973	$663,474	$550,999	$497,610	$499,051	$475,774	$400,568	$379,873
Chief Operating Officer						$454,785	$473,762	$445,037
Chief of Medicine	$664,689	$555,465	$500,547	$480,323	$474,233	$411,214		$374,604
Neurosurgeon		$542,218						
Director of Cardiology	$476,866	$463,175			$459,292	$382,490	$377,094	$360,863
Director Hospitalist Medicine	$438,866							
Hospitalist		$598,728	$491,528		$450,815	$415,460	$439,224	
Director Surgical Oncology	$712,251	$645,121	$487,581					
Chief of Psychiatry		$498,562	$484,686		$440,082		$360,201	
Medical Director of Quality					$420,419			
Vice President Human Resources		$644,445		$461,731				
Vice President Patient Services				$455,425				
Vice President Finance			$598,466	$458,671				
VP Analytics & Decision Report	$604,754							
Oncologic Surgeon				$439,374	$376,249			
Chief Financial Officer					$309,038	$547,595	$604,747	$479,362
Medical Director BMH ED	$461,593		$447,047			$364,789	$356,421	$337,862
Medical Director NBG ED	$474,401		$438,419	$418,618				
Total	**$7,651,627**	**$6,459,721**	**$6,275,211**	**$7,281,676**	**$4,642,558**	**$7,119,196**	**$5,022,706**	**$4,611,102**

Charlotte Hungerford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician Surgeon	$784,306	$748,423	$661,640	$619,607	$378,765				
Pathologist Medical Director	$498,959	$511,240	$520,852	$530,760	$536,040	$499,855	$473,687	$455,147	$249,074
CEO President	$625,107	$522,445	$503,491	$504,603	$540,443	$476,023	$456,011	$413,138	$358,641
Physician Surgeon	$745,495	$659,650	$581,148	$473,947					
Cardiologist	$459,094	$443,487	$515,457						
VP Medical Affairs	$409,022		$400,445	$368,032	$427,464	$447,908	$363,622	$340,417	$309,144
Physician Surgeon	$592,094	$640,888	$498,646	$365,008					
Cardiologist	$450,788	$430,722	$483,052						
Cardiologist	$433,352	$430,225	$441,292						
Cardiologist		$422,353	$435,124						
Psychiatrist Medical Director				$349,331	$372,589	$356,994	$312,884	$293,876	$278,137
CFO					$330,796	$375,568	$288,650	$300,901	$251,468
Orthopedic Surgeon	$724,504			$343,470	$285,223				
Physician Hospitalist				$289,357	$312,841	$303,332	$213,128		
VP Administration						$292,016	$220,139	$240,948	$195,225
Physician Surgeon				$279,548	$308,569				
Pathologist						$254,361	$243,633	$233,915	
VP Human Resources						$252,639			
Physician Hospitalist						$249,054			
Walk in Physician									$211,324
Physician Walk In Med Director							$217,483	$218,017	
Psychiatrist							$212,833	$215,421	$208,815
Psychiatrist									$204,676
VP Patient Care									$201,576
Medical Physicist								$181,556	
Hospitalist Med Director		$546,781			$288,930				
Total	**$5,722,721**	**$5,356,214**	**$5,041,147**	**$4,123,663**	**$3,781,660**	**$3,507,750**	**$3,002,070**	**$2,893,336**	$2,468,080

CT Children's Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician in Chief		$460,190	$512,905	$468,345	$468,999	$388,964	$513,586	$366,915	$380,057
Former President & CEO									$735,259
Executive VP & CFO		$426,289	$478,476	$429,575	$443,284	$352,157			
Senior VP & CFO							$485,969	$354,737	$388,977
EVP & COO	$444,836	$420,424	$468,676						
Chief Operating Officer				$336,211	$375,179	$339,764	$399,608	$282,887	
President & CEO	$618,181	$516,728	$748,347	$315,696	$480,870	$336,532	$490,926	$368,969	
Senior VP and General Counsel	$413,375	$367,734	$391,769	$299,663					
General Council					$338,238	$250,232	$308,223	$251,259	$264,825
VP Clinical Services & Chief RN Officer		$286,793	$250,382		$285,981	$237,795	$292,464	$239,987	$251,280
Senior VP Quality Improvement & Patient Safety	$548,936	$469,599	$253,456	$277,035	$391,164	$264,622			
Executive VP Community & Child Health	$506,930								
VP Quality Improvement & Patient Safety							$248,438	$231,484	$189,791
Interim CFO	$315,779								
CIO	$299,080	$292,330	$300,302	$266,623					
President, Specialty Group			$267,602						
Chief Medical Information Officer	$335,252	$293,608							
VP Human Resources	$292,022			$229,430	$262,535	$211,180	$266,708	$233,645	
Director, Human Resources									$175,107
Director of IT					$210,421	$185,045			
VP Marketing & Business Development	$334,482	$323,482							
VP Strategy & Regional Development					$191,027		$402,005	$326,282	$323,556
Staff Nurse - Operating Room						$167,452			$213,405
Staff Nurse - Emergency Department								$197,469	$169,796
Mid-Level Practitioner NICU							$204,601		
Professional Practice RN IV				$221,543					
Director, Perioperative Services			$235,505	$173,491					
Total	**$4,108,873**	**$3,857,177**	**$3,907,420**	**$3,017,612**	**$3,447,698**	**$2,733,743**	**$3,612,528**	**$2,853,634**	**$3,092,053**

Danbury Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$1,173,053	$1,056,889	$955,838	$1,075,078	$1,867,610	$6,445,204	$1,010,458	$957,098	$734,223
Executive VP/CEO					$862,137	$475,935			
VP Human Resources	$820,052	$948,869	$836,281	$872,756	$838,535	$726,912	$2,050,637	$470,470	$400,817
Chief Information Officer	$412,631	$377,700		$570,359	$362,411	$312,899	$318,742		$355,439
Chief Financial Officer	$672,565	$616,267	$614,912	$562,520	$555,894	$309,028	$4,650,958	$839,689	$496,428
Chief Operating Officer	$475,605	$428,450	$456,821	$399,887			$550,628	$513,664	$452,822
Executive VP, Medical Education									$413,029
Medical Director Southbury Geriatric								$331,878	
VP IT								$323,281	
VP Planning	$338,621	$307,327							$387,954
Chief Nursing Officer	$389,086	$363,505	$366,115	$368,420	$439,491	$373,122	$347,111		
VP Marketing				$327,799	$384,914	$343,416		$300,910	
Medical Director Community Health Center					$362,936	$362,935	$333,882	$278,085	
Senior VP Operations					$349,398	$309,492			$333,766
Cardiac Perfusionist								$272,516	$256,225
VP Operations							$279,730		
General Counsel	$410,471	$385,527	$318,627						
VP Compliance							$273,892		
Executive Medical Director			$324,499	$319,748					
Director Education and Research	$380,708	$368,511	$317,847	$316,265					
VP Facilities	$322,491	$311,890	$288,360	$314,273	$326,248	$318,800	$308,571	$311,928	$316,438
Chief Compliance Officer			$269,435						
Total	**$5,395,283**	**$5,164,935**	**$4,748,735**	**$5,127,105**	**$6,349,574**	**$9,977,743**	**$10,124,609**	**$4,599,519**	**$4,147,141**

Day Kimball Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$516,452	$513,986	$514,375	$474,666	$560,836	$411,409	$507,590	$345,096	
Interim President & CEO									$216,080
Director, OBS/GYN									$354,236
Director, ICU									$323,919
DB/GYN Physician			$411,489	$407,455	$336,629	$313,335	$338,181	$331,018	$299,684
ICU Physician	$300,114	$296,501							
Chief Nursing Officer/COD	$258,269								
VP Philanthropy/Corp. Communications								$274,810	
VP Information Technology							$414,745	$227,892	
Director Informatics		$224,605							
Pulmonary Physician		$376,468	$349,728	$346,213	$296,573	$256,479			
VP Medical Affairs	$344,214	$336,971	$364,114	$339,071	$306,047	$294,738	$305,808		
Senior VP Human Resources							$273,219		$230,147
Primary Care Physician		$345,634	$310,908	$303,899					
Sr. VP of Finance/CFO	$223,937	$224,475					$269,690	$248,725	$264,433
Corporate Controller	$188,798								
Director, Pulmomary Services									$242,043
Clinical Coordinator	$165,232								
Psychiatric Physician	$257,275	$368,447	$285,299	$282,325	$315,466	$334,821			
Senior VP, M.I.S.									$240,796
Director, Pediatric Center									$238,397
Pulmonary Physician		$261,912					$263,369	$233,040	
OB/GYN Physician			$233,012	$230,477	$300,832				
Psychiatric Physician	$250,064	$260,024							
Psychiatric Physician	$232,919								
Cardiologist			$309,121		$266,480	$253,808	$263,028	$240,878	
OB/GYN Physician					$230,630	$237,022		$301,577	
Pediatrician			$228,861	$226,361	$230,070	$210,606		$236,100	
Pediatrician			$225,507	$223,035	$226,780	$209,303			
Pediatrician				$221,314					
Director of Diagnostic Imaging							$262,389		
Sr. VP of Patient Services						$204,924	$241,376	$220,463	$232,287
Total	**$2,737,274**	**$3,209,023**	**$3,232,414**	**$3,054,816**	**$3,070,343**	**$2,726,445**	**$3,139,395**	**$2,659,599**	**$2,642,022**

Essent-Sharon

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$277,021	$314,605	$736,907	$259,785	$270,070	$317,324	$474,064	$283,984	$262,966
General Surgeon								$306,608	$325,221
Hospitalist								$259,673	$239,511
Chief Financial Officer	$244,320	$268,966	$149,605	$243,219	$223,506	$218,844	$210,290	$154,111	$157,443
Chief Nursing Officer	$169,868		$189,966	$166,424	$173,838	$170,212	$216,423	$195,159	$136,670
Hospitalist								$183,785	$191,623
Registered Nurse	$145,966			$168,971	$164,087				$147,995
Registered Nurse, Operating Room		$141,012						$129,873	
Director of Clinical Services, RN		$134,126							
Director, Rehab Services	$148,054	$140,011	$134,254						
Radiology Technician							$150,220	$120,207	$141,799
Registered Nurse, ICU							$150,198	$119,137	
Associate Administrator/Director HR	$178,790	$176,514	$168,637	$165,449	$156,926	$151,963			
Director, Human Resources							$139,260	$118,928	
Registered Nurse, Surgical Services							$136,772		
Chief Quality Officer				$154,903	$149,086	$145,354			
Assistant Chief Financial Officer					$141,916	$136,640			
Director Information Management		$151,335					$133,325		
Director					$141,526				
Director Cardiology							$131,238		
Director, OB/OR									$133,378
Ultrasound Technician					$131,927	$126,922			
Corp. Compliance/Director HIM	$154,697			$140,648		$139,163			
Director ICU/Medical Floor						$137,798			
Registered Nurse			$130,821	$138,152					$124,818
Director				$132,448	$136,750				
Director, Facilities	$137,605	$134,220							
Director Surgical Services			$132,286	$130,566		$123,914	$121,299		
Director, Emergency Services	$140,971	$137,453	$132,012						
Registered Nurse			$130,196						
Director, Quality	$137,992	$136,886	$130,009						
Total	**$1,735,284**	**$1,735,128**	**$2,034,693**	**$1,700,565**	**$1,689,632**	**$1,668,134**	**$1,863,089**	**$1,871,465**	**$1,861,424**

Greenwich Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$1,357,317	$1,523,283	$1,530,629	$1,712,494	$5,220,127	$1,370,221	$1,197,091	$1,043,126	$967,072
Executive VP & COO	$854,537	$687,992	$791,085	$773,054	$2,249,823	$697,391	$606,122	$561,225	
Senior VP & CFO	$794,818	$772,022	$716,899	$717,888	$749,638	$701,024	$613,265	$580,578	
CFO									$555,583
COO									$538,885
Physician - Emergency Medicine				$600,733					
Director, Pathology	$630,556	$594,309	$602,825	$588,104	$637,971	$633,638	$530,313	$653,882	$568,169
Pathologist	$586,829	$568,771	$592,050	$566,033	$591,098	$599,523	$571,407	$543,299	$505,003
Breast Cancer Surgeon							$487,387	$493,628	
Pathologist		$543,930	$567,963	$562,933	$568,572	$570,470	$518,699	$538,592	$485,429
Pathologist		$484,800	$538,472	$555,083	$550,747	$568,928	$452,651	$521,624	$474,045
Pathologist	$483,016	$433,270		$548,782	$501,860	$464,975	$431,605		$449,961
Sr VP of Medical Services	$545,816							$476,104	
Perinatologist								$469,742	$444,738
VP YNHH/COO Greenwich			$546,303						
SVP - Health System Development	$564,526	$524,668	$504,529	$510,007	$520,234	$501,699	$429,141		
Pathologist	$564,333					$451,166			$419,929
Chief Quality Officer		$513,401	$506,060		$500,206				
Chief Safety Officer/Director OPC	$392,587								
Total	**$6,774,335**	**$6,646,446**	**$6,896,815**	**$7,135,111**	**$12,090,276**	**$6,559,035**	**$5,837,681**	**$5,881,800**	**$5,408,814**

Griffin Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$557,181	$499,284	$558,543	$489,758	$547,978	$411,802	$454,181	$443,596	$395,345
Chief, Psychiatric Physician	$291,115	$320,377	$314,419	$291,232	$296,341	$299,790	$308,476	$303,398	
Chief Financial Officer	$296,929	$256,683		$289,096	$346,302	$244,324	$268,883	$262,323	$219,846
Chair, Preventative Medicine		$337,159							
Director, Preventative Medicine		$282,169	$308,557	$277,693	$301,503	$273,033	$240,111	$217,064	
Chief, Pulmonary Physician	$287,582	$280,819	$279,175	$272,275	$307,978	$246,624	$241,934	$234,407	$187,340
Psychiatric Physician	$280,396	$310,078	$303,559	$269,168	$332,866	$257,518	$249,306		$229,293
Chief Medical Director		$244,481	$271,028	$255,557	$344,552				
Vice President Ancillary Services	$255,685	$227,218	$255,880	$233,095					
Vice President Communication			$244,003	$224,973	$301,463	$237,288	$240,378		
Vice President Support Services		$219,892							
Emergency Room Physician					$261,883	$309,873		$232,257	$293,228
Chief, Emergency Room Physician					$265,122	$320,932	$316,904	$308,016	
Emergency Room Physician						$239,993	$299,902	$273,151	$246,891
Emergency Room Physician							$237,606	$208,609	$230,109
Emergency Room Physician									$215,742
Emergency Room Physician									$215,163
Vice President, Facilities	$218,056							$215,178	
Vice President, Nursing	$255,126		$231,317	$211,004					
Psychiatric Physician	$231,109		$225,621						$206,328
Psychiatric Physician	$215,966								
Total	**$2,889,145**	**$2,978,160**	**$2,992,102**	**$2,813,851**	**$3,305,988**	**$2,841,177**	**$2,857,681**	**$2,697,999**	**$2,439,285**

Hartford Hartford

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Director of Arrythmia Center	$493,748				$1,900,259				$481,940
VP, Medical Affairs								$1,820,511	
VP Academic Affairs & Chief Academic Officer	$659,689		$3,351,507						
VP Physician Relations	$775,366		$2,975,037						
President and CEO			$917,623	$1,738,078	$1,730,709	$1,200,432	$1,037,800	$1,225,925	$1,129,631
Director of Maternal & Fetal Medicine			$1,198,676						
President and CEO (former)					$1,176,466	$7,222,700	$1,271,472		
VP Finance and CFO (former)						$2,183,659	$732,281		
Executive VP and COO (former)							$686,910		
VP, Support Services (former)							$691,664		
VP, Human Resources						$1,946,399	$672,239		
Executive VP and COO		$1,023,714		$770,537	$718,644	$916,347		$820,361	$632,172
SVP & Chief Strategy Officer		$662,244							
SVP & Treasurer		$647,196							
Director of Nuclear Cardiology						$863,309			
VP, Finance and Admin Services								$731,102	$663,234
Director of Surgery	$807,330	$735,506	$687,588	$708,508	$637,627	$623,888	$587,306	$582,937	$552,460
Chair, Cancer Institute	$673,632								
VP, Psychiatry		$3,235,078	$736,656	$705,069	$726,491				
VP Behavioral Health		$747,573							
Director of Cardiology	$599,205	$694,590	$1,694,841	$694,379	$671,144	$635,051	$602,750	$571,217	$522,269
Director of Electrophysiology	$532,089								
Director of Critical Care	$511,264								
Director of Medicine	$466,270								
Executive VP and CFO		$879,820	$783,046	$673,245	$642,618				
VP, Academic Affairs		$724,793	$705,560	$660,035	$840,004	$1,838,533	$601,862	$592,607	$563,150
VP, HR and Support Services								$575,835	$539,645
SVP & Chief Medical Officer		$821,632	$663,431						
Chief Medical Officer				$615,860					
Director of Emergency Med. & Trauma Svcs.				$604,599	$601,875	$638,169	$704,026	$680,234	$627,615
Director of OB/GYN	$693,448							$522,364	$495,873
Director of Women's Health Services				$594,607					
Total	**$6,212,041**	**$10,172,146**	**$13,713,965**	**$7,764,917**	**$9,645,837**	**$18,068,487**	**$7,588,310**	**$8,123,093**	**$6,207,989**

John Dempsey Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CFO					$423,912	$467,571	$433,800		
Professor/Clinical Operation/CEO								$366,377	$226,139
Assistant Professor/Clinical/ ER	$302,012	$305,075	$270,370	$336,160	$298,171	$282,759	$323,057	$339,593	$340,415
Assistant Professor/Clinical/ ER	$300,619	$297,040	$264,648	$280,994	$280,062	$282,087	$287,737	$284,186	$272,033
Assistant Professor/Clinical/ ER	$297,959	$291,942	$258,459	$279,646	$279,395	$281,404	$281,933		$247,466
Assistant Professor/Clinical/ ER	$263,242	$289,832	$226,433	$256,709	$278,719		$255,721		
Assistant Professor/Clinical/ ER		$268,015		$256,097	$273,502				
Associate VP/Quality Assurance				$255,248					
Associate Vice President/Nursing		$264,858	$261,801						
Associate VP/Clinical Operation					$239,014	$280,309	$245,858	$358,640	$229,110
Associate VP/Clinical Operation								$239,070	
Professor/Clinical Operation						$227,704	$266,034		
Assistant Professor/Clinical/ ER				$246,747		$260,249		$235,231	
Assistant Professor/Clinical/ ER				$224,026					
Instructor/Clinical					$235,563			$273,965	$219,033
Director of Nursing/Clinical/COO								$268,125	$257,788
Director/Nursing	$320,187								
Director/Nursing	$294,743								
Assistant VP/Application Development									$219,585
Professor, Clinical Care Improvement									$256,050
Professor/Clinical Operation								$263,030	
CEO	$332,520	$613,215	$477,518		$228,363	$122,728	$427,968		
Chief Operating Officer/Finance/CFO								$171,946	$274,404
COO		$322,932	$309,737		$143,634	$288,884	$278,220		
Staff Nurse		$258,118							
Pharmacist	$264,600		$249,078						
Chief Perfusionist			$235,662						
Director/Care Coordination	$258,829								
Medical Physicist/Clinical Radiology				$243,983		$237,831	$230,310		
Associate VP/Quality Assurance				$231,828					
Associate Professor/Clinical/ ER	$363,522	$357,331	$322,819						
Total	**$2,998,233**	**$3,268,358**	**$2,876,525**	**$2,611,438**	**$2,680,335**	**$2,731,526**	**$3,030,638**	**$2,800,163**	**$2,542,023**

Johnson Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	$198,324	$477,819	$483,070	$439,647			$605,558	$682,469	$236,771
Vice President Medical Affairs			$176,895	$365,673	$409,004	$405,455	$392,694	$314,833	$230,598
VP Human Resources	$169,393				$159,122	$193,937			
Chief Financial Officer	$311,922	$309,070	$313,450	$277,196					
Medical Director of Emergency Medicine					$142,788	$416,901			
Emergency Room Physician					$132,475	$362,056		$322,870	$541,108
Chief of Pathology					$121,619	$297,052	$279,230	$238,786	
Emergency Room Physician					$119,808	$338,007	$381,418	$285,669	$310,265
Emergency Room Physician					$119,592	$308,800	$342,751	$274,052	$305,792
Emergency Room Physician					$118,828	$305,737	$331,902	$244,867	$274,657
Emergency Room Physician					$91,680		$291,416	$222,387	$267,637
Pathologist					$19,825	$265,952			
Vice President Operations	$144,662							$231,870	
Emergency Room Physician						$213,194	$288,524		$257,326
Vice President, Patient Care Services	$184,847	$205,683	$208,759	$189,280					
Vice President Finance							$268,980	$297,447	$215,515
Emergency Room Physician							$267,113		$245,908
Director, Perioperative Services		$129,118	$130,075	$155,610					
RN	$170,448	$178,553	$154,463	$153,493					
Corporate Director, Information Technology				$153,090					
Corporate Director, Physical Therapy			$155,226	$150,314					
Corporate Controller	$152,428	$147,108	$145,680						
RN	$148,565	$147,631	$145,058	$147,917					
Corporate Director, Pharmacy				$143,925					
RN		$142,565	$143,158						
RN, Nursing Administration	$150,823	$125,578							
RN, Med Surg Unit	$148,549	$143,973							
Total	**$1,779,961**	**$2,007,098**	**$2,055,834**	**$2,176,145**	**$1,434,741**	**$3,107,091**	**$3,449,586**	**$3,115,250**	**$2,885,577**

Lawrence and Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President, CEO	$761,873	$694,776	$761,734	$743,210	$723,845	$682,508	$607,001	$506,695	$521,633
President, CEO								$413,795	$488,744
VP, Medical Staff								$351,265	$323,290
Chair, Amb. Services									$411,637
VP, COO		$456,567			$434,976		$382,094	$342,528	
Executive Vice President/COO									$323,371
Neonatologist								$313,122	
Chair, Dept. of Medicine								$304,762	$303,344
Chief Operating Officer	$455,107		$484,902	$448,642		$426,450			
Chair, Department of Surgery			$428,327	$392,627	$329,508				
Vice President, CFO		$375,843	$431,702	$409,269	$390,983	$384,955	$363,470	$292,612	
Vice President of Strategic Planning	$305,928	$301,458	$347,841	$328,400	$317,427				
Vice President, Chief Transformation Officer	$370,291								
Chief Legal Officer	$314,655	$291,513	$324,214	$307,829	$298,788				
Vice President, Human Resources				$303,273					
Chief Information Officer	$279,344	$263,482	$300,811	$291,003					
Vice President, Patient Care	$289,965	$268,052	$307,103	$287,396					
Vice President, Physician Practice Mgmt	$571,419	$259,091	$287,114						
Vice President, Development	$259,338	$227,889							
ER Physician					$293,348	$292,898	$318,715	$459,149	$339,944
ER Physician					$292,410	$292,249	$280,475	$282,018	$334,402
ER Physician					$281,359	$288,100	$269,065		$308,049
ER Physician						$283,183	$268,588		$296,538
ER Physician						$267,590	$267,500		
ER Physician						$266,996	$266,945		
ER Physician							$265,510		
Neonatologist								$280,617	
Medical Director Physician	$237,574	$260,900	$269,719	$280,326	$305,139	$351,937			
Total	**$3,845,494**	**$3,399,571**	**$3,943,467**	**$3,791,975**	**$3,667,783**	**$3,536,866**	**$3,289,363**	**$3,546,563**	**$3,650,952**

Manchester Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	$683,398	$558,098	$560,793	$730,743	$475,878	$509,190	$433,628	$430,334	$386,610
CFO				$416,311	$306,482	$335,082	$323,493	$301,441	$285,916
Behavioral Health Director, MD									$314,757
Senior VP of Medical Affairs	$375,056	$333,973		$376,267	$304,418				
Medical Director ED	$486,729	$347,998	$377,339	$304,562	$286,005	$315,238	$331,415		
Emergency Room MD	$411,993	$407,087	$410,390	$280,429	$262,183	$361,900	$359,032	$339,513	$296,890
Emergency Room MD	$384,580	$401,584	$378,568	$302,168	$260,466	$331,476	$309,185	$321,084	$296,661
Emergency Room MD	$374,550	$372,004	$374,663	$274,218	$255,360	$330,931	$311,748	$334,337	$293,784
Psychiatrist							$317,634		
Treasurer/Exec VP		$338,414	$342,391						
Emergency Room MD	$371,405	$363,455	$359,568	$272,895	$259,570	$321,268	$305,500	$304,625	$286,261
Emergency Room MD	$362,526	$355,113	$340,878	$267,058	$247,008	$316,460	$305,252	$290,023	$285,301
Medical Director ED	$396,992		$336,920						
Emergency Room MD		$370,834	$334,601	$258,061	$235,264	$327,577	$288,101	$287,442	$264,082
Emergency Room MD						$316,051		$284,711	
Medical Director MD	$383,624							$281,648	$275,259
Total	**$4,230,853**	**$3,848,560**	**$3,816,111**	**$3,482,712**	**$2,892,634**	**$3,465,173**	**$3,284,988**	**$3,175,158**	**$2,985,521**

Middlesex Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President/CEO	$1,059,523	$1,047,527	$1,022,460	$855,550		$1,377,566	$1,894,107	$1,933,120	$1,884,150
President/CEO (11 mos), Retired 8/31/10					$1,698,891				
Sr. VP, Finance & Operations (11 mos), Pres/CEO (1mo)					$713,168				
VP, Quality and Patient Safety	$552,948	$514,956	$495,392						
Sr. VP/COO						$583,273	$568,734		
VP, Clinical Affairs	$639,942	$712,317	$692,616	$527,592	$522,169	$425,075			
VP, Nursing					$515,525	$455,108	$589,921	$422,093	
Chairman, Emergency Medicine	$465,412	$457,572	$437,030	$458,361	$437,785	$414,514	$407,600	$530,229	$359,355
VP, Finance/CFO/Treasurer	$507,273	$491,453	$472,027	$443,841	$420,113	$366,834			$476,898
VP, Human Resources	$407,633	$485,999	$458,638					$771,255	$571,732
Sr. VP, Finance & Operations								$688,373	
Sr. VP, Strategic Planning & Operations	$410,991	$398,871							
Associate Director, Family Practice									$326,086
VP, Operations				$437,276			$345,141	$398,682	
Chairman, Dept. of Medicine					$402,393	$383,550	$355,939		
Physician, Emergency Department	$404,116	$438,794	$410,969	$412,833	$383,357	$359,933	$380,476		$313,468
Physician, Emergency Department			$382,622				$342,129		$302,881
Physician, Emergency Department							$333,436		
Chief, Dept. of Psychiatry								$480,747	$319,133
Medical Director/MMC Shoreline									$306,084
Clinical Director of Infectious Disease		$393,196	$384,870	$397,220	$399,022	$373,789		$471,634	
Clinical Director, Family Practice								$385,914	
Chief, Department of Medicine & Secretary	$410,301	$395,704	$387,577	$391,924	$398,797				
ED Physician, Shoreline								$383,310	
Former President/CEO				$390,210					
Medical Director/Emergency Department	$396,768			$385,161		$354,820	$363,313		$305,760
Total	**$5,254,907**	**$5,336,389**	**$5,144,201**	**$4,699,968**	**$5,891,220**	**$5,094,462**	**$5,580,796**	**$6,465,357**	**$5,165,547**

Midstate Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President/CEO		$943,218	$958,020	$903,186	$852,851	$856,294	$818,081	$724,372	$583,640
CFO				$500,859	$472,514	$417,879	$370,141	$325,521	$318,218
Hospitalist Physician Director				$402,481	$384,467	$362,957	$334,211		
Hospitalist	$389,707	$450,232							
Hospitalist	$347,566	$383,916							
Hospitalist	$336,773	$372,952							
Hospitalist	$324,813	$365,712							
Hospitalist	$320,553	$359,039							
Hospitalist	$316,325	$348,383							
Hospitalist	$257,561	$347,761							
Per Diem Hospitalist	$314,391								
Medical Director Mediquick	$365,164								
Vice President			$390,197	$361,186					
Physician/ED Physician			$409,553	$357,013	$523,033	$515,538	$452,689	$454,104	$416,177
Physician/ED Physician			$409,432	$338,014	$392,805	$426,115	$410,223	$395,225	$368,814
Physician/ED Physician			$351,649	$327,442	$373,523	$366,218	$354,336	$345,308	$336,495
CMO		$538,417	$419,637	$324,801					
Senior VP Operations	$362,653								
Vice President				$317,948					
COO		$418,703						$418,216	$372,092
Physician/ED Physician			$348,160	$310,134	$359,090	$352,368	$319,583	$341,842	$316,487
Physician/ED Physician			$340,888		$352,973	$343,935	$319,411	$329,998	$311,835
Physician/ED Physician			$340,517		$345,949	$336,351	$310,987	$323,821	$311,615
Physician/ED Physician			$339,775		$343,328	$331,467	$310,000	$322,437	$305,567
Total	**$3,335,506**	**$4,528,333**	**$4,307,828**	**$4,143,064**	**$4,400,533**	**$4,309,122**	**$3,999,662**	**$3,980,844**	**$3,640,940**

Milford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	$875,081	$596,448	$579,475	$409,804	$369,792	$368,100	$584,198	$564,048	$542,425
Physician, Dir. ICU						$435,314	$436,656	$366,809	$311,211
Vice President Finance							$367,778	$359,990	$335,416
Physician, Chief Operating Officer	$824,032	$556,742	$538,527	$390,015	$451,013				
Hospitalist		$363,430	$351,489	$358,094	$370,807		$308,051		
Pathologist	$369,566	$344,700	$345,094	$350,286					
ER Physician	$274,722	$373,044	$341,173	$333,021	$337,610	$341,036	$332,309	$324,830	$313,159
ER Physician	$246,745	$359,350	$341,090	$332,969	$337,610	$350,539	$331,769	$324,668	$311,318
ER Physician		$339,255	$340,882	$331,803	$327,796	$335,078	$330,092	$321,487	$306,348
Physician, Dir., ER				$329,567	$334,377			$319,726	$318,225
Hospitalist			$346,959	$329,539	$318,975	$332,513			
House Physician	$373,895							$294,558	$269,738
House Physician	$357,857								
House Physician	$346,822								
House Physician	$286,221								
House Physician	$267,192								
ER Physician		$339,099	$339,691	$322,711	$327,783	$325,638	$326,820	$320,258	
ER Physician		$335,714	$332,195		$323,799	$326,493	$307,639	$291,567	$241,487
ER Physician		$335,209				$322,325			$234,035
ER Physician						$315,317			
Vice President Finance							$301,943		
Total	**$4,222,133**	**$3,942,991**	**$3,856,575**	**$3,487,809**	**$3,499,562**	**$3,452,353**	**$3,627,255**	**$3,487,941**	**$3,183,362**

New Milford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
VP Human Resources				$598,225					
President/CEO	$240,264	$216,471	$195,774			$579,769	$551,928	$378,612	$510,994
SVP Operations	$305,899	$390,795	$399,446						
Controller	$175,328	$169,748	$187,679						
Director, Finance	$202,764	$197,173	$187,168						
Ex-President						$504,699	$520,642	$556,305	
Director, Patient Experience	$185,544	$181,583							
PVT-Physician				$524,365	$415,363	$388,286		$314,473	$294,239
PVT-Physician					$402,659				
PVT-Physician					$372,602				
Lab-Physician			$480,036	$433,162	$458,129	$444,620	$431,352	$393,499	$395,072
Dir., Emergency Services				$425,241	$455,760	$442,595	$493,692	$391,352	$397,819
Ear, Nose & Throat Physician						$393,109	$419,422		
Chief Medical Physicist	$241,166	$236,050	$236,050						
Manager, Cancer Center	$172,631								
Radiology-Physician			$237,151	$388,596	$463,809	$453,172	$452,354	$409,046	$390,278
ER-Physician				$324,724	$356,520		$357,558	$333,064	$303,683
VP, Finance				$304,635	$320,582	$1,574,460	$332,954	$286,657	$291,461
ER-Physician				$296,090	$325,727	$341,992	$324,888	$301,257	$301,090
ER Physician								$296,044	$297,204
ER Physician									$290,550
VP, Nursing, COO			$206,897	$279,629	$335,896	$379,013	$377,312		
PVT-Physician				$268,123					
Director, Nursing	$169,779	$213,871							
Director, Medical Affairs & Quality	$199,888	$197,694							
Director, Planetree			$180,756						
Director, Employee Health	$171,529	$173,850	$180,359						
Mgr, Pharmacy Operations		$157,679							
MIS Officer			$178,965						
Total	**$2,064,792**	**$2,134,914**	**$2,670,281**	**$3,842,790**	**$3,907,047**	**$5,501,715**	**$4,262,102**	**$3,660,309**	**$3,472,390**

Norwalk Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
VP & Chief Medical Officer				$810,916	$911,520				
President & CEO	$1,268,795	$1,050,930	$901,148	$797,727		$941,545	$947,473	$753,038	$712,447
COO									$624,360
President & CEO (through April 2010)					$2,769,742				
VP & Chief Operating Officer/President & CEO					$631,222				
VP & Chief Operating Officer						$580,806			
VP Quality				$651,642					
Physician, Emergency Department	$590,305	$626,548	$685,615	$644,978	$598,761	$546,877	$571,541	$581,690	
Chairman, Dept. of Emergency Medicine		$568,977	$585,218	$582,032		$520,710	$499,071	$471,022	$530,410
VP Planning/VP and Chief Operating Officer					$495,864				
Chairman, Dept. of OB/GYN				$576,298		$787,458	$510,698	$469,596	$458,545
Sr. VP & COO			$535,681	$534,321			$715,282	$475,350	
Physician, Emergency Department	$516,291	$475,854	$519,445	$518,578	$616,208	$539,434	$508,100	$555,721	$464,069
Chairman, Dept. of Medicine				$499,713	$545,236	$827,220	$708,223	$574,213	$564,770
VP & Chief Financial Officer	$664,111	$610,069	$489,543				$461,558		
VP Nursing Patient Care Services						$436,783			
VP Planning and Business Development						$407,117			$358,054
Sr. VP Strategy & System Development	$601,931								
Sr. VP & COO		$560,049					$413,961		
VP, Human Resources	$926,697	$472,049							
Chairman, Dept. of Surgery				$478,153	$437,306		$400,520	$436,043	
Chief Pulmonary/Critical Care					$495,115				
Director, Real Estate								$411,611	
Physician, Emergency Department	$501,242		$478,304		$392,756	$392,120		$380,719	$401,936
Chief Financial Officer									$399,721
VP & Chief Nursing Officer			$472,525						
Chairman, Psychiatry		$454,227							$395,655
Physician, Emergency Department	$473,446	$420,766	$442,639						
Physician, Emergency Department	$472,663	$411,006	$412,040						
Physician, Emergency Department	$455,025								
Total	**$6,470,506**	**$5,650,475**	**$5,522,158**	**$6,094,358**	**$7,893,730**	**$5,980,070**	**$5,736,427**	**$5,109,003**	**$4,909,967**

Rockville General Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	$269,844	$239,511	$240,340	$313,176	$203,947	$218,224	$185,155	$184,429	$165,690
Medical Director	$338,865	$353,700	$324,458						
Medical Director		$279,461	$267,332						
Emergency Room Staff MD						$298,633	$288,830	$316,140	$284,842
Urgent Care MD	$311,021	$237,773							
Urgent Care MD	$256,590	$198,751							
Urgent Care MD	$237,577								
OB/GYN				$296,847	$287,075	$253,645	$134,771		
VP Patient Care Services	$224,341	$194,226	$168,500						
Infection Control Director MD	$264,351			$267,035	$213,063	$231,082	$231,252	$251,377	
Emergency Room Staff MD						$156,625	$286,392	$308,333	$279,951
Emergency Room Staff MD								$233,212	$275,186
Infectious Disease MD									$250,121
Emergency Room Staff MD									$227,994
Psychiatrist	$261,240	$226,768							
CFO				$178,419	$131,350	$143,386	$140,036	$129,190	$122,535
Senior VP of Medical Affairs				$161,257	$131,123	$134,648			
RN - Amb Surg					$144,581				
VP Quality							$151,625		$153,245
Emergency Room Staff MD									$135,879
Senior Director									$128,113
RN Supervisor		$174,125	$167,806	$144,695	$126,755				
RN Supervisor		$185,757							
Registered Nurse	$176,954		$148,917						
Treasurer/Exec VP			$146,739						
Admin Director				$147,232	$140,026	$139,004	$131,485		
Medical Director MD		$149,601	$144,450					$120,706	
Staff Nurse Practitioner								$119,658	
Registered Nurse			$126,837						
Senior VP/Medical Director			$124,441						
Clinician	$155,922								
Admin Director							$134,895		
RN-ICU				$146,783	$135,200	$132,657			
RN-ICU					$128,826				
Medical Director ED				$130,526		$135,102	$142,034	$117,224	
Pharmacist								$126,810	
Medical Imaging Director				$149,607					
Total	$2,496,705	$2,239,673	$1,859,820	$1,935,577	$1,641,946	$1,843,006	$1,826,475	$1,907,079	$2,023,556

Saint Francis Hospital and Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	$3,135,570	$1,697,418	$1,521,090	$1,422,730	$1,534,640	$1,225,460	$1,295,178	$1,161,713	$1,052,791
Retired President									$842,802
Senior Vice President and CFO			$715,743		$820,051	$764,883	$782,085	$592,563	$525,978
Executive Vice President						$776,959	$732,722	$624,226	$553,559
Executive Vice President and COO	$635,702	$898,975	$731,103	$693,126	$629,960	$506,142			
Executive Vice President, Chief Admin Officer	$785,531	$843,425							
Senior Vice President and General Counsel			$395,262			$739,382	$543,618	$436,409	
Department Chairman, Surgery	$731,925	$667,064	$627,085			$433,126			
Executive Vice President and CPO		$823,171	$564,996						
President - Saint Francis Foundation				$568,974	$475,818	$480,084			
Senior Vice President, Chief Academic Officer	$505,762	$522,703	$497,259	$515,074	$498,851	$453,270			
Senior Vice President, Chief Dev. Officer	$483,872	$487,359							
Section Chief - Pathology					$489,166	$434,053	$487,549	$473,932	$455,029
President, JMMC	$442,406								
Vice President, Financial Planning		$380,990	$495,310						
Department Chairman - Pathology					$467,804		$471,696	$460,763	$442,915
Senior Vice President - Nursing		$441,176	$419,088						
Program Director - Pathology					$442,922		$440,671	$428,034	$409,916
Vice President - Interim CFO				$436,565		$494,094			
Department Chairman - Emergency				$427,080	$410,602		$473,425	$433,598	$415,766
Senior Vice President - Planning	$415,876	$412,053	$413,512	$426,075	$444,464		$418,495		
SVP, Human Resources	$376,149								
SVP, Chief Information Officer	$374,456								
Staff Physician - Emergency				$417,086			$398,410		$422,436
Staff Physician - Emergency				$419,896					$348,989
Staff Physician - Emergency				$394,466				$397,797	
Psychiatrist								$388,889	
Total	**$7,887,249**	**$7,174,334**	**$6,380,448**	**$5,721,072**	**$6,214,278**	**$6,307,453**	**$6,043,849**	**$5,397,924**	**$5,470,181**

St. Mary's Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$913,009	$853,512	$791,256	$649,453	$599,134			$765,051	$764,919
Medical Director Cardiology									$314,576
Vice President & CFO former								$306,178	$166,517
Executive Vice President						$593,749	$404,367		
Vice President and CFO	$334,247	$266,887	$218,577	$479,091	$363,355	$392,216	$424,741	$199,564	$299,653
Vice President & CNO	$256,164	$338,629							
Vice President & CNO, former		$265,011							
Vice President Patient Services			$560,617	$284,285	$293,715	$296,546	$343,210	$259,189	$228,563
VP, Marketing & Business Development								$224,306	$172,878
Former President & CEO							$305,243		
Vice President Human Resources	$303,346	$280,376	$290,284	$255,565	$240,600	$246,038	$247,611		$163,764
Physician Hospitalist Program Internal Med.									$190,874
Chairman, Department of Medicine		$275,582							
Vice President & Chief Medical Officer	$435,298	$245,516	$425,825	$432,762	$475,162	$270,057			
Chief Information Officer		$228,524	$244,993	$240,094	$200,300	$178,502	$181,117	$152,782	
Chief Marketing Officer	$257,678	$240,125	$226,403	$221,048	$201,173	$178,752	$159,775		
Vice President Surgical Services			$353,905	$318,435	$201,394				
Vice President Surgical Services, Former	$372,127								
Vice President Operations	$349,154	$325,082	$333,779	$296,349	$241,116		$284,820	$222,746	$167,537
Chief Operating Officer	$307,756								
Critical Care Nurse						$162,859			
Div. Dir. Perioperative and Invasive Services							$168,939	$161,555	
Divisional Director, Clinical Quality			$185,905	$185,753		$173,009	$163,605	$158,061	
Director of Pharmacy								$151,739	
Director, Operating Room					$178,178	$162,039			$146,949
Executive Director Revenue Cycle	$219,286								
Total	**$3,748,065**	**$3,319,244**	$3,631,544	$3,362,835	**$2,994,127**	**$2,653,767**	**$2,683,428**	**$2,601,171**	**$2,616,230**

St. Raphael

Position Title	2012	2011	2010	2009	2008	2007	2006
President	$1,803,605	$1,043,560	$911,333	$4,282,605	$1,013,140	$903,330	$890,725
Former President			$2,168,074				
Senior Vice President, COO & CFO		$734,111	$987,313	$635,609			
Senior Vice President, CMO (MD)	$724,139	$705,420	$773,004	$651,886			
Clinical Chair, Surgery (MD)			$680,736	$713,955	$648,922	$624,624	$527,845
Clinical Chair, Emergency Medicine (MD)	$460,733	$630,934		$629,011	$516,934	$437,898	
Vice President - Medical Services							$488,498
Clinical Chair, Medicine (MD)	$541,652	$595,195		$714,365	$534,595	$503,169	$483,632
Former Sr. Vice President, CMO (MD)			$635,338				
Cardiologist (MO)	$514,489	$524,696				$501,371	$325,398
Clinical Chair, Women's/Children's Services (MD)	$472,267			$580,409	$621,357	$613,674	$545,164
Associate Clinical Chair, Surgery (MD)						$400,079	$387,694
Director, Cardiology Fellowship/CDU (MD)	$503,734	$510,919	$515,784				
Director, Surgical Intensive Care Unit (MD)	$478,876	$487,030			$439,540	$405,821	$384,802
Section Chief, Thoracic Surgery (MD)	$564,767	$484,735	$486,810	$468,291	$493,505		
Section Chief, Cardiology (MO)			$447,832	$420,950	$397,602	$621,619	$386,114
Associate Clinical Chair, Medicine (MD)	$368,478	$387,201	$377,221	$360,560	$348,214	$340,498	
Directors, McGivney Cancer Center (MD)							$308,371
Medical Information Officer (MD)					$345,612		
Total	**$6,432,740**	**$6,103,801**	**$7,983,445**	**$9,457,641**	**$5,359,421**	**$5,352,083**	**$4,728,243**

St. Vincent's Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$1,076,770	$984,669	$2,394,278	$1,484,755	$1,485,490	$1,275,826	$922,813	$954,683	$813,986
Former Chief Executive Officer		$1,110,833							
President/Chief Academic Officer			$978,878						
Chairperson Medicine					$771,879				
Senior Vice President			$929,797						
CMO/Clinical VP Cardiology							$715,872	$815,402	$588,172
Chief, Cardiothoracic Surgery						$714,299	$688,391	$470,873	
Clinical Chair Oncology						$659,205	$567,940	$562,094	
Corp. Sr. VP Marketing/Govt Relations						$624,541	$575,899	$497,550	$640,952
Sr. VP Chief Clinical/Chief Medical Officer	$921,307	$910,454			$717,509				
Clinical Chair Oncology/Chief Medical Officer				$837,791					
Clinical Vice President Cardiac Services			$774,448	$634,145					
Clinical Vice President Surgical Services		$894,493	$778,042	$630,797	$587,507	$594,139		$561,609	$562,403
Senior Vice President/Chief Financial Officer	$688,869	$673,021	$747,134	$567,478	$527,089				
Clinical Vice President Medicine	$675,890	$643,993	$613,539	$554,058		$622,403	$624,660	$602,937	$732,012
Vice President/Chief Legal Counsel	$534,713	$513,004							
Sr. VP/Chief Nuring Officer/COO	$497,600	$482,467							
Senior VP, Corporate Affairs	$390,699	$354,899							
Chairperson, Department of Surgery	$481,159								
Director, Cardiothoracic Surgery						$536,707	$582,197		
General Surgeon						$506,107	$622,697		
Trauma Surgeon								$491,733	
Chair Neonatology							$505,356		
Chairperson Emergency Care	$443,244		$592,032	$525,145	$626,929		$454,732	$457,191	$476,961
Vice Chairperson Emergency Care				$491,021	$527,678				$354,263
ED Physician						$443,302		$378,793	$331,842
ED Physician						$435,153			$313,453
Chief Financial Officer									$420,933
Senior Vice President				$456,215	$653,854				
Sr. VP/Chief Administrative Officer			$590,696		$427,992				
Chairperson, Obstetrics & Gynecology	$376,404				$390,454				
Sr. VP/Chief Human Resources Officer		$454,673	$477,436						
Vice President CHRO Employee Council				$455,920					
Total	**$6,086,655**	**$7,022,506**	**$8,876,280**	**$6,637,325**	**$6,716,381**	**$6,411,682**	**$6,260,557**	**$5,792,865**	**$5,234,977**

Stamford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$2,402,748	$2,222,554	$1,532,094	$2,241,639	$1,695,727	$2,399,609	$1,552,751	$1,424,969	$1,505,731
Sr. VP Finance CFO									$1,177,667
Sr. VP of Medical Affairs	$929,239	$779,389	$681,212	$1,080,817	$911,568	$844,466	$1,084,950	$916,043	$827,193
VP of Physician Network Development		$873,017							
Surgery Physician									$707,094
Pediatric Physician									$612,001
Chief of Cardiac Surgery	$898,824	$996,839	$1,180,752	$992,541					
Chief of Surgery	$857,348		$768,216	$906,571	$716,968	$677,257	$718,271	$603,072	
Exec. VP and Chief Operating Officer	$1,316,300		$784,363	$756,653	$586,964	$556,035	$669,998	$555,285	
Sr. VP Operations COO		$807,104							$531,798
Sr. VP of Strategy & Marketing	$721,788	$649,400	$663,125	$740,648	$584,749	$555,766	$702,165	$560,141	$516,754
VP of Finance & Chief Financial Officer	$1,008,955	$816,687	$735,596	$720,187					
Chief Information Officer					$572,108			$659,960	
Chief Financial Officer					$538,917	$584,026	$685,468	$642,151	
VP Ambulatory Services			$662,001	$656,204	$537,897				
Chief of Cardiology		$619,201	$608,165	$580,278					
Chair, Dept. of Pediatrics						$535,091	$599,219	$596,484	
Cardiac Surgeon			$604,033						$526,501
Director of Cardiology					$577,961	$527,830	$567,360	$533,258	
Chief of Bariatric Surgery	$719,194	$616,054							
Sr. VP Patient Services					$523,138				$608,443
VP and Chief Information Officer	$688,889								
Chief Financial Officer								$527,027	
Dept. of Medicine Physician									$500,240
Sr. VP of Talent & Culture						$507,757	$560,848		
Chief, Dept Medicine							$489,451		
Chair, Dept. of Obstetrics	$1,063,073	$673,597		$579,437		$579,607			
Total	**$10,606,358**	**$9,053,842**	**$8,219,557**	**$9,254,975**	**$7,245,997**	**$7,767,444**	**$7,630,481**	**$7,018,390**	**$7,513,422**

Waterbury Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
COO			$285,001	$372,533	$349,800	$346,933	$336,115		$303,422
President	$700,205	$663,566	$520,298		$559,086	$557,177	$543,225	$497,412	$495,175
Medical Director ICU							$429,416	$404,073	$368,600
Chief Financial Officer	$412,354								
Chief Information Officer	$390,922	$343,254							
Physician, Director of ED			$220,141			$434,224	$419,545	$385,225	$360,832
VP Medical Affairs		$168,103	$200,000		$401,415	$399,001	$386,234	$361,690	$356,362
VP Patient Care/CNO	$277,791	$246,766							
Vice President Operations		$182,207							
Medical Director Internal Medicine						$406,881	$390,191	$374,049	$363,491
Psychiatrist	$241,985		$206,039						
Medical Director ICU						$401,214			
ED Physician						$375,695	$347,516	$301,684	$292,832
Staff Pharmacist		$183,278							
Physician Assistant Director of Surgery									$337,710
Associate Director of Surgery							$350,943	$342,946	
Attending Faculty Surgeon						$351,552	$340,601	$354,404	
Physician, Oirector of ED								$357,059	
CFO			$174,602	$366,538	$342,259	$340,322			$304,167
Chief Medical Information Officer: MD				$279,141	$241,679				
Chief Medicaid Information Officer		$235,757							
Medical Director Behavioral Health	$250,037	$235,528	$204,736	$245,009	$253,710				
Medical Director Behavioral Health	$234,438		$193,939	$234,970	$234,482				
Medical Oirector Adolescent Services	$230,941								
Psychiatrist		$189,684	$200,840	$240,995	$242,964				
VP Human Resources	$272,995	$249,234	$177,500	$224,139	$213,388				
Psychiatarist	$238,483			$237,376	$237,430				
ED Physician						$327,404	$334,097	$313,796	$282,454
COO				$214,294					
VP Finance				$191,630					
Total	**$3,250,151**	**$2,697,377**	**$2,383,096**	**$2,606,625**	**$3,076,213**	**$3,940,403**	**$3,877,883**	**$3,692,338**	**$3,465,045**

Windham Community Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer				$545,243	$585,128	$520,920	$469,982	$367,447	$368,288
Director of ER									$454,329
Associate Director Emergency Department							$323,865	$434,562	
Physician/Hospitalist		$288,962	$463,270	$441,376	$376,126				
Medical Director			$347,208	$359,517	$290,378				
Chief Financial Officer/VP Finance			$249,090	$337,633	$341,410	$318,624	$293,324	$241,639	
Chief Financial Officer									$242,778
Emergency Department Physician							$293,059	$414,618	$376,809
Emergency Department Physician							$246,715	$366,186	$345,570
Emergency Department Physician							$242,264	$352,725	$302,407
Emergency Department Physician							$214,742	$315,865	$289,138
Emergency Department Physician							$206,331	$312,993	$273,434
Emergency Department Physician							$143,862	$306,390	$226,486
Emergency Department Physician								$247,438	$178,510
Physician/Hospitalist	$378,887	$436,964	$433,682	$269,810	$221,757				
Physician/Hospitalist	$296,315	$320,462	$284,341	$265,443					
Physician/Hospitalist	$279,557	$305,674	$279,696	$264,125					
Physician/Hospitalist	$264,022	$269,719							
Physician/Hospitalist	$261,230								
Vice-President Operations		$263,290	$257,531	$245,308					
Physician/Hospitalist	$250,041	$301,846	$245,831						
Physician/Hospitalist	$233,954								
Medical Director			$223,976	$229,559	$222,030				
Vice President Patient Care		$255,343			$237,440	$292,675	$190,886		
Vice President Human Resources	$198,295	$349,509			$199,093	$183,859			
IT Director		$248,557							
Registered Nurse	$232,524		$257,641			$193,937			
Registered Nurse	$212,515			$214,202	$196,156	$165,936			
Director Inpatient Nursing						$162,875			
Registered Nurse						$160,759			
Registered Nurse						$160,524			
Registered Nurse					$192,973	$158,314			
Total	**$2,607,340**	**$3,040,326**	**$3,042,266**	**$3,172,216**	**$2,862,491**	**$2,318,423**	**$2,625,030**	**$3,359,863**	**$3,057,749**

Yale-New Haven Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO (YNHH & YNHHS)	$3,520,872	$3,263,758	$2,803,228	$2,592,381	$2,547,699	$2,612,895	$2,022,544	$1,798,621	$1,488,980
Exec. VP, COO (YNHH & YNHHS)	$2,143,135	$1,942,688	$1,680,133	$1,636,424	$1,643,996	$1,625,653	$1,516,169	$1,403,271	$350,233
SR VP, Chief of Staff (YNHH & YNHHS)	$1,593,847	$1,482,123	$1,673,612	$1,383,291	$2,713,552	$1,339,602	$1,234,724	$1,115,331	
SR VP Finance, CFO (YNHH & YNHHS)	$1,806,166	$1,597,211	$1,432,214	$1,359,691	$1,345,514	$1,260,656	$1,114,791	$1,083,817	$1,124,783
SVP, Med. Aff/Chief									$1,102,233
Sr. VP of Quality & Safety	$909,375								
Senior VP HR (YNHH & YNHHS)	$1,078,184	$1,002,344	$945,388	$963,800	$954,346	$976,093		$725,218	$656,327
Senior VP Administration				$920,989	$924,331	$870,911	$726,378	$636,947	$577,249
VP of Legal Services	$1,100,951	$998,877	$903,335	$802,811	$780,372				
VP & Exec Dir of Childrens Hospital		$853,117				$739,113	$594,779		
Sr. VP of OPS/Children	$875,071								
Senior VP Patient Services		$703,474	$769,813	$736,309	$724,577	$729,091	$1,093,847	$565,102	$528,715
Senior VP, CIO (YNHH & YNHHS)	$1,133,727	$1,003,592	$895,982	$687,019	$902,132	$985,608	$739,064	$686,872	$676,045
Vice President, Administration									$508,390
Vice President, Administration									$486,639
SVP OPS/Smilow	$898,353	$800,103	$647,666						
VP Finance					$726,759	$718,587	$574,932	$539,790	
VP Ambulatory Services			$622,898	$654,217			$601,502	$562,377	
Total	**$15,059,681**	**$13,647,287**	**$12,374,269**	**$11,736,932**	**$13,263,278**	**$11,858,209**	**$10,218,730**	**$9,117,346**	**$7,499,594**

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

C-126

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
EMAIL:hfmurray@lapm.org

July 1, 2016

Via Email and Hand Delivery

Kimberly Martone, Director of Operations
Kevin Hansted, Hearing Officer
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, CT 06106

Re: Certificate of Need Applications,
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and Northeast Medical Group, Inc. and,
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation

Dear Ms. Martone and Mr. Hansted:

Attached please find originals and two copies of pre-file testimony submitted by the Intervenors in the above captioned matters. Thank you.

Very truly yours,

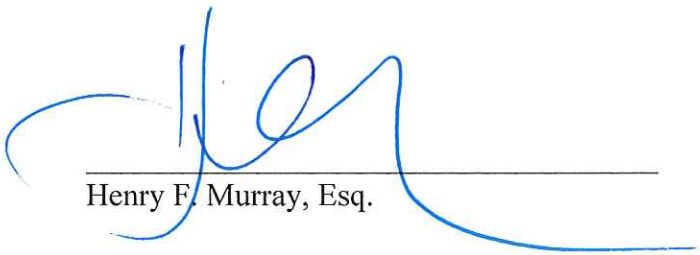
Henry F. Murray

HFM:vds
Enclosure

CERTIFICATION

This certifies that the Intervenors' pre-file testimony was sent via email and First Class Mail, pre-paid on July 1, 2016, to the following counsel of record:

Joan W. Feldman, Esq.
SHIPMAN & GOODWIN LLP
One Constitution Plaza
Hartford, CT 06103-1919
jfeldman@goodwin.com



Henry F. Murray, Esq.

Connecticut Health Policy Project

The Grove, 760 Chapel St., New Haven CT 06510
Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

TESTIMONY to the Office of Health Care Access
July 1, 2016
Re: CON application regarding acquisition of Lawrence & Memorial Hospital and its physicians' group by Yale-New Haven Health System
Ellen Andrews, PhD, Executive Director

My name is Ellen Andrews. I reside at 49 Wilkins St., Hamden Connecticut. I am Executive Director of the Connecticut Health Policy Project. I'm here today to urge OHCA not to approve the application of Yale-New Haven Health System to take over Lawrence and Memorial Health.

We are in the midst of enormous transition in our health care system. The Affordable Care Act has enabled 16 million Americans to gain health insurance coverage, and covered thousands of Connecticut's previously uninsured residents. The ACA offers ongoing incentives and supports to help our state get coverage for the remaining 250,000 uninsured that live in Connecticut.

But not all the news is good. The continued consolidation of providers and insurers is driving an ongoing cost spiral that threatens to undo much of the positive change that we've seen in the past few years. . Dr. Hyde has described the overwhelming body of research demonstrating that as competition is drained from our health care system, costs inevitably go up, and consumers lose choice.

The Connecticut Health Policy Project is particularly concerned about the impact of these trends on low income and underserved communities, the state budget and the growing trend of underinsurance among those with private coverage.

Connecticut has received national recognition for its work reining in Medicaid costs.[1] We are the only state to take back Medicaid recipients from private managed care plans and negotiate provider rates ourselves. That decision and resulting reforms has reduced per member costs, increased the number of physicians participating in the Medicaid program, and reduced emergency room visits. More people covered for less money seen by more providers and better quality care in the appropriate setting. Sounds like a win.

But it hasn't been enough. Underlying provider prices are destroying access to care for many in our state. Due to budget constraints, 11,677 working parents are losing HUSKY coverage at the end of this month. Medicaid beneficiaries in high cost areas like New Haven still struggle to get appointments. HUSKY families "transitioning" to coverage in AccessHealthCT insurance plans, our state's health insurance exchange, are expected to meet a $500 deductible and spend 10-12% of their income on health care. Enrollees in AccessHealthCT plans face enormous

[1] Melinda Beck, "Connecticut Moves Away From Private Insurers to Administer Medicaid Program," *Wall Street Journal*, March 18, 2016. http://www.wsj.com/articles/connecticut-moves-away-from-private-insurers-to-administer-medicaid-program-1458325696

deductibles as subsidies decrease up the income scale. Even workers with decent jobs are increasingly stuck in cost-prohibitive plans. Nearly a quarter of workers are in high deductible plans, up from just 4% in 2006. According to the Kaiser Family Foundation deductibles have increased at nearly seven times the rate of workers' earnings.

Some policymakers insist that high cost sharing is necessary to reduce excess utilization. But utilization isn't really our main problem. Despite progress, Medicaid members, the remaining uninsured and the growing ranks of underinsured state residents still struggle to access recommended care. The US has the highest health care costs by far in the world – we spend twice as much per person on average as the rest of the world, and nobody spends even three quarters as much as we do. Except for Switzerland, we already have the highest out of pocket costs. So if out of pocket costs are the solution, why isn't the problem solved?

As Dr. Hyde's literature review shows, our problem is price, not utilization, and monopoly creates a disaster for prices. Jason Pelletier's testimony contains a shocking fact – workers at a corporate cafeteria run by a global food service company serving food to workers at one of the most profitable companies in the world *are forced to go without health insurance or be covered by state assistance programs because their premium share is too high.* Shame on those employers, but let's not kid ourselves. Employers are fighting with workers over premiums because underlying provider prices are forcing them to.

And when you lose your coverage, or your deductible goes up to five thousand dollars, what happens? You go to the doctor, and, now that the hospitals are buying up all the doctors, you get charged a facility fee for the privilege of seeing a new sign on your doctor's office door. You find yourself choosing between rent, food, and the electric bill for your family or going to the doctor for yourself.

To approve this CON, OHCA must look the public in the eye and say "Yale is different." Unlike all the other giant monopolies, Yale will throw away its monopoly bargaining advantage and keep prices low. Or you must say "New London County is different." For some reason Yale won't buy up all the doctors the way they have in the New Haven area.

No one can take those arguments seriously. One of the few things that Yale's proposed $300 million investment clearly identifies as a specific priority is physician recruitment. To most of us, that suggests recruiting neurologists to move to New London so that telemedicine visits or an hour's drive to New Haven aren't patients' only options. But Yale's past behavior in the New Haven area suggests that money is earmarked for physician practice acquisitions – which means more market power, more facility fees, higher prices and people skipping needed care because of cost.

Perhaps the most telling passage in the CON can be found on page 34. Asked how "low income persons, racial and ethnic minorities, disabled persons and other underserved groups" will benefit from the proposal, YNHHS replies that L+M and YNHHS provide services to the uninsured, underinsured and all patients regardless of race, ethnicity, income or ability to pay. "That will not change as a result of this proposal."

The proposal offers no visions for improvement of services to underserved populations save for the general clinical benefits presumed to accrue to all patients. One must assume that this, like so many other specifics, would be left to the post-acquisition strategic planning process to decide. The rest of us are supposed to wait and hope.

As a member of the Governor's Health Care Cabinet, I view this proposal as the leading example of one of the most dangerous trends in health care, and one of the few key issues we must grapple with to set Connecticut on course

for an accountable 21st Century health care system. I urge you not to rule on this application until my colleagues and I, and our counterparts on the Certificate of Need Task Force have completed our recommendations. If you must rule before that, you must deny the application. Without dramatic changes to address the issues of access, price and quality within a framework of true accountability to the community and protections for underserved and at-risk residents, you must deny it whenever it ripens for decision. There is no public need for this deal and very great risk to state residents and the state's budget.

Pre-file testimony from Stephen R. Smith, M.D., M.P.H.

My name is Stephen R. Smith, M.D. I am a professor emeritus of family medicine at the Warren Alpert Medical School of Brown University. I live in New London.

I am a family physician working at the Community Health Center of New London. I also speak on behalf of the National Physicians Alliance in Connecticut. This group includes physicians from a variety of different specialties who serve on the medical staff and/or work as community-based physicians who refer their patients to either Yale/New Haven Hospital or Lawrence and Memorial (L+M) Hospital.

I am also speaking on behalf of the Universal Health Care Foundation of Connecticut in my capacity as a member of the board of directors of the Connecticut Health Advancement and Research Trust (CHART), the parent organization of the foundation.

I am a lifelong resident of New London residing at 899 Montauk Avenue and have served on the medical staff at Lawrence and Memorial Hospital in the past.

The initial position that the Office of Health Care Access should take when considering any hospital merger or acquisition is that such mergers are not in the best interest of the public and should be denied. As our testimony has previously shown, hospital mergers are, by their very nature, anti-competitive and generally lead to higher prices without concomitant improvements in efficiency, quality, accessibility, or accountability. Mergers and acquisitions should be permitted *only* when convincing evidence has been presented demonstrating that no other means is available to achieve the purported goals of the merger that would serve the community's interests in preserving high-quality, affordable, and accessible health services.

The proposed acquisition of L+M by Yale/New Haven Health Services Corporation does not demonstrate any compelling public interest, or evidence suggesting a public good.

Close clinical coordination and cooperation is already achieved between the two institutions and with health care providers in the community without the benefit of formal acquisition.

As a family physician working in an independent community health center in New London, I already have instant access to the L+M computers to obtain laboratory data, x-ray reports, emergency room reports, and hospital discharge summaries on my patients. If a patient of our health center is seen in the emergency room at L+M, procedures already exist that allow the emergency physician to schedule a visit for the patient with us within 24 hours. Yet our community health center and L+M are separate, independent entities.

I already have excellent relationships with the specialists at Yale/New Haven, many of whom have office hours at L+M for the convenience of our patients. Yale/New Haven specialists have often called me on the telephone to discuss mutual patients with serious vascular problems and pulmonary conditions. At their behest, I have seen the patients and ordered tests and managed their conditions in between visits to the specialists in New Haven. All of this is done without the need for one hospital to "own" the other, especially given all of the bad results from such ownership.

The neonatal intensive care unit at L+M is already staffed by Yale/New Haven neonatologists. The NICU staff already arrange for babies to be seen within 24 hours at our community health center following their discharge. This occurs without the necessity of L+M being owned by Yale/New Haven.

This and other evidence demonstrates that close clinical coordination and cooperation already exists between L+M and Yale/New Haven. This clinical coordination already exists between Yale/New Haven personnel and community health providers in the New London area. The formal acquisition of L+M by Yale/New Haven is neither required nor justified to achieve clinical goals—that is, to serve our patients.

Should the Office of Health Care Access nevertheless consider approval of such an acquisition, it must condition such an acquisition on agreement by both parties to stipulations that would safeguard health care services in Southeastern Connecticut. These stipulations should be in force for at least 10 years and would include:

- Retaining existing health services in the New London community and not outsourcing them to other Yale hospitals or relocating them to more affluent communities in the L+M service area
- Freezing the prices charged and negotiated by L+M to existing levels with annual increases no greater than the Consumer Price Index
- Ensuring help with any transportation for health care that has to be delivered at another hospital
- Expanding health services to Southeastern Connecticut by fully funding and implementing all the recommendations emanating from the 2016 Community Health Needs Assessment conducted by L+M and the Ledge Light Health District
- Requiring that L+M and Yale/New Haven negotiate with a representative cross-section of the community a written Community Benefits Agreement with binding commitments enforced by an independent monitor on the issues of access, affordability, community benefits, efficiencies and jobs
- Assuring that L+M Hospital remains under the control of a locally controlled and locally elected Board of Directors with decision making authority and accountability to the community.

The Office of Health Care Access must consider this proposed acquisition in the context of the entire state's health care system. Consolidation of the health care system is not in the best interests of patients or communities. Consolidation weakens accountability to the communities these hospitals serve. Consolidation erodes competition and innovation, increase costs, and provides little or no additional benefits in terms of quality, safety, or accessibility.

I urge the Office of Health Care Access to deny the proposals to transfer ownership of L+M to Yale/New Haven Health Services Corporation and the merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.

Stephanie Johnson, RPSGT
President, AFTCT Local 5051 LPN/Technologists
43 Converse Pl.
New London CT
(c) 860-961-1635

Pre-filed Testimony
July 1, 2016
Office of Health Care Access

My name is Stephanie Johnson and I am the president of AFTCT Local 5051 which represents more than 270 LPN's and Technologists at Lawrence Memorial Hospital. I am a 15 year employee, the last 13 years being in my current position as a polysomnographic technologist and a resident of East Lyme. Today I am here to ask you, Office of Health Care Access, to follow Governor Malloy's directive to hold off on this takeover of Lawrence Memorial Hospital by Yale New Haven Hospital.

As a caregiver in the hospital and as president of the union, I have seen many changes and understand that sometimes change is necessary. In this instance I would say that not only is this change for the sake of change but also the changes that are made can be devastating to our community. I have reservations about many things but primarily I am concerned about access to the quality care that we provide. I think it is irresponsible for a community hospital to not be there for the region we are supposed to be here to care for. The story has already played out in Windham, how long before it reaches New London and Westerly?

I was at a meeting held jointly by L&M and Yale recently and heard for myself from Bruce Cummings, CEO of L&M Hospital that Westerly Hospital does not have the physical footprint that the hospital needs to do inpatient and outpatient services. As an employee of the New London hospital, which is also land locked and has constraints that might prevent future growth, how long until we are told that the services we provide are not going to continue. How far will our patients have to travel to receive care? I am not just a care giver but I also utilize the hospital for my care. I was born at Lawrence and Memorial Hospital, gave birth to my son there and have said final good byes to close relatives who died there. I cannot imagine having to drive to Yale to visit a sick family member and more importantly, I cannot imagine how our patients who may not have the benefit of transportation and rely on public transportation will get there.

Decisions about which services will be kept at both campuses will be made by Yale. We are asking for assurances that services for our patients will not be made by a board that seeks to fatten the already large pocket of Yale New Haven's system, as there will no longer be any viable competition which. That means reduced patient's choice to seek care at a lower cost. I have personally read the bylaws changes in the Certificate of Need and have seen the handover of control to Yale. When I asked about it, I was not taken seriously and told "Oh those are just words written in the contract." Luckily, I know how to read contracts.

We were surprised to see Yale and L+M say that L+M lacks the financial and clinical resources to run the programs necessary to take care of our community. We've watched management spend $17 million dollars that could have gone to take care of people in Greater New London on strikebreakers, lawyers

and other expenses to lock their workers out of their jobs. We've watched management spend $35 million dollars to buy an unprofitable hospital out of bankruptcy. We've watched management spend more $78 million of our hospital's profits subsidizing the growth of its physician practice, and now Yale-New Haven says the combined NEMG/LMPA practice will run $70 million a year in losses.

All of that money could have, and should have gone to strengthening our hospital's clinical programs. Instead, we see staffing cuts, the first of what may be many. In the CON, Yale-New Haven says it doesn't have any planned service cuts, but it may reduce "duplicate" services in the future. We are concerned that the duplicate services may simply be the profitable services, which will be extracted from the hospital and placed far from New London, where poorer patients and those who need help with transportation will struggle with access.

When you look at this proposal, make sure you ask what Yale's goals will be. We've already lived under management that thought they were building a small empire. Now the biggest empire in the state wants to take over.

We are asking that services be made available to this community in this community. We are asking that the community be made aware of who will be in control of these services. We are asking that any promises be guaranteed, in writing, with enforcement and oversight by the community. We are asking for you, Office of Healthcare Access to slow down this process. If, after all is said and done, and the bodies that Governor Malloy put in place to look into the laws that govern deals like this find that our concerns are not necessary, we can start a new conversation about the future of L+M, Yale and our health care system. Please allow the process to be followed, and give us time so that all questions can be asked and answered—truthfully.

Pre-filed testimony of Jason Pelletier

Office of Health Care Access

Docket #s 15-30233 CON and 15-30233, Acquisition of L+M Health Care by Yale-New Haven Health Services Corporation and Merger of Lawrence and Memorial Physicians Association into Northeast Medical Group

June 30, 2016

My name is Jason Pelletier. I live at 28 E Street, Groton Connecticut. I am a cook in the cafeteria at Pfizer in Groton, and a shop steward for UNITE HERE Local 217.

I am now almost 49 years old and have always been in great health until last year, when I contracted Lyme disease. After a run of antibiotics, all was well until symptoms started to recur this year.

My health care coverage is very important in order to cover costs of recurring doctor visits and prescriptions. I am also concerned about having adequate health coverage as I get older and have more health issues.

We are in in contract negotiations with our employers. So are 7 other corporate cafeterias in Connecticut that are operated by Compass, including our brothers and sisters at Electric Boat. We pay 20% of our premiums now, and are trying to reduce that percentage at the bargaining table.

The cost of employees' share of the premiums went up by 10% last October. That means that everyone who had coverage had a big bite taken out of the raises that we negotiated with our employer. We have a really good health plan and have fought to keep costs down, but I have coworkers who are uninsured or on state assistance because they can't afford the premiums.

Before I talk about Yale taking over our hospital, I want to tell you how hard our union works on health care costs. Our health plan, UNITE HERE Health, is run jointly by our union and employers in our industries. Workers in our union take leave from their jobs for several weeks to educate their coworkers and help them sign up for a primary care doctor and get their biometric tests so that they can work with our health plan to improve their health and avoid going the hospital. We have run a union-wide education program to educate our coworkers on how to tell the difference between a health care problem and a real emergency, and to use Urgent Care or see their doctors instead of the Emergency Room, unless they really need to go. As a steward, I'm trained to help my coworkers use health care the right way, and to help them connect with our health plan if they have problems.

But that won't matter if prices for hospitals and doctors go up because Yale takes over our hospital. Even if we convince our employer to lower the percentage of the premiums that we pay, if the care itself gets more expensive, premiums will go up and we'll be paying what we paid before. Please stop this takeover, or, if it is approved, make Yale-New Haven guarantee in writing that they won't raise prices.

We don't make a lot of money. As a cook, I make $16.44 an hour, and I'm one of the better paid people in our workplace. I'm fortunate to have full-time hours and a steady paycheck. But none of us can afford

to pay more for health care. Affordable health insurance has always been important to me, but where I'm at in my life now, I can't do without it. Thank you.

Pre-filed Testimony
July 1, 2016

Fred Hyde, M.D.
57 Main Street
Ridgefield, CT 06877

A. General Background

(1) The proposed acquisition of L+M Health Corporation (L+M) by Yale-New Haven Health Services Corporation (YNHHSC) comes at an important moment in the American and Connecticut health care systems.

(2) The Patient Protection and Affordable Care Act (PPACA) has failed to control the ongoing growth of health care costs.

(3) In the five years since passage of the PPACA, private sector health care insurance premiums grew at three times the rate of general inflation, faster in relation to inflation than during the five years prior to passage.

(4) A portion of this increase in health and hospital expense can be *directly attributable to the consolidation of hospitals and health systems*. These consolidations result in:

(a) Higher prices through monopoly market position;

(b) Inflated expenses resulting from more complex and more generously compensated management, with hospital administration now accounting for 1.43% of the nation's Gross Domestic Product; and

(c) Compromise to the integrity of physician judgment when such hospital and health system consolidations include physician practices.

(5) The burden of these costs falls on the patient, the patients' families, and society, through higher health insurance premiums, higher out-of-pocket payments and compromises to choice and freedom. The Kaiser Family Foundation reports that insurance deductibles grew nearly seven times faster than worker earnings in the five years following PPACA passage.

(6) This is the background against which OHCA is called upon to evaluate yet another attempt at monopoly acquisition (another hospital by a health system) and consolidation of institutional control over professional judgment through hospital-sponsored medical groups.

(7) *OHCA's task is non-delegable*. Legal redress opposing or attempting to remedy hospital monopolies has proven to be unreliable: even when "after-the-merger" remedies or checks are in place, inevitable cost increase occurs.

The FTC has allowed the Hart-Scott-Rodino review period to lapse, and the federal government continues to struggle to win cases under antitrust laws.

(8) OHCA awards a Certificate of Need "franchise" to private corporations which are engaged in publicly funded services: the *award must be based on the public good*, not on private gain.

One state with challenges parallel to those of Connecticut is Massachusetts. Testimony is offered on the applicability of findings from that state to the challenge facing OHCA in this and similar Certificate of Need applications.

B. The Applicants assert these arguments in support of Docket No. 15-32033-CON (**affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Corporation**), and Docket No 15-32032, (**merger of L&M Physician Association and Northeast Medical Group**):

(1) Lawrence + Memorial as a system *does "not have the clinical and financial resources" to "integrate service delivery and assume responsibility for achieving specific quality, cost and service outcomes."* [1];

a. Lawrence + Memorial only lacks financial resources as a result of empire building and other imprudent management decisions, including:

(i) Expensive attempts to outsource services, and to "lock out" unionized employees performing those services, about which other members of the coalition will provide more detailed testimony;

(ii) The acquisition of the bankrupt Westerly Hospital for a reported price of $35 million; and

(iii) The extraordinary subsidy of physician practices. The **first attachment** to this document shows the extent to which hospital revenues are generating adequate margins to support operations and maintenance, but are subsidizing physician practice and other "system" losses. Those losses amount to $78 million over the past five years. The combined new NEMG practice is expected to lose $70 million per year.

b. In general, not-for-profit hospitals are doing well financially.[2] In fiscal year 2015 Moody's reports that not-for-profit hospitals had median annual growth rate of 7.4% and median three-year revenue compounded annual growth rate of 5.6%.

(2) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial as a system would *achieve efficiencies through economies of scale*, and patients will receive *"the right care at the right time and in the most cost effective setting."*

a. However, evidence provided here (the **second attachment**, a list of peer-reviewed journal articles provided electronically) shows that such economies have not been achieved in similar health system acquisitions in the past, and that consolidation leads to significant price increases and resulting systemic cost growth. Consider these critical examples from a body of literature that grows daily:

i. A comprehensive study by the Massachusetts Health Policy Commission found that market power is the primary determinant of prices in the state,

[1] OHCA Docket 15-32033-CON, p. 25
[2] Health Care Policies and Trends, *Healthcare Financial Management*, June 2016, Page 18

and that community hospitals provide the same care at much lower price as the dominant system.

ii. Cooper[3] et al studied nearly 4 billion private sector claims nationwide and found that the primary determinant of health care costs is the price of provider services, and that the most powerful determinant of provider price is market power – not quality, not size, not academic status or reputation. Parenthetically, these authors noted that one area of the country with ***both*** high Medicare and high private commercial health insurance costs is New Haven, CT.

iii. Gowrisankaran[4] et al studied data on post-merger pricing and found that separately negotiated prices do not negate the impact of a system's market power. Newly purchased hospitals still gain a price premium.

A new study of leverage in California hospitals[5] indicates that monopolist health systems took active advantage of their status, leading to steadily increasing price differentials, separating them from non-monopolist hospitals by as much as $4,000 per discharge.

iv. The Applicant's own evidence makes this point. The Health Care Cost Institute's report submitted with the application notes that the primary driver of health care cost increases is provider and pharmaceutical pricing.

b. Despite OHCA's request and the urging of legislators, the Applicants flatly refuse to provide comparative price data between L+M and the YNHHS hospitals. However, original analysis of Medicare payments submitted as part of this testimony shows that, almost uniformly, payments for services at Yale-New Haven (including low acuity services) are significantly higher than those at Lawrence + Memorial and much higher than other currently independent hospitals.

The **third attachment** to this testimony is excerpted from 2013 CMS records of billing and payment by DRG by hospital for the top 100 DRGs in Connecticut hospitals.

No evidence has been offered by applicants to demonstrate that past acquisitions or affiliations (Bridgeport, Greenwich) have produced economies similar to those predicted in the current application. To the contrary, these hospitals remain among the most expensive in Connecticut;

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[3] Cooper, Z. et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015

[4] Gowrisankaran, G., et al, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *The American Economic Review*, March 2013

[5] Melnick, G. and K. Fonkych, "Hospital Price Increases in California, Especially Among Hospitals in the Largest Multi-hospital Systems," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, Volume 53: 1-7, 2016

c. A report by members of the intervenor coalition from December of last year, submitted as the **fourth attachment,** demonstrates that this acquisition will lead to extreme market concentration in the L+M service area, and intensify Yale-New Haven's market power from New York to the Rhode Island border. If this acquisition is consummated, Yale-New Haven Health Systems will account for 83% of discharges in L+M's primary service area, and nearly 60% of all inpatient discharges in the southern half of the state. Using the federal government's standard measure, the growth in market concentration in each of those areas would be presumed to create excessive market power.

d. Consolidation can alter financial and referral relationships to create a "death spiral" for community hospitals. The Massachusetts Health Policy Commission, in its comprehensive study of community hospitals and the effect of monopolist systems, has concluded that the provision of *routine* hospital care at academic medical centers and teaching hospitals leads to lower total and commercial inpatient volume at community hospitals.

   This sequence of events, in turn, leads to lower prices at community hospitals, poor hospital financial performance, limited ability to invest, and barriers to adoption of new technology. This cycle reinforces patient preferences for academic medical centers and teaching hospitals, even for routine hospital care.

   For patients left behind in communities like Windham and New London, especially those (i) without transportation to the central hospital, (ii) good health insurance, or (iii) well-connected doctors, this practice results ***in patient red-lining***, leaving the poor and aged to be served by inferior hospitals, made inferior as their patients are drawn out of local services, and into the central "name-brand" academic medical center.

   The initial and understandable community "rapture" at being part of a larger, more exciting, more capable health system becomes, in short order, the recognition that the community hospital has been "left behind."

e. The Applicants have offered no evidence that the acquisition of Lawrence + Memorial Physicians Association, L+M's 70-physician group medical practice, will create efficiencies with any meaningful return to patients and payers. Extensive bibliographic evidence of studies in academic, professional and public service literature, submitted as the **fifth attachment**, indicates that such efficiencies will not result.

f. For example, Robinson[6] et al, found that physician practices in California that were owned by local community hospitals had costs 10% higher than physician-owned organizations. Practices owned by regional multi-hospital systems generated costs 20% higher than physician-owned practices.

g. **Excessive bureaucracy** will increase expenses, including (a) more layers of management between the physician and the patient, (b) attempts to conform

[6] Robinson, J. and K.Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA*, October 22/29, 2014;312(16):1663-1669

physician behavior to purchasing, referral or other financial direction, (c) hospital-oriented -- that is, institutional and hospital revenue cycle-oriented -- information systems.

h. OHCA should view with skepticism the idea that installation of the EPIC electronic medical record system will generate efficiency or improve quality. The Partners system in Massachusetts spent $1.2 billion to go live in 2015, double the original budgeted $600 million. Auditors for Southcoast Health hospitals in Massachusetts attribute a $30 million 2014 operating loss and 105 layoffs in part to the cost of EPIC.[7] Southcoast (and other Massachusetts hospitals) are attempting to "keep up" with the highest priced system, Partners, as Partners attempts to meet its own budget requirements by electronic steering of patients from distant corners of that State.

   Moreover, "efficiencies" or quality improvements resulting from the use of one or another brand of electronic health record systems are purely speculative. There is no generalizable data showing that EHRs are actually helping control health costs, and EPIC is an extraordinarily expensive product.

(3) If acquired by Yale-New Haven Health Services Corporation, Lawrence + Memorial would achieve *higher quality* in care provided.

a. The recent comprehensive study of all hospitals in Massachusetts by the Health Policy Commission (HPC), cited above, reveals that spending at community hospitals is lower for low acuity inpatients and "is not associated with any difference in quality."

b. In fact, the HPC study showed that "Most community hospitals provide care at a lower cost per discharge, without significant differences in quality," nearly $1,500 less per inpatient according to that study. This HPC study is **the sixth attachment** to this testimony.

c. The **fifth attachment** (as also noted above) is a list of peer-reviewed journal articles that report, among other findings, no evidence that consolidation of large and small hospital systems produces higher quality care. There is, to the contrary, some evidence that care improvements and patient safety both become victims of bureaucratic inertia and indifference.

d. Extensive bibliographic evidence of studies in academic, professional and public service literature indicates that the "quality" of physician services will not increase, and may, in fact, be compromised.

(4) That *access to primary and advanced specialty care will be greatly enhanced* for the citizens of the Lawrence and Memorial hospital service area through the acquisition. This argument is contradicted by:

a. The example of Windham Hospital's acquisition by Hartford HealthCare, to which testimony will be given by others.

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[7] Akanksha Jayanthi, "8 Epic EHR implementations with the biggest price tags in 2015," *Becker's Health IT and CIO Review*, 7/1/2015

b. Compromise to physician resistance achieved through acquisition of medical practices. Doctors will ordinarily be fighting for their patients' rights, with insurance companies, vendors and even with hospitals. When the doctor is owned by the hospital, judgments may be altered concerning necessary services, referrals and costs. See the **fifth attachment** for journal studies in this area;

c. Changing governance and control will render local officials and L+M itself incapable of protecting local services. The hearing notice makes clear that OHCA rejects the notion that this is not an acquisition. Upon consummation, the deal will leave all relevant decision-making authority in the hands of Yale-New Haven Health System.

d. **Patient choice** will be severely compromised, if not eliminated. The Massachusetts Health Policy Commission study indicated that, as the result of consolidation in that state, "Patients often mentioned that they did not feel they had a choice of hospitals because their primary care provider or insurance plan determined where they could go for care."

   In fact, insurance carriers are driven by the financial impact of monopolist pricing to develop narrow networks of providers. This results in limited or non-existent flexibility for the patient and the patient's treating physician. Insurers are compelled to this strategy as a means of attempting to secure discounted prices from price-gouging monopolist systems, in return for assurance of increased volume.

e. **Physician integrity** may be compromised. Since patients rarely evaluate the quality of medical care, instead valuing the recommendations of physicians, those recommendations become very important.

   Contracts involving "owned" physicians reveal requirements for which service to use, what imaging center, what laboratory, what pharmaceutical products have been included in the formulary of the monopolist system, all of these limitations on the ability of the practicing physician to put their patients' interest first.

   Many physicians in independent practice face overwhelming bureaucracy and micro-regulation. These bureaucratic challenges are complicated by the extraordinary difficulty of actually being paid for work done. Many therefore have thrown in this particular "towel," resigned to doing the best they are able under the constraints of monopolist systems. By way of recompense, physicians who have ceded such freedoms now have salaries or practice income guarantees supported by double billing and price-gouging associated with large health systems.

f. Applicants' submission of misleading data about the flow of patients to out-of-state providers, obscuring a potential reduction in the diversity of providers. The applicants break out discharges from New York and Massachusetts providers, but neglect discharges from Rhode Island Hospital. RIH, the affiliated hospital of Brown University Medical School, is the most obvious competitor for subspecialty care to Yale-New Haven Hospital – the two hospitals are exactly equidistant from New London.

   OHCA must ask the Applicants what mechanism they will use to shift patient flows from "distant" competitors. Why should an acquisition change referral patterns? Without reviewing all provider employment, affiliation and practice management

agreements between YNHHS, NEMG and all employed physicians and/or affiliated group practices, OHCA cannot fairly evaluate the impact on access. If doctors are contractually bound to refer to YNHHS, patients – especially those in towns west of the Thames River – will lose choice and will incur higher costs due to monopoly pricing effects.

The cancellation of L+M's affiliation with the Dana Farber Institute offers an ominous foreshadowing of this effect. There is no reason L+M can't allow its doctors and their patients access to two brand-name cancer hospitals. Patients should have their choice of providers when their care requires subspecialty services only available outside New London.

g. The terms of the supposed **$300 million investment** in health in Southeastern Connecticut. The applicants refuse to offer specifics about how much they will really invest, what they will invest in, or where the money will come from.

All of the hypothetical $300 million appears to be contingent on future programs being consistent with the YNHHSC strategic plan, mutually agreed upon (between YNHHS and L+M), and *displaying a positive return on investment.* In other words, there would be no new investment in the Greater New London community's health unless that investment earns Yale-New Haven Health System a profit.

The proposed expenditures for "physician and clinical recruitment" require scrutiny. The system spent $54.5 million in cash to buy PriMed LLC in 2014. If by "recruitment," Yale actually means "buying up the physician practices that L+M hasn't already purchased," patients will not benefit.

In fact some or all of the $300 million is supposed to come from efficiencies that lead to lower expenses in L+M's future operations, or perhaps from the other YNHHS hospitals. The application assumes that L+M will eliminate more than 200 jobs and more than $130 million in wage and benefit expense ***during the first three years***. (See **attachment seven**, excerpts from the application.) Over seven to ten years, L+M could generate its own $300 million in funds to invest, and have control over how they would be invested. Of course, these may be needed jobs for the delivery of patient services.

h. **Financial pressure on patients** will be increased, perhaps intolerably so, as evidenced by these examples:

There is a well-known history of abusive bill collection practices at Yale-New Haven. These abuses were investigated by the then-Attorney General;

Approximately 35% of the accounts receivable of the nation's hospitals is now categorized as "patient responsibility." Articles in the hospital field call the patient the "new payer." Pressure on hospital revenue cycle performance will, of necessity, be addressed now more directly and forcefully to patients;

Also, narrow networks allow referral only to "approved" doctors, leading to "surprise" bills (for out-of-network services, specialties not covered, services in other parts of Connecticut, other states).

Hospitals Owning Doctors

The shift of physician practices from 70% physician-owned in 2003 to less than 55% physician-owned by the end of 2010 (Mathews, A., "When the Doctor Has a Boss," *The Wall Street Journal*, November 8, 2010) was accompanied by extraordinary increases in the cost of medical care, even by the standards of high prices and inflation in the health care field.

Who benefits? If these proposals before OHCA will not produce efficiency, improvement in quality or control of cost, but will, to the contrary, lead to bureaucratic inefficiency, decline in physician integrity and accountability, and increase in cost, why then do their sponsors put them forward?

Hospitals and the Public Interest

Put simply, executives prosper. At Yale-New Haven, for example, **attachment eight** demonstrates that compensation of the top ten most highly compensated executives has increased by 100% in the time period (2006-2014) when smaller and independent hospitals have had increases of 20 – 25%.

Moreover, the doubling of administrative cost has an impact on the perception of those less handsomely compensated, such as practicing doctors. The surge of doctors seeking to become administrators has spawned extraordinary growth in schools of business, public health and hospital administration. Doctors see the lavish compensation of executives, the unhurried hours, and quickly deduce the market strategy (get bigger, earn more). Of course, all of this affects the patient.

A study published in *Health Affairs* and summarized by the Commonwealth Fund compared hospital administrative costs in eight countries and found that such costs accounted for 25% of hospital spending in the United States, twice the proportion seen in other advanced nations.

The hospital administration share of gross domestic product for the entire country rose from .98% to 1.43% between 2000 and 2011. Moreover, "There was no apparent link between higher administrative costs and better-quality care."

This anomaly—societal concern and even outrage over health prices, yet skyrocketing compensation for hospital administrators—is made possible by the financial insulation enjoyed by members of those hospital boards.

In short, public agencies—not private boards or conflicted executives—will have to "stand in" for governance, if public interests are to be served.

C. Summary

In summary, the applicants have failed to successfully address these issues identified by OHCA:

(1) Public need:

a. There is no "public need" demonstrated for this proposal;

b. To the contrary, the public good (preservation of the lowest possible rates for health services and health insurance; the guarantee of local autonomy concerning decisions involving access to services; measures preserving the independence and integrity of physicians) argues against this proposal;

(2) **Impact on residents**, including how access to services (including specialty care) will be maintained or improved:

a. The applicants have failed to provide evidence that the access to specialty services will be improved. To the contrary, evidence has been presented that in other acquisitions by market-leading health systems in Connecticut (e.g., Hartford HealthCare acquisition of Windham Hospital), services have diminished. In that example, specialty and hospital care has been transferred incrementally to centrally-located specialists with Hartford.

b. Similar migration of specialty services has been demonstrated in a comprehensive study of community hospitals in Massachusetts by the Massachusetts Health Policy Commission.

(3) **Benefits achieved** in the Bridgeport/Greenwich Hospitals service areas:

a. There is no evidence that has been presented that either financial stability or enhanced programs or services have taken place in the Bridgeport and/or Greenwich Hospital services areas, beyond whatever trends and factors have applied to the hospital industry as a whole.

b. Neither OHCA nor the applicants have produced complete records of the "before" and "after" assessment of "financial stability or enhanced programs or services." The submission of incremental and selected information by the applicants more than six months after the beginning of the CoN process indicates that demonstration of the benefits of previous hospital acquisitions has not been a priority.

These applications fail to meet the standards in PA 14-168 Section 7(a)(3), (4), (5), (11) and (12).

(3) Applicants have not demonstrated a clear public need.

(4) By refusing to provide price data, applicants have failed to adequately demonstrate how the proposal will impact the financial strength of the health care system, particularly if one views patients and payers as part of the system.

(5) Applicants have not satisfactorily demonstrated how the proposal will improve the quality, accessibility, and cost effectiveness of health care. Intervenors have presented a large volume of evidence to the contrary.

(11) Applicants have not satisfactorily demonstrated that the proposal will *not* negatively impact the diversity of health care providers and patient choice in the geographic region. This is a new and much higher burden of proof for both OHCA and the Applicants. Intervenors have raised a series of questions about the vague generalities in the application, without answers to which OHCA cannot plausibly certify having met this standard.

(12) Applicants have failed to provide any evidence that the consolidation from the proposal will *not* adversely affect health care costs or accessibility to care. Again, this is a new standard, enacted by the General Assembly specifically to address the circumstances currently under review. When OHCA pressed the applicants to say whether any of the supposed cost savings from the acquisition would be passed on to consumers, they simply refused.

These proposals should not be ruled on until January 15, 2017 or until the Governor's Task Force makes its recommendations. If forced to rule by the statutory calendar, OHCA must deny them. Regardless of Executive Order 51, the applications as written fail the relevant statutory tests and must be denied whenever they ripen for decision.

The only possible scenario under which a proposed takeover of L+M by YNHHS or any other major system could proceed is with permanent, concrete written guarantees on access, cost, quality and workplace standards, all negotiated directly with a representative cross-section of the community and with ongoing enforceable community oversight. We have attached our coalition's "Vision and Values Statement" which includes details of our vision for the future of the Southeastern Connecticut health care system.

Thank you for your attention.

EXHIBIT 1

YNHHS and L+M, Holding Company Profit and Loss, Hospital Profit, Physician Subsidy

	2015	2014	2013	2012	2011
Yale New Haven Health System					
Holding Company Profit (Loss)	$144,091,000	$204,301,000	$168,660,000	$130,416,000	$71,016,000
Hospital/Hosp + Sub Profit	$105,816,000	$160,785,000	$178,722,000	$130,609,000	$67,162,000
Physician Subsidy	$53,931,000	$45,621,000			
Lawrence + Memorial					
Holding Company Profit (Loss)	$1,536,369	($3,388,068)	$2,253,354	$7,721,331	$15,902,773
Hospital Profit	$14,522,752	$5,979,688	$10,767,187	$17,549,573	$16,766,396
Physician Subsidy	$20,061,502	$20,865,372	$15,724,357	$12,069,947	$9,263,443

Source: audited financial statements

EXHIBIT 2

Exhibit One
Monopoly Prices in Health Care, The Result of Hospital Consolidation

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EXHIBIT 3

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Septicemia or Severe Sepsis W MV 96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	81	$310,648	**$85,235**	$74,434	**$10,801**
St. Francis Hospital & Medical Center	29	$158,137	$60,347	$48,067	$12,280
Bridgeport Hospital	15	$158,715	**$57,016**	$53,003	**$4,013**
Hospital of Central Connecticut	28	$124,601	$52,428	$41,063	$11,365
Hartford Hospital	33	$139,676	$52,283	$46,420	$5,863
Manchester Memorial Hospital	16	$174,226	$50,655	$49,772	$883
William W. Backus Hospital	11	$91,957	$48,128	$38,732	$9,396
Saint Mary's Hospital	19	$72,890	$45,681	$42,864	$2,817
Lawrence & Memorial Hospital	15	$93,194	**$44,932**	$44,211	**$721**
Waterbury Hospital	25	$143,911	$43,622	$39,899	$3,723
Middlesex Hospital	16	$161,074	$43,016	$41,385	$1,631
MidState Medical Center	12	$71,954	$38,774	$38,038	$736

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Infectious & Parasitic Diseases W O.R.
Procedure W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	12	$140,156	$68,723	$62,636	$6,087
Yale-New Haven Hospital	120	$202,690	**$63,477**	$56,019	**$7,458**
Norwalk Hospital Association	15	$214,160	$62,501	$56,386	$6,115
Bridgeport Hospital	23	$156,619	**$54,100**	$43,510	**$10,590**
Stamford Hospital	34	$178,845	$51,370	$49,450	$1,920
St. Francis Hospital & Medical Center	34	$128,416	$51,080	$44,622	$6,458
Waterbury Hospital	25	$200,489	$50,593	$46,907	$3,686
Hartford Hospital	98	$114,399	$48,902	$43,311	$5,591
Saint Mary's Hospital	25	$78,892	$44,855	$42,893	$1,962
St. Vincent's Medical Center	22	$108,916	$43,810	$36,102	$7,708
Griffin Hospital	15	$111,374	$41,967	$40,039	$1,928
Lawrence & Memorial Hospital	37	$86,724	**$41,567**	$39,538	**$2,029**
William W. Backus Hospital	37	$83,688	$41,302	$36,969	$4,333
Danbury Hospital	16	$86,609	$40,480	$38,556	$1,924
Middlesex Hospital	27	$152,242	$39,522	$37,910	$1,612
Hospital of Central Connecticut	42	$78,346	$38,158	$34,812	$3,346
Greenwich Hospital Association	11	$123,456	**$38,080**	$36,732	**$1,348**
Manchester Memorial Hospital	30	$112,079	$37,533	$36,745	$788
MidState Medical Center	26	$71,300	$35,872	$33,463	$2,409
Charlotte Hungerford Hospital	17	$53,134	$31,503	$30,075	$1,428

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	11	$130,340	$63,059	$58,620	$4,439
Yale-New Haven Hospital	90	$174,277	**$58,706**	$52,041	**$6,665**
Stamford Hospital	24	$205,005	$50,763	$48,905	$1,858
Norwalk Hospital Association	17	$161,687	$49,798	$46,130	$3,668
Bridgeport Hospital	14	$183,169	**$49,112**	$45,626	**$3,486**
St. Francis Hospital & Medical Center	34	$138,873	$48,929	$45,632	$3,297
Danbury Hospital	26	$122,442	$47,977	$42,206	$5,771
St. Vincent's Medical Center	22	$168,701	$46,987	$43,328	$3,659
Hartford Hospital	42	$99,028	$42,729	$39,399	$3,330
Middlesex Hospital	21	$172,377	$42,616	$41,002	$1,614
Lawrence & Memorial Hospital	12	$96,118	**$40,832**	$35,154	**$5,678**
Saint Mary's Hospital	11	$96,824	$40,716	$38,949	$1,767
Greenwich Hospital Association	12	$125,846	$38,204	$36,592	$1,612
Bristol Hospital	16	$118,331	$37,414	$36,530	$884
Waterbury Hospital	15	$136,953	$37,140	$35,004	$2,136
Hospital of Central Connecticut	27	$88,070	$36,713	$35,055	$1,658
MidState Medical Center	27	$75,716	$36,492	$33,697	$2,795
Manchester Memorial Hospital	13	$89,343	$34,247	$29,579	$4,668
William W. Backus Hospital	14	$61,329	$32,713	$31,709	$1,004
Charlotte Hungerford Hospital	14	$57,485	$31,433	$30,673	$760

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Respiratory System Dx W Ventilator Support
96+ Hours

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	60	$202,775	**$60,818**	$56,656	**$4,162**
Bridgeport Hospital	13	$176,297	**$56,366**	$52,897	**$3,469**
Norwalk Hospital Association	26	$185,081	$54,524	$52,202	$2,322
Hartford Hospital	28	$176,005	$52,351	$47,429	$4,922
Manchester Memorial Hospital	14	$145,965	$52,058	$40,189	$11,869
Danbury Hospital	13	$123,626	$50,969	$36,085	$14,884
St. Francis Hospital & Medical Center	24	$142,835	$50,483	$47,648	$2,835
St. Vincent's Medical Center	12	$169,032	$47,863	$39,396	$8,467
Saint Mary's Hospital	14	$72,570	$42,707	$33,796	$8,911
Lawrence & Memorial Hospital	20	$72,632	**$42,362**	$35,254	**$7,108**
William W. Backus Hospital	14	$94,899	$42,219	$35,684	$6,535
Hospital of Central Connecticut	24	$102,087	$40,720	$38,574	$2,146
Waterbury Hospital	11	$133,217	$38,140	$34,802	$3,338
MidState Medical Center	13	$84,483	$37,188	$36,733	$455
Middlesex Hospital	21	$127,717	$35,824	$34,429	$1,395
Charlotte Hungerford Hospital	13	$58,770	$34,149	$32,069	$2,080

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Spinal Fusion Except Cervical W/O MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	107	$88,003	**$41,497**	$35,917	**$5,580**
John Dempsey Hospital	55	$54,387	$40,845	$37,805	$3,040
Bridgeport Hospital	23	$100,121	**$37,203**	$31,497	**$5,706**
Hartford Hospital	78	$57,900	$34,783	$27,294	$7,489
Norwalk Hospital Association	29	$100,576	$34,032	$32,417	$1,615
Danbury Hospital	54	$72,815	$33,594	$27,322	$6,272
Stamford Hospital	17	$129,246	$32,690	$29,709	$2,981
Saint Mary's Hospital	25	$81,847	$32,119	$25,184	$6,935
St. Vincent's Medical Center	21	$70,481	$32,054	$30,560	$1,494
Greenwich Hospital Association	28	$158,360	**$31,394**	$27,047	**$4,347**
St. Francis Hospital & Medical Center	70	$42,545	$31,302	$27,700	$3,602
Lawrence & Memorial Hospital	16	$75,241	**$30,013**	$28,832	**$1,181**
Waterbury Hospital	26	$144,435	$29,952	$25,218	$4,734
Hospital of Central Connecticut	29	$79,744	$29,488	$28,308	$1,180
New Milford Hospital	13	$36,857	$28,916	$24,487	$4,429
Middlesex Hospital	19	$110,939	$28,693	$25,097	$3,596
MidState Medical Center	12	$72,749	$27,806	$26,627	$1,179
William W. Backus Hospital	72	$47,418	$27,151	$24,440	$2,711
Rockville General Hospital	29	$45,887	$24,461	$22,523	$1,938
Charlotte Hungerford Hospital	33	$21,714	$23,945	$21,278	$2,667

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Other Vascular Procedures With MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Middlesex Hospital	12	$174,250	$38,456	$36,551	$1,905
Yale-New Haven Hospital	79	$135,606	**$38,296**	$35,731	**$2,565**
Stamford Hospital	12	$159,728	$34,254	$32,540	$1,714
Danbury Hospital	22	$96,541	$32,267	$25,353	$6,914
Hartford Hospital	73	$83,857	$29,041	$26,612	$2,429
St. Francis Hospital & Medical Center	30	$83,915	$26,624	$25,165	$1,459
St. Vincent's Medical Center	16	$76,358	$25,618	$24,552	$1,066
Saint Mary's Hospital	13	$52,451	$25,068	$24,006	$1,062

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Hip L& Femur Procedures Except Major Joint
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	41	$138,463	**$38,348**	$33,057	**$5,291**
Stamford Hospital	13	$127,169	$29,561	$28,118	$1,443
Bridgeport Hospital	14	$81,959	**$28,016**	$25,755	**$2,261**
Hartford Hospital	56	$60,199	$25,384	$22,919	$2,465
Norwalk Hospital Association	13	$79,773	$25,255	$23,679	$1,576
St. Vincent's Medical Center	15	$86,790	$25,218	$23,223	$1,995
Lawrence & Memorial Hospital	16	$46,929	**$24,778**	$19,022	**$5,756**
St. Francis Hospital & Medical Center	25	$69,793	$24,706	$23,328	$1,378
Danbury Hospital	25	$57,373	$24,119	$22,871	$1,248
Hospital of Central Connecticut	25	$64,529	$22,876	$21,677	$1,199
Waterbury Hospital	15	$79,965	$22,327	$20,985	$1,342
Greenwich Hospital	14	$101,216	**$22,016**	$20,670	**$1,346**
Middlesex Hospital	20	$78,502	$20,670	$19,232	$1,438
MidState Medical Center	15	$55,966	$20,173	$19,315	$858
Charlotte Hungerford Hospital	12	$37,816	$18,874	$17,996	$878

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Major Small & Large Bowel Procedures W CC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
John Dempsey Hospital	14	$47,604	$27,884	$25,212	$2,672
Yale-New Haven Hospital	93	$74,952	**$26,205**	$21,802	**$4,403**
Stamford Hospital	24	$124,873	$25,037	$23,465	$1,572
Norwalk Hospital Association	23	$86,327	$24,176	$21,118	$3,058
Bridgeport Hospital	20	$74,235	**$23,887**	$19,380	**$4,507**
Greenwich Hospital Association	42	$78,156	**$23,388**	$17,851	**$5,537**
Waterbury Hospital	19	$106,740	$23,111	$21,013	$2,098
Hartford Hospital	68	$51,502	$22,477	$18,355	$4,122
MidState Medical Center	25	$53,290	$22,143	$13,714	$8,429
St. Francis Hospital & Medical Center	62	$56,193	$21,189	$18,850	$2,339
Danbury Hospital	33	$67,201	$20,728	$18,782	$1,946
St. Vincent's Medical Center	32	$52,380	$20,438	$17,881	$2,557
Hospital of Central Connecticut	33	$43,989	$19,505	$17,296	$2,209
Saint Mary's Hospital	25	$54,208	$19,306	$17,936	$1,370
Griffin Hospital	13	$67,822	$19,135	$17,659	$1,476
Middlesex Hospital	31	$86,394	$18,870	$17,074	$1,796
Lawrence & Memorial Hospital	17	$48,783	**$18,657**	$17,678	**$979**
William W. Backus Hospital	45	$39,831	$17,888	$15,142	$2,746
Manchester Memorial Hospital	21	$50,777	$17,071	$14,998	$2,073
Bristol Hospital	15	$57,521	$16,599	$15,813	$786
Charlotte Hungerford Hospital	21	$31,548	$15,957	$14,889	$1,068

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Circulatory Disorders Except AMI, W Card Cath
W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	65	$120,592	**$28,531**	$25,275	**$3,256**
Hartford Hospital	64	$71,032	$21,132	$16,888	$4,244
St. Vincent's Medical Center	26	$79,241	$19,916	$16,494	$3,422
St. Francis Hospital & Medical Center	40	$53,805	$18,661	$16,819	$1,842
Danbury Hospital	12	$48,886	$18,543	$13,047	$5,496
Lawrence & Memorial Hospital	14	$39,395	**$15,344**	$14,496	**$848**
Hospital of Central Connecticut	11	$36,002	$14,949	$13,855	$1,094

Source: FY2013, CMS Data

Variation in Connecticut Hospital Charges and Medicare Payment (Medicare plus patient)

Intracranial Hemorrhage or Cerebral Infarction W MCC

Hospital	Discharges	Average Charge (Hospital bills Medicare)	Average Payment (Medicare and patient)	Average Medicare Payment	Average Patient Payment
Yale-New Haven Hospital	138	$94,839	**$24,649**	$21,717	**$2,932**
John Dempsey Hospital	19	$27,682	$20,308	$18,596	$1,712
Bridgeport Hospital	29	$49,352	**$19,343**	$15,691	**$3,652**
Hartford Hospital	143	$55,092	$17,903	$15,145	$2,758
St. Francis Hospital & Medical Center	86	$57,287	$17,058	$15,649	$1,409
Windham Community Memorial Hospital	13	$19,960	$16,147	$15,323	$824
Danbury Hospital	50	$37,247	$15,970	$14,198	$1,772
Norwalk Hospital Association	39	$48,086	$15,837	$13,720	$2,117
St. Vincent's Medical Center	33	$45,394	$15,776	$14,137	$1,639
Stamford Hospital	39	$62,925	$15,021	$13,826	$1,195
Saint Mary's Hospital	29	$25,038	$14,670	$13,448	$1,222
Hospital of Central Connecticut	53	$34,972	$14,643	$12,615	$2,028
Waterbury Hospital	33	$49,025	$14,378	$13,132	$1,246
Griffin Hospital	15	$42,608	$13,961	$12,562	$1,399
Greenwich Hospital Association	37	$47,276	**$13,639**	$12,463	**$1,176**
Lawrence & Memorial Hospital	41	$30,269	**$13,047**	$12,207	**$840**
Middlesex Hospital	36	$55,045	$12,635	$11,568	$1,067
William W. Backus Hospital	19	$26,775	$12,458	$11,657	$801
MidState Medical Center	31	$32,481	$12,041	$11,245	$796
Charlotte Hungerford Hospital	15	$14,539	$11,321	$10,460	$861

Source: FY2013, CMS Data

EXHIBIT 4

HOSPITAL MARKET CONCENTRATION IN CONNECTICUT:

The Impact of Yale-New Haven Health System's Expansion

CCAG
CONNECTICUT CITIZEN ACTION GROUP

Connecticut Health Policy Project

United Action Connecticut

1199NE | SEIUHealthcare United for Quality Care

Council 4 AFSCME
We Make Connecticut Happen

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A Union of Professionals

UNITEHERE! Connecticut

EXECUTIVE SUMMARY

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If currently proposed mergers are completed, more than 80% of Connecticut's patients will receive care from hospitals owned by large, powerful multi-hospital systems. Driven in part by new "shared savings" reimbursement policies in the state Medicaid and federal Medicare programs, this trend is accelerating.

Connecticut now has five major acquisitions pending, including the expansion of the state's most powerful health care entity. The Yale-New Haven Health System has proposed to buy Lawrence and Memorial Health, which owns both Lawrence and Memorial Hospital in New London and Westerly Hospital in Rhode Island. At the same time, Milford Hospital was forced to shut down Labor and Delivery services when its leading Obstetrician/Gynecologists defected to Yale-New Haven Hospital. Financially distressed, Milford now leases space to Yale-New Haven Hospital for its regional inpatient rehabilitation services. A slow-motion takeover appears to be in process.

The most recent data available show that Connecticut has the 4th highest health care costs in the United States, but lags in most measures of quality. Numerous academic studies show that as providers take each other over and limit competition, prices go up without service improvement—and the more heavily concentrated the market is to begin with, the higher the price increases.

The co-authors of *Hospital Market Concentration in Connecticut: The Impact of Yale-New Haven Health System's Expansion*, have worked together on legislative solutions to the challenges of growing hospital monopoly for the past several years. In continuing that work, we have analyzed state inpatient hospital discharge data and mapped the potential changes to the state's health care markets if Yale-New Haven buys L+M and swallows up Milford Hospital. The report examines five geographic areas, from L+M's relatively small self-defined service area, to an area covering the southern half of the state.

The data yield three key metrics: the percentage market share held by Yale-New Haven Health, the score for each area on a standard government measure of market concentration called the Herfindahl-Hirschmann Index, or "HHI", and the amount of change in the concentration of the hospital market in each area. The findings include:

- Though consumers already face a market with limited competitive pressure to protect them, the Milford and L+M takeovers will significantly increase the Yale-New Haven Health System's market share in all five areas. In L+M's primary service area, Yale-New Haven Health System will grow from 14% to 83% of inpatient discharges.
- All five geographic regions studied easily meet the federal government's standard for a "highly concentrated" market even before the two takeovers. Highly concentrated markets lack competition and can lead to artificially excessive prices.
- In the market areas studied, the size of the increase in consolidation caused by YNHHS's expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will "obtain market power," which federal regulatory standards warn against.[1] Studies show that mergers in already highly consolidated markets can often lead to price increases of 20%.
- Although hospitals are consolidating across the state, the shoreline areas dominated by YNHHSC are the most heavily concentrated regions in Connecticut, and thus most vulnerable to price increases. The three-hospital Yale-New Haven system claims a "local service area" comprising nearly half the state's population. Upon full absorption of Milford and L+M, the Yale-New Haven system will account for 59% of discharges in this area.

The report's co-authors urge public officials to take three steps before any decisions are made on whether or not, and under what conditions, the merger should proceed.

- In 2015, Connecticut passed a sweeping health care consumer protection law, SB 811. The law requires a cost and market analysis prior to regulatory action on hospital mergers. Although Yale-New Haven and L+M applied for approval before the new law took effect, state officials should conduct the cost and market analysis prior to any action on the proposed merger.
- In particular, state officials should examine the pricing impact in Greater New Haven of Yale-New Haven Hospital's 2012 takeover of the Hospital of St. Raphael. No data will better illuminate the potential impact of Yale-New Haven's expansion than what happened to prices after this deal, which created the 6th largest hospital in the United States.
- The L+M transaction should not be viewed in isolation. Yale-New Haven's market power on the shoreline is expanding by leasing a wing of Milford Hospital. This adds a small but significant further increase in the extent of Yale-New Haven's market control. State officials should include the potential absorption of Milford in their analyses.

1. GROWING CONCENTRATION IN THE HEALTH CARE MARKETPLACE

The last twenty years have transformed the Connecticut health care system. As recently as 1995, every hospital in the state was independent, but the era of the community hospital is over. If current proposed mergers are completed, more than 80% of Connecticut's inpatients will pass through hospitals owned by large, powerful multi-hospital systems, with few legal checks on price increases to protect them.

The Affordable Care Act has delivered health insurance to millions of people, a significant policy victory. At the same time, however, changes in reimbursement policies, mandates for technology improvements, and new regulations have tilted the market even further in favor of large, wealthy hospital systems. In Connecticut, the State Innovation Model (SIM) and "shared savings" policies for Medicare and Medicaid are creating incentives for large combinations of hospitals and doctors that can accept risk for broad patient populations. These systems are taking advantage of the new conditions to overrun their smaller competitors and build market power.

Unfortunately, the ACA contains few proven cost control measures. Congress largely left it up to states, employers, payers, municipalities, and individual patients to rein in costs as health care systems undergo rapid consolidation. Academic studies consistently show that the main impact of hospital consolidation is increased prices without improvement in quality.[2] Nationally, ballooning prices threaten newly expanded access. Although increasing numbers of Americans have health insurance, out of pocket costs are rising at 3-4 times the rate of wages.[3] More Americans than ever report delaying needed medical care for cost reasons.[4] Without cost control, the long-overdue expansion of health insurance coverage will not be sustainable.

These challenges have become clear in Connecticut in recent years. Despite a dramatic growth in their market power - which will continue if the combined $91 billion Anthem-Cigna and Aetna-Humana deals are completed - health insurers have done little to restrain costs.[5] Meanwhile, the rise of multi-hospital systems has created concentrated markets in the state, and the Yale-New Haven and Hartford HealthCare systems have developed a dominant grip on health care statewide. The two major health systems account for nearly half the inpatient discharges in the state, and each has even tighter regional control in its respective market. Hospital consolidation and price inflation will continue unless checked at the state level.

Acquisition and Absorption: Yale-New Haven Expands

Yale-New Haven Hospital (YNHH) began the process of industry consolidation in Connecticut in 1995, when YNHH added Bridgeport Hospital to its network. Greenwich Hospital joined the growing system in 1998. In 2010, the health system added Northeast Medical Group, a start-up physician multispecialty group that now employs over 550 doctors and is wholly owned by the Yale-New Haven Health Services Corporation, the parent corporation of the Yale-New Haven Health System (YNHHS).

In 2012, Yale-New Haven Hospital's takeover of the Hospital of St. Raphael created the 6th largest hospital in the country.[6] After the merger, the Yale-New Haven Health System (YNHHS) market share rose to 98% of inpatient discharges among New Haven residents and 76% in Greater New Haven, up from 68% and 48% respectively.[7]

In 2014, Texas-based for-profit hospital operator Tenet Healthcare proposed purchasing five Connecticut hospitals in an equity partnership with YNHHS, with Tenet owning 80% and Yale-New Haven 20%. Adding five of its competitors to Yale-New Haven's existing market share would have meant that 37.5% of all discharges in the state were from the newly merging system, a major expansion of the Yale network. The deal fell through after the Office of Health Care Access imposed unusually strong requirements on the terms of the deal, in the face of concerns about the impact of the transaction on cost, access, services, financial burden on the uninsured, and accountability of the hospitals to local communities.

Now, YNHHS has two impending hospital takeovers that will expand its control over the health care market along Connecticut's coastline.

One is widely known. The Yale-New Haven Health System has announced a deal to purchase Lawrence + Memorial Health, a smaller system that controls: Lawrence + Memorial Hospital in New London; Westerly Hospital in Westerly, Rhode Island; L+M Physicians Association, a 72-member multispecialty physician practice; and several other outpatient facilities.[9]

In a series of less publicized moves, YNHHS seems to be quietly acquiring pieces of financially struggling Milford Hospital.

Milford has reported negative operating margins in each of the last seven years. The hospital's license allows it to operate 118 beds, but due to declining patient volume, only 43 are currently staffed. Documents filed with the state Office of Health Care Access reveal that physician defections to Yale-New Haven Hospital contributed to those losses and inflicted severe competitive damage on Milford's labor and delivery service. According to these documents, in 2012, six OB/GYN doctors who accounted for a majority of Milford Hospital's deliveries told management that they would no longer deliver babies there. One had decided to stop delivering babies altogether, but the other five told Milford management that they were making Yale-New Haven Hospital their "exclusive hospital provider."[10]

Milford subsequently attempted to hire additional obstetricians, but could not keep them. In February of 2015, Milford applied for state approval to terminate its Labor and Delivery service. Milford's family birthing center, which occupies a large portion of the hospital's third floor, will no longer accept patients.[11]

Having expanded its OB/GYN network due to Milford's financial distress, Yale-New Haven Hospital announced last fall that it would open a 24-bed inpatient rehabilitation clinic on one of the three floors of Milford Hospital. The clinic would serve patients suffering from certain neurological, orthopedic, musculoskeletal, and other conditions. These patients typically have received inpatient treatment such as surgery for their conditions, and require extensive nursing care and supervision while undergoing treatments such as physical or occupational therapy.

YNHH's proposal would shift all patients who would have been treated in the current rehab unit at the St. Raphael's campus to Milford. Shortly after, YNHHS-owned Bridgeport Hospital submitted its

own paperwork to terminate its inpatient rehabilitation services as well.[12] In essence, YNHHS is regionalizing its inpatient rehabilitation services at its leased space at Milford Hospital, even as Milford's traditional hospital services decline and close. Taken together, these events suggest that Yale-New Haven Health System's absorption of Milford Hospital is in process. Yet state regulators have treated each submission—Milford's closure of its Labor and Delivery service, the opening of Yale-New Haven's inpatient rehabilitation unit, and the two separate YNHHS inpatient rehabilitation unit closures—as distinct, unrelated events.

In contrast to Milford Hospital, Lawrence + Memorial Hospital is a financially successful 256-bed hospital in New London that recently acquired Westerly Hospital in Rhode Island, pledging to invest $36.5 million over five years in the new acquisition. In September, the parent company of the two hospitals and Yale New Haven Health System filed a Certificate of Need application for YNHHS to take over the L+M system. In the application, YNHHS promises to make a $300 million capital investment in the region.[13] This deal is now in front of state regulators seeking approval.

Connecticut's Growing Monopolies

Hospital consolidation is a recent and rapid phenomenon in Connecticut: twenty years ago, every hospital in the state was independent.

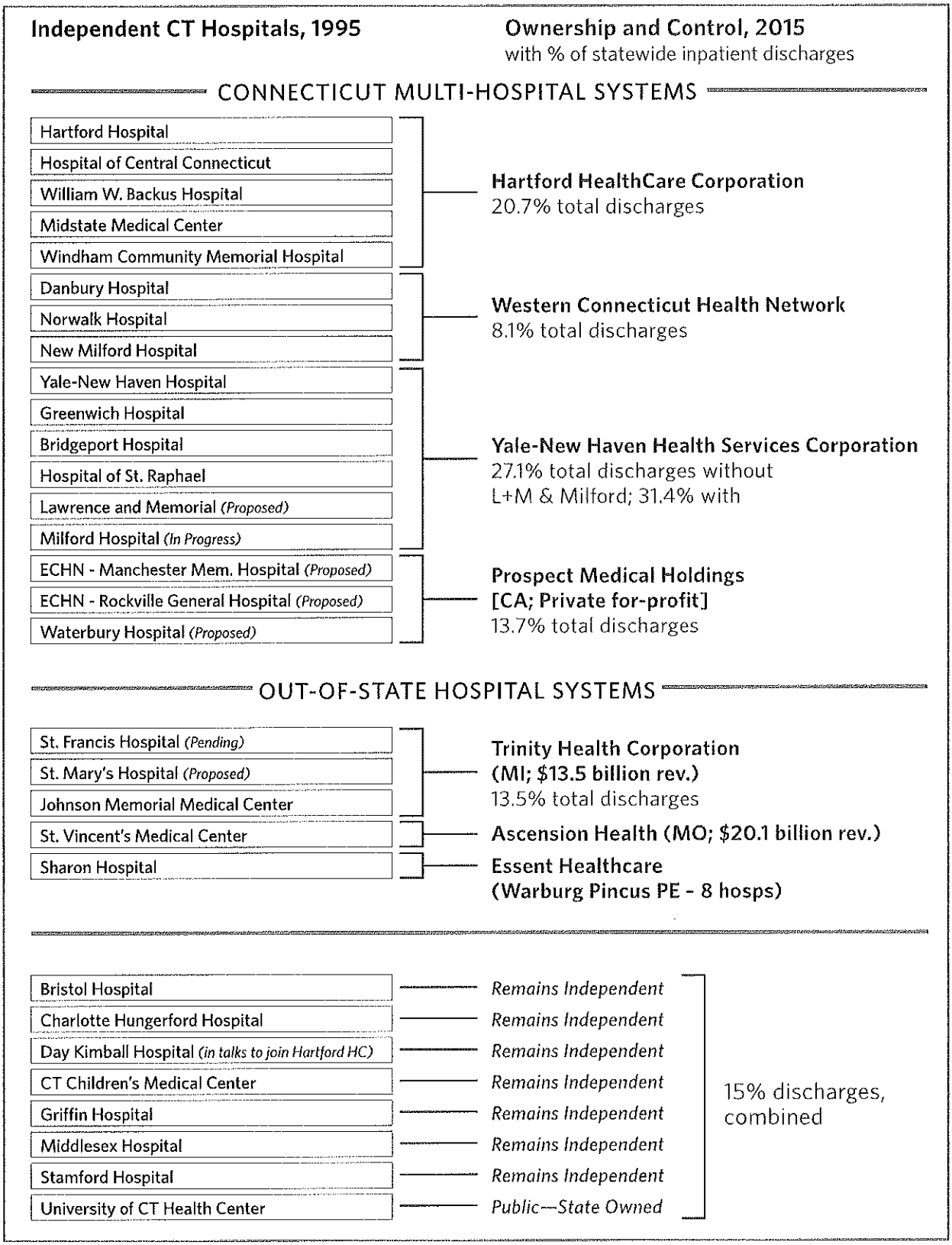
The trend has accelerated recently. A tally of transactions by the Universal Health Care Foundation in December 2014 reported that "between 2009 and 2013 there were thirteen attempted and seven successful hospital consolidations and/or partnerships [in Connecticut], a substantial increase from the four that occurred in the previous decade."[14]

As a result of these consolidations, Hartford HealthCare accounted for 20.7% of inpatient discharges in the state in FY 2013, while Yale-New Haven Health System saw another 27.1%. The two health systems combine for nearly half of the state's discharges, a lopsided market for Connecticut consumers.

In the year since the UHCF report, at least five major hospital affiliations or purchases have been announced or proposed: private for-profit Prospect Medical Holdings has moved to purchase the Eastern Connecticut Health Network and Waterbury Hospital; St. Francis Hospital affiliated with Trinity Health Corporation, a $16 billion national company based in Michigan, has acquired Johnson Memorial Hospital, and has moved to acquire St. Mary's Hospital; and Ascension Health has purchased St. Vincent's Medical Center—all in addition to Yale's proposed acquisition of L+M and progressive annexation of Milford. Today, the eight hospitals that will remain independent if all pending transactions are approved provide only 15% of inpatient discharges in the state.

Unless radical change to reimbursement and support for financially distressed hospitals is on the horizon, some consolidation is inevitable. Unlike many of the other recent and proposed hospital acquisitions, however, the Lawrence + Memorial deal is not spurred by a community hospital's financial crisis. The conditions of this proposal create an opportunity for regulators to take a closer look at the growing monopolies in the state.

Figure 1: Hospital Ownership Changes, 1995-2015



2. THE DATA: YALE-NEW HAVEN'S LATEST MOVES INCREASE CONSOLIDATION

New data make it possible to chart the development of Connecticut's hospital systems, including the expansion of Yale's regional control in the last several years, and to anticipate how such control will grow as hospital networks expand. The authors obtained general acute inpatient care discharge data from the Office of Health Care Access, showing the number of discharges from each hospital by patients' town of residence during fiscal year 2013.

The question of how to define health care markets is highly contested and technically complex. For a detailed discussion, see Appendix A. Courts, hospitals, and regulators have disputed market boundaries for a quarter of a century while hospital systems completed 1,881 mergers.[15]

Recently, economists have developed improved tools to measure market boundaries, but courts are still catching up. Despite an academic consensus that hospital markets are much smaller and therefore more concentrated than courts were willing to accept a decade ago, only a handful of cases have actually seen anti-trust remedies applied to mergers.[16] Meanwhile, mergers are proceeding at a rate of more than 90 per year.[17]

For our initial analysis, we focus on market areas defined by the health systems and hospitals themselves, including concentric areas surrounding different hospitals that define smaller and larger markets. This approach gives a thorough preliminary analysis of market concentration at varying scales. The analysis examines five areas:

- **Yale-New Haven Health System's local service area:** In the Official Statement accompanying its most recent bond offering, YNHHSC defined the "local service area" for its full system as a 55-town region encompassing roughly the southern half of the state. The area includes 1.6 million people, 46% of the state's population.[18]
- **Yale-New Haven Hospital local service area:** A 34-town region also defined in YNHHS bond statements.[19]
- **Greater New Haven Area/Southern Connecticut Region Council of Governments (SCRCOG):** We use the area defined by membership in the Southern Connecticut Regional Council of Governments (SCRCOG) as a definition of Greater New Haven. SCRCOG contains fifteen towns with 16% of the state's population.
- **Lawrence + Memorial Hospital Primary Service Area:** L+M Hospital defines its primary service area as a ten-town region surrounding New London, both in the Official

Statement for its most recent bond issue and in its Certificate of Need application.

- **Lawrence and Memorial Hospital Secondary Service Area:** In the same sources, L+M also identifies as its secondary service area a twenty-town area surrounding New London.[20]

Within these five areas, our analysis focuses on three key metrics:

- The percentage market share for the Yale-New Haven Health System in each area prior to and after the absorption of Milford and the purchase of L+M Health.
- The Herfindahl-Hirschman Index, or "HHI," score for each area pre- and post-acquisitions. HHI measures the degree to which a market is concentrated, and thus how likely consumers are to face anticompetitive practices. It is a standard FTC and DOJ metric, also used by the American Medical Association, Congressional Budget Office, Kaiser Family Foundation, insurance industry, and other economists and regulators for analyses.
- The change in HHI for each area before and after a transaction, a prediction of merging hospitals' gain in market power.

In examining these metrics, we found that:

- Though consumers already face a market with limited competitive pressure to protect them, the ongoing absorption of Milford and the proposed purchase of L+M will significantly increase the Yale-New Haven Health System's market share in all five areas we examined – by a factor of 5 or 6 in the markets surrounding New London – at the further expense of competition.
- All five geographic regions studied easily meet the federal government's standard for a "highly concentrated" market even before the two takeovers. Highly concentrated markets can lead to artificially excessive prices.
- In the market areas studied, the size of the increase in consolidation caused by YNHHS's expansion would be significantly higher—by a factor ranging between 50% and 900%—than the level that requires regulators to presume that merging entities will "obtain market power," which federal regulatory standards warn against.[21]
- Although there is rapid consolidation across the state, the coastline areas dominated by YNHHS are the most heavily concentrated regions of the state and therefore are most vulnerable to price increases.

In each of these areas, the expansion is significant. The ultimate absorption of Milford Hospital and the L+M deal as proposed will leave YNHHS with nearly 60% of inpatient discharges in the Yale-New Haven Health System's local service area, which covers roughly the southern half of the state, including 46% of its population. It will also add the L+M service area to the swath of coastal areas in which YNHHS dominates the market. *[See Figures 3 and 4.]* Yale-New Haven Hospital already treats the second highest volume of patients in L+M's primary service area and third highest in its larger secondary service area. Combining the two hospital networks will leave YNHHS with monopoly pricing power.

When federal and state anti-trust regulators measure the degree to which a market is concentrated, they use a tool called the Herfindahl-Hirschman Index (HHI), which measures market concentration by aggregating measures of firms' market shares.

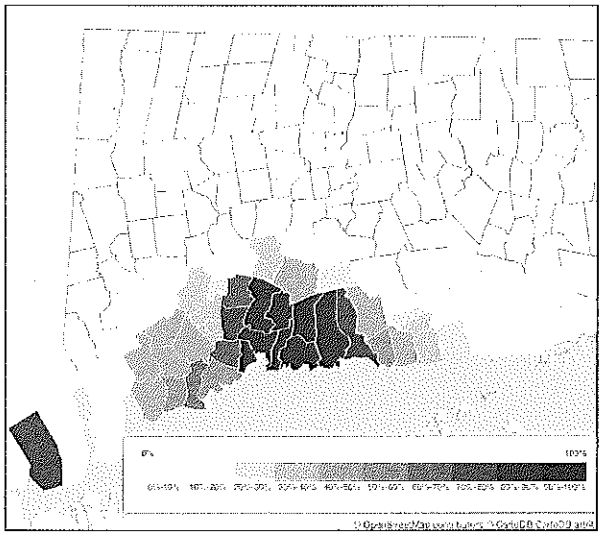
The DOJ and FTC assert that "mergers should not be permitted to create, enhance, or entrench market power or to facilitate its exercise" because of the threat to competition. When a merger increases the HHI in a highly concentrated market by 100 points, regulators expect that merger to "potentially" raise significant concerns because of an increase in market power. When it increases by 200 points or more, they "presume" that an impermissible market power increase is likely. This presumption can be rebutted only by "persuasive evidence showing that the merger is unlikely to enhance market power."[22] We applied HHI to the discharge data from towns and multi-town areas to determine the health of the state's markets.

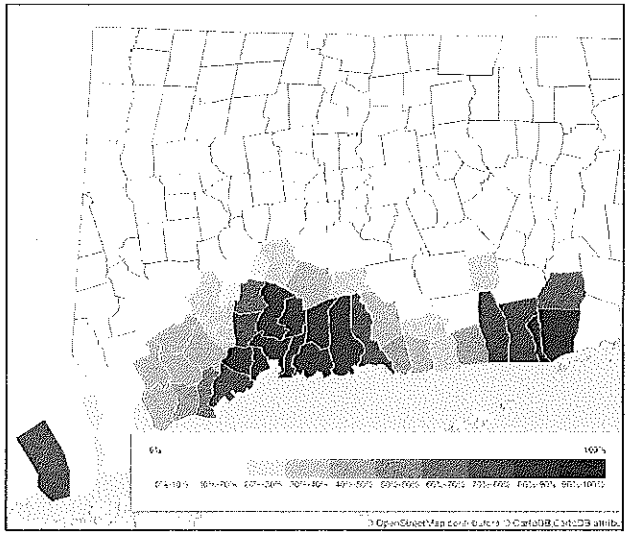
Figure 2: YNHHS inpatient discharge share by region, before and after addition of L+M and Milford

	Population	YNHHS discharge share now	YNHHS discharge share with deals
Statewide	3,570,000	27%	31%
YNHHS local service area	1,650,000	51%	59%
YNHH local service area	1,096,135	60%	65%
GNH/SCRCOG	570,000	74%	83%
L+M primary service area	175,000	14%	83%
L+M secondary service area	362,000	12%	59%

Figures 3 and 4: YNHHS local service area market share, before and after

These maps illustrate the percentage of inpatients from each town within the Yale-New Haven Health System's local service area who were discharged from a hospital in the YNHHS, before and after the addition of L+M and Milford.





Measuring Market Power

To calculate HHI, one adds the squares of the market shares together to get a number on a scale of 100-10,000:

- A region with a pure monopoly on a good or service would score an HHI of 10,000: $(100\%)^2 = 10{,}000$.
- A region with 10 competitors, each with equal market shares of 10% would score 1,000: $(10\%)^2 = 100$ for each competitor. 100 x 10 competitors = 1,000.
- A region with five competitors, one with 50% market share, one with 20% market share, and three with 10% market share would score 3,200 on HHI. $(50\%)^2 = 2{,}500$; $(20\%)^2 = 400$; $(10\%)^2 = 100$ x 3 competitors = 300.

The federal government divides markets into three categories based on HHI scores to assess the risk of monopoly:

- Less than 1,500—unconcentrated market with adequate competition
- Between 1,500 and 2,500—"moderately concentrated" market
- Above 2,500—"highly concentrated" market with an elevated risk of inefficiency and collusion to fix prices.

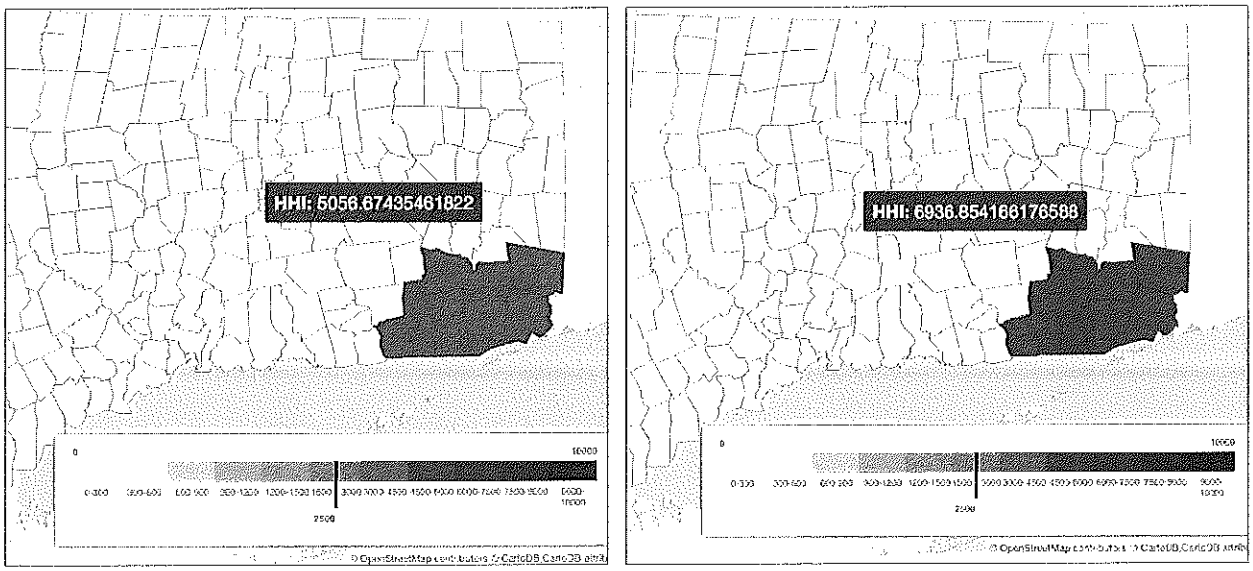
Regulators apply the strictest scrutiny to "highly concentrated" markets with scores of 2,500 or above.[18]

We found that every one of the five regions is already a highly concentrated hospital market to begin with. In every region, the increase in HHI was dramatic. The maps on the opposite page illustrate the HHI increase in the L+M service area. For the full table showing HHI and change in HHI for each geographic area, see Appendix B.

In every relevant local or regional area we examined, the HHI indicates that the market is already highly concentrated. When concentration is already high, increases to HHI are more concerning: federal standards indicate that the strictest scrutiny should be applied to markets like these because of the risk to competition. In every one of these markets, the magnitude of the HHI increase is far higher than the 200-point threshold at which federal regulations presume an impermissible increase to market power. In the L+M primary service area, the increase is over nine times the 200-point standard. In the YNHHS local service area—which encompasses 46% of the state's population—the increase is more than quadruple the standard.

The state of Connecticut is far too large to consider a "market." Even if we did consider Connecticut as a "market" of its own, however, it would already have an HHI of 1412. After these transactions, it would have an HHI of 1716—an increase of 304 points that would move it from the "unconcentrated" category to the "moderately concentrated" category. These two acquisitions constitute a substantial increase to overall market concentration in the state because they bolster the market power of its largest health system.

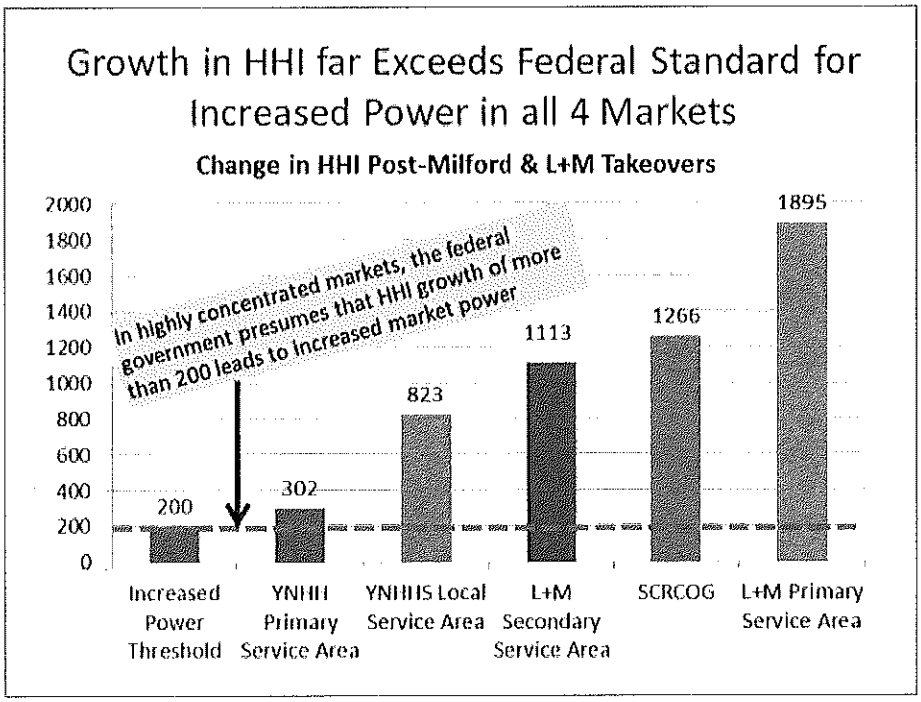
Consolidation is not equally threatening everywhere, however. We also calculated market concentration on a town-by-town basis for the entire state to demonstrate the distribution and comparative level of concentration across regions. Hartford's expansion in northern Connecticut has been more diffuse than Yale-New Haven's southern growth to date. In Hartford, for example, Hartford Hospital continues to face direct competition from St. Francis, which is now aligned with a multi-billion dollar national non-profit chain and is itself seeking to buy two hospitals. In the southern half of the state, highly concentrated multi-town regions clearly show the dominance of the Yale-New Haven Health System.



Figures 5 and 6: L+M Service Area HHI, before and after YNHHS takeover

This map demonstrates the dramatic increase in market concentration for the L+M Primary Service Area that will result from the potential takeovers. Because the market is already highly concentrated before the acquisition, combining YNHHS and L+MH will cause a large spike in market concentration, leaving few alternatives to the newly dominant Yale-New Haven system.

Figure 7



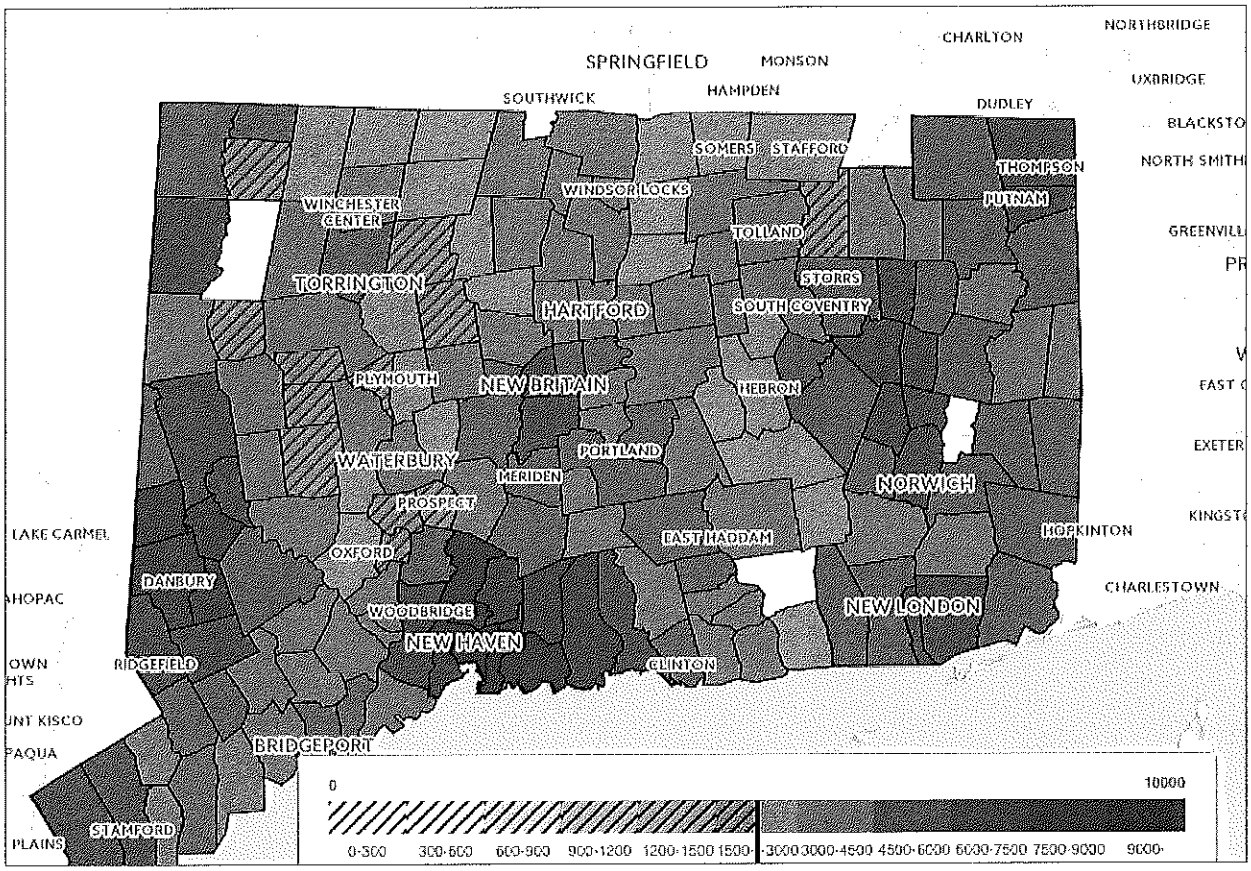


Figure 8: Town-by-town market concentration, Connecticut

This map shows the existing HHI scores for each town in Connecticut. Though discrete towns are not complete health care markets in themselves, the map shows roughly the distribution of highly and extremely concentrated markets throughout the state. Though Hartford HealthCare controls a large number of hospitals statewide, its hospitals are distributed in such a way that most towns in the north of the state exhibit comparatively lower market concentration, although most would still be defined as "highly concentrated" under federal standards. In the Yale-New Haven-controlled southern half, however, we see the highest density of towns with extremely high market concentration—above 6,000, indicating that Yale-New Haven's control of the market is geographically consolidated. Note that the region around New London is already heavily concentrated, and will become even more so if Yale-New Haven takes over L+M.

3. THE UNAFFORDABLE CONSEQUENCES OF MARKET CONCENTRATION

Prices Go Up as Hospitals Gain Market Power

Hospitals often claim that consolidation increases efficiency. There is little evidence to support this claim.

Independent comprehensive reviews of the academic literature have rejected this interpretation. Nationally, the Robert Wood Johnson Foundation reports, based on a review of five independent studies, that when hospitals "merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent."[23] Locally, the Universal Health Care Foundation of Connecticut concluded in its December 2014 review that "almost all retrospective studies suggest that hospital consolidation results in concentration of market power and a rise in the price of care."[24]

In Massachusetts, the Attorney General has documented that monopoly pricing, especially by the non-profit Harvard-affiliated Partners system, is the state's most significant cost driver.[25] In a court ruling this year against a hospital merger involving Partners, the Massachusetts judge found that the system was able to "exercise 'near monopoly power' that allows it to charge prices far in excess of its competitors for the same services."[26]

The fact that the dominant systems in Connecticut are nominally not-for-profit corporations does not protect Connecticut patients. A majority of U.S. acute care hospitals are structured as private, non-profit enterprises. That fact has not prevented a massive wave of mergers and skyrocketing prices.

For years, judges permitted mergers of non-profit hospitals on the theory that they would behave charitably with greater market power. In 2007, the Federal Trade Commission studied the pricing impacts of a non-profit merger in Illinois. It found that, according to the hospitals' own economist, managed care prices increased by 42% over four years, 12% above the market as a whole.[27]

With rising health care costs one of the largest drivers of perennial state budget crises, state officials are increasingly concerned about the long-term cost of consolidation to taxpayers. Comptroller Kevin Lembo, who administers the state employee health plan covering 210,000 people at a cost of $1.4 billion annually, recently testified stating, "We're going to be negotiating potentially with 2 or 3 large systems and that's basically it, if things keep going the way they are going. I don't think you need to be an actuary to know that that's going to be a tough spot for us."[28]

Non-profit hospitals claim they need surplus revenue to serve low income people. But Duke University Professor Clark Havighorst points out that the IRS allows non-profit hospitals "to spend their untaxed surpluses on anything that arguably 'promotes health.' Much of what hospitals count as charitable behavior or community benefit is not spent on lower income people."[29] University of Illinois tax law professor John Colombo adds:

> *"The standard non-profit hospital doesn't act like a charity any more than Microsoft does—they also give some stuff away for free. Hospitals' primary purpose is to deliver high quality health care for a fee, and they're good at that. But don't try to tell me that's charity. They price like a business. They make acquisitions like a business. They are businesses."*[30]

We're Not Getting the Quality Care We're Paying For

Already, Connecticut has the 4th highest per capita health care costs in the nation: we paid 27% more per person than the national average for health care in 2009, the most recent year for which data are available,[31] and what we spend at the hospital annually nearly tripled from 1991 to 2009, from $3.9 billion to $9.3 billion.[32]

The science of measuring hospital quality is still in its infancy. No single set of metrics is backed by a wide consensus. However, we examined several federal and independent evaluations. The available data provide no evidence that Connecticut's high health care costs are correlated to high quality. On several currently available metrics, Connecticut ranks among the states with the lowest scores.

For example, Medicare penalizes hospitals if patients are frequently readmitted within a month of their discharge. Based on these readmission standards, 90% of Connecticut hospitals received penalties for the 2015-2016 fiscal year, the second highest penalty rate for any state.[33] These 28 penalized hospitals included all three in the Yale-New Haven Health System, and Yale-New Haven Hospital itself received the seventh most severe penalty in the state.[34]

Medicare also assesses hospitals based on patient satisfaction across a number of areas like communication, cleanliness, and pain management. In the most recent scores compiled from quarterly Hospital Consumer Assessment of Healthcare Providers and Systems surveys, no Connecticut hospital received the top rating of five stars. Eighteen out of twenty-five hospitals received a three star rating, including YNHHS's Bridgeport and Yale-New Haven hospitals.[35]

The independent Leapfrog Group assesses hospital quality nationally and grades hospitals "A" to "F" based on factors such as safe surgery practices, infection rates, and use of correct staffing and procedures to minimize mistakes.[36] Connecticut ranked 36th in the percentage of hospitals scoring "A" in Fall 2015.[37] Maine and Massachusetts were 1st and 2nd nationally. Yale-New Haven and Greenwich Hospitals received "C" grades, Bridgeport a "D". Three of Hartford HealthCare's five hospitals received "C" grades, one a "B" and one a "D".[38]

As the science of quality measurement improves, and analysts are better able to account for factors such as the severity of patients' conditions across populations, these scorecards may yield different results. However, the Robert Wood Johnson Foundation examined the literature on hospital consolidation in relation to currently available quality indicators, and found that "a slim majority of studies find that, at least for some procedures, increases in hospital concentration reduce quality. The strongest studies confirm this result."[39]

4. CONFRONTING CONNECTICUT'S HOSPITAL MONOPOLIES

The Affordable Care Act and new Connecticut reimbursement policy are accelerating changes in how care is delivered and measured, and how the business of health care is structured. Before our very eyes, Connecticut is being carved up by a few hospital systems. The leader is clearly Yale-New Haven, with a level of control in many areas that easily meets any definition of market power. Meanwhile, our patients and payers are carrying a heavier and heavier financial burden as their health care costs rise.

Fortunately, Connecticut's legislative leaders have acted to curb the threat of consolidation by giving more tools to public consumers and to regulators. Two hospital regulatory bills in the last two years leave Connecticut better prepared to protect its consumers from the ill effects of monopoly. These reforms have put us in the forefront of states asserting the public interest in creating a fair health marketplace that benefits all. State regulators and advocates should use those tools now.

The acquisition of Lawrence + Memorial Health by the Yale-New Haven Health Services Corporation is a pivotal opportunity for stemming the growth of monopoly in Connecticut's health care market and limiting the ill effects of consolidation. The proposal will be reviewed under Public Act 14-168, which passed in 2014. Portions of Public Act 14-168 were quickly superseded by SB 811, which passed in 2015. However, the L+M acquisition application was submitted before the newer law took effect. Nevertheless, PA 14-168 added new standards for the Certificate of Need. In any decision to grant or refuse a CoN, the law requires the Office of Health Care Access to take into account whether the applicants have

> *"satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographic region; and [w]hether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care."*[40]

The sale as proposed unquestionably poses a threat to both provider diversity and health care costs along the shoreline.

In light of this threat, state officials should

rigorously examine the likely consequences of the transaction in order to decide whether to allow it to proceed. In particular, we recommend that prior to any approval or rejection, and prior to developing any proposed conditions, regulators take the following steps:

- SB 811 requires the state to undertake a "cost and market analysis" for such mergers. Although SB 811 does not formally apply, the Attorney General retains responsibility to enforce the Connecticut Anti-trust Act, and the Office of Health Care Access now must specifically examine the impact of merger-related consolidation on cost and access. Having public market analysis was critical to the process of public comment to the judge in the case of proposed mergers by Partners Health System in Massachusetts. Accordingly, we urge regulators to conduct the cost and market analysis that our state legislators have deemed appropriate for sales like this one.

- In order to understand the likely results of these acquisitions, we also believe that a thorough analysis of potential consolidation-related cost and access impacts calls for a retrospective look at any price changes following YNHH's acquisition of the Hospital of St. Raphael three years ago. This is a clear test of whether or not YNHHS exercises market power to artificially inflate prices: if St. Raphael's or Yale-New Haven's overall prices increased significantly post-merger, there is no question that the system is flexing monopoly muscle within the SCRCOG region. Understanding any changes in the two hospitals' prices may portend similar behavior in eastern Connecticut.

- We urge OHCA and the Attorney General to view the L+M acquisition in tandem with the unannounced takeover of Milford Hospital. To date, the relationship between YNHHS and Milford Hospital has been viewed as a series of individual transactions.

The changes to the market statewide pose high potential risks to patients. In the interest of quality and affordability in our health care marketplace, regulators must use these tools and more before they decide whether this transaction should proceed.

APPENDIX A: DEFINING AND MEASURING HOSPITAL MARKETS

The authors have chosen to apply HHI to the five geographic areas identified in the report as an initial illustration of the challenges posed by YNHHS's slow-motion consumption of Milford Hospital and proposed acquisition of L+M Health. We are awaiting further data to allow more thorough analysis, and also expect that regulators will apply a more rigorous methodology as full information on the transaction becomes available.

The definition and measurement of hospital markets is a hotly contested legal subject. As noted in the body of the report, for many years courts tended to assume that it was appropriate to entrust not-for-profit entities with market power because of their "charitable" nature. As courts began to take the threat to competition from consolidating non-profit hospitals seriously, the prosecution of anti-trust cases foundered on the use of analytic tools that fail adequately to account for the inelasticity of hospital demand.

In 1982, the FTC and Department of Justice Guidelines adopted a test that sets the boundaries of a monopoly market at the furthest limits at which a potential cartel or monopolist can impose a small but significant non-transitory increase in price ("SSNIP"). A SSNIP is generally assumed to be a 5% increase for a year without losing market share.

To define the SSNIP boundary, economists used two tests. For hospitals, the Elzinga-Hogarty test uses "patient flow" data to determine consumers' ability to enter and exit the market boundaries. Any boundary in which 10% or more patients leave to get care elsewhere is assumed to have enough competition to preclude anti-competitive behavior. "Critical Loss Analysis" examines the ability of firms to withstand profitably the loss of customers expected under a given market definition following a price increase. Once the market was defined, analysts would then apply a measure of market concentration such as the Herfindahl-Hirschman Index (HHI) to determine the anti-trust risk.

E-H and CLA both proved inadequate for hospital mergers. Neither accounts for factors that influence patient choice other than price (3rd party payment, role of the physician, proximity, availability of subspecialty services, etc.). Standard CLA analysis often results in "inconsistent logic and erroneous conclusions." Use of these tools allowed hospital defendants to win a series of cases between 1997 and 2004 in part by successfully defining markets as large geographic areas within which any single combination of hospitals posed a minimal threat to competition.

Gaynor, Kleiner, and Vogt estimate that these older methods overstated the elasticity of hospital demand "by a factor of 2.4 to 3.4 and were likely a contributing factor to the permissive legal environment for hospital mergers." That permissive environment allowed 1,425 mergers and acquisitions to be consummated between 1994 and 2009. Dr. Elzinga himself questioned the value of his own test on hospital markets in 2011.

In the early 2000s, economists developed the "option demand" analysis (Town and Vistnes, 2001; Capps, Dranove, and Satterthwaite, 2003) and the Differentiated Bertrand Oligopoly Model (DB). These models attacked the issue of third party reimbursement by envisioning a hypothetical health plan attempting to construct a provider network in the region of the merging competitors. "This is a reasonable characterization of managed care markets," write Gaynor, et al., of the option demand model.

The new methods yield markets far smaller and closer to economic reality than the older tests, and

lead to clearer pictures of market concentration. According to Gaynor et al, they allow analysts "to assess merger effects without a market definition."

However, they are not yet universally accepted in court, and even though the new methods are capable of assessing merger effects without a market definition, courts expect definitions and FTC guidelines for state Attorneys General insist on them as well. The new tools are powerful, and once we obtain data sufficient to apply them we will attempt to do so.

For our initial analysis, we have chosen to examine markets defined by the hospitals in their public descriptions of themselves. These analyses serve as an adequate preliminary basis for gauging the degree of concentration, and we examine several concentric markets that present analyses at varying scales of market definitions.

However, we recognize that in the policy process, any attempt at market definition will be contentious. Therefore, we urge regulators to heed the words of Kenneth Elzinga closely. In evaluating the usefulness of his original model in the context of hospital mergers, Dr. Elzinga notes "where direct evidence of anticompetitive effects attributable to a merger is available, its use may diminish the need to rely on geographic market definition tools such as the E-H test," writes Dr. Elzinga. "Such direct evidence is most readily available in post-closing merger challenges such as the FTC's Evanston case."

Connecticut patients cannot wait until Milford and L+M are fully in the Yale-New Haven orbit to understand the potential price impact of the deals. Although there is no direct evidence, there is a useful precedent. Yale-New Haven's purchase of the Hospital of St. Raphael resulted in intense market concentration in the Greater New Haven area.

The Certificate of Need filed for that transaction in 2012 states that "YNHH has no plans to raise charges as a result of the HSR acquisition," language similar to that in the Certificate of Need for L+M. If an analysis of the market before and after that merger reveals significant price increases, there will be little question that YNHHS exerts monopoly pricing power.

APPENDIX B:
HHI TABLE, BEFORE AND AFTER BOTH HOSPITAL ACQUISITIONS, BY AREA

Market name	HHI before	HHI after	Change
Lawrence + Memorial Primary Service Area	5087	6982	+1895
Lawrence + Memorial Secondary Service Area	3485	4598	+1113
YNHHS Local Service Area	2911	3735	+823
Greater New Haven (SCRCOG)	5665	6931	+1266
YNHH Primary Service Area	3920	4222	+302

APPENDIX C:
MARKET SHARE AND HHI CALCULATIONS FOR L+M ACQUISITION ONLY, WITHOUT MILFORD HOSPITAL ACQUISITION, BY AREA

Data in this table include YNHHS's proposed acquisition of L+M, but not the addition of Milford Hospital. HHI increase is compared to HHI with the Yale-New Haven system as is.

Market name	YNHHS Discharges	HHI	HHI Increase
State	31%	1667	+254
Lawrence + Memorial Primary Service Area	83%	6972	+1884
Lawrence + Memorial Secondary Service Area	59%	4592	+1107
YNHHS Local Service Area	57%	3539	+628
Greater New Haven (SCRCOG)	79%	6309	+643
YNHH Primary Service Area	61%	3933	+14

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EXHIBIT 5

Exhibit Two
Higher Cost but No Higher Quality: Hospital-Owned Physician Groups, Academic Medical Centers

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EXHIBIT 6

Community Hospitals at a Crossroads

Findings from an Examination of the Massachusetts Health Care System

MASSACHUSETTS
HEALTH POLICY COMMISSION

Background of the report: building a path to a thriving, community-based health care system

The need for the report

- Hospitals and health systems across the country are facing **unprecedented impetus to adapt** to new care delivery approaches and value-based payments
- Community hospitals are under particular pressure to change and are uniquely challenged **by current market and utilization trends,** as evidenced by a number of recent consolidations, closures, and conversions in Massachusetts
- The state is pursuing sweeping delivery system transformation to achieve shared cost containment goals, and effective, **action-oriented planning is necessary**

Objectives of the report

- To understand and describe the **current state of and challenges facing community hospitals**
- To examine the implications of **market dynamics** that can lead to elimination or reduction of community hospital services
- **To identify challenges to and opportunities for transformation** in community hospitals
- To **encourage proactive planning** to ensure sustainable access to high-quality and efficient care and catalyze a **multi-stakeholder dialogue** about the future of community health systems

> *"I don't see any future for community hospitals…I think there's a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care]."*
>
> *COMMUNITY HOSPITAL CEO*

Key themes of the report

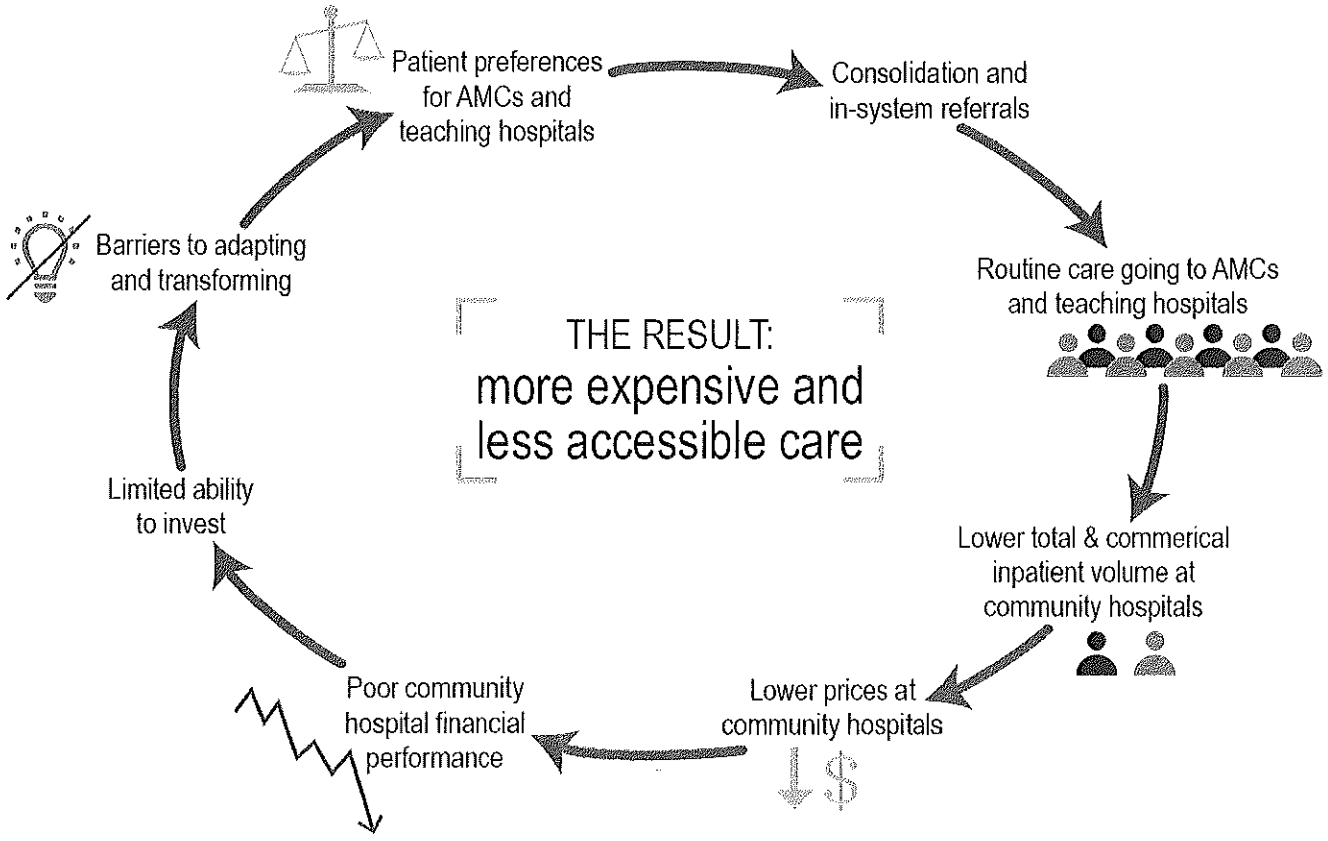
Community hospitals provide a unique value to the Massachusetts health care system

- While individual characteristics vary, as a cohort community hospitals play a critical role in care for publicly insured patients; providing local, community-based access; and, in particular, meeting behavioral health needs
- Community hospitals provide more than half of all inpatient discharges and more than 2/3 of all ED visits statewide
- Community hospitals generally provide high-quality health care at a low-cost, providing a direct benefit to the consumers and employers who ultimately bear the costs of the health care system

The traditional role and operational model for many community hospitals faces tremendous challenges

- Community hospitals generally have worse financial status, older facilities, and lower average occupancy rates than AMCs and teaching hospitals
- Many hospitals face barriers to transformation:
  - Consolidation of acute and physicians services into major health systems
  - Routine care going to AMCs and teaching hospitals
  - Lower commercial volume and prices leading to lack of resources for reinvestment
  - Difficulty participating in current alternative payment models

Community hospitals face self-reinforcing challenges that lead to more expensive and less accessible care

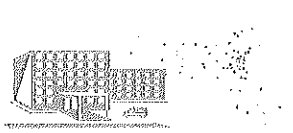


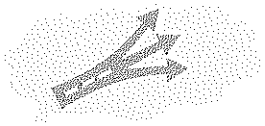
Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System

Overview | **Value** | **Challenges** | **Path Forward**

- An **overview** of community hospitals in Massachusetts
- The **value** of community hospitals to the health care system
- **Challenges** facing community hospitals
- The **path** to a thriving community-based health care system

An overview of community hospitals in Massachusetts

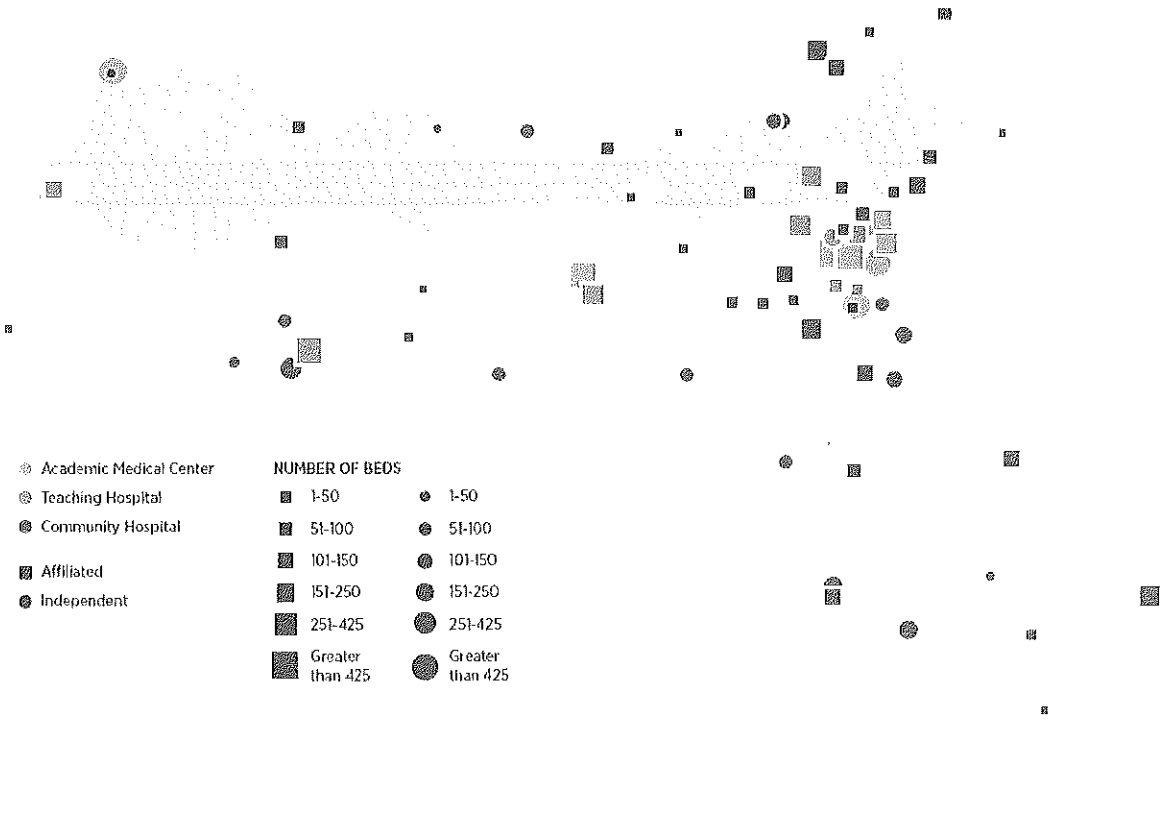


Overview – Value – Challenges – Path Forward

- Key distinguishing features of community hospitals (geographic distribution, patient populations, services, financial condition)
- Key community hospital trends (transitions, consolidation and closure)

Community hospitals serve all parts of the Commonwealth



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Community hospitals at a glance

43
Community Hospitals

27 | **18**
DSH | non-DSH

7,518 | 52%
more than half of beds statewide
(19 – 556)

417,275 | 51.3%
more than half of discharges statewide
(556 – 40,303)

5.8 million | **42** %
outpatient visits

1.9 million | **65** %
2/3 of ED visits
(10,329 – 155,236)

64% community hospitals | **84%** AMCs
low occupancy rate
(29% – 74%)

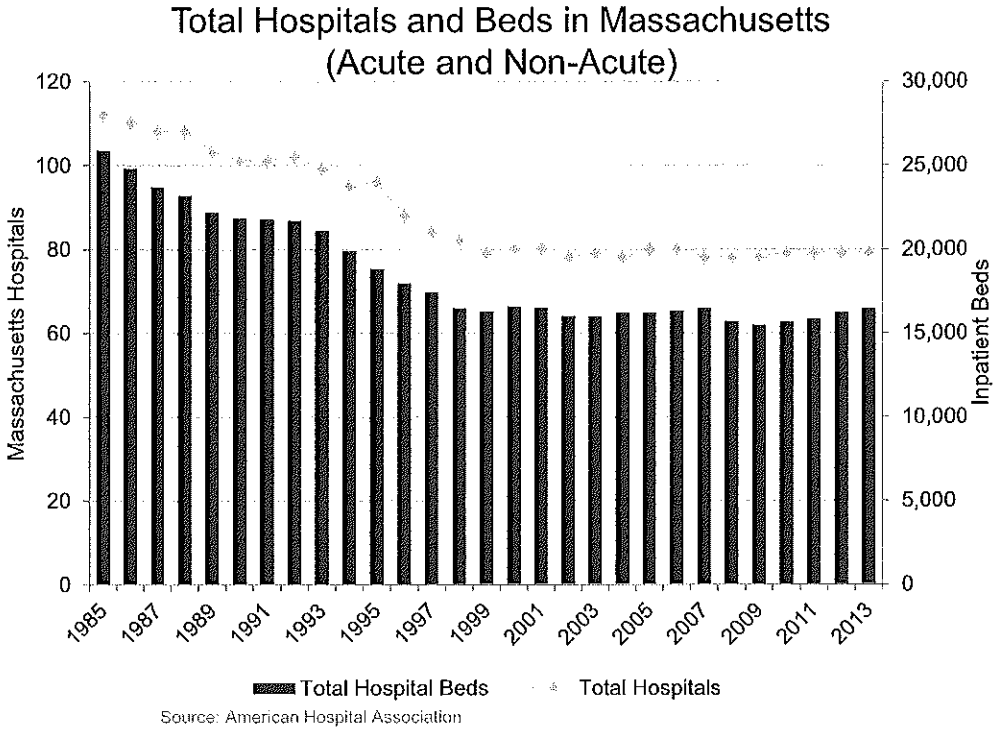
0.8 community hospitals | **1.33** AMCs
low case mix index
(0.60 – 0.93)

9.3 minutes | **+11** minutes
local patients drive 9.3 minutes on average to community hospitals; they would drive 11 minutes more on average to get to the next closest hospital

Older age of plant
Community hospitals generally have older physical plants than AMCs or teaching hospitals

Higher public payer mix
Community hospitals generally have disproportionately high shares of Medicaid and Medicare patients

Consolidations and closures over the last 30 years have contributed to a dynamic hospital market in Massachusetts



Source: American Hospital Association

Recent Conversions in Massachusetts Have Had Varied Impact

North Adams Regional Hospital

Steward Quincy Medical Center

Two Conversions Are Being Currently Contemplated

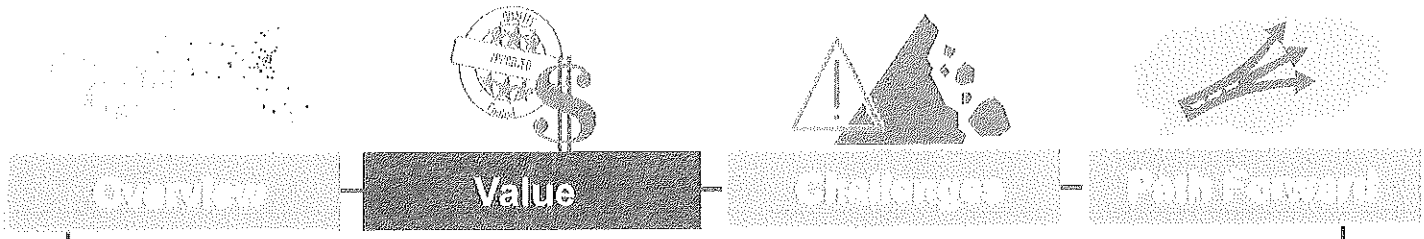
Baystate Mary Lane Hospital

Partners North Shore Medical Center – Union Hospital

Hospital-related Material Change Notices since 2013

11	16	5
mergers or acquisitions of one hospital by another	new contracting or clinical relationships between hospitals	hospitals acquiring physician groups

The value of community hospitals to the health care system



Community-based care and access

- Care close to home / drive time analyses
- Patient populations / payer mix

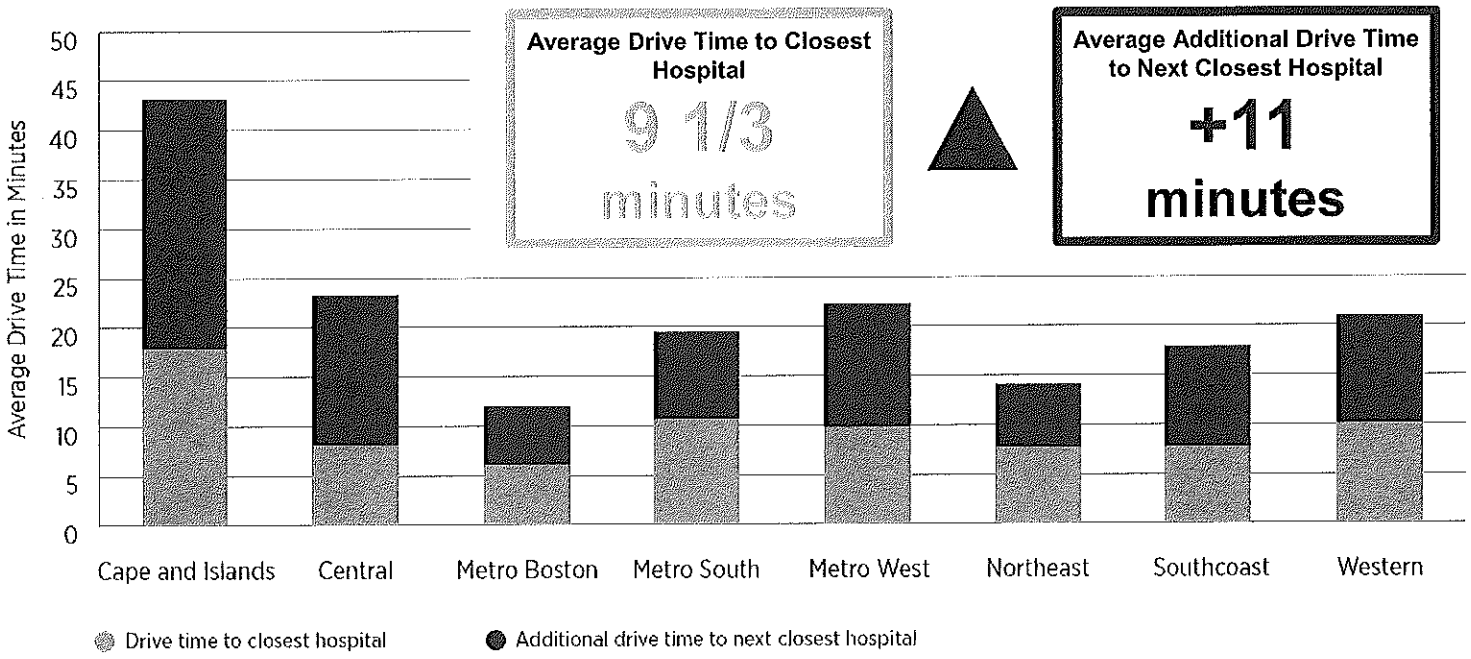
Quality and Efficiency

- Examination of quality performance by community hospitals and patient perception of quality and value
- Variation in spending and costs for community-appropriate care at community vs other hospitals

Community hospitals provide local access for local patients

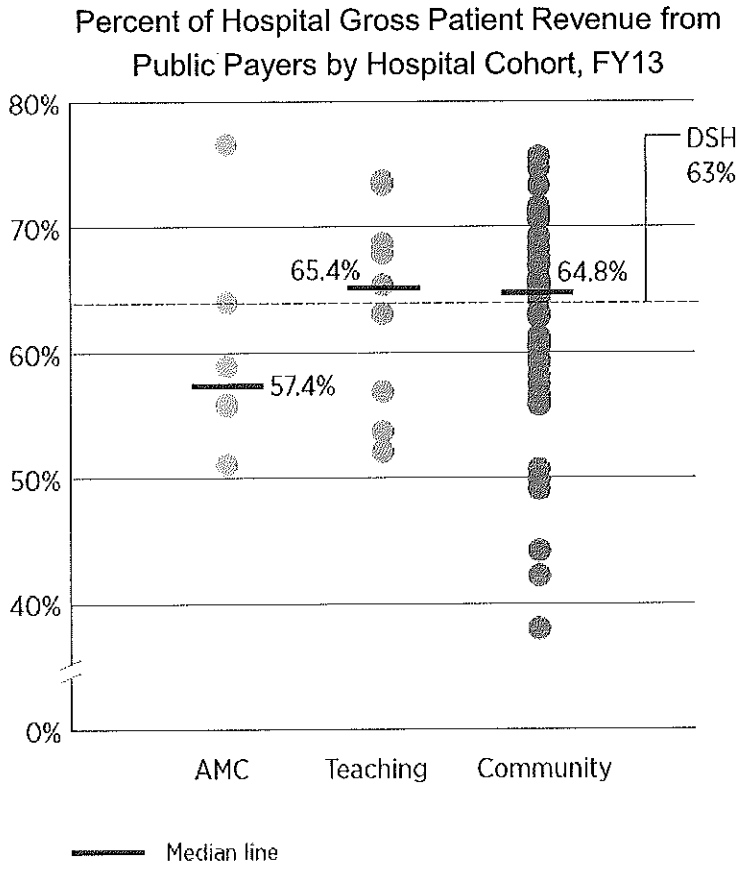
Average Drive Times for Patients Using Their Local Community Hospital

Analysis of patients who use their closest community hospital as a usual site of care



Source: HPC analysis of MHDC 2013 discharge data.
Notes: Drive times may underrepresent travel time and travel time differentials for populations relying on public modes of transportation. The Cape and Islands region includes only Falmouth and Cape Cod Hospital for the purposes of this analysis, since measuring drive times for Hospitals on Nantucket and Martha's Vineyard islands would not be meaningful.

Community hospitals serve a high proportion of vulnerable populations for whom access to care is often difficult, such as elders, individuals with disabilities, and individuals with low incomes



> *The community hospital plays a role as a cultural and social staple for the community that it serves. It's the place you're born at, that you grow up with, and get most of your basic care at…The state should ensure access to community-based, cost-effective care*
>
> *MASSACHUSETTS STATE LEGISLATOR*

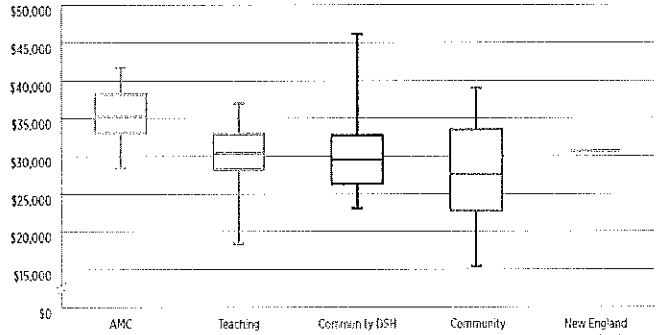
Source: HPC analysis of CHIA Acute Hosp. Databook, supra footnote 11, at Appendix D.
Note: Public payers include Medicare and Medicaid/Massachusetts fee for service and managed care plans, Health Safety Net payments, and charges designated by hospitals as "other government."

Spending at community hospitals is generally lower for low-acuity orthopedic and maternity care and is not associated with any difference in quality

Orthopedics

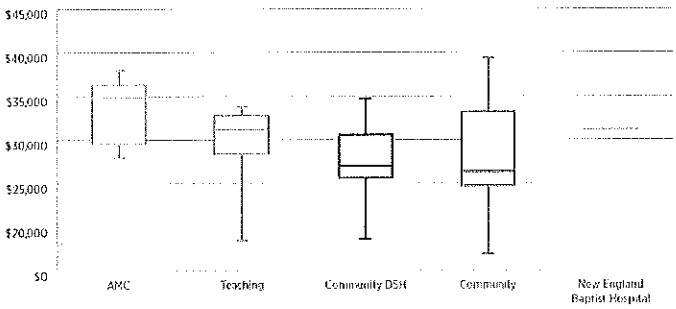
Deliveries

Hip Replacement



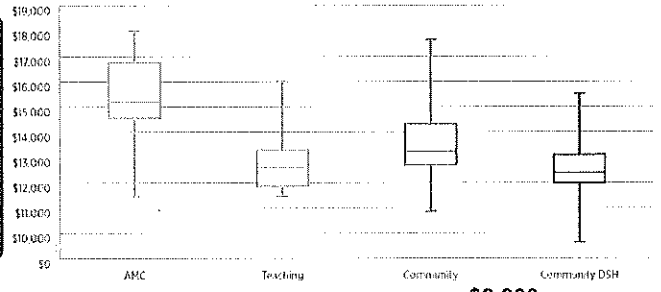
$6,750 less than AMCs

Knee Replacement



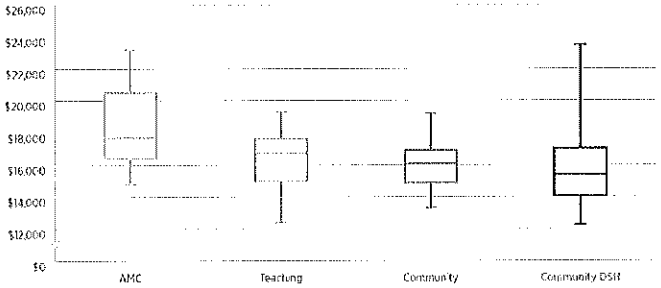
$8,200 less than AMCs

Pregnancy - Vaginal Delivery



$2,200 less than AMCs

Pregnancy - Caesarian Delivery



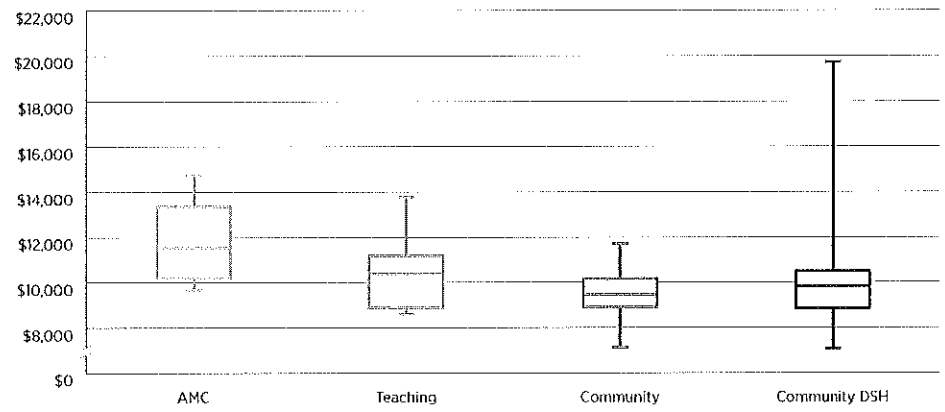
$2,100 less than AMCs

Source: HPC analysis of 2011 and 2012 APCD data for Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Plan patients

We found no correlation between hospital cost and quality. Each group of hospitals has higher and lower quality performers, but no notion of prestige stands out as either overall

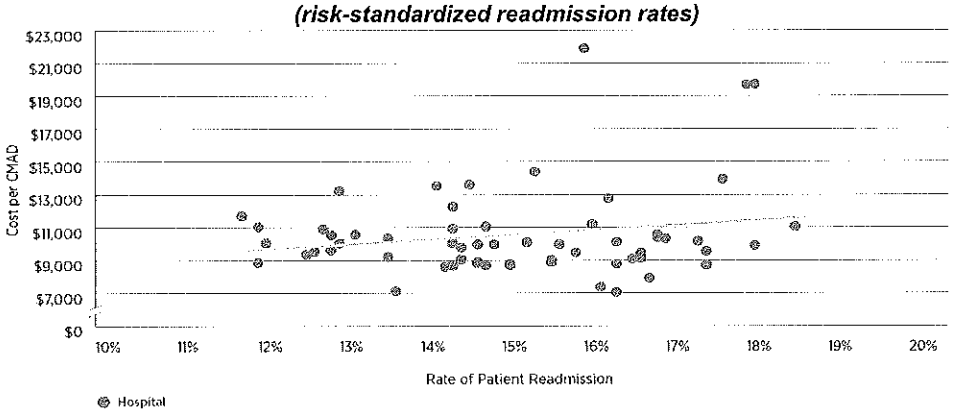
Most community hospitals provide care at a lower cost per discharge, without significant differences in quality

Hospital costs per case mix adjusted discharge, by cohort



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Costs per CMAD are not correlated with lower quality
(risk-standardized readmission rates)



Source: HPC analysis of CHIA Hosp. Profiles, 2013; CHIA Focus on Provider Quality Databook, Jan 2015

On average, **community hospital costs are nearly $1,500 less per inpatient stay** as compared to AMCs, although there is some variation among the hospitals in each group

Although costs per discharge for community hospitals have grown at a slightly higher rate than those for AMCs, the gap between AMC and community hospital costs has not substantially changed

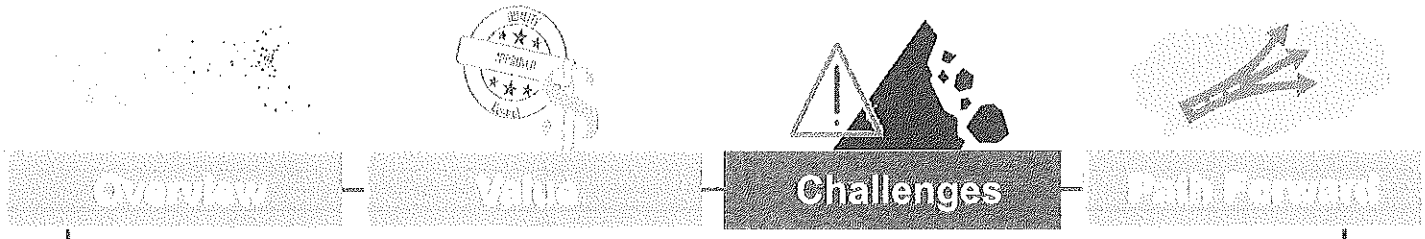
Reasons for differences in efficiency likely vary, and may include service offerings, support for teaching programs, and, particularly for community hospitals, the pressure of tight operating margins

Increases in health care spending on inpatient care would result from the closure of most community hospitals, due to commercial price variation

The HPC modeled where patients would likely seek care if community hospitals were to close and to estimate commercial spending impact.

- In most cases, a community hospital closure would **increase annual spending on inpatient care**
- **The majority of these increases would be less than $4 million**, due to the disproportionately low volume of commercially insured patients at many community hospitals
- Spending would increase by **more than $5 million for seven community hospitals**
    - The closure of **Lowell General Hospital** would cause the greatest increase: **over $16 million**
- Spending would actually **decrease** in the event of the closure of any of eight community hospitals, primarily those with higher relative prices
    - The greatest decreases in spending would result from **South Shore Hospital ($4.2 million annually)** or **Cooley-Dickinson Hospital ($2.8 million annually)** becoming unavailable

Challenges facing community hospitals



- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Competition from non-traditional market entrants
- Implications if current trends continue

Driven by referrals and perceived quality, many patients are choosing AMCs and teaching hospitals over community hospitals for routine care

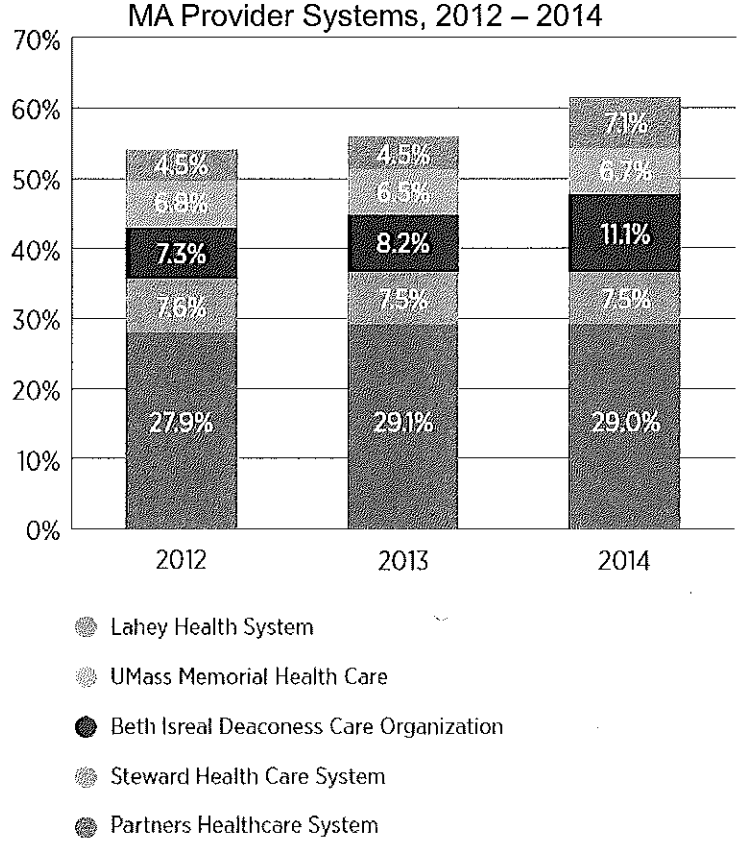
HPC commissioned qualitative analyses (8 focus groups in four regions of the state) by Tufts University to better understand what drives consumer choices of hospitals

> *"I guess it might be something in your psyche because I like brand-name products. So maybe that's what drives me to Boston."*
>
> *FOCUS GROUP PARTICIPANT*

- Patients often mentioned that **they did not feel that they had a choice** of hospitals because their primary care provider or insurance plan determined where they could go for care
- **Two in three Massachusetts adults** have **never sought information** about the safety or quality of medical care, instead valuing the experiences of peers and recommendations of their primary care physicians.
- Many patients stated that they felt that **AMCs and teaching hospitals were better** because they had the best physicians, including doctors who had graduated from medical schools they considered prestigious. Many patients indicated that they **believed AMCs and teaching hospitals had developed reputable brands**
- Some patients stated that the **higher costs of AMCs and teaching hospitals must mean that they provided better quality**, regardless of what quality data showed. Many also said they wanted to "get their money's worth" from the health care system after investing heavily in health insurance coverage. Others reported that **cost is not a factor when it comes to health**

Increased consolidation of providers has driven referrals to large provider systems, including their anchor AMCs and teaching hospitals

Percent of Statewide Inpatient Discharges at the Five Largest MA Provider Systems, 2012 – 2014

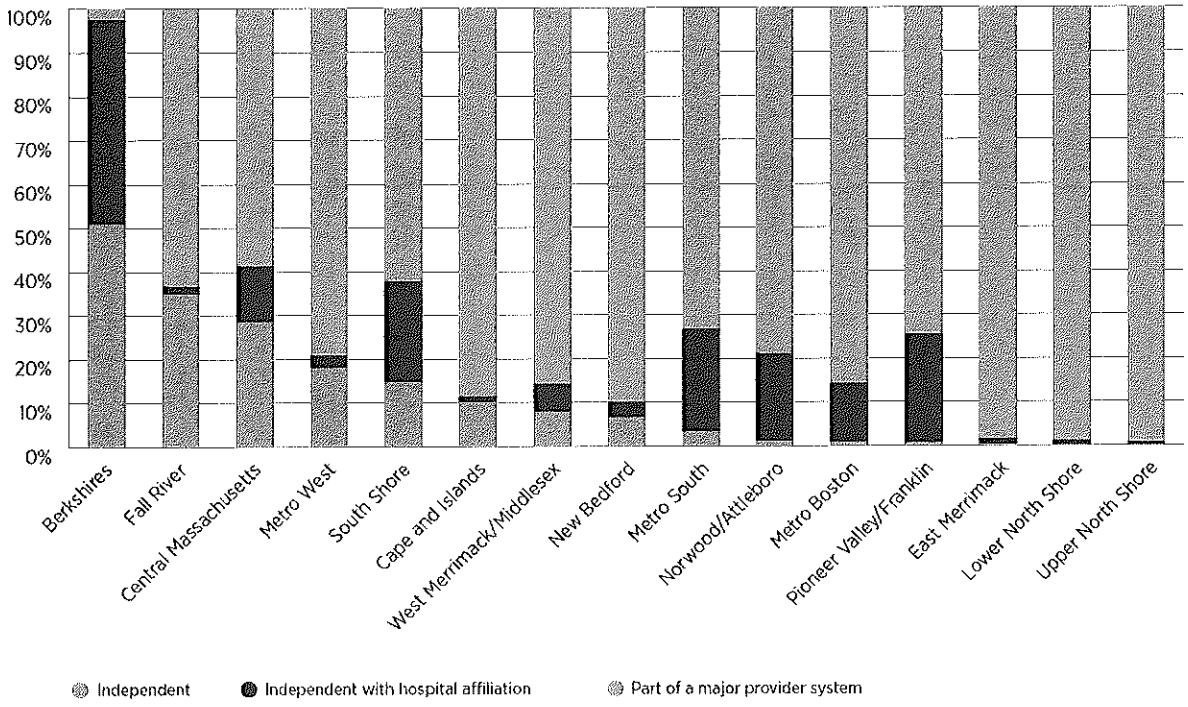


> *"Retaining primary care staff and specialists, 'the gatekeepers to volume' is challenging. Providers continue to leave for big-name systems and AMCs – and patients follow"*
>
> *Synthesis of MASSACHUSETTS PROVIDER INTERVIEWS*

Source: HPC analysis of MCDC discharge data
Note: Systems shown have the highest total net patient service revenue among providers in the Commonwealth.

Most primary care services are now delivered by physicians affiliated with major provider systems

Percentage of Primary Care Services Delivered by Independent versus Affiliated Physicians by Region, 2012



Percentage of PCPs Affiliated with Eight Largest Systems Grew from

62%

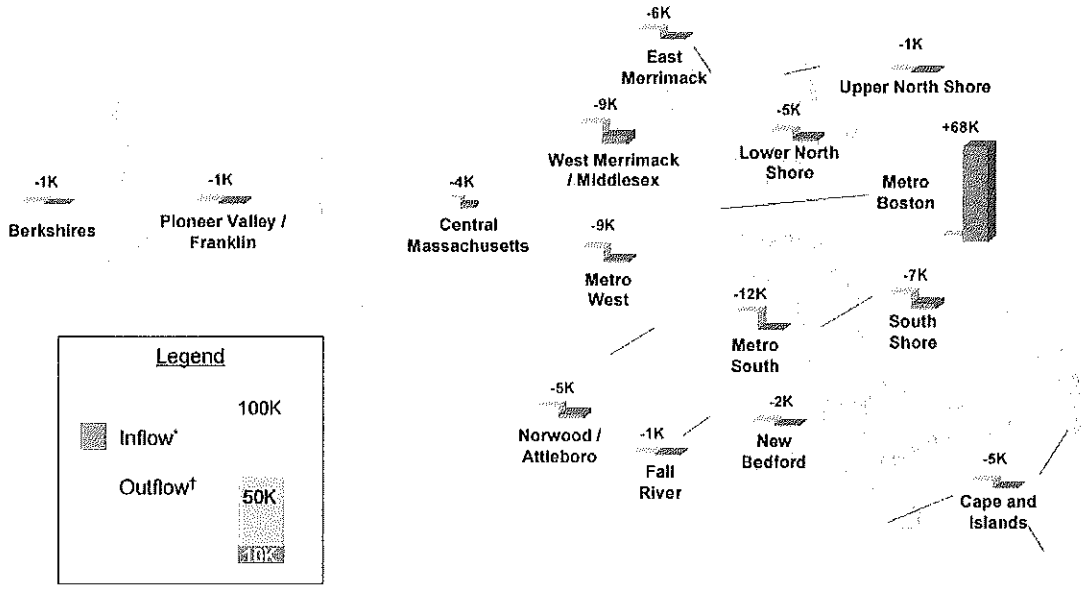
in 2008 to

76%

in 2014

Source: HPC analysis of 2012 APCD claims for BCBS and HPHC; 2012 MHQP Master Provider Database.
Note: For the purposes of this analysis, major provider systems include Atrius Health, Baycare Health Partners, Beth Israel Deaconess Care Organization, Lahey Health System, New England Quality Alliance, Partners Community Health Care, Steward Health Care Network, and UMass Memorial Health Care. PCPs affiliated with multiple systems are counted as being part of a major provider system.

Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



Commercially insured patients are most likely to outmigrate to Boston

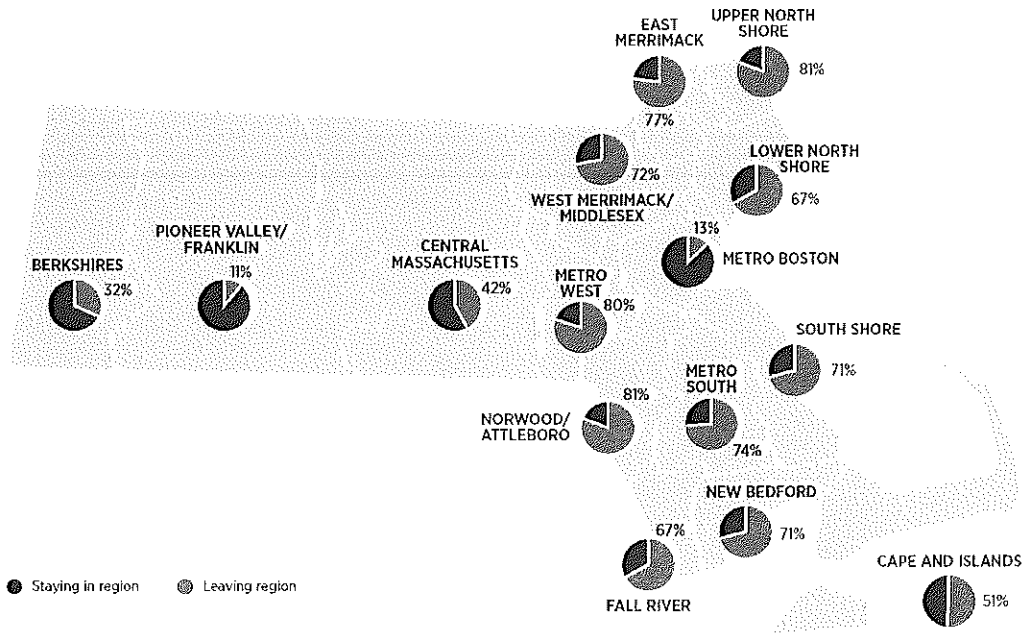
Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
Source: HPC Cost Trends Report, July 2014 Supplement

Large proportions of patients leave their home regions for deliveries

Percentage of Patients Leaving their Home Regions for Community-Appropriate Deliveries, 2013



74%→50%

change in proportion of all births in community hospitals from 1992 – 2012[1]

[1] Healthcare Equality and Affordability League. *Healthcare Inequity in Massachusetts: Breaking the Vicious Cycle.*

6 hospitals saw **53%**

of low risk births in 2011-2012. 5 of these hospitals had above average delivery costs.

Massachusetts General Hospital and Brigham and Women's Hospital have highest costs statewide for maternity care and saw

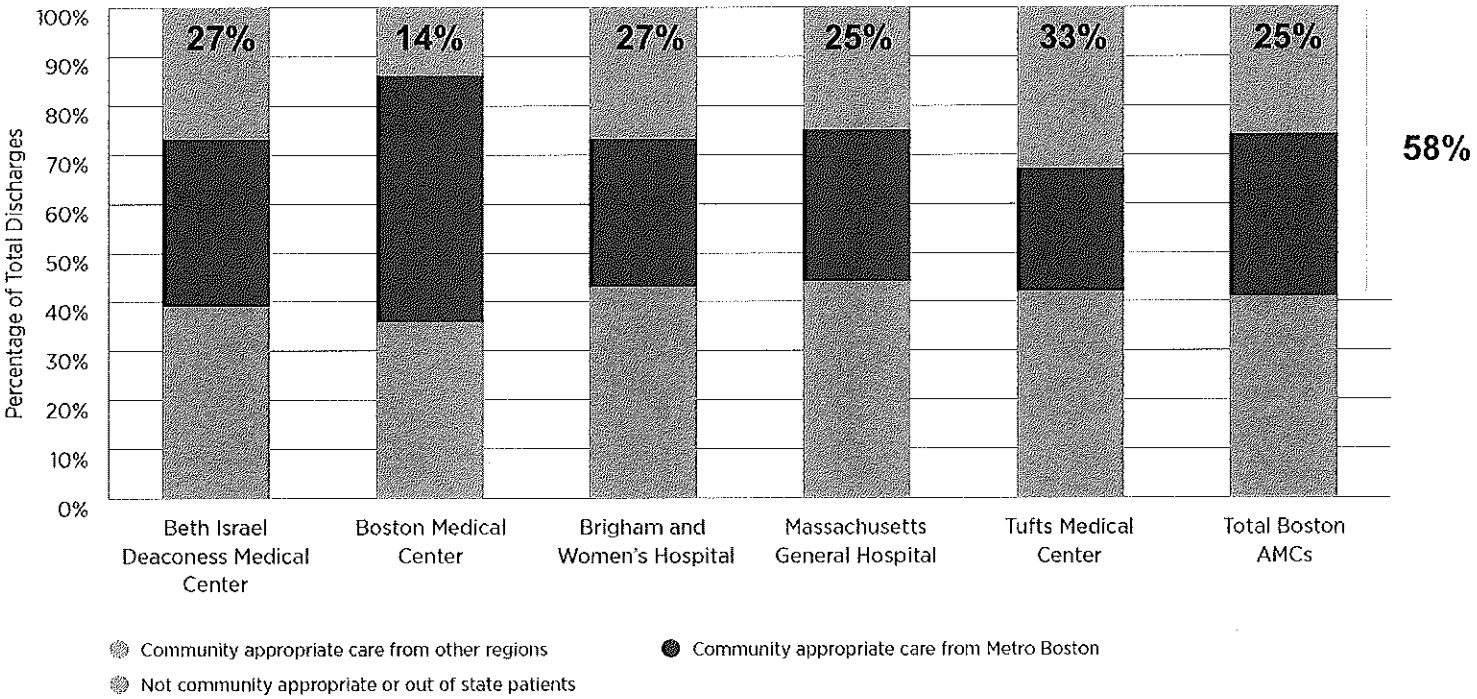
20%

of all low-risk births in the state

Source: HPC analysis of MHDO discharge data.

A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting

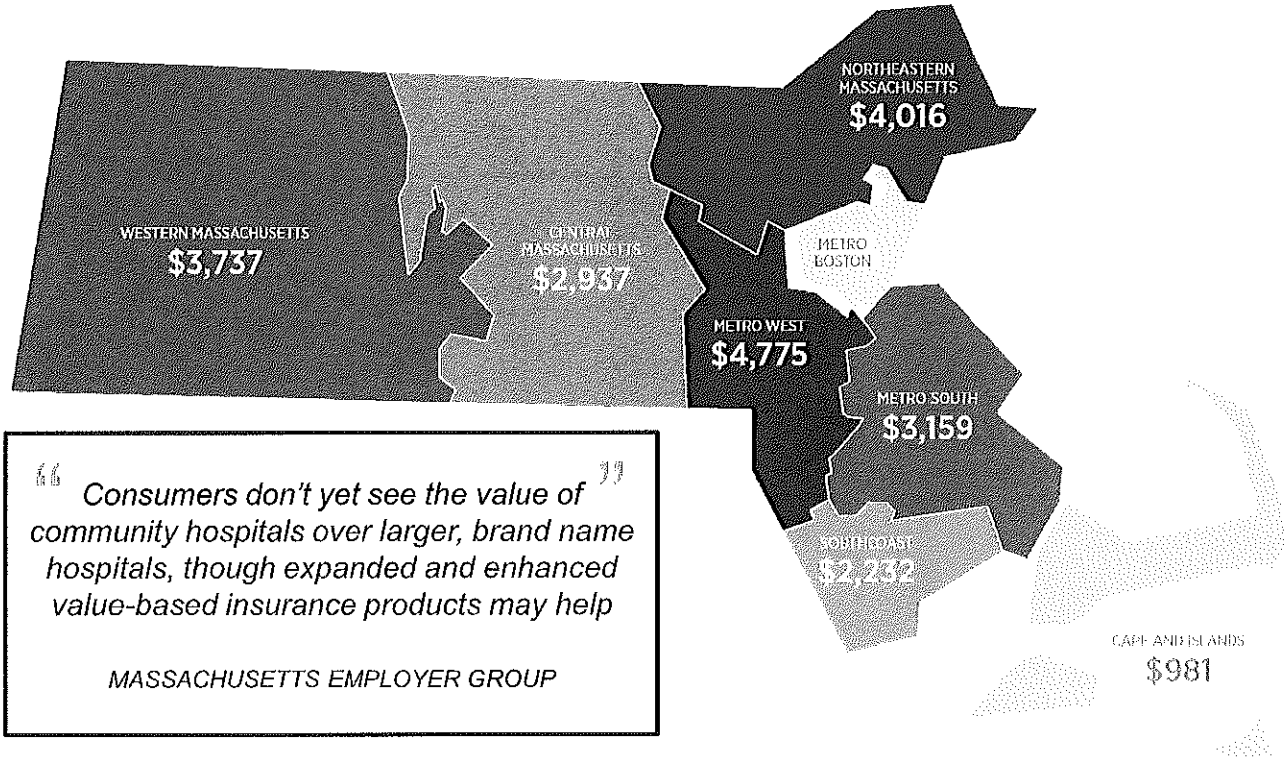
Inpatient Discharges at Boston AMCs, 2013
Community-Appropriate Volume as a Proportion of Total Volume



Source: HPC analysis of MHDC 2013 discharge data.
Note: Figure shows proportion of volume at each hospital, and does not reflect differences in total volume amongst the hospitals shown. Estimates of the volume of community appropriate care provide at AMCs are conservative as community appropriate care is defined to exclude cases which some community hospitals could effectively handle but that many community hospitals could not.

Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

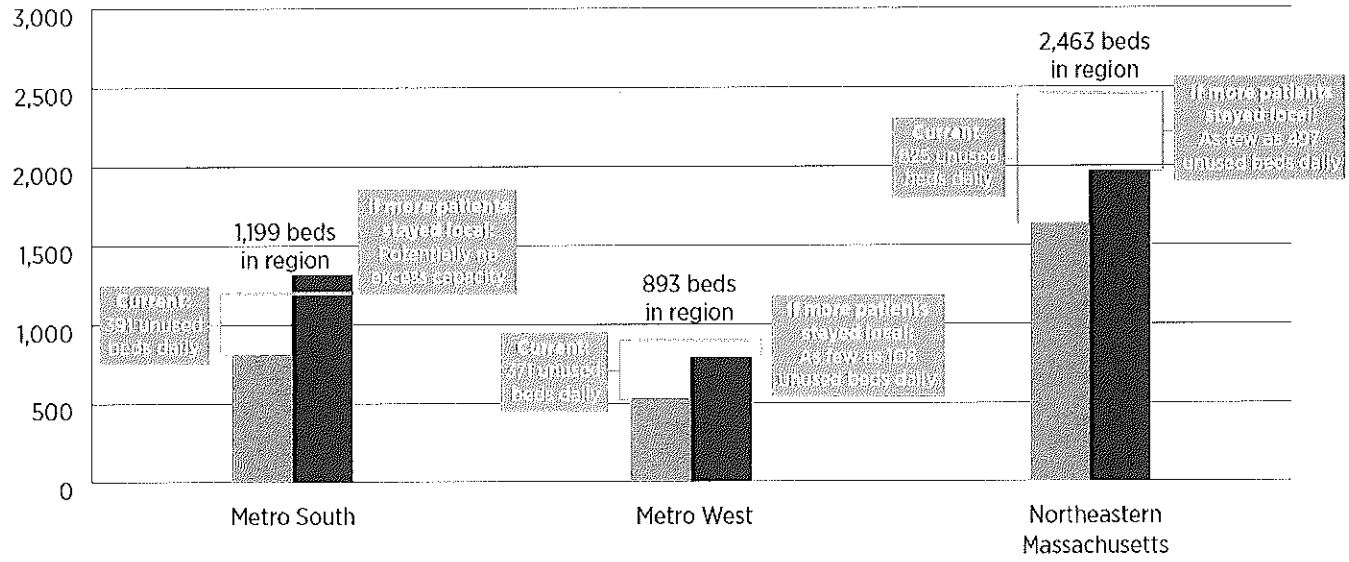


> *"Consumers don't yet see the value of community hospitals over larger, brand name hospitals, though expanded and enhanced value-based insurance products may help"*
>
> *MASSACHUSETTS EMPLOYER GROUP*

Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

In most regions, hospitals have the capacity to treat more patients locally

Average Use of Hospitals in Regions Neighboring Metro Boston versus Average Use of All Hospitals by Region Residents, 2013

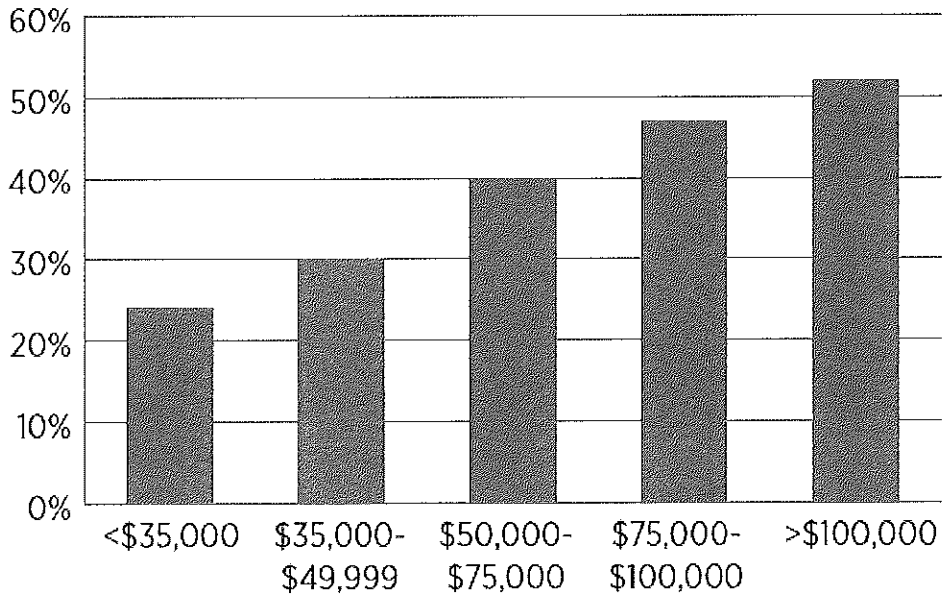


- Average daily utilization of hospitals in region by patients in the region
- Average daily utilization by all patients from region (at hospitals anywhere in Massachusetts)
- The total hospital bed supply in region

Source: HPC analysis of MHDC 2013 discharge data and CHIA hospital 403 reports.

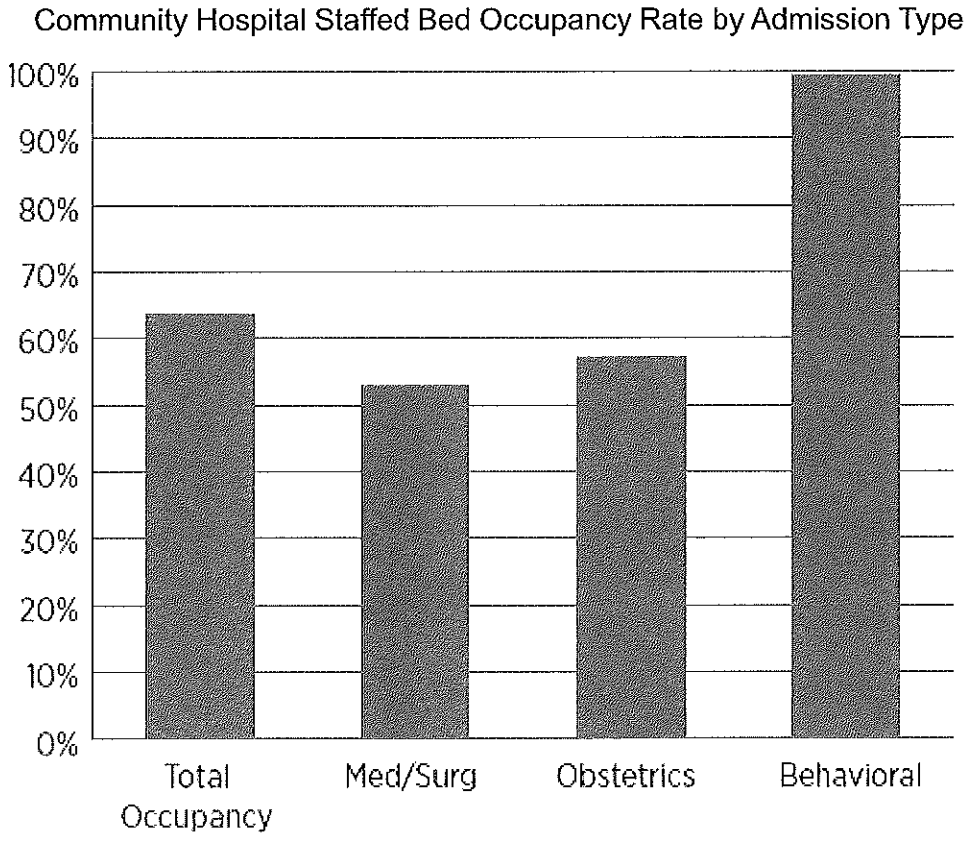
Commercially insured patients and patients from wealthier communities are more likely to migrate to Boston for care

Probability that Patient will Travel Outside of His/Her Home Region for Inpatient Care, Based on Home Community Income



Source: HPC analysis of MHDC 2012 discharge data and U.S. Census Bureau American Community Survey data.

In addition to lowering volume, migration results in community hospitals seeing larger proportions of government payer patients and those seeking low-margin services



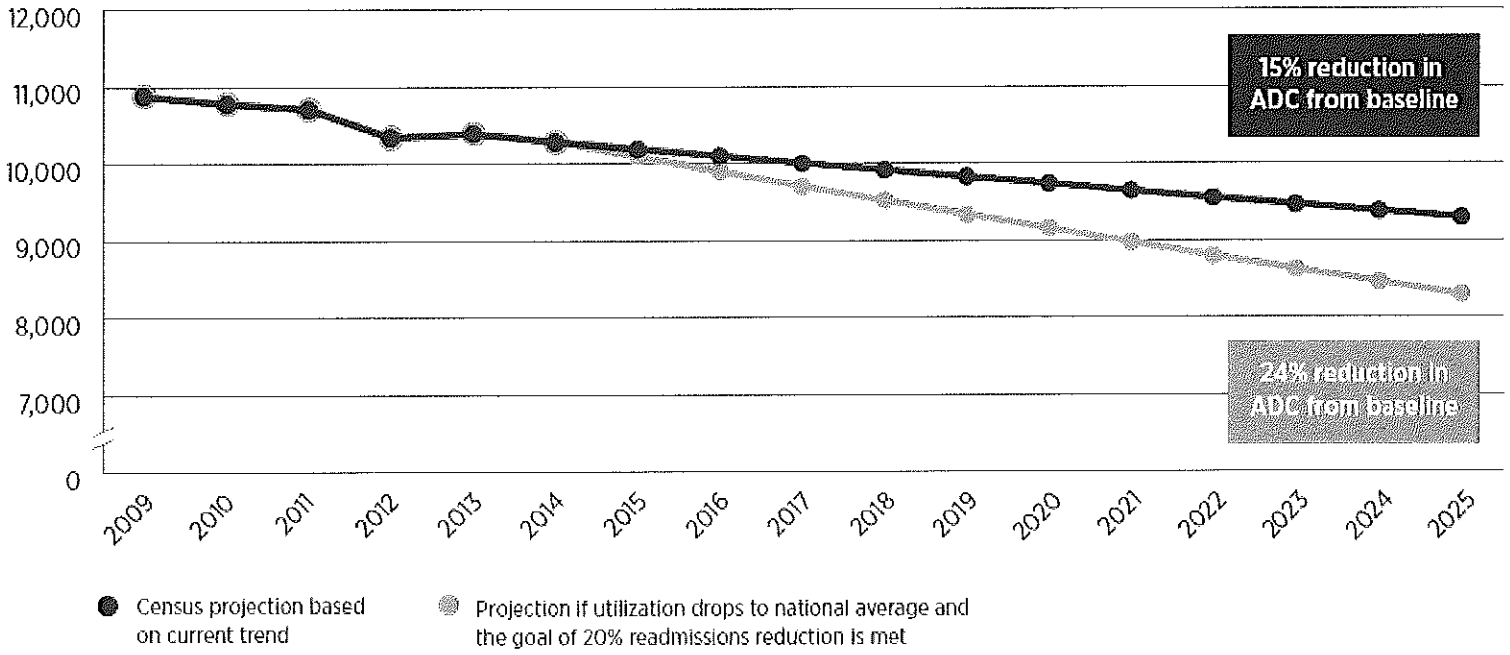
Boarding of behavioral health patients in emergency departments increased by

40%

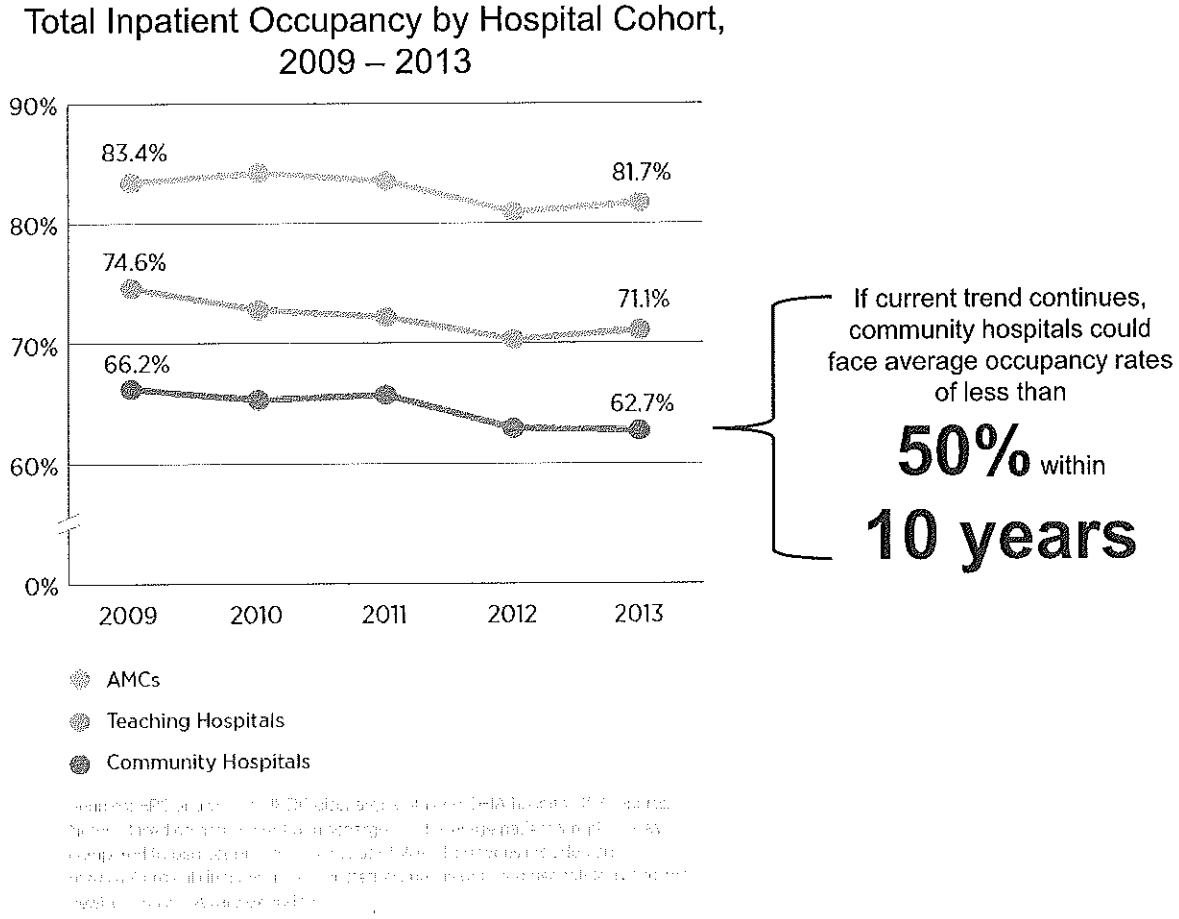
from 2012 - 2014

Declining inpatient utilization poses a structural challenge to the traditional community hospital model

Total Average Daily Census Projections for all Massachusetts Hospitals, 2009 - 2025

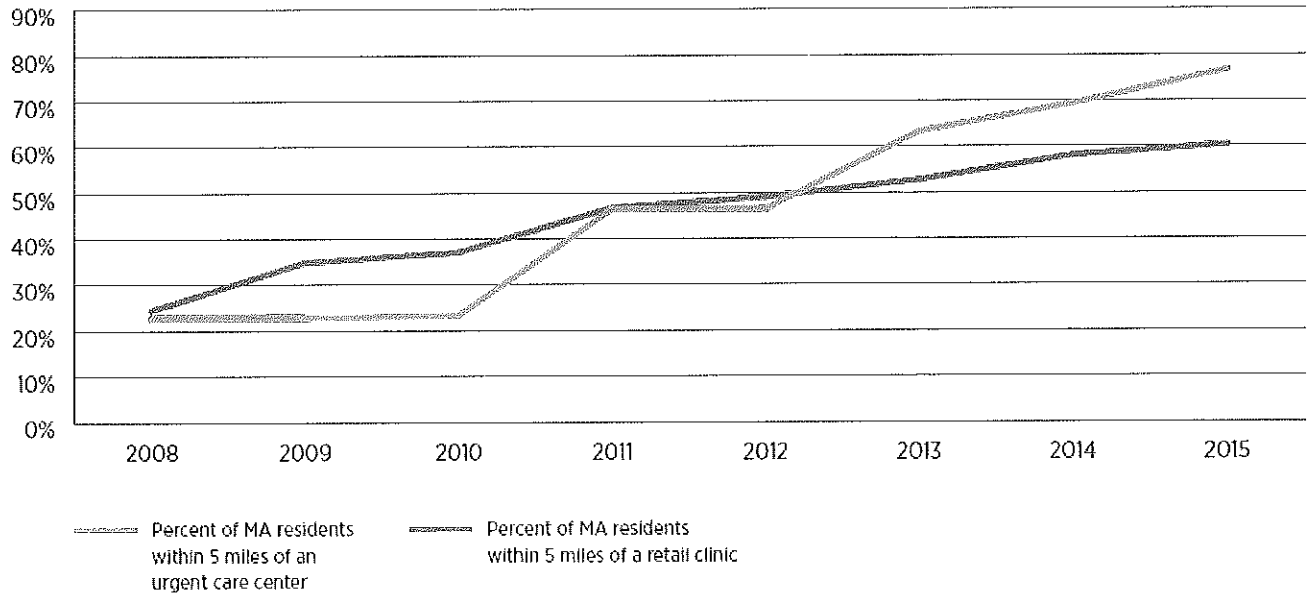


Community hospitals have lower average occupancy, and declining hospital utilization has further impacted occupancy rates



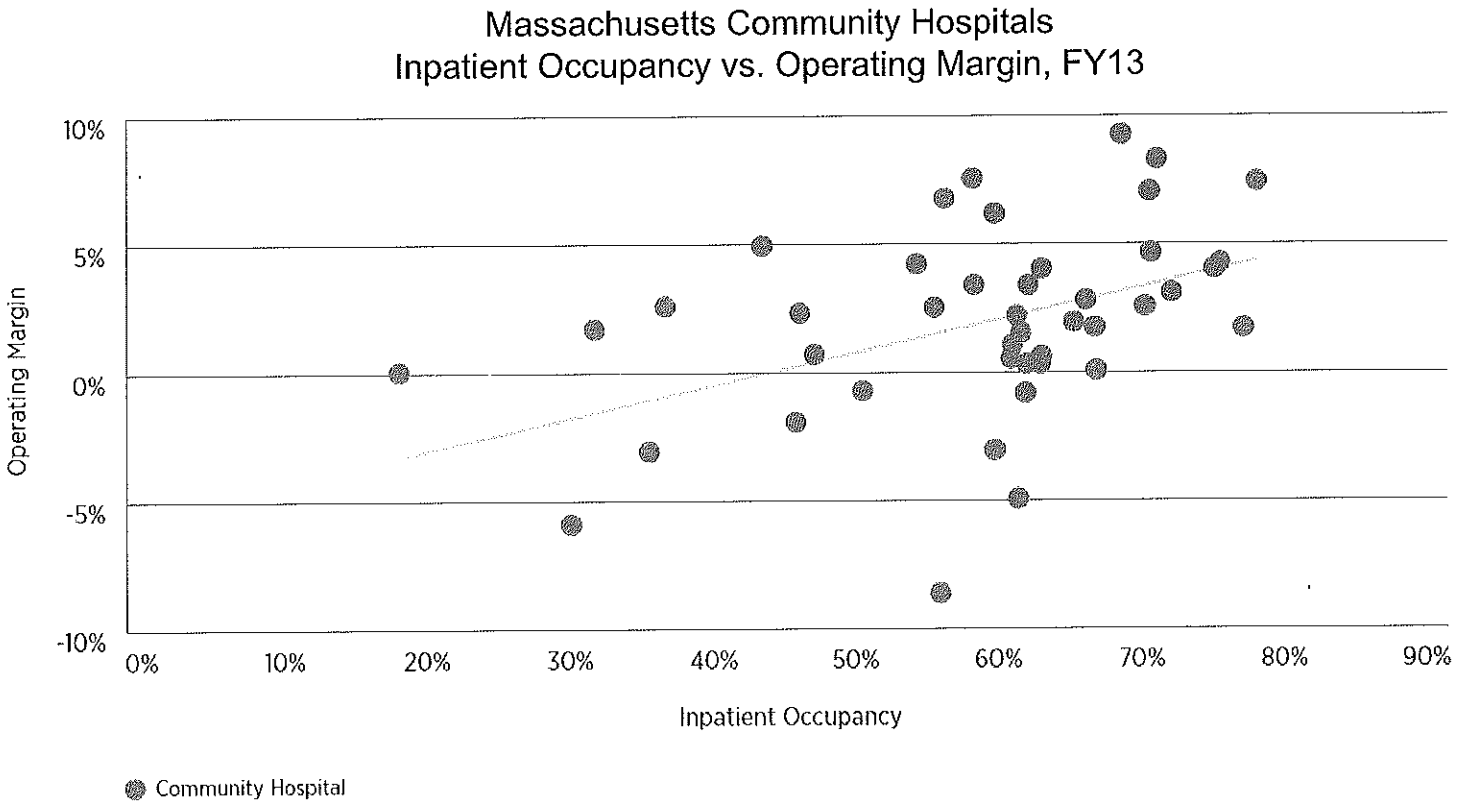
Declining inpatient utilization is driven in part by growing accessibility of non-hospital health care providers

Percent of MA Residents Living Within 5 Miles of Retail Clinics and Urgent Care Centers



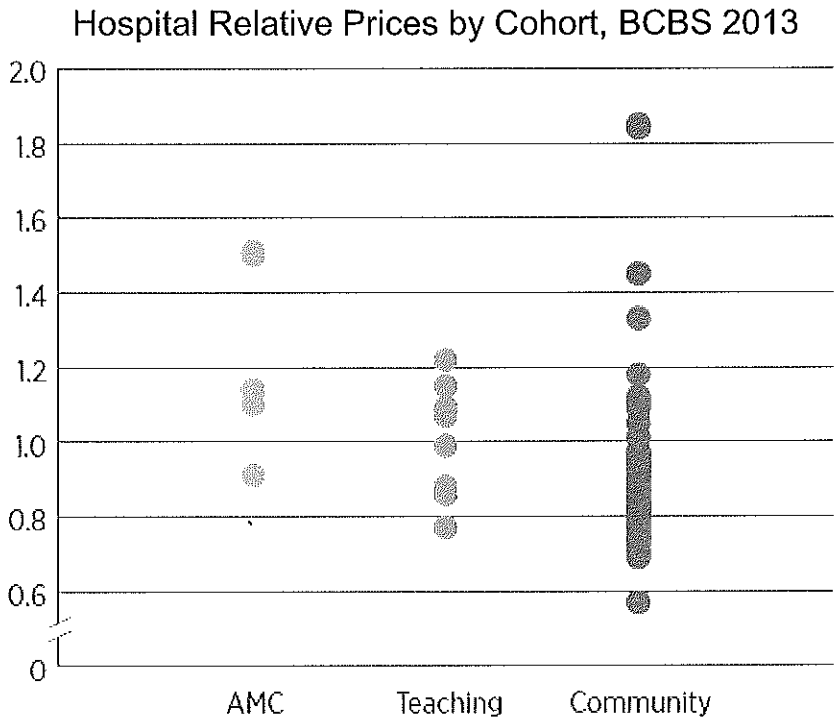
> *"When [they] opened an urgent care center down the block we saw an immediate and precipitous decline in ED volume, especially the commercially insured, non-acute patients. It might be good for costs in the short term, but if we cannot keep our ED open, then what's next?"*
>
> *COMMUNITY HOSPITAL CHIEF STRATEGY OFFICER*

Lower occupancy is associated with lower operating margins for community hospitals, and may threaten their financial stability



Sources: HPC analysis of CHIA Hosp. Profiles, 2013; MHDC 2013 discharge data; CHIA hospital 403 reports

Community hospitals tend to receive lower commercial relative prices than AMCs or teaching hospitals

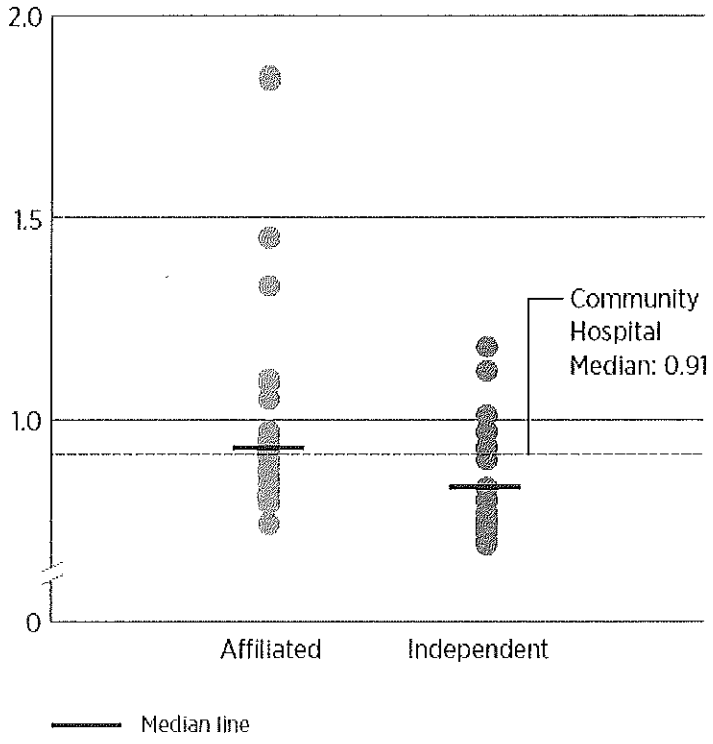


> *"The gap in prices, [which is] a reflection of the market power dynamics in the state, is probably the biggest threat to a lot of the community hospitals"*
>
> *MASSACHUSETTS HEALTH INSURANCE LEADER*

Sources: HPC analysis of Ctr. For Health Info & Analysis, Provider Price Variation in the Massachusetts Health Care Market (calendar year 2013 data), Databook (Feb. 2015), [hereinafter CHIA 2013 RP Databook] available at http://chiamass.gov/assets/Uploads/relative-price-databook-2013.xlsx

Community hospitals affiliated with systems tend to have higher relative prices

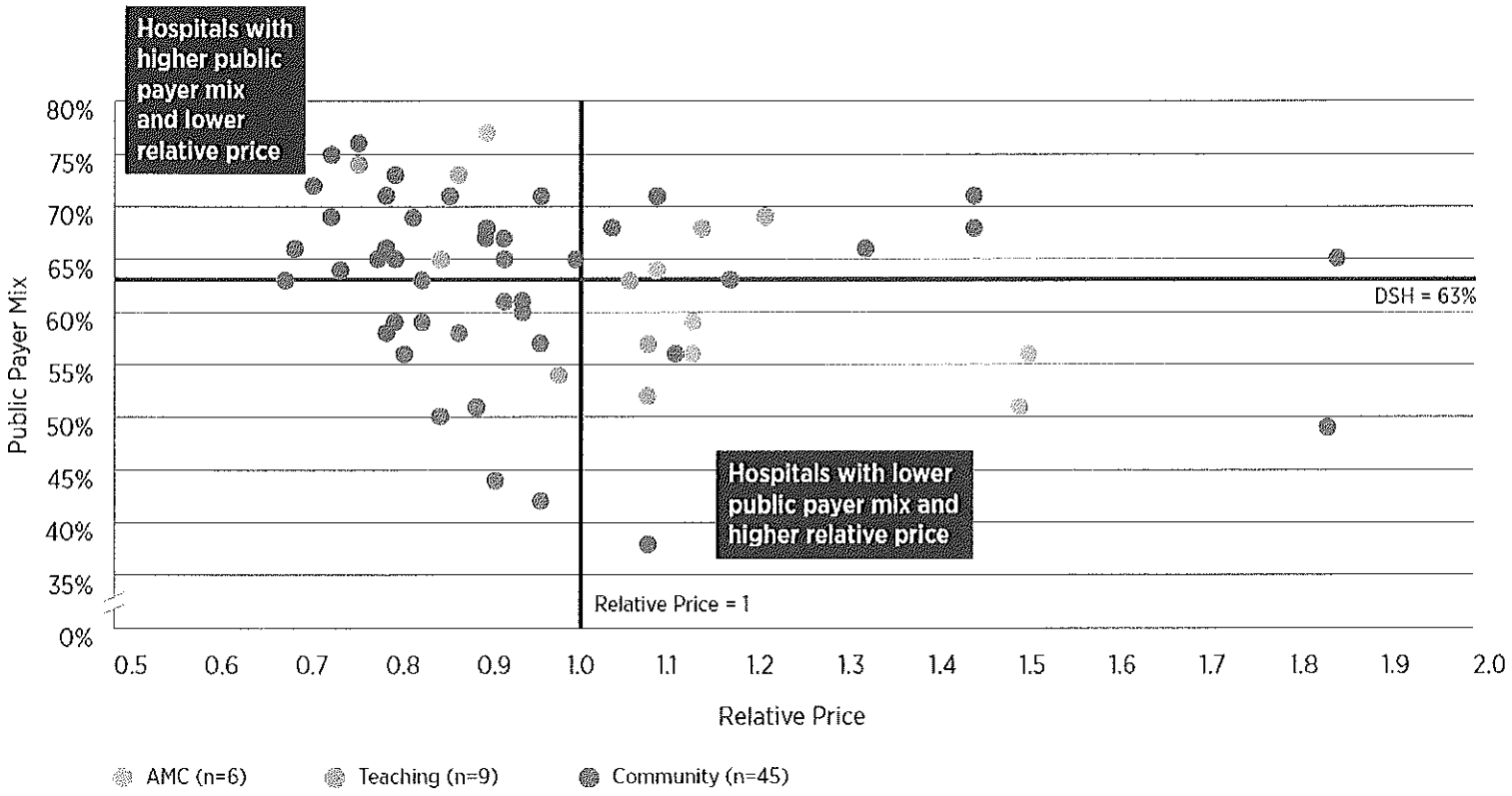
Community Hospital Relative Prices and Affiliation Status, BCBS FY13



Source: HPC analysis of CHIA 2013 RP Databook
Note: While this graph shows relative prices for only one major commercial payer, price and affiliation status are similarly correlated for the other two major commercial payers.

Hospitals with higher public payer mix tend to have lower relative prices, compounding financial stresses; cross-subsidization of higher public payer mix with higher commercial prices is not observed

Hospital Commercial RP and Percent of Revenue from Public Payers by Cohort, BCBS FY13



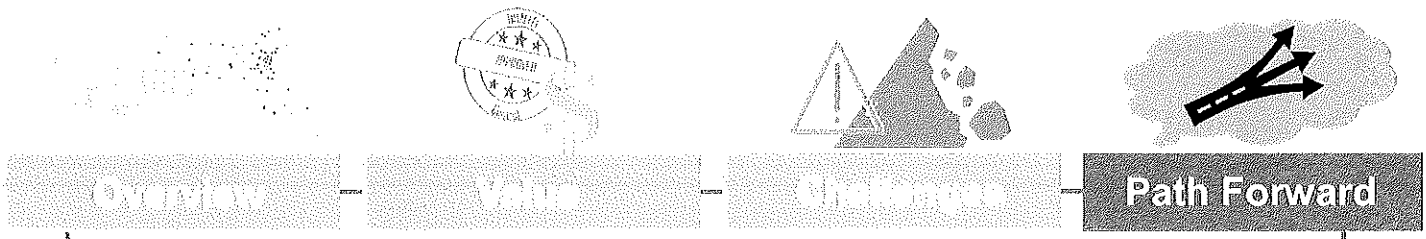
Source: HPC analysis of CHIA 2013 RP Databook and CHIA Hosp. Profiles, 2013

Market participants report facing additional barriers to transformation

To successfully meet challenges and adapt to a changing delivery and payment system, community hospitals must overcome barriers and utilize resources and capabilities that may not be readily available. Barriers reported to the HPC during stakeholder interviews include:

- Lack of **resources**, including financial resources and the ability to attract and retain new staff.
- Lack of needed **data and analytic support** to enable transformation efforts, including a lack of information about health needs and coordinated health planning.
- **Concern about change** by hospital governing bodies and community representatives.
- Challenges **aligning the interests of hospital labor and management** to more effectively pursue transformation efforts.
- Difficulty participating in **alternative payment models**, including challenges under current risk adjustment methodologies for hospitals serving patient populations with socioeconomic disadvantages.
- **Insufficient alignment** among programs designed to fund or assist transformation efforts.
- **Policy or regulatory frameworks** that limit deployment of new structures of care.

The path to a thriving community-based health care system



- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and policies should align to support them
- Call to develop an Action Plan in concert with market participants

Building a path to a thriving community-based health care system

Vision of Community-based Health

A health care system in which patients in Massachusetts are able to get most of their health care in a local, convenient, cost-effective, high-quality setting.

- **The traditional role and operational model for many community hospitals faces tremendous challenges:**
  - evolution in the health care delivery and payment system
  - persistent market dysfunction → resource inequities and overreliance on higher cost care settings
- **A re-envisioning of the role of community hospitals will require:**
  - development of a roadmap for care delivery transformation focused around the community
  - planning and investment for better alignment of providers with community needs
- **Multi-sector dialogue** is necessary to build consensus and identify a series of targeted actions to be taken by providers, payers, consumers, and government

Fostering dialogue and developing an Action Plan

Community Hospitals at a Crossroads:
A Conversation to Foster a Sustainable Community Health System

Developing a successful path to a thriving community-based health care system requires multi-stakeholder engagement and incorporation of many diverse viewpoints.

The report findings are designed to spur market-wide dialogue and support identification of priority actions to be taken by providers, payers, purchasers and government.

March 29, 2016 at 9:00AM at Suffolk University School of Law

The HPC Commissioners and staff will convene industry leaders and stakeholders to discuss findings from the report and its implications for transformation of the Commonwealth's community hospitals. Interested members of the public are invited to attend: register online at www.mass.gov/hpc

In collaboration with stakeholders, HPC will develop an Action Plan to address findings of the report. Action Plan recommendations will be oriented towards providers, payers, purchasers and policymakers

Key themes for further discussion, consensus-building, and action planning

Community Hospitals at a Crossroads:
A Conversation to Foster a Sustainable Community Health System

Planning and support for community hospital transformation

Encouraging consumers to use high-value providers for their care

Creating a sustainable, accessible, and value-based payment system

> *We need to **stop playing defense and start playing offense**. This [challenge of supporting community hospitals] is one of the most complex health policy issues we have, but we cannot keep just relying on short term fixes. These hospitals are the backbones of our communities — we owe it to our communities to come together to develop a plan for their future*
>
> *MASSACHUSETTS STATE LEGISLATOR*

EXHIBIT 7

NON-PROFIT

Applicant: LHH Health System
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
	Description	FY 2014 Actual Results	FY 2016 Projected W/out CON	FY 2016 Projected Incremental	FY 2016 Projected With CON	FY 2017 Projected W/out CON	FY 2017 Projected Incremental	FY 2017 Projected With CON	FY 2018 Projected W/out CON	FY 2018 Projected Incremental	FY 2018 Projected With CON	FY 2019 Projected W/out CON	FY 2019 Projected Incremental	FY 2019 Projected With CON
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$1,076,627,000	$1,165,643,000	($18,627,000)	$1,151,116,000	$1,213,309,000	($24,164,000)	$1,189,145,000	$1,291,841,000	($9,784,000)	$1,282,057,000	$1,312,915,000	$3,739,000	$1,316,654,000
2	Less: Allowances	$616,057,000	$673,832,000	($8,486,000)	$665,346,000	$717,136,000	($9,305,000)	$708,831,000	$762,009,000	$105,000	$762,114,000	$811,078,000	$8,494,000	$820,472,000
3	Less: Charity Care	$6,783,000	$7,336,000	$39,000	$7,374,000	$7,830,000	$130,000	$7,760,000	$7,835,000	$232,000	$8,107,000	$8,282,000	$328,000	$8,610,000
4	Less: Other Deductions	$2,468,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000	$18,202,000	$0	$18,202,000
	Net Patient Service Revenue	$463,629,000	$467,273,000	($3,079,000)	$458,194,000	$470,341,000	($16,989,000)	$454,352,000	$473,815,000	($10,121,000)	$463,694,000	$473,883,000	($5,083,000)	$468,800,000
5	Medicare	$161,244,000	$169,859,000	($2,854,000)	$166,705,000	$170,162,000	($4,894,000)	$165,268,000	$171,320,000	($2,648,000)	$168,472,000	$171,415,000	($1,094,000)	$170,321,000
6	Medicaid	$48,110,000	$53,591,000	($1,355,000)	$48,236,000	$50,771,000	($2,495,000)	$48,276,000	$51,119,000	($1,665,000)	$49,230,000	$51,144,000	($1,363,000)	$49,781,000
7	CHAMPUS & TriCare	$12,447,000	$13,089,000	($276,000)	$12,813,000	$13,136,000	($493,000)	$12,643,000	$13,225,000	($333,000)	$12,889,000	$13,232,000	($200,000)	$13,032,000
8	Other	($2,468,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)	($18,202,000)	$0	($18,202,000)
	Total Government	$219,343,000	$216,037,000	($4,485,000)	$210,552,000	$215,867,000	($7,883,000)	$207,984,000	$217,459,000	($5,070,000)	$212,389,000	$217,589,000	($2,657,000)	$214,932,000
9	Commercial Insurers	$216,839,000	$229,750,000	($1,072,000)	$222,888,000	$227,587,000	($7,250,000)	$220,317,000	$229,116,000	($4,617,000)	$224,598,000	$228,242,000	($2,170,000)	$227,072,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$9,955,000	$10,486,000	$24,000	$10,403,000	$10,606,000	$109,000	$10,815,000	$10,677,000	$236,000	$10,813,000	$10,583,000	$344,000	$10,927,000
12	Workers Compensation	$9,592,000	$9,036,000	($124,000)	$8,911,000	$9,057,000	($203,000)	$8,854,000	$9,120,000	($294,000)	$8,826,000	$9,124,000	($1,000)	$9,133,000
13	Other	$0	$5,973,000	($422,000)	$5,550,000	$7,334,000	($781,000)	$6,553,000	$7,334,000	($676,000)	$6,659,000	$7,334,000	$1,232,000	$8,566,000
	Total Non-Government	$234,386,000	$252,236,000	($1,594,000)	$247,642,000	$254,474,000	($8,105,000)	$246,369,000	$256,166,000	($5,050,000)	$251,106,000	$256,283,000	($595,000)	$255,698,000
	Net Patient Service Revenue* (Government+Non-Government)	$453,629,000	$467,273,000	($3,079,000)	$458,194,000	$470,341,000	($16,989,000)	$454,352,000	$473,814,000	($10,120,000)	$463,694,000	$473,882,000	($5,282,000)	$470,630,000
14	Less: Provision for Bad Debts	$20,398,000	$17,177,000	($54,000)	$17,123,000	$17,240,000	($289,000)	$16,951,000	$17,369,000	($291,000)	$17,078,000	$17,369,000	($291,000)	$17,078,000
	Net Patient Service Revenue less provision for bad debts	$433,231,000	$450,096,000	($3,025,000)	$441,071,000	$453,101,000	($15,700,000)	$437,401,000	$456,266,000	($9,830,000)	$446,436,000	$456,514,000	($4,792,000)	$451,722,000
15	Other Operating Revenue	$20,765,000	$18,625,000	($4,622,000)	$14,003,000	$18,625,000	($9,243,000)	$9,382,000	$18,625,000	($9,243,000)	$9,382,000	$18,625,000	($9,243,000)	$9,382,000
17	Net Assets Released from Restrictions	$976,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	$454,902,000	$468,721,000	($13,647,000)	$455,074,000	$471,726,000	($24,943,000)	$446,783,000	$474,891,000	($19,073,000)	$455,818,000	$475,139,000	($14,035,000)	$461,104,000
B.	OPERATING EXPENSES													
1	Salaries and Wages	$218,468,000	$221,743,000	($16,504,000)	$205,239,000	$218,732,000	($12,626,000)	$186,106,000	$220,764,000	($33,139,000)	$187,626,000	$223,224,000	($32,879,000)	$190,345,000
2	Fringe Benefits	$59,186,000	$61,335,000	($2,499,000)	$58,850,000	$59,392,000	($4,898,000)	$54,494,000	$59,611,000	($4,866,000)	$54,745,000	$59,980,000	($4,677,000)	$55,303,000
3	Physicians Fees	$54,479,000	$39,293,000	$11,193,000	$47,468,000	$29,552,000	$16,303,000	$45,875,000	$29,231,000	$17,197,000	$46,428,000	$29,015,000	$18,070,000	$47,085,000
4	Supplies and Drugs	$71,998,000	$77,728,000	($1,408,000)	$76,320,000	$76,133,000	($2,333,000)	$73,800,000	$79,258,000	($1,760,000)	$77,498,000	$80,383,000	($1,273,000)	$79,110,000
5	Depreciation and Amortization	$27,478,000	$28,416,000	$41,000	$28,456,000	$30,071,000	$67,000	$30,138,000	$30,248,000	$65,000	$30,413,000	$31,453,000	$55,000	$31,508,000
6	Provision for Bad Debts-Other*	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,656,000	$3,368,000	$0	$3,368,000	$3,188,000	$0	$3,188,000	$2,974,000	$0	$2,974,000	$2,749,000	$0	$2,749,000
8	Malpractice Insurance Cost	$14,513,000	$16,833,000	($1,286,000)	$15,547,000	$16,833,000	($2,571,000)	$14,262,000	$16,833,000	($2,571,000)	$14,262,000	$16,833,000	($2,571,000)	$14,262,000
9	Lease Expense	$6,970,000	$7,964,000	($1,068,000)	$6,896,000	$7,964,000	($2,136,000)	$5,828,000	$7,964,000	($2,136,000)	$5,828,000	$7,964,000	($2,136,000)	$5,828,000
10	Other Operating Expenses	$21,044,000	$23,767,000	($2,057,000)	$21,710,000	$20,818,000	($4,115,000)	$16,603,000	$21,103,000	($4,128,000)	$16,975,000	$21,670,000	($4,137,000)	$17,439,000
	TOTAL OPERATING EXPENSES	$473,584,000	$477,417,000	($13,572,000)	$463,842,000	$464,433,000	($32,219,000)	$432,214,000	$468,036,000	($31,338,000)	$436,748,000	$473,277,000	($29,648,000)	$444,229,000
	INCOME/(LOSS) FROM OPERATIONS	($18,686,000)	($8,696,000)	($72,000)	($8,768,000)	$7,293,000	$7,276,000	$14,569,000	$6,795,000	$12,266,000	$19,060,000	$1,862,000	$15,613,000	$16,876,000
	NON-OPERATING REVENUE	$15,297,000	$8,859,000	$0	$8,859,000	$8,859,000	$0	$8,859,000	$8,859,000	$0	$8,859,000	$8,859,000	$0	$8,859,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	($3,389,000)	$163,000	($72,000)	$91,000	$16,152,000	$7,276,000	$23,428,000	$15,654,000	$12,266,000	$27,919,000	$10,721,000	$15,613,000	$25,734,000
	Principal Payments	$5,350,000	$5,511,000	$0	$5,511,000	$5,726,000	$0	$5,726,000	$5,911,000	$0	$5,911,000	$6,137,000	$0	$6,137,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	-4.1%	-1.9%	0.5%	-1.9%	1.5%	-29.2%	3.3%	1.4%	-64.3%	4.2%	0.3%	-110.5%	3.7%
2	Hospital Non Operating Margin	3.4%	1.9%	0.0%	1.9%	1.9%	0.0%	2.0%	1.9%	0.0%	1.9%	1.9%	0.0%	1.9%
3	Hospital Total Margin	-0.7%	0.0%	0.5%	0.0%	3.4%	-29.2%	5.2%	3.3%	-64.3%	6.1%	2.3%	-110.5%	5.6%
D.	FTEs	2,849	2,821	(180)	2,641	2,711	(326)	2,386	2,701	(323)	2,378	2,691	(313)	2,378

FTEs associated with the integration of NEMG and LMPA are excluded in the incremental column. Please refer to the Medical Group CON to reference the corresponding additional FTEs

E.	VOLUME STATISTICS*													
1	Inpatient Discharges	17,288	17,243	211	17,454	17,081	393	17,474	16,900	574	17,474	16,753	755	17,508
2	Outpatient Visits	585,965	618,643	4,454	623,097	620,384	11,680	632,244	621,913	15,930	637,843	621,913	15,558	640,471
	TOTAL VOLUME	603,253	635,786	4,765	640,551	637,465	12,273	649,718	638,813	16,204	655,017	638,666	16,313	657,979

*Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

NON-PROFIT

Applicant: L+M Hospital
Financial Worksheet (A)

Please provide one year of actual results and three years of projections of Total Entity revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

LINE	Total Entity:	(1) FY 2014 Actual Results	(2) FY 2016 Projected W/out CON	(3) FY 2016 Projected Incremental	(4) FY 2016 Projected With CON	(5) FY 2017 Projected W/out CON	(6) FY 2017 Projected Incremental	(7) FY 2017 Projected With CON	(8) FY 2018 Projected W/out CON	(9) FY 2018 Projected Incremental	(10) FY 2018 Projected With CON	(11) FY 2019 Projected W/out CON	(12) FY 2019 Projected Incremental	(13) FY 2019 Projected With CON
	Description													
A.	OPERATING REVENUE													
1	Total Gross Patient Revenue	$796,267,000	$860,163,000	$14,094,000	$874,277,000	$894,590,000	$37,460,000	$932,050,000	$930,374,000	$53,320,000	$983,694,000	$967,589,000	$58,938,000	$1,026,497,000
2	Less: Allowances	$450,261,000	$487,244,000	$8,282,000	$495,526,000	$521,292,000	$22,693,000	$543,882,000	$553,773,000	$32,780,000	$586,553,000	$590,539,000	$43,352,000	$633,891,000
3	Less: Charity Care	$5,449,000	$6,894,000	$97,000	$6,991,000	$6,576,000	$287,000	$6,642,000	$6,895,000	$395,000	$7,290,000	$7,457,000	$531,000	$7,988,000
4	Less: Other Deductions	$2,459,000	$16,202,000	$0	$16,202,000	$16,202,000	$0	$16,202,000	$16,202,000	$0	$16,202,000	$16,202,000	$0	$16,202,000
	Net Patient Service Revenue	$337,129,000	$348,843,000	$5,715,000	$354,558,000	$348,721,000	$14,681,000	$363,324,000	$361,504,000	$20,145,000	$373,649,000	$361,391,000	$25,026,000	$376,416,000
5	Medicare	$118,164,000	$123,501,000	$1,924,000	$125,505,000	$123,639,000	$4,916,000	$128,455,000	$124,491,000	$6,783,000	$131,274,000	$124,452,000	$8,426,000	$132,878,000
6	Medicaid	$36,749,000	$39,097,000	$609,000	$39,706,000	$39,084,000	$1,555,000	$40,639,000	$39,385,000	$2,146,000	$41,531,000	$39,373,000	$2,666,000	$42,039,000
7	CHAMPUS & TriCare	$10,981,000	$11,683,000	$182,000	$11,865,000	$11,078,000	$465,000	$12,144,000	$11,769,000	$641,000	$12,410,000	$11,768,000	$797,000	$12,563,000
8	Other	(32,459,000)	($16,202,000)	$0	($16,202,000)	($16,202,000)	$0	($16,202,000)	($16,202,000)	$0	($16,202,000)	($16,202,000)	$0	($16,202,000)
	Total Government	$161,425,000	$158,189,000	$2,715,000	$160,874,000	$166,100,000	$6,936,000	$163,036,000	$167,443,000	$9,570,000	$187,013,000	$167,389,000	$11,889,000	$189,278,000
9	Commercial Insurers	$163,214,000	$173,849,000	$2,704,000	$176,353,000	$173,691,000	$6,908,000	$180,499,000	$174,928,000	$9,531,000	$184,459,000	$174,873,000	$11,839,000	$186,712,000
10	Uninsured	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
11	Self Pay	$5,132,000	$6,460,000	$85,000	$5,545,000	$5,456,000	$217,000	$5,675,000	$5,500,000	$300,000	$5,800,000	$5,408,000	$372,000	$5,870,000
12	Workers Compensation	$7,359,000	$7,829,000	$122,000	$7,951,000	$7,026,000	$311,000	$8,137,000	$7,886,000	$430,000	$8,316,000	$7,884,000	$534,000	$8,418,000
13	Other	$0	$5,746,000	$69,000	$5,815,000	$5,746,000	$229,000	$5,975,000	$5,746,000	$315,000	$6,061,000	$5,746,000	$392,000	$6,138,000
	Total Non-Government	$176,704,000	$192,884,000	$3,000,000	$195,684,000	$192,021,000	$7,665,000	$200,286,000	$194,060,000	$10,576,000	$204,636,000	$194,001,000	$13,137,000	$207,138,000
	Net Patient Service Revenue* (Government+Non-Government)	$337,129,000	$348,843,000	$5,715,000	$354,558,000	$348,721,000	$14,601,000	$363,322,000	$361,503,000	$20,146,000	$371,649,000	$361,390,000	$25,026,000	$376,416,000
14	Less: Provision for Bad Debts	$14,930,000	$13,803,000	$210,000	$14,013,000	$13,799,000	$537,000	$14,336,000	$13,909,000	$741,000	$14,650,000	$13,904,000	$921,000	$14,826,000
	Net Patient Service Revenue less provision for bad debts	$322,199,000	$335,040,000	$5,505,000	$340,545,000	$334,923,000	$14,064,000	$348,989,000	$337,595,000	$19,404,000	$356,999,000	$337,487,000	$24,104,000	$361,591,000
15	Other Operating Revenue	$28,151,000	$31,186,000	$0	$31,186,000	$31,186,000	$0	$31,186,000	$31,186,000	$0	$31,186,000	$31,186,000	$0	$31,186,000
17	Net Assets Released from Restrictions	$672,000	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	TOTAL OPERATING REVENUE	$351,022,000	$366,226,000	$5,505,000	$371,731,000	$366,109,000	$14,066,000	$380,175,000	$368,781,000	$19,404,000	$388,185,000	$368,673,000	$24,104,000	$392,777,000
B.	OPERATING EXPENSES													
1	Salaries and Wages	$143,839,000	$143,677,000	$604,000	$144,181,000	$140,019,000	$761,000	$140,780,000	$141,973,000	$755,000	$142,728,000	$143,983,000	$1,270,000	$145,253,000
2	Fringe Benefits	$61,045,000	$64,026,000	$848,000	$64,874,000	$62,457,000	$1,229,000	$63,686,000	$62,771,000	$1,255,000	$64,026,000	$63,068,000	$1,406,000	$64,486,000
3	Physicians Fees	$38,649,000	$30,254,000	$2,845,000	$33,099,000	$22,993,000	$4,678,000	$27,671,000	$22,633,000	$4,789,000	$27,322,000	$22,849,000	$4,922,000	$27,771,000
4	Supplies and Drugs	$59,638,000	$64,299,000	$55,000	$64,344,000	$64,610,000	$346,000	$64,956,000	$65,541,000	$652,000	$66,193,000	$66,471,000	$918,000	$67,389,000
5	Depreciation and Amortization	$22,729,000	$26,054,000	$77,000	$26,131,000	$27,572,000	$154,000	$27,726,000	$27,826,000	$154,000	$27,980,000	$28,040,000	$154,000	$28,194,000
6	Provision for Bad Debts-Other*	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
7	Interest Expense	$3,643,000	$3,388,000	$0	$3,388,000	$3,166,000	$0	$3,166,000	$2,974,000	$0	$2,974,000	$2,749,000	$0	$2,749,000
8	Malpractice Insurance Cost	$4,539,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000	$4,813,000	$0	$4,813,000
9	Lease Expense	$4,619,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000	$4,852,000	$0	$4,852,000
10	Other Operating Expenses	$25,353,000	$30,491,000	$0	$30,491,000	$30,491,000	$0	$30,491,000	$30,795,000	$0	$30,795,000	$29,256,000	$0	$29,256,000
	TOTAL OPERATING EXPENSES	$363,832,000	$361,724,000	$4,429,000	$366,163,000	$359,975,000	$7,168,000	$368,143,000	$364,976,000	$7,605,000	$381,683,000	$366,901,000	$8,672,000	$385,573,000
	INCOME/(LOSS) FROM OPERATIONS	($2,810,000)	$4,502,000	$1,076,000	$5,578,000	$6,134,000	$6,898,000	$12,032,000	$14,763,000	$11,799,000	$26,502,000	$11,772,000	$15,432,000	$27,204,000
	NON-OPERATING REVENUE	$8,789,000	$8,263,000	$0	$8,263,000	$8,263,000	$0	$8,263,000	$8,263,000	$0	$8,263,000	$8,263,000	$0	$8,263,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$5,979,000	$12,765,000	$1,076,000	$13,841,000	$23,397,000	$6,898,000	$30,295,000	$22,966,000	$11,799,000	$34,765,000	$20,035,000	$15,432,000	$35,467,000
	Principal Payments	$5,153,000	$5,511,000	$0	$5,511,000	$5,726,000	$0	$5,726,000	$5,911,000	$0	$5,911,000	$6,137,000	$0	$6,137,000
C.	PROFITABILITY SUMMARY													
1	Hospital Operating Margin	-0.8%	1.2%	19.5%	1.5%	1.7%	49.0%	3.2%	4.0%	60.8%	6.8%	3.2%	64.0%	6.9%
2	Hospital Non Operating Margin	2.5%	2.3%	0.0%	2.2%	2.3%	0.0%	2.2%	2.2%	0.0%	2.1%	2.2%	0.0%	2.1%
3	Hospital Total Margin	1.7%	3.5%	19.5%	3.7%	6.4%	49.0%	8.0%	6.2%	60.8%	9.0%	5.4%	64.0%	9.0%
D.	FTEs	1,849	1,827	2	1,829	1,755	3	1,758	1,745	7	1,752	1,735	18	1,753
E.	VOLUME STATISTICS*													
1	Inpatient Discharges	14,151	14,212	179	14,391	14,083	329	14,412	13,940	476	14,416	13,823	627	14,450
2	Outpatient Visits	458,110	455,077	3,462	458,539	455,077	10,930	466,007	455,077	14,489	469,566	455,077	17,407	472,484
	TOTAL VOLUME	472,261	469,289	3,641	472,930	469,160	11,259	480,419	469,017	14,967	483,984	468,900	18,034	486,935

*Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.
*Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.
*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Lawrence + Memorial Health System Affiliation with Yale New Haven Health System Assumptions

Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	0 - 1.4%	0 - 1.4%	0 - 1.2%	0 - 1.2%
2) Non-Government	0 - 2.5%	0 - 2.0%	0 - 2.0%	0 - 2.0%
3) Inpatient Volume	1.1%	0.1%	0.0%	0.2%
4) Outpatient Volume	1.0%	1.5%	0.8%	0.5%

	FY 2016	FY 2017	FY 2018	FY 2019
EXPENSES				
A. Salaries and Fringe Benefits	1.5%	1.5%	1.5%	1.5%
B. Non-Salary				
1) Supplies and Drugs	2.0%	1.5%	1.5%	1.5%
2) Professional and Contracted Services	2.0%	1.5%	1.5%	1.5%
3) Malpractice Insurance and Lease Expense	0.0%	0.0%	0.0%	0.0%
4) All Other Expenses	1.0%	1.0%	1.0%	1.0%
5) All Other Expenses				

	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	2,641	2,386	2,378	2,378

Note - The above increase projections reflect all changes relating to Medicare and Medicaid reimbursement regulations.

YALE-NEW HAVEN System
Lawrence + Memorial Affiliation
Assumptions

Net Revenue Rate Increases	FY 2016	FY 2017	FY 2018	FY 2019
1) Government	1.0%	1.0%	1.0%	1.0%
2) Non-Government	1.0%	1.0%	1.0%	1.0%
3) Inpatient Volume	1.0%	1.0%	1.0%	1.0%
4) Outpatient Volume	1.0%	1.0%	1.0%	1.0%

	FY 2016	FY 2017	FY 2018	FY 2019
EXPENSES				
A. **Salaries and Fringe Benefits**	3.0%	3.0%	3.0%	3.0%
B. **Non-Salary**				
1) Supplies and Drugs	3.0%	3.0%	3.0%	3.0%
2) Professional and Contracted Services	3.0%	3.0%	3.0%	3.0%
3) Malpractice Insurance and Lease Expense	3.0%	3.0%	3.0%	3.0%
4) All Other Expenses	3.0%	3.0%	3.0%	3.0%

	FY 2016	FY 2017	FY 2018	FY 2019
FTEs				
1) Total estimated FTEs	14,391	14,412	14,418	14,450

EXHIBIT 8

EXHIBIT 9

William W. Backus Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Former President & CEO			$3,357,690	$738,636	$666,118	$925,503	$645,419		
Regional President		$858,680							
President & CEO			$975,550	$664,781	$573,317	$410,672		$627,001	$596,473
Regional VP, Finance		$598,856							
Medical Affairs Regional VP	$410,993	$577,237							
Medical Director, Medicare Care Admin	$552,137								
BPS Physician	$622,339	$558,100		$523,896	$497,357				
Hospitalist Physician	$489,374								
Sr. Vice President & CFO			$659,230	$488,297	$438,868	$494,684	$407,839	$404,988	$382,897
Chief of Emergency Medicine		$495,605							$357,592
Clinical Services Sr. VP & CMO			$587,917						
ER Physician	$424,203	$414,709				$437,095	$415,402	$406,279	$345,324
Medical Director				$479,197	$458,448	$407,519	$380,678	$366,158	
ER Physician	$418,265	$414,453		$469,984	$471,117	$404,362	$379,087	$347,302	$330,183
Vice President & COO						$391,942	$360,153	$345,700	$317,502
BPS Physician		$551,117	$548,961	$400,639	$397,513				
BPS Physician			$504,965	$384,636	$377,448				
ER Physician	$416,812								
ER Physician	$409,255	$405,635	$481,414	$380,816	$382,452	$369,115	$346,575	$339,930	$328,021
ER Physician	$391,415	$396,123	$421,693	$372,326	$380,316	$362,716	$344,000	$336,916	$326,419
ER Physician			$411,993			$358,594	$343,575	$332,063	$322,176
ER Physician			$403,912				$342,098	$326,881	$320,727
Rhuematology Physician	$407,038								
Total	**$4,541,831**	**$5,270,515**	**$8,353,325**	**$4,903,208**	**$4,642,954**	**$4,562,202**	**$3,964,826**	**$3,833,218**	**$3,627,314**

Bridgeport Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$1,447,989	$1,222,022	$1,101,139	$764,779	$1,352,509	$1,702,615	$2,543,047	$1,021,040	$932,810
Chief Financial Officer									$510,450
Physician Chief								$1,222,471	
Sr. VP of Administration	$955,867	$929,905	$885,638						
Senior VP of Finance & CFO	$941,809	$796,077	$741,380	$668,999	$687,985	$646,716	$572,020	$572,249	
VP of Finance	$778,986								
Medical Director			$632,905	$570,304	$571,351	$748,468			
Physician General Surgery								$561,283	
Sr. VP Medical Affairs	$582,014	$516,861					$640,909	$646,930	
Senior VP of Human Resources				$468,241	$494,194	$464,453	$449,781	$445,356	$425,297
Surgeon in Chief & Chairman of Surgery Dept								$518,721	
Senior VP & COO				$458,001	$529,615	$514,318	$475,065	$477,510	$416,311
Chief, ER Physician									$353,048
Chief, Section of Cardiology								$504,253	
Chief, Maternal Fetal Medicine								$488,249	
VP				$452,611					
Senior VP, Planning & Marketing	$522,220	$487,114	$460,560		$465,508				$328,370
ER Physician	$481,515	$457,886	$455,310		$409,341	$414,117	$386,542		$327,312
ER Physician	$466,707	$433,118		$402,984	$404,703	$375,929	$353,626		$315,697
VP of Performance Management	$436,837								
Sr. VP of Quality Control and Risk Management			$412,762	$397,219	$396,540	$355,398	$331,960		
ER Physician	$393,898	$403,033	$397,495	$391,752	$366,594	$354,567	$337,643		$308,417
ER Physician		$399,524	$393,302	$365,621		$351,726	$334,460		$307,444
ER Physician		$381,032	$392,410						
Total	**$7,007,842**	**$6,026,572**	**$5,872,901**	**$4,940,511**	**$5,678,340**	**$5,928,307**	**$6,425,053**	**$6,458,062**	**$4,225,156**

Bristol Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$756,841	$659,742	$605,526	$495,299	$441,821	$368,985	$358,071	$301,300	$145,757
Interim CEO/CFO									$250,043
Chief Operating Officer									$236,857
Senior Vice President, Chief Medical Officer	$395,340	$375,135	$368,261	$392,474	$353,187	$307,376			
Vice President of Admin Services								$202,603	
Oncology Physician						$327,712	$280,817		
Senior Vice President, Patient Care Services & CNO	$318,668	$308,975	$304,551	$237,201		$212,105			
Senior Vice President/CFO		$328,273	$268,516		$331,856	$287,078		$134,945	
Vice President/CFO	$348,020					$200,460	$186,930		
Vice President, Human Resources and Support Services	$221,100	$207,363	$204,326						
Clinic Physician						$197,383	$202,405	$199,016	
Vice President of Operations					$227,176	$195,850			
Occupational Health Physician	$179,366	$177,125	$176,987			$157,692	$213,798	$216,973	$186,222
Assistant Vice President, Information Services	$215,018	$210,272	$198,613	$197,149	$180,780				
Assistant Vice President/In House Counsel								$166,354	$146,325
Vice President of Patient Care Services				$195,892			$196,267		$143,244
Assistant Vice President, Human Resources & Support				$181,069	$146,022	$142,091			
Director of Physician Recruitment									$140,180
Controller			$168,117	$174,159					
Director of Revenue Cycle		$157,556							
Staff Psychiatrist				$168,640	$206,727		$189,381	$200,513	
Psych Physician								$143,448	$194,500
Psych Physician									$140,095
Assistant Vice President, Chief Development Officer	$193,117	$186,781	$169,549	$168,198	$149,114				
Director, Clinical Operations	$168,848		$165,578	$168,106					
Director, Diagnostic Imaging	$167,114								
Biomedical Technician							$149,554		
Director of Perioperative Services							$148,407		
Manager of Applications & Programming		$156,752			$145,775		$147,965	$139,438	
Psychologist								$138,061	$135,572
Clinical Staff Pharmacist					$143,422				
Total	**$2,963,432**	**$2,767,974**	**$2,630,024**	**$2,378,187**	**$2,325,880**	**$2,396,732**	**$2,073,595**	**$1,842,651**	**$1,718,795**

Hospital of Central Connecticut

Position Title	2014	2013	2012	2011	2010	2009	2008	2007
President & CEO	$2,325,846	$999,354	$1,499,546	$2,764,505	$609,893	$2,851,220	$1,110,502	$852,338
Physician, Private Practice								$625,058
Executive Vice President and CMO		$849,179	$776,392	$736,855	$603,486			
Senior VP of Medical Affairs						$652,298	$498,636	
Chief of Pediatrics						$563,571	$401,551	$360,656
Hospitalist	$763,388			$568,564				$395,449
Chief Emergency Room Physician	$728,973	$663,474	$550,999	$497,610	$499,051	$475,774	$400,568	$379,873
Chief Operating Officer						$454,785	$473,762	$445,037
Chief of Medicine	$664,689	$555,465	$500,547	$480,323	$474,233	$411,214		$374,604
Neurosurgeon		$542,218						
Director of Cardiology	$476,866	$463,175			$459,292	$382,490	$377,094	$360,863
Director Hospitalist Medicine	$438,866							
Hospitalist		$598,728	$491,528		$450,815	$415,460	$439,224	
Director Surgical Oncology	$712,251	$645,121	$487,581					
Chief of Psychiatry		$498,562	$484,686		$440,082		$360,201	
Medical Director of Quality					$420,419			
Vice President Human Resources		$644,445		$461,731				
Vice President Patient Services				$455,425				
Vice President Finance			$598,466	$458,671				
VP Analytics & Decision Report	$604,754							
Oncologic Surgeon				$439,374	$376,249			
Chief Financial Officer					$309,038	$547,595	$604,747	$479,362
Medical Director BMH ED	$461,593		$447,047			$364,789	$356,421	$337,862
Medical Director NBG ED	$474,401		$438,419	$418,618				
Total	**$7,651,627**	**$6,459,721**	**$6,275,211**	**$7,281,676**	**$4,642,558**	**$7,119,196**	**$5,022,706**	**$4,611,102**

Charlotte Hungerford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician Surgeon	$784,306	$748,423	$661,640	$619,607	$378,765				
Pathologist Medical Director	$498,959	$511,240	$520,852	$530,760	$536,040	$499,855	$473,687	$455,147	$249,074
CEO President	$625,107	$522,445	$503,491	$504,603	$540,443	$476,023	$456,011	$413,138	$358,641
Physician Surgeon	$745,495	$659,650	$581,148	$473,947					
Cardiologist	$459,094	$443,487	$515,457						
VP Medical Affairs	$409,022		$400,445	$368,032	$427,464	$447,908	$363,622	$340,417	$309,144
Physician Surgeon	$592,094	$640,888	$498,646	$365,008					
Cardiologist	$450,788	$430,722	$483,052						
Cardiologist	$433,352	$430,225	$441,292						
Cardiologist		$422,353	$435,124						
Psychiatrist Medical Director				$349,331	$372,589	$356,994	$312,884	$293,876	$278,137
CFO					$330,796	$375,568	$288,650	$300,901	$251,468
Orthopedic Surgeon	$724,504			$343,470	$285,223				
Physician Hospitalist				$289,357	$312,841	$303,332	$213,128		
VP Administration						$292,016	$220,139	$240,948	$195,225
Physician Surgeon				$279,548	$308,569				
Pathologist						$254,361	$243,633	$233,915	
VP Human Resources						$252,639			
Physician Hospitalist						$249,054			
Walk in Physician									$211,324
Physician Walk In Med Director							$217,483	$218,017	
Psychiatrist							$212,833	$215,421	$208,815
Psychiatrist									$204,676
VP Patient Care									$201,576
Medical Physicist								$181,556	
Hospitalist Med Director		$546,781			$288,930				
Total	**$5,722,721**	**$5,356,214**	**$5,041,147**	**$4,123,663**	**$3,781,660**	**$3,507,750**	**$3,002,070**	**$2,893,336**	**$2,468,080**

CT Children's Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Physician in Chief		$460,190	$512,905	$468,345	$468,999	$388,964	$513,586	$366,915	$380,057
Former President & CEO									$735,259
Executive VP & CFO		$426,289	$478,476	$429,575	$443,284	$352,157			
Senior VP & CFO							$485,969	$354,737	$388,977
EVP & COO	$444,836	$420,424	$468,676						
Chief Operating Officer				$336,211	$375,179	$339,764	$399,608	$282,887	
President & CEO	$618,181	$516,728	$748,347	$315,696	$480,870	$336,532	$490,926	$368,969	
Senior VP and General Counsel	$413,375	$367,734	$391,769	$299,663					
General Council					$338,238	$250,232	$308,223	$251,259	$264,825
VP Clinical Services & Chief RN Officer		$286,793	$250,382		$285,981	$237,795	$292,464	$239,987	$251,280
Senior VP Quality Improvement & Patient Safety	$548,936	$469,599	$253,456	$277,035	$391,164	$264,622			
Executive VP Community & Child Health	$506,930								
VP Quality Improvement & Patient Safety							$248,438	$231,484	$189,791
Interim CFO	$315,779								
CIO	$299,080	$292,330	$300,302	$266,623					
President, Specialty Group			$267,602						
Chief Medical Information Officer	$335,252	$293,608							
VP Human Resources	$292,022			$229,430	$262,535	$211,180	$266,708	$233,645	
Director, Human Resources									$175,107
Director of IT					$210,421	$185,045			
VP Marketing & Business Development	$334,482	$323,482							
VP Strategy & Regional Development					$191,027		$402,005	$326,282	$323,556
Staff Nurse - Operating Room						$167,452			$213,405
Staff Nurse - Emergency Department								$197,469	$169,796
Mid-Level Practitioner NICU							$204,601		
Professional Practice RN IV				$221,543					
Director, Perioperative Services			$235,505	$173,491					
Total	**$4,108,873**	**$3,857,177**	**$3,907,420**	**$3,017,612**	**$3,447,698**	**$2,733,743**	**$3,612,528**	**$2,853,634**	**$3,092,053**

Danbury Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$1,173,053	$1,056,889	$955,838	$1,075,078	$1,867,610	$6,445,204	$1,010,458	$957,098	$734,223
Executive VP/CEO					$862,137	$475,935			
VP Human Resources	$820,052	$948,869	$836,281	$872,756	$838,535	$726,912	$2,050,637	$470,470	$400,817
Chief Information Officer	$412,631	$377,700		$570,359	$362,411	$312,899	$318,742		$355,439
Chief Financial Officer	$672,565	$616,267	$614,912	$562,520	$555,894	$309,028	$4,650,958	$839,689	$496,428
Chief Operating Officer	$475,605	$428,450	$456,821	$399,887			$550,628	$513,664	$452,822
Executive VP, Medical Education									$413,029
Medical Director Southbury Geriatric								$331,878	
VP IT								$323,281	
VP Planning	$338,621	$307,327							$387,954
Chief Nursing Officer	$389,086	$363,505	$366,115	$368,420	$439,491	$373,122	$347,111		
VP Marketing				$327,799	$384,914	$343,416		$300,910	
Medical Director Community Health Center					$362,936	$362,935	$333,882	$278,085	
Senior VP Operations					$349,398	$309,492			$333,766
Cardiac Perfusionist								$272,516	$256,225
VP Operations							$279,730		
General Counsel	$410,471	$385,527	$318,627						
VP Compliance							$273,892		
Executive Medical Director			$324,499	$319,748					
Director Education and Research	$380,708	$368,511	$317,847	$316,265					
VP Facilities	$322,491	$311,890	$288,360	$314,273	$326,248	$318,800	$308,571	$311,928	$316,438
Chief Compliance Officer			$269,435						
Total	**$5,395,283**	**$5,164,935**	**$4,748,735**	**$5,127,105**	**$6,349,574**	**$9,977,743**	**$10,124,609**	**$4,599,519**	**$4,147,141**

Day Kimball Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$516,452	$513,986	$514,375	$474,666	$560,836	$411,409	$507,590	$345,096	
Interim President & CEO									$216,080
Director, OBS/GYN									$354,236
Director, ICU									$323,919
OB/GYN Physician			$411,489	$407,455	$336,629	$313,335	$338,181	$331,018	$299,684
ICU Physician	$300,114	$296,501							
Chief Nursing Officer/COO	$258,269								
VP Philanthropy/Corp. Communications								$274,810	
VP Information Technology							$414,745	$227,892	
Director Informatics		$224,605							
Pulmonary Physician		$376,468	$349,728	$346,213	$296,573	$256,479			
VP Medical Affairs	$344,214	$336,971	$364,114	$339,071	$306,047	$294,738	$305,808		
Senior VP Human Resources							$273,219		$230,147
Primary Care Physician		$345,634	$310,908	$303,899					
Sr. VP of Finance/CFO	$223,937	$224,475					$269,690	$248,725	$264,433
Corporate Controller	$188,798								
Director, Pulmomary Services									$242,043
Clinical Coordinator	$165,232								
Psychiatric Physician	$257,275	$368,447	$285,299	$282,325	$315,466	$334,821			
Senior VP, M.I.S.									$240,796
Director, Pediatric Center									$238,397
Pulmonary Physician		$261,912					$263,369	$233,040	
OB/GYN Physician			$233,012	$230,477	$300,832				
Psychiatric Physician	$250,064	$260,024							
Psychiatric Physician	$232,919								
Cardiologist			$309,121		$266,480	$253,808	$263,028	$240,878	
OB/GYN Physician					$230,630	$237,022		$301,577	
Pediatrician			$228,861	$226,361	$230,070	$210,606		$236,100	
Pediatrician			$225,507	$223,035	$226,780	$209,303			
Pediatrician				$221,314					
Director of Diagnostic Imaging							$262,389		
Sr. VP of Patient Services						$204,924	$241,376	$220,463	$232,287
Total	**$2,737,274**	**$3,209,023**	**$3,232,414**	**$3,054,816**	**$3,070,343**	**$2,726,445**	**$3,139,395**	**$2,659,599**	**$2,642,022**

Essent-Sharon

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$277,021	$314,605	$736,907	$259,785	$270,070	$317,324	$474,064	$283,984	$262,966
General Surgeon								$306,608	$325,221
Hospitalist								$259,673	$239,511
Chief Financial Officer	$244,320	$268,966	$149,605	$243,219	$223,506	$218,844	$210,290	$154,111	$157,443
Chief Nursing Officer	$169,868		$189,966	$166,424	$173,838	$170,212	$216,423	$195,159	$136,670
Hospitalist								$183,785	$191,623
Registered Nurse	$145,966			$168,971	$164,087				$147,995
Registered Nurse, Operating Room		$141,012						$129,873	
Director of Clinical Services, RN		$134,126							
Director, Rehab Services	$148,054	$140,011	$134,254						
Radiology Technician							$150,220	$120,207	$141,799
Registered Nurse, ICU							$150,198	$119,137	
Associate Administrator/Director HR	$178,790	$176,514	$168,637	$165,449	$156,926	$151,963			
Director, Human Resources							$139,260	$118,928	
Registered Nurse, Surgical Services							$136,772		
Chief Quality Officer				$154,903	$149,086	$145,354			
Assistant Chief Financial Officer					$141,916	$136,640			
Director Information Management		$151,335					$133,325		
Director					$141,526				
Director Cardiology							$131,238		
Director, OB/OR									$133,378
Ultrasound Technician					$131,927	$126,922			
Corp. Compliance/Director HIM	$154,697			$140,648		$139,163			
Director ICU/Medical Floor						$137,798			
Registered Nurse			$130,821	$138,152					$124,818
Director				$132,448	$136,750				
Director, Facilities	$137,605	$134,220							
Director Surgical Services			$132,286	$130,566		$123,914	$121,299		
Director, Emergency Services	$140,971	$137,453	$132,012						
Registered Nurse			$130,196						
Director, Quality	$137,992	$136,886	$130,009						
Total	**$1,735,284**	**$1,735,128**	**$2,034,693**	**$1,700,565**	**$1,689,632**	**$1,668,134**	**$1,863,089**	**$1,871,465**	**$1,861,424**

Greenwich Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$1,357,317	$1,523,283	$1,530,629	$1,712,494	$5,220,127	$1,370,221	$1,197,091	$1,043,126	$967,072
Executive VP & COO	$854,537	$687,992	$791,085	$773,054	$2,249,823	$697,391	$606,122	$561,225	
Senior VP & CFO	$794,818	$772,022	$716,899	$717,888	$749,638	$701,024	$613,265	$580,578	
CFO									$555,583
COO									$538,885
Physician - Emergency Medicine				$600,733					
Director, Pathology	$630,556	$594,309	$602,825	$588,104	$637,971	$633,638	$530,313	$653,882	$568,169
Pathologist	$586,829	$568,771	$592,050	$566,033	$591,098	$599,523	$571,407	$543,299	$505,003
Breast Cancer Surgeon							$487,387	$493,628	
Pathologist		$543,930	$567,963	$562,933	$568,572	$570,470	$518,699	$538,592	$485,429
Pathologist		$484,800	$538,472	$555,083	$550,747	$568,928	$452,651	$521,624	$474,045
Pathologist	$483,016	$433,270		$548,782	$501,860	$464,975	$431,605		$449,961
Sr VP of Medical Services	$545,816							$476,104	
Perinatologist								$469,742	$444,738
VP YNHH/COO Greenwich			$546,303						
SVP - Health System Development	$564,526	$524,668	$504,529	$510,007	$520,234	$501,699	$429,141		
Pathologist	$564,333					$451,166			$419,929
Chief Quality Officer		$513,401	$506,060		$500,206				
Chief Safety Officer/Director OPC	$392,587								
Total	**$6,774,335**	**$6,646,446**	**$6,896,815**	**$7,135,111**	**$12,090,276**	**$6,559,035**	**$5,837,681**	**$5,881,800**	**$5,408,814**

Griffin Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$557,181	$499,284	$558,543	$489,758	$547,978	$411,802	$454,181	$443,596	$395,345
Chief, Psychiatric Physician	$291,115	$320,377	$314,419	$291,232	$296,341	$299,790	$308,476	$303,398	
Chief Financial Officer	$296,929	$256,683		$289,096	$346,302	$244,324	$268,883	$262,323	$219,846
Chair, Preventative Medicine		$337,159							
Director, Preventative Medicine		$282,169	$308,557	$277,693	$301,503	$273,033	$240,111	$217,064	
Chief, Pulmonary Physician	$287,582	$280,819	$279,175	$272,275	$307,978	$246,624	$241,934	$234,407	$187,340
Psychiatric Physician	$280,396	$310,078	$303,559	$269,168	$332,866	$257,518	$249,306		$229,293
Chief Medical Director		$244,481	$271,028	$255,557	$344,552				
Vice President Ancillary Services	$255,685	$227,218	$255,880	$233,095					
Vice President Communication			$244,003	$224,973	$301,463	$237,288	$240,378		
Vice President Support Services		$219,892							
Emergency Room Physician					$261,883	$309,873		$232,257	$293,228
Chief, Emergency Room Physician					$265,122	$320,932	$316,904	$308,016	
Emergency Room Physician						$239,993	$299,902	$273,151	$246,891
Emergency Room Physician							$237,606	$208,609	$230,109
Emergency Room Physician									$215,742
Emergency Room Physician									$215,163
Vice President, Facilities	$218,056							$215,178	
Vice President, Nursing	$255,126		$231,317	$211,004					
Psychiatric Physician	$231,109		$225,621						$206,328
Psychiatric Physician	$215,966								
Total	**$2,889,145**	**$2,978,160**	**$2,992,102**	**$2,813,851**	**$3,305,988**	**$2,841,177**	**$2,857,681**	**$2,697,999**	**$2,439,285**

Hartford Hartford

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Director of Arrythmia Center	$493,748				$1,900,259				$481,940
VP, Medical Affairs								$1,820,511	
VP Academic Affairs & Chief Academic Officer	$659,689		$3,351,507						
VP Physician Relations	$775,366		$2,975,037						
President and CEO			$917,623	$1,738,078	$1,730,709	$1,200,432	$1,037,800	$1,225,925	$1,129,631
Director of Maternal & Fetal Medicine			$1,198,676						
President and CEO (former)					$1,176,466	$7,222,700	$1,271,472		
VP Finance and CFO (former)						$2,183,659	$732,281		
Executive VP and COO (former)							$686,910		
VP, Support Services (former)							$691,664		
VP, Human Resources						$1,946,399	$672,239		
Executive VP and COO		$1,023,714		$770,537	$718,644	$916,347		$820,361	$632,172
SVP & Chief Strategy Officer		$662,244							
SVP & Treasurer		$647,196							
Director of Nuclear Cardiology						$863,309			
VP, Finance and Admin Services								$731,102	$663,234
Director of Surgery	$807,330	$735,506	$687,588	$708,508	$637,627	$623,888	$587,306	$582,937	$552,460
Chair, Cancer Institute	$673,632								
VP, Psychiatry		$3,235,078	$736,656	$705,069	$726,491				
VP Behavioral Health		$747,573							
Director of Cardiology	$599,205	$694,590	$1,694,841	$694,379	$671,144	$635,051	$602,750	$571,217	$522,269
Director of Electrophysiology	$532,089								
Director of Critical Care	$511,264								
Director of Medicine	$466,270								
Executive VP and CFO		$879,820	$783,046	$673,245	$642,618				
VP, Academic Affairs		$724,793	$705,560	$660,035	$840,004	$1,838,533	$601,862	$592,607	$563,150
VP, HR and Support Services								$575,835	$539,645
SVP & Chief Medical Officer		$821,632	$663,431						
Chief Medical Officer				$615,860					
Director of Emergency Med. & Trauma Svcs.				$604,599	$601,875	$638,169	$704,026	$680,234	$627,615
Director of OB/GYN	$693,448							$522,364	$495,873
Director of Women's Health Services				$594,607					
Total	**$6,212,041**	**$10,172,146**	**$13,713,965**	**$7,764,917**	**$9,645,837**	**$18,068,487**	**$7,588,310**	**$8,123,093**	**$6,207,989**

John Dempsey Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CFO					$423,912	$467,571	$433,800		
Professor/Clinical Operation/CEO								$366,377	$226,139
Assistant Professor/Clinical/ ER	$302,012	$305,075	$270,370	$336,160	$298,171	$282,759	$323,057	$339,593	$340,415
Assistant Professor/Clinical/ ER	$300,619	$297,040	$264,648	$280,994	$280,062	$282,087	$287,737	$284,186	$272,033
Assistant Professor/Clinical/ ER	$297,959	$291,942	$258,459	$279,646	$279,395	$281,404	$281,933		$247,466
Assistant Professor/Clinical/ ER	$263,242	$289,832	$226,433	$256,709	$278,719		$255,721		
Assistant Professor/Clinical/ ER		$268,015		$256,097	$273,502				
Associate VP/Quality Assurance				$255,248					
Associate Vice President/Nursing		$264,858	$261,801						
Associate VP/Clinical Operation					$239,014	$280,309	$245,858	$358,640	$229,110
Associate VP/Clinical Operation								$239,070	
Professor/Clinical Operation						$227,704	$266,034		
Assistant Professor/Clinical/ ER				$246,747		$260,249		$235,231	
Assistant Professor/Clinical/ ER				$224,026					
Instructor/Clinical					$235,563			$273,965	$219,033
Director of Nursing/Clinical/COO								$268,125	$257,788
Director/Nursing	$320,187								
Director/Nursing	$294,743								
Assistant VP/Application Development									$219,585
Professor, Clinical Care Improvement									$256,050
Professor/Clinical Operation								$263,030	
CEO	$332,520	$613,215	$477,518		$228,363	$122,728	$427,968		
Chief Operating Officer/Finance/CFO								$171,946	$274,404
COO		$322,932	$309,737		$143,634	$288,884	$278,220		
Staff Nurse		$258,118							
Pharmacist	$264,600		$249,078						
Chief Perfusionist			$235,662						
Director/Care Coordination	$258,829								
Medical Physicist/Clinical Radiology				$243,983		$237,831	$230,310		
Associate VP/Quality Assurance				$231,828					
Associate Professor/Clinical/ ER	$363,522	$357,331	$322,819						
Total	**$2,998,233**	**$3,268,358**	**$2,876,525**	**$2,611,438**	**$2,680,335**	**$2,731,526**	**$3,030,638**	**$2,800,163**	**$2,542,023**

Johnson Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	$198,324	$477,819	$483,070	$439,647			$605,558	$682,469	$236,771
Vice President Medical Affairs			$176,895	$365,673	$409,004	$405,455	$392,694	$314,833	$230,598
VP Human Resources	$169,393				$159,122	$193,937			
Chief Financial Officer	$311,922	$309,070	$313,450	$277,196					
Medical Director of Emergency Medicine					$142,788	$416,901			
Emergency Room Physician					$132,475	$362,056		$322,870	$541,108
Chief of Pathology					$121,619	$297,052	$279,230	$238,786	
Emergency Room Physician					$119,808	$338,007	$381,418	$285,669	$310,265
Emergency Room Physician					$119,592	$308,800	$342,751	$274,052	$305,792
Emergency Room Physician					$118,828	$305,737	$331,902	$244,867	$274,657
Emergency Room Physician					$91,680		$291,416	$222,387	$267,637
Pathologist					$19,825	$265,952			
Vice President Operations	$144,662							$231,870	
Emergency Room Physician						$213,194	$288,524		$257,326
Vice President, Patient Care Services	$184,847	$205,683	$208,759	$189,280					
Vice President Finance							$268,980	$297,447	$215,515
Emergency Room Physician							$267,113		$245,908
Director, Perioperative Services		$129,118	$130,075	$155,610					
RN	$170,448	$178,553	$154,463	$153,493					
Corporate Director, Information Technology				$153,090					
Corporate Director, Physical Therapy			$155,226	$150,314					
Corporate Controller	$152,428	$147,108	$145,680						
RN	$148,565	$147,631	$145,058	$147,917					
Corporate Director, Pharmacy				$143,925					
RN		$142,565	$143,158						
RN, Nursing Administration	$150,823	$125,578							
RN, Med Surg Unit	$148,549	$143,973							
Total	**$1,779,961**	**$2,007,098**	**$2,055,834**	**$2,176,145**	**$1,434,741**	**$3,107,091**	**$3,449,586**	**$3,115,250**	**$2,885,577**

Lawrence and Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President, CEO	$761,873	$694,776	$761,734	$743,210	$723,845	$682,508	$607,001	$506,695	$521,633
President, CEO								$413,795	$488,744
VP, Medical Staff								$351,265	$323,290
Chair, Amb. Services									$411,637
VP, COO		$456,567			$434,976		$382,094	$342,528	
Executive Vice President/COO									$323,371
Neonatologist								$313,122	
Chair, Dept. of Medicine								$304,762	$303,344
Chief Operating Officer	$455,107		$484,902	$448,642		$426,450			
Chair, Department of Surgery			$428,327	$392,627	$329,508				
Vice President, CFO		$375,843	$431,702	$409,269	$390,983	$384,955	$363,470	$292,612	
Vice President of Strategic Planning	$305,928	$301,458	$347,841	$328,400	$317,427				
Vice President, Chief Transformation Officer	$370,291								
Chief Legal Officer	$314,655	$291,513	$324,214	$307,829	$298,788				
Vice President, Human Resources				$303,273					
Chief Information Officer	$279,344	$263,482	$300,811	$291,003					
Vice President, Patient Care	$289,965	$268,052	$307,103	$287,396					
Vice President, Physician Practice Mgmt	$571,419	$259,091	$287,114						
Vice President, Development	$259,338	$227,889							
ER Physician					$293,348	$292,898	$318,715	$459,149	$339,944
ER Physician					$292,410	$292,249	$280,475	$282,018	$334,402
ER Physician					$281,359	$288,100	$269,065		$308,049
ER Physician						$283,183	$268,588		$296,538
ER Physician						$267,590	$267,500		
ER Physician						$266,996	$266,945		
ER Physician							$265,510		
Neonatologist								$280,617	
Medical Director Physician	$237,574	$260,900	$269,719	$280,326	$305,139	$351,937			
Total	**$3,845,494**	**$3,399,571**	**$3,943,467**	**$3,791,975**	**$3,667,783**	**$3,536,866**	**$3,289,363**	**$3,546,563**	**$3,650,952**

Manchester Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	$683,398	$558,098	$560,793	$730,743	$475,878	$509,190	$433,628	$430,334	$386,610
CFO				$416,311	$306,482	$335,082	$323,493	$301,441	$285,916
Behavioral Health Director, MD									$314,757
Senior VP of Medical Affairs	$375,056	$333,973		$376,267	$304,418				
Medical Director ED	$486,729	$347,998	$377,339	$304,562	$286,005	$315,238	$331,415		
Emergency Room MD	$411,993	$407,087	$410,390	$280,429	$262,183	$361,900	$359,032	$339,513	$296,890
Emergency Room MD	$384,580	$401,584	$378,568	$302,168	$260,466	$331,476	$309,185	$321,084	$296,661
Emergency Room MD	$374,550	$372,004	$374,663	$274,218	$255,360	$330,931	$311,748	$334,337	$293,784
Psychiatrist							$317,634		
Treasurer/Exec VP		$338,414	$342,391						
Emergency Room MD	$371,405	$363,455	$359,568	$272,895	$259,570	$321,268	$305,500	$304,625	$286,261
Emergency Room MD	$362,526	$355,113	$340,878	$267,058	$247,008	$316,460	$305,252	$290,023	$285,301
Medical Director ED	$396,992		$336,920						
Emergency Room MD		$370,834	$334,601	$258,061	$235,264	$327,577	$288,101	$287,442	$264,082
Emergency Room MD						$316,051		$284,711	
Medical Director MD	$383,624							$281,648	$275,259
Total	**$4,230,853**	**$3,848,560**	**$3,816,111**	**$3,482,712**	**$2,892,634**	**$3,465,173**	**$3,284,988**	**$3,175,158**	**$2,985,521**

Middlesex Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President/CEO	$1,059,523	$1,047,527	$1,022,460	$855,550		$1,377,566	$1,894,107	$1,933,120	$1,884,150
President/CEO (11 mos), Retired 8/31/10					$1,698,891				
Sr. VP, Finance & Operations (11 mos), Pres/CEO (1mo)					$713,168				
VP, Quality and Patient Safety	$552,948	$514,956	$495,392						
Sr. VP/COO						$583,273	$568,734		
VP, Clinical Affairs	$639,942	$712,317	$692,616	$527,592	$522,169	$425,075			
VP, Nursing					$515,525	$455,108	$589,921	$422,093	
Chairman, Emergency Medicine	$465,412	$457,572	$437,030	$458,361	$437,785	$414,514	$407,600	$530,229	$359,355
VP, Finance/CFO/Treasurer	$507,273	$491,453	$472,027	$443,841	$420,113	$366,834			$476,898
VP, Human Resources	$407,633	$485,999	$458,638					$771,255	$571,732
Sr. VP, Finance & Operations								$688,373	
Sr. VP, Strategic Planning & Operations	$410,991	$398,871							
Associate Director, Family Practice									$326,086
VP, Operations				$437,276			$345,141	$398,682	
Chairman, Dept. of Medicine					$402,393	$383,550	$355,939		
Physician, Emergency Department	$404,116	$438,794	$410,969	$412,833	$383,357	$359,933	$380,476		$313,468
Physician, Emergency Department			$382,622				$342,129		$302,881
Physician, Emergency Department							$333,436		
Chief, Dept. of Psychiatry								$480,747	$319,133
Medical Director/MMC Shoreline									$306,084
Clinical Director of Infectious Disease		$393,196	$384,870	$397,220	$399,022	$373,789		$471,634	
Clinical Director, Family Practice								$385,914	
Chief, Department of Medicine & Secretary	$410,301	$395,704	$387,577	$391,924	$398,797				
ED Physician, Shoreline								$383,310	
Former President/CEO				$390,210					
Medical Director/Emergency Department	$396,768			$385,161		$354,820	$363,313		$305,760
Total	**$5,254,907**	**$5,336,389**	**$5,144,201**	**$4,699,968**	**$5,891,220**	**$5,094,462**	**$5,580,796**	**$6,465,357**	**$5,165,547**

Midstate Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President/CEO		$943,218	$958,020	$903,186	$852,851	$856,294	$818,081	$724,372	$583,640
CFO				$500,859	$472,514	$417,879	$370,141	$325,521	$318,218
Hospitalist Physician Director				$402,481	$384,467	$362,957	$334,211		
Hospitalist	$389,707	$450,232							
Hospitalist	$347,566	$383,916							
Hospitalist	$336,773	$372,952							
Hospitalist	$324,813	$365,712							
Hospitalist	$320,553	$359,039							
Hospitalist	$316,325	$348,383							
Hospitalist	$257,561	$347,761							
Per Diem Hospitalist	$314,391								
Medical Director Mediquick	$365,164								
Vice President			$390,197	$361,186					
Physician/ED Physician			$409,553	$357,013	$523,033	$515,538	$452,689	$454,104	$416,177
Physician/ED Physician			$409,432	$338,014	$392,805	$426,115	$410,223	$395,225	$368,814
Physician/ED Physician			$351,649	$327,442	$373,523	$366,218	$354,336	$345,308	$336,495
CMO		$538,417	$419,637	$324,801					
Senior VP Operations	$362,653								
Vice President				$317,948					
COO		$418,703						$418,216	$372,092
Physician/ED Physician			$348,160	$310,134	$359,090	$352,368	$319,583	$341,842	$316,487
Physician/ED Physician			$340,888		$352,973	$343,935	$319,411	$329,998	$311,835
Physician/ED Physician			$340,517		$345,949	$336,351	$310,987	$323,821	$311,615
Physician/ED Physician			$339,775		$343,328	$331,467	$310,000	$322,437	$305,567
Total	**$3,335,505**	**$4,528,333**	**$4,307,828**	**$4,143,064**	**$4,400,533**	**$4,309,122**	**$3,999,662**	**$3,980,844**	**$3,640,940**

Milford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	$875,081	$596,448	$579,475	$409,804	$369,792	$368,100	$584,198	$564,048	$542,425
Physician, Dir. ICU						$435,314	$436,656	$366,809	$311,211
Vice President Finance							$367,778	$359,990	$335,416
Physician, Chief Operating Officer	$824,032	$556,742	$538,527	$390,015	$451,013				
Hospitalist		$363,430	$351,489	$358,094	$370,807		$308,051		
Pathologist	$369,566	$344,700	$345,094	$350,286					
ER Physician	$274,722	$373,044	$341,173	$333,021	$337,610	$341,036	$332,309	$324,830	$313,159
ER Physician	$246,745	$359,350	$341,090	$332,969	$337,610	$350,539	$331,769	$324,668	$311,318
ER Physician		$339,255	$340,882	$331,803	$327,796	$335,078	$330,092	$321,487	$306,348
Physician, Dir., ER				$329,567	$334,377			$319,726	$318,225
Hospitalist			$346,959	$329,539	$318,975	$332,513			
House Physician	$373,895							$294,558	$269,738
House Physician	$357,857								
House Physician	$346,822								
House Physician	$286,221								
House Physician	$267,192								
ER Physician		$339,099	$339,691	$322,711	$327,783	$325,638	$326,820	$320,258	
ER Physician		$335,714	$332,195		$323,799	$326,493	$307,639	$291,567	$241,487
ER Physician		$335,209				$322,325			$234,035
ER Physician						$315,317			
Vice President Finance							$301,943		
Total	**$4,222,133**	**$3,942,991**	**$3,856,575**	**$3,487,809**	**$3,499,562**	**$3,452,353**	**$3,627,255**	**$3,487,941**	**$3,183,362**

New Milford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
VP Human Resources				$598,225					
President/CEO	$240,264	$216,471	$195,774			$579,769	$551,928	$378,612	$510,994
SVP Operations	$305,899	$390,795	$399,446						
Controller	$175,328	$169,748	$187,679						
Director, Finance	$202,764	$197,173	$187,168						
Ex-President						$504,699	$520,642	$556,305	
Director, Patient Experience	$185,544	$181,583							
PVT-Physician				$524,365	$415,363	$388,286		$314,473	$294,239
PVT-Physician					$402,659				
PVT-Physician					$372,602				
Lab-Physician			$480,036	$433,162	$458,129	$444,620	$431,352	$393,499	$395,072
Dir., Emergency Services				$425,241	$455,760	$442,595	$493,692	$391,352	$397,819
Ear, Nose & Throat Physician						$393,109	$419,422		
Chief Medical Physicist	$241,166	$236,050	$236,050						
Manager, Cancer Center	$172,631								
Radiology-Physician			$237,151	$388,596	$463,809	$453,172	$452,354	$409,046	$390,278
ER-Physician				$324,724	$356,520		$357,558	$333,064	$303,683
VP, Finance				$304,635	$320,582	$1,574,460	$332,954	$286,657	$291,461
ER-Physician				$296,090	$325,727	$341,992	$324,888	$301,257	$301,090
ER Physician								$296,044	$297,204
ER Physician									$290,550
VP, Nursing, COO			$206,897	$279,629	$335,896	$379,013	$377,312		
PVT-Physician				$268,123					
Director, Nursing	$169,779	$213,871							
Director, Medical Affairs & Quality	$199,888	$197,694							
Director, Planetree			$180,756						
Director, Employee Health	$171,529	$173,850	$180,359						
Mgr, Pharmacy Operations		$157,679							
MIS Officer			$178,965						
Total	**$2,064,792**	**$2,134,914**	**$2,670,281**	**$3,842,790**	**$3,907,047**	**$5,501,715**	**$4,262,102**	**$3,660,309**	**$3,472,390**

Norwalk Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
VP & Chief Medical Officer				$810,916	$911,520				
President & CEO	$1,268,795	$1,050,930	$901,148	$797,727		$941,545	$947,473	$753,038	$712,447
COO									$624,360
President & CEO (through April 2010)					$2,769,742				
VP & Chief Operating Officer/President & CEO					$631,222				
VP & Chief Operating Officer						$580,806			
VP Quality				$651,642					
Physician, Emergency Department	$590,305	$626,548	$685,615	$644,978	$598,761	$546,877	$571,541	$581,690	
Chairman, Dept. of Emergency Medicine		$568,977	$585,218	$582,032		$520,710	$499,071	$471,022	$530,410
VP Planning/VP and Chief Operating Officer					$495,864				
Chairman, Dept. of OB/GYN				$576,298		$787,458	$510,698	$469,596	$458,545
Sr. VP & COO			$535,681	$534,321			$715,282	$475,350	
Physician, Emergency Department	$516,291	$475,854	$519,445	$518,578	$616,208	$539,434	$508,100	$555,721	$464,069
Chairman, Dept. of Medicine				$499,713	$545,236	$827,220	$708,223	$574,213	$564,770
VP & Chief Financial Officer	$664,111	$610,069	$489,543				$461,558		
VP Nursing Patient Care Services						$436,783			
VP Planning and Business Development						$407,117			$358,054
Sr. VP Strategy & System Development	$601,931								
Sr. VP & COO		$560,049					$413,961		
VP, Human Resources	$926,697	$472,049							
Chairman, Dept. of Surgery				$478,153	$437,306		$400,520	$436,043	
Chief Pulmonary/Critical Care					$495,115				
Director, Real Estate								$411,611	
Physician, Emergency Department	$501,242		$478,304		$392,756	$392,120		$380,719	$401,936
Chief Financial Officer									$399,721
VP & Chief Nursing Officer			$472,525						
Chairman, Psychiatry		$454,227							$395,655
Physician, Emergency Department	$473,446	$420,766	$442,639						
Physician, Emergency Department	$472,663	$411,006	$412,040						
Physician, Emergency Department	$455,025								
Total	**$6,470,506**	**$5,650,475**	**$5,522,158**	**$6,094,358**	**$7,893,730**	**$5,980,070**	**$5,736,427**	**$5,109,003**	**$4,909,967**

Rockville General Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
CEO	$269,844	$239,511	$240,340	$313,176	$203,947	$218,224	$185,155	$184,429	$165,690
Medical Director	$338,865	$353,700	$324,458						
Medical Director		$279,461	$267,332						
Emergency Room Staff MD						$298,633	$288,830	$316,140	$284,842
Urgent Care MD	$311,021	$237,773							
Urgent Care MD	$256,590	$198,751							
Urgent Care MD	$237,577								
OB/GYN				$296,847	$287,075	$253,645	$134,771		
VP Patient Care Services	$224,341	$194,226	$168,500						
Infection Control Director MD	$264,351			$267,035	$213,063	$231,082	$231,252	$251,377	
Emergency Room Staff MD						$156,625	$286,392	$308,333	$279,951
Emergency Room Staff MD								$233,212	$275,186
Infectious Disease MD									$250,121
Emergency Room Staff MD									$227,994
Psychiatrist	$261,240	$226,768							
CFO				$178,419	$131,350	$143,386	$140,036	$129,190	$122,535
Senior VP of Medical Affairs				$161,257	$131,123	$134,648			
RN - Amb Surg					$144,581				
VP Quality							$151,625		$153,245
Emergency Room Staff MD									$135,879
Senior Director									$128,113
RN Supervisor		$174,125	$167,806	$144,695	$126,755				
RN Supervisor		$185,757							
Registered Nurse	$176,954		$148,917						
Treasurer/Exec VP			$146,739						
Admin Director				$147,232	$140,026	$139,004	$131,485		
Medical Director MD		$149,601	$144,450					$120,706	
Staff Nurse Practitioner								$119,658	
Registered Nurse			$126,837						
Senior VP/Medical Director			$124,441						
Clinician	$155,922								
Admin Director							$134,895		
RN-ICU				$146,783	$135,200	$132,657			
RN-ICU					$128,826				
Medical Director ED				$130,526		$135,102	$142,034	$117,224	
Pharmacist								$126,810	
Medical Imaging Director				$149,607					
Total	**$2,496,705**	**$2,239,673**	**$1,859,820**	**$1,935,577**	**$1,641,946**	**$1,843,006**	**$1,826,475**	**$1,907,079**	**$2,023,556**

Saint Francis Hospital and Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President	$3,135,570	$1,697,418	$1,521,090	$1,422,730	$1,534,640	$1,225,460	$1,295,178	$1,161,713	$1,052,791
Retired President									$842,802
Senior Vice President and CFO			$715,743		$820,051	$764,883	$782,085	$592,563	$525,978
Executive Vice President						$776,959	$732,722	$624,226	$553,559
Executive Vice President and COO	$635,702	$898,975	$731,103	$693,126	$629,960	$506,142			
Executive Vice President, Chief Admin Officer	$785,531	$843,425							
Senior Vice President and General Counsel			$395,262			$739,382	$543,618	$436,409	
Department Chairman, Surgery	$731,925	$667,064	$627,085			$433,126			
Executive Vice President and CPO		$823,171	$564,996						
President - Saint Francis Foundation				$568,974	$475,818	$480,084			
Senior Vice President, Chief Academic Officer	$505,762	$522,703	$497,259	$515,074	$498,851	$453,270			
Senior Vice President, Chief Dev. Officer	$483,872	$487,359							
Section Chief - Pathology					$489,166	$434,053	$487,549	$473,932	$455,029
President, JMMC	$442,406								
Vice President, Financial Planning		$380,990	$495,310						
Department Chairman - Pathology					$467,804		$471,696	$460,763	$442,915
Senior Vice President - Nursing		$441,176	$419,088						
Program Director - Pathology					$442,922		$440,671	$428,034	$409,916
Vice President - Interim CFO				$436,565		$494,094			
Department Chairman - Emergency				$427,080	$410,602		$473,425	$433,598	$415,766
Senior Vice President - Planning	$415,876	$412,053	$413,512	$426,075	$444,464		$418,495		
SVP, Human Resources	$376,149								
SVP, Chief Information Officer	$374,456								
Staff Physician - Emergency				$417,086			$398,410		$422,436
Staff Physician - Emergency				$419,896					$348,989
Staff Physician - Emergency				$394,466				$397,797	
Psychiatrist								$388,889	
Total	**$7,887,249**	**$7,174,334**	**$6,380,448**	**$5,721,072**	**$6,214,278**	**$6,307,453**	**$6,043,849**	**$5,397,924**	**$5,470,181**

St. Mary's Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$913,009	$853,512	$791,256	$649,453	$599,134			$765,051	$764,919
Medical Director Cardiology									$314,576
Vice President & CFO former								$306,178	$166,517
Executive Vice President						$593,749	$404,367		
Vice President and CFO	$334,247	$266,887	$218,577	$479,091	$363,355	$392,216	$424,741	$199,564	$299,653
Vice President & CNO	$256,164	$338,629							
Vice President & CNO, former		$265,011							
Vice President Patient Services			$560,617	$284,285	$293,715	$296,546	$343,210	$259,189	$228,563
VP, Marketing & Business Development								$224,306	$172,878
Former President & CEO							$305,243		
Vice President Human Resources	$303,346	$280,376	$290,284	$255,565	$240,600	$246,038	$247,611		$163,764
Physician Hospitalist Program Internal Med.									$190,874
Chairman, Department of Medicine		$275,582							
Vice President & Chief Medical Officer	$435,298	$245,516	$425,825	$432,762	$475,162	$270,057			
Chief Information Officer		$228,524	$244,993	$240,094	$200,300	$178,502	$181,117	$152,782	
Chief Marketing Officer	$257,678	$240,125	$226,403	$221,048	$201,173	$178,752	$159,775		
Vice President Surgical Services			$353,905	$318,435	$201,394				
Vice President Surgical Services, Former	$372,127								
Vice President Operations	$349,154	$325,082	$333,779	$296,349	$241,116		$284,820	$222,746	$167,537
Chief Operating Officer	$307,756								
Critical Care Nurse						$162,859			
Div. Dir. Perioperative and Invasive Services							$168,939	$161,555	
Divisional Director, Clinical Quality			$185,905	$185,753		$173,009	$163,605	$158,061	
Director of Pharmacy								$151,739	
Director, Operating Room					$178,178	$162,039			$146,949
Executive Director Revenue Cycle	$219,286								
Total	**$3,748,065**	**$3,319,244**	**$3,631,544**	**$3,362,835**	**$2,994,127**	**$2,653,767**	**$2,683,428**	**$2,601,171**	**$2,616,230**

St. Raphael

Position Title	2012	2011	2010	2009	2008	2007	2006
President	$1,803,605	$1,043,560	$911,333	$4,282,605	$1,013,140	$903,330	$890,725
Former President			$2,168,074				
Senior Vice President, COO & CFO		$734,111	$987,313	$635,609			
Senior Vice President, CMO (MD)	$724,139	$705,420	$773,004	$651,886			
Clinical Chair, Surgery (MD)			$680,736	$713,955	$648,922	$624,624	$527,845
Clinical Chair, Emergency Medicine (MD)	$460,733	$630,934		$629,011	$516,934	$437,898	
Vice President - Medical Services							$488,498
Clinical Chair, Medicine (MD)	$541,652	$595,195		$714,365	$534,595	$503,169	$483,632
Former Sr. Vice President, CMO (MD)			$635,338				
Cardiologist (MD)	$514,489	$524,696				$501,371	$325,398
Clinical Chair, Women's/Children's Services (MD)	$472,267			$580,409	$621,357	$613,674	$545,164
Associate Clinical Chair, Surgery (MD)						$400,079	$387,694
Director, Cardiology Fellowship/CDU (MD)	$503,734	$510,919	$515,784				
Director, Surgical Intensive Care Unit (MD)	$478,876	$487,030			$439,540	$405,821	$384,802
Section Chief, Thoracic Surgery (MD)	$564,767	$484,735	$486,810	$468,291	$493,505		
Section Chief, Cardiology (MD)			$447,832	$420,950	$397,602	$621,619	$386,114
Associate Clinical Chair, Medicine (MD)	$368,478	$387,201	$377,221	$360,560	$348,214	$340,498	
Directors, McGivney Cancer Center (MD)							$308,371
Medical Information Officer (MD)					$345,612		
Total	**$6,432,740**	**$6,103,801**	**$7,983,445**	**$9,457,641**	**$5,359,421**	**$5,352,083**	**$4,728,243**

St. Vincent's Medical Center

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer	$1,076,770	$984,669	$2,394,278	$1,484,755	$1,485,490	$1,275,826	$922,813	$954,683	$813,986
Former Chief Executive Officer		$1,110,833							
President/Chief Academic Officer			$978,878						
Chairperson Medicine					$771,879				
Senior Vice President			$929,797						
CMO/Clinical VP Cardiology							$715,872	$815,402	$588,172
Chief, Cardiothoracic Surgery						$714,299	$688,391	$470,873	
Clinical Chair Oncology						$659,205	$567,940	$562,094	
Corp. Sr. VP Marketing/Govt Relations						$624,541	$575,899	$497,550	$640,952
Sr. VP Chief Clinical/Chief Medical Officer	$921,307	$910,454			$717,509				
Clinical Chair Oncology/Chief Medical Officer				$837,791					
Clinical Vice President Cardiac Services			$774,448	$634,145					
Clinical Vice President Surgical Services		$894,493	$778,042	$630,797	$587,507	$594,139		$561,609	$562,403
Senior Vice President/Chief Financial Officer	$688,869	$673,021	$747,134	$567,478	$527,089				
Clinical Vice President Medicine	$675,890	$643,993	$613,539	$554,058		$622,403	$624,660	$602,937	$732,012
Vice President/Chief Legal Counsel	$534,713	$513,004							
Sr. VP/Chief Nuring Officer/COO	$497,600	$482,467							
Senior VP, Corporate Affairs	$390,699	$354,899							
Chairperson, Department of Surgery	$481,159								
Director, Cardiothoracic Surgery						$536,707	$582,197		
General Surgeon						$506,107	$622,697		
Trauma Surgeon								$491,733	
Chair Neonatology							$505,356		
Chairperson Emergency Care	$443,244		$592,032	$525,145	$626,929		$454,732	$457,191	$476,961
Vice Chairperson Emergency Care				$491,021	$527,678				$354,263
ED Physician						$443,302		$378,793	$331,842
ED Physician						$435,153			$313,453
Chief Financial Officer									$420,933
Senior Vice President				$456,215	$653,854				
Sr. VP/Chief Administrative Officer			$590,696		$427,992				
Chairperson, Obstetrics & Gynecology	$376,404				$390,454				
Sr. VP/Chief Human Resources Officer		$454,673	$477,436						
Vice President CHRO Employee Council				$455,920					
Total	**$6,086,655**	**$7,022,506**	**$8,876,280**	**$6,637,325**	**$6,716,381**	**$6,411,682**	**$6,260,557**	**$5,792,865**	**$5,234,977**

Stamford Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO	$2,402,748	$2,222,554	$1,532,094	$2,241,639	$1,695,727	$2,399,609	$1,552,751	$1,424,969	$1,505,731
Sr. VP Finance CFO									$1,177,667
Sr. VP of Medical Affairs	$929,239	$779,389	$681,212	$1,080,817	$911,568	$844,466	$1,084,950	$916,043	$827,193
VP of Physician Network Development		$873,017							
Surgery Physician									$707,094
Pediatric Physician									$612,001
Chief of Cardiac Surgery	$898,824	$996,839	$1,180,752	$992,541					
Chief of Surgery	$857,348		$768,216	$906,571	$716,968	$677,257	$718,271	$603,072	
Exec. VP and Chief Operating Officer	$1,316,300		$784,363	$756,653	$586,964	$556,035	$669,998	$555,285	
Sr. VP Operations COO		$807,104							$531,798
Sr. VP of Strategy & Marketing	$721,788	$649,400	$663,125	$740,648	$584,749	$555,766	$702,165	$560,141	$516,754
VP of Finance & Chief Financial Officer	$1,008,955	$816,687	$735,596	$720,187					
Chief Information Officer					$572,108			$659,960	
Chief Financial Officer					$538,917	$584,026	$685,468	$642,151	
VP Ambulatory Services			$662,001	$656,204	$537,897				
Chief of Cardiology		$619,201	$608,165	$580,278					
Chair, Dept. of Pediatrics						$535,091	$599,219	$596,484	
Cardiac Surgeon			$604,033						$526,501
Director of Cardiology					$577,961	$527,830	$567,360	$533,258	
Chief of Bariatric Surgery	$719,194	$616,054							
Sr. VP Patient Services					$523,138				$608,443
VP and Chief Information Officer	$688,889								
Chief Financial Officer								$527,027	
Dept. of Medicine Physician									$500,240
Sr. VP of Talent & Culture						$507,757	$560,848		
Chief, Dept Medicine							$489,451		
Chair, Dept. of Obstetrics	$1,063,073	$673,597		$579,437		$579,607			
Total	**$10,606,358**	**$9,053,842**	**$8,219,557**	**$9,254,975**	**$7,245,997**	**$7,767,444**	**$7,630,481**	**$7,018,390**	**$7,513,422**

Waterbury Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
COO			$285,001	$372,533	$349,800	$346,933	$336,115		$303,422
President	$700,205	$663,566	$520,298		$559,086	$557,177	$543,225	$497,412	$495,175
Medical Director ICU							$429,416	$404,073	$368,600
Chief Financial Officer	$412,354								
Chief Information Officer	$390,922	$343,254							
Physician, Director of ED			$220,141			$434,224	$419,545	$385,225	$360,832
VP Medical Affairs		$168,103	$200,000		$401,415	$399,001	$386,234	$361,690	$356,362
VP Patient Care/CNO	$277,791	$246,766							
Vice President Operations		$182,207							
Medical Director Internal Medicine						$406,881	$390,191	$374,049	$363,491
Psychiatrist	$241,985		$206,039						
Medical Director ICU						$401,214			
ED Physician						$375,695	$347,516	$301,684	$292,832
Staff Pharmacist		$183,278							
Physician Assistant Director of Surgery									$337,710
Associate Director of Surgery							$350,943	$342,946	
Attending Faculty Surgeon						$351,552	$340,601	$354,404	
Physician, Director of ED								$357,059	
CFO			$174,602	$366,538	$342,259	$340,322			$304,167
Chief Medical Information Officer: MD				$279,141	$241,679				
Chief Medicaid Information Officer		$235,757							
Medical Director Behavioral Health	$250,037	$235,528	$204,736	$245,009	$253,710				
Medical Director Behavioral Health	$234,438		$193,939	$234,970	$234,482				
Medical Director Adolescent Services	$230,941								
Psychiatrist		$189,684	$200,840	$240,995	$242,964				
VP Human Resources	$272,995	$249,234	$177,500	$224,139	$213,388				
Psychiatarist	$238,483			$237,376	$237,430				
ED Physician						$327,404	$334,097	$313,796	$282,454
COO				$214,294					
VP Finance				$191,630					
Total	**$3,250,151**	**$2,697,377**	**$2,383,096**	**$2,606,625**	**$3,076,213**	**$3,940,403**	**$3,877,883**	**$3,692,338**	**$3,465,045**

Windham Community Memorial Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
Chief Executive Officer				$545,243	$585,128	$520,920	$469,982	$367,447	$368,288
Director of ER									$454,329
Associate Director Emergency Department							$323,865	$434,562	
Physician/Hospitalist		$288,962	$463,270	$441,376	$376,126				
Medical Director			$347,208	$359,517	$290,378				
Chief Financial Officer/VP Finance			$249,090	$337,633	$341,410	$318,624	$293,324	$241,639	
Chief Financial Officer									$242,778
Emergency Department Physician							$293,059	$414,618	$376,809
Emergency Department Physician							$246,715	$366,186	$345,570
Emergency Department Physician							$242,264	$352,725	$302,407
Emergency Department Physician							$214,742	$315,865	$289,138
Emergency Department Physician							$206,331	$312,993	$273,434
Emergency Department Physician							$143,862	$306,390	$226,486
Emergency Department Physician								$247,438	$178,510
Physician/Hospitalist	$378,887	$436,964	$433,682	$269,810	$221,757				
Physician/Hospitalist	$296,315	$320,462	$284,341	$265,443					
Physician/Hospitalist	$279,557	$305,674	$279,696	$264,125					
Physician/Hospitalist	$264,022	$269,719							
Physician/Hospitalist	$261,230								
Vice-President Operations		$263,290	$257,531	$245,308					
Physician/Hospitalist	$250,041	$301,846	$245,831						
Physician/Hospitalist	$233,954								
Medical Director			$223,976	$229,559	$222,030				
Vice President Patient Care		$255,343			$237,440	$292,675	$190,886		
Vice President Human Resources	$198,295	$349,509			$199,093	$183,859			
IT Director		$248,557							
Registered Nurse	$232,524		$257,641			$193,937			
Registered Nurse	$212,515			$214,202	$196,156	$165,936			
Director Inpatient Nursing						$162,875			
Registered Nurse						$160,759			
Registered Nurse						$160,524			
Registered Nurse					$192,973	$158,314			
Total	**$2,607,340**	**$3,040,326**	**$3,042,266**	**$3,172,216**	**$2,862,491**	**$2,318,423**	**$2,625,030**	**$3,359,863**	**$3,057,749**

Yale-New Haven Hospital

Position Title	2014	2013	2012	2011	2010	2009	2008	2007	2006
President & CEO (YNHH & YNHHS)	$3,520,872	$3,263,758	$2,803,228	$2,592,381	$2,547,699	$2,612,895	$2,022,544	$1,798,621	$1,488,980
Exec. VP, COO (YNHH & YNHHS)	$2,143,135	$1,942,688	$1,680,133	$1,636,424	$1,643,996	$1,625,653	$1,516,169	$1,403,271	$350,233
SR VP, Chief of Staff (YNHH & YNHHS)	$1,593,847	$1,482,123	$1,673,612	$1,383,291	$2,713,552	$1,339,602	$1,234,724	$1,115,331	
SR VP Finance, CFO (YNHH & YNHHS)	$1,806,166	$1,597,211	$1,432,214	$1,359,691	$1,345,514	$1,260,656	$1,114,791	$1,083,817	$1,124,783
SVP, Med. Aff/Chief									$1,102,233
Sr. VP of Quality & Safety	$909,375								
Senior VP HR (YNHH & YNHHS)	$1,078,184	$1,002,344	$945,388	$963,800	$954,346	$976,093		$725,218	$656,327
Senior VP Administration				$920,989	$924,331	$870,911	$726,378	$636,947	$577,249
VP of Legal Services	$1,100,951	$998,877	$903,335	$802,811	$780,372				
VP & Exec Dir of Childrens Hospital		$853,117				$739,113	$594,779		
Sr. VP of OPS/Children	$875,071								
Senior VP Patient Services		$703,474	$769,813	$736,309	$724,577	$729,091	$1,093,847	$565,102	$528,715
Senior VP, CIO (YNHH & YNHHS)	$1,133,727	$1,003,592	$895,982	$687,019	$902,132	$985,608	$739,064	$686,872	$676,045
Vice President, Administration									$508,390
Vice President, Administration									$486,639
SVP OPS/Smilow	$898,353	$800,103	$647,666						
VP Finance					$726,759	$718,587	$574,932	$539,790	
VP Ambulatory Services			$622,898	$654,217			$601,502	$562,377	
Total	**$15,059,681**	**$13,647,287**	**$12,374,269**	**$11,736,932**	**$13,263,278**	**$11,858,209**	**$10,218,730**	**$9,117,346**	**$7,499,594**

Greer, Leslie

From: Feldman, Joan <JFeldman@goodwin.com>
Sent: Wednesday, July 06, 2016 1:07 PM
To: Hansted, Kevin; Riggott, Kaila; Greer, Leslie
Cc: Carannante, Vincenzo; hfmurray@lapm.org
Subject: FW: Applicants' Supplemental Prefiled Testimony Rebutting Prefile Testimony of Fred Hyde 15-32032-CON and 15-32033-CON
Attachments: 15-32032-CON.PDF; 15-32033-CON.PDF

Please accept our supplemental prefiled testimony in response to the Intervenors' Prefile Testimony.
Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	**DOCKET NO. 15-32033-CON**
	:	**July 11, 2016**

APPLICANTS' SUPPLEMENTAL PREFILED TESTIMONY REBUTTING PREFILE TESTIMONY OF FRED HYDE ON BEHALF OF INTERVENORS

The Applicants are filing this supplemental prefiled testimony to address the unsubstantiated, conclusory and false and misleading statements made by Dr. Hyde ("Hyde") in his prefiled testimony on behalf of the Intervenors. More particularly, Hyde's prefiled testimony impugns the intent, the community commitment, and the integrity of the Applicants. The Applicants believe that such statements are irresponsible and self-serving given Hyde's personal history with Windham Community Memorial Hospital ("Windham Hospital") and his role as a member of the Certificate of Need Task Force established pursuant to the Governor's Executive Order No. 51 (the "Task Force"). Certainly, one would expect that the members of the Task Force would refrain from participating in matters in which they have an apparent conflict of interest in or, at a minimum, be less biased and inflammatory in their statements.

Accordingly, for the purpose of ensuring an accurate record, the Applicants respectfully dispute and respond to Hyde's prefiled testimony for the reasons described below and in the order they are presented in his prefiled testimony:

Hyde's Statement:

"A portion of this increase in health and hospital expense can be directly attributable to the consolidation of hospitals and health systems. These consolidations result in:

a) Higher prices through monopoly market position;
b) Inflated expenses resulting from more complex and more generously compensated management, with hospital administration now accounting for 1.43% of the nation's Gross Domestic Product; and
c) Compromise to the integrity of physician judgment when such hospital and health system consolidations include physician practices."[1]

[1] See Page 1 of Hyde's Prefiled Testimony.

Applicants' Response:

The above statements are unsubstantiated, generalized and based upon Hyde's own personal opinion, rather than the facts in the instant Application. Hyde selectively picks and chooses excerpts from publications to support his desired position, objectives and beliefs, and by doing so creates a montage of statements and arguments to support his belief that all affiliations and consolidations of community hospitals with larger systems are bad for consumers. The reality is far more complex and depends on the facts of the particular affiliation in question, as demonstrated by the prefiled testimony of Dr. Noether.

The Applicants would like to provide OHCA with information regarding Hyde's misuse of the word "monopoly." There is no monopoly being created by virtue of the proposal and further, neither Yale New Haven Health nor L+M is currently a monopolist. "Monopoly" is a specific term used by economists and antitrust regulators – the same regulators who declined to further investigate the affiliation between Yale New Haven Health and L+M - to indicate a situation in which a firm faces no competition. Given the geographic distance between the systems and their different clinical focuses, it simply defies common sense that the affiliation of Yale New Haven Health and L+M would eliminate meaningful competition or result in the creation of a monopolist.

The studies referenced by Hyde are neither definitive nor relevant to the instant case. At best, they may show correlation between certain consolidations and price increases, but Dr. Hyde has failed to demonstrate any causal relationship between the two, nor has he demonstrated that the literature applies to the specific market conditions in which this proposed affiliation will occur. In some contexts to assess the competitive effects of an affiliation, regulators may have to consider whether the pass-through of cost-savings (economic theory indicates that a portion of any cost savings is almost always passed on to consumers, even by monopolists) is enough to offset the increase in prices that is associated with the creation of market power. But that is not the calculus that OHCA is faced with here: the affiliation of Yale New Haven Health and L+M results in significant cost savings with no creation or enhancement of market power. So contrary to Hyde's belief, the proposed affiliation can only benefit consumers.

Hyde's Statement:

"In general, not-for-profit hospitals are doing well financially…In fiscal year 2015 Moody's reports that not-for-profit hospitals had median annual growth rate of 7.4% and median three-year revenue compounded annual growth rate of 5.6%."

Applicants' Response:

On May 17, 2016, L+M's bond rating for its CHEFA Series F bonds was downgraded to a BBB+ rating from the A+ rating it was given just three (3) years earlier. According to the Standard & Poor's Global rating agency, this downgrade can be attributed to three (3) factors: "a sharp decrease in operating profitability in the last three fiscal years from historic levels, pressure from the Connecticut state hospital tax, the

impact of which has incrementally increased each year, continued inpatient softness in fiscal 2016 with mix shift to outpatient; and a weakened balance sheet position with less financial flexibility than when the rating was initially assigned." It is worth noting that in the same report, the rating agency stated that:

> There's upward rating potential if the integration with Yale New Haven Health System (which includes Yale New Haven Hospital) comes to fruition and provides immediate lift to financial performance and stability to the balance sheet and our group rating methodology would then apply.[2]

Clearly, the report referenced by Hyde is irrelevant in the instant case.

Hyde's Statement:

"This is the background against which OHCA is called upon to evaluate yet another attempt at monopoly acquisition (another hospital by a health system) and consolidation of institutional control over professional judgment through hospital-sponsored medical groups."[3]

Applicants' Response:

Neither Yale New Haven Health nor L+M have any control over the professional judgment of the physicians employed or contracted with their affiliated medical foundations. Hyde has provided no evidence to support these statements in the instant case and the Applicants consider such statements to be harmful to the trust developed by the Applicants with their respective communities. Financial relationships between hospitals and physicians are highly regulated and both Applicants take compliance with these laws very seriously. Had the Connecticut legislature thought that a medical foundation would have interfered with the professional judgment of physicians, it would not have created this statutory exception to the corporate practice of medicine doctrine.

Hyde's Statement:

"The FTC has allowed the Hart-Scott-Rodino review period to lapse, and the federal government continues to struggle to win cases under the antitrust laws."[4]

Applicant's Response:

This is a misleading statement at best. First, the use of the word "lapse" suggests that the FTC was negligent in its review of the proposed affiliation, which is not the case.[5] Second, the FTC cleared the proposed affiliation only several months before filing three hospital merger challenges in federal court. At the time they cleared the proposed

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[2] See Page 6 of Bruce Cumming's Prefiled Testimony in Docket No. 15-32033
[3] See Page 1 of Hyde's Prefiled Testimony.
[4] See Page 1 of Hyde's Prefiled Testimony.
[5] Please note that the Connecticut Attorney General participated in the same FTC review.

affiliation, the FTC had not lost a hospital merger challenge since the late 1990s. So, it seems unlikely that the FTC would have hesitated to bring a case in the instant case if they thought there was cause to do so.

Hyde's Statement:

"OHCA awards a Certificate of Need 'franchise' to private corporations which are engaged in publicly funded services: the award must be based on the public good, not on private gain."[6]

Applicants' Response:

The above statement is false and wrongly characterizes the statutory purpose of OHCA and imbues to OHCA a purpose that only exists in Hyde's own mind.

Hyde's Statement:

"Lawrence + Memorial only lacks financial resources as a result of empire building and other imprudent management decisions, including:

(i) Expensive attempts to outsource services, and to 'lock out' unionized employees performing those services....

(ii) The acquisition of the bankrupt Westerly Hospital for a reported price of $35 million; and

(iii) The extraordinary subsidy of physician practices. The **first attachment** to this document shows the extent to which hospital revenues are generating adequate margins to support operations and maintenance, but are subsidizing practices and other "system" losses...."[7]

Applicants' Response:

Hyde fails to understand the efforts and investments made by L+M to bring primary care and specialty services to the Eastern Connecticut region for the purpose of improving access to high quality care for those who live in the region. L+M's financial difficulties are not due to its acquisition of Westerly Hospital. In fact, the continued operation of Westerly Hospital has been very positive for consumers in the Eastern Connecticut region. L+M's financial difficulties are due to declining state and federal government revenues and dramatic increases in state hospital taxes. They are also not caused by executive compensation. It is particularly ironic that Hyde characterizes these actions as mismanagement given the news stories that are highly critical of Hyde's efforts to financially manage the institutions in which he was in charge.

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[6] See Page 1 of Hyde's Prefiled Testimony.
[7] See Page 2 of Hyde's Prefiled Testimony.

More specifically, with respect to Hyde's criticism of mission support associated with the Applicants' two medical foundations, Hyde fails to realize that prior to formation of the legislatively created medical foundations, these expenses would have been incurred by their affiliated hospitals. Both L+M and Yale New Haven Health are tax-exempt entities, and the hospitals that are part of these systems are subject to strict regulatory requirements and limitations with respect to their financial relationships with physicians. Therefore, the extent to which these systems provide mission support to their medical foundations is by no means extraordinary, and complies with all relevant legal standards. Rather, the extent of mission support represents the true cost of maintaining access to physicians in their respective communities. Consistent with a commitment to excellence and innovation in patient care and service to the community, the financial investments made by each Applicant represents an investment in furtherance of the charitable mission of the health system and its hospitals. In order to provide for the key elements of the charitable mission, there are certain programs/service lines that are unable to collect patient revenue in amounts sufficient to cover their associated expenses. For these reasons, hospitals and health systems, including L+M and Yale New Haven Health, typically provide support to physician foundations to cover these losses. Without this mission support, access by Medicaid patients and other underserved populations would be very limited because many physicians in private practice are unwilling to care for individuals whose only source of payment is the government. Moreover, as stated in the Applicants' prefiled testimony and CON application, L+M has historically had challenges recruiting physicians to its community. Without L+M providing mission support to these physician practices, certain specialty services would not be available in the community.

While NEMG and L&MPA have reported losses from an accounting perspective, medical foundations are key strategic initiatives of integrated health systems that provide a number of benefits, including but not limited to: (i) development of stronger clinical integration among various medical disciplines and operating units of the health system allowing for management of the patient continuum of care within the health system; (ii) development of greater focus on evidence-based quality measures in primary care and specialty physician services; and (iii) management of the transition from traditional volume-based reimbursement to alternative payment models with government and commercial payers. Thus, focusing solely on the accounting results of NEMG and L&MPA does not account for the benefits associated with patient access, continuum of care, preparedness for population health and community need fulfillment that NEMG and L&MPA provide to their respective systems.

Hyde's Statement:

"[A] list of peer-reviewed journal articles…shows that such economies [of scale] have not been achieved in similar health system acquisitions in the past, and that consolidation leads to significant price increases and resulting systemic cost growth…."[8]

[8] See Page 2 of Hyde's Prefiled Testimony.

Applicants' Response:

Hyde is clearly unaware of the significant cost savings achieved by Yale New Haven Hospital at the Hospital of Saint Raphael campus. Specifically, since 2012, Yale New Haven Hospital achieved over $250 million dollars in cost savings from a hospital that was previously on the brink of bankruptcy, while upgrading its facilities and services. Hyde must also be unaware of the clinical and operational improvements that have been achieved by Bridgeport Hospital and Greenwich Hospital also discussed in the Applicants' application and prefiled testimony. If Hyde had read the Applicants' CON Application carefully, the substantial efforts by both Applicants to improve quality would be very evident. See Attachment II of CON application at page 645-722. Comparisons to other states are irrelevant when most would agree that Yale New Haven Hospital is nationally recognized by independent third parties for its exceptional quality.

Hyde's Statement:

"Despite OHCA's request and the urging of legislators, the Applicants flatly refuse to provide comparative price data between L+M and the YNHHS hospitals. However, original analysis of Medicare payments submitted as part of this testimony shows that, almost uniformly, payments for services at Yale-New Haven (including low acuity services) are significantly higher than those at Lawrence + Memorial and much higher than other currently independent hospitals."[9]

Applicants' Response:

As Applicants have previously explained, comparable risk-adjusted price data are not readily available and therefore could not be submitted. The so-called "original analysis" that is presented in Exhibit 3 of Hyde's prefiled testimony does not provide complete and/or useful information. It presents "prices" that are administratively determined by the Medicare program (CMS) rather than those that are the result of market-based negotiations between hospital systems and health insurers. Because these are administratively determined prices, the fact that Yale New Haven Hospital is paid more than most other hospitals in Connecticut reflects CMS' recognition that Yale New Haven Hospital incurs higher costs because of its teaching mission and the higher patient acuity (within a particular DRG) that it treats. But those administratively determined prices have no relevancy as to the cost efficiency of a hospital.

Notably, a hospital's Medicare DRG rate is not based on its specific costs or efficiency, but rather on standardized factors intended to reflect the typical costs of providing medical education, providing services to a disproportionate share of low-income patients, providing outlier services to patients requiring additional services, and not having the payments reduced for short stay transfers to other Medicare providers.[10] All of these

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[9] See Page 3 of Hyde's Prefiled Testimony.

[10] Specifically, Medicare's annual base DRG per discharge amount is uniformly set for all hospitals at national base payment rates for standardized amounts at each hospital. The final DRG payment rate at a hospital is then adjusted by the following: (i) the Hospital Geographic classification; (ii) an Indirect Medical

factors influence the DRG rate at Yale New Haven Hospital and Bridgeport Hospital both of which have substantial teaching programs. This aside, the emphasis on price differences between Yale New Haven Health, L+M Hospital, and other hospitals in Connecticut is entirely misplaced. In a market in which competitors are highly differentiated, it should be expected that they receive different reimbursement.

The same analysis offered by Hyde also presents gross charges across different hospitals, but these are also not informative as they do not reflect the prices actually negotiated by health insurers or paid by patients. Even if prices paid are sometimes based on a percentage of charges, the percentage discount is negotiated and can vary, so, again, a comparison of the gross charges by themselves is not indicative of relative payment amounts across hospitals. Moreover, even if there were some validity to an analysis based on gross charges as proxies for pricing power, then the data does not support a conclusion that Yale-New Haven Hospital possesses market power.

In connection with Hyde's claims that Yale New Haven Health affiliated hospitals are the most expensive in Connecticut, Hyde references 2013 CMS records of billing and payment by DRG by hospital for the top 100 DRGs in Connecticut Hospitals.[11] As noted above, the Medicare payments are set on national rates and national formulas; the Medicare payments are not based on the hospitals' actual costs. In describing these data, CMS states that "Users will be able to make comparisons between the amount charged by individual hospitals within local markets, and nationwide, for services that might be furnished in connection with a particular inpatient stay." CMS does not state that this information reflects on hospitals' costs or efficiency.

Moreover, Hyde appears to have cherry-picked his data. In reviewing the DRGs that Hyde selected, the Applicants noted the following:

- All the DRGs selected had relative weights above that of the typical discharge;
- None of the DRGs selected are provided by all 29 Medicare Acute Care Hospitals in Connecticut in 2013; and
- Yale New Haven Hospital had more residents as it has the largest teaching program in the state. It also has a high DSH adjustment and is the largest provider of services to Medicaid beneficiaries, along with outlier payments.

Education add-on based on the hospital's Resident to Bed Ratio; (iii) a DSH add-on for hospitals that treat a disproportionate share of low-income patients; (iv) a DRG Outlier add-on for claims utilizing services beyond the outlier threshold established by CMS; (v) CMS' Transfer Reduction Policy for short stays that are transferred to other Medicare facilities.

[11] The data used by Hyde was published by CMS on their website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient.html. The data published included the hospital-specific data for the more than 3,000 U.S. hospitals that receive Medicare Inpatient Prospective Payment System (IPPS) payments for Fiscal Year (FY) 2011, 2012, 2013, and 2014; 2014 was recently published.

Of the top 100 DRGs in the CMS data, Yale New Haven Hospital has the highest charge-to-Medicare allowed ratio for only 7 DRGs, which is less than Middlesex (44 DRGs), Stamford (10), Waterbury (8), and tied with Norwalk (Greenwich has the highest multiple for 13 DRGs, while Bridgeport Hospital has the highest ratio for only one DRG). Hyde also uses these data to argue that there is no evidence that the acquisitions of Greenwich and Bridgeport Hospitals produced savings for consumers. Again, because the Medicare data have nothing to do with pricing or costs, he has no basis for such a conclusion. Moreover, even if the data were valid, the pattern does not reflect any variation in cost or quality and therefore would not be dispositive.

Most importantly, even assuming that Hyde's analysis demonstrated that YNHH did currently negotiate higher prices than L+M, it does not follow that the affiliation will allow Yale New Haven Health to confer those higher prices on the services provided at L+M. Rather, the question is whether the proposed affiliation will increase the market power of Yale New Haven Health, which would allow it to negotiate higher prices for L+M. We have previously explained in the prefiled testimony of Monica Noether, our expert economist, that YNHH and L+M are not close competitors, and, as a result, the affiliation will not change bargaining dynamics with managed care companies or otherwise allow YNHH to increase the prices charged by L+M.

Hyde's Statement:

"[T]his acquisition will lead to extreme market concentration in the L+M service area, and intensify Yale-New Haven's market power from New York to the Rhode Island border. If this acquisition is consummated, Yale-New Haven Health Systems will account for 83% of discharges in L+M's primary service area, and nearly 60% of all inpatient discharges in the southern half of the state...."[12]

Applicant's Response:

We agree that, once L+M affiliates with Yale New Haven Health, as a system, Yale New Haven Health will account for over 80% of the discharges from L+M's primary service area ("PSA"). However, that is attributable to the strong presence that L+M already enjoys in its service area – of the post-affiliation share of approximately 75% in L+M's PSA, L+M already has approximately 67%.[13] That does not contradict the fact that it also faces competition from proximate competitors such as Backus Hospital.

Hyde also includes as an attachment a report that concludes the affiliation will exceed the FTC/DOJ *Horizontal Merger Guidelines'* thresholds for a change in the Herfindahl-Hirschman index ("HHI"). This report does not identify any authors or provide their qualifications for drawing such conclusions, or in any other way provide OHCA with enough information to determine whether this report is a credible source of factual information. Even assuming this report's reported HHI is calculated correctly, as with

[12] See Page 4 of Hyde's Prefiled Testimony.
[13] 64% to 67% does not include Rhode Island in that OHCA is interested in Connecticut. Please note that Monica Noether's prefiled testimony includes Westerly and is at 77%.

Hyde's discussion of the post-affiliation share in L+M's PSA, it is likely attributable to L+M's strong existing presence in its own service area, not because the affiliation will eliminate meaningful competition with YNHH. Most importantly, however, the HHI is only an initial screen; it is not dispositive. Indeed the FTC itself, which along with the Department of Justice issued the *Horizontal Merger Guidelines*, determined that there was no reason to investigate this transaction beyond the statutory filing period.

Also, OHCA should note that even this report acknowledges the economic imperative behind affiliations: "In Connecticut, the State Innovation Model (SIM) and 'shared savings' policies for Medicare and Medicaid are creating incentives for large combinations of hospitals and doctors that can accept risk for broad patient populations." [14]

This is correct and explains why community hospitals such as L+M that might have been successful historically as independent entities can no longer deliver care effectively on their own. The ensuing combinations into larger systems, however, are not anticompetitive. Rather they can benefit patients by providing more integrated care and allowing health systems to become accountable for the cost of delivering effective care, which in turn reduces incentives for excess utilization.

Hyde's Statement:

"The Applicants have offered no evidence that the acquisition of Lawrence + Memorial Physicians Association, L+M's 70-physician group medical practice, will create efficiencies with any meaningful return to patients and payers."[15]

Applicants' Response:

As discussed above, Hyde fails to understand the purpose and importance of the L&MPA and NEMG merger as discussed above with respect to maintaining access to primary and specialty care in the L+M service area. Once merged, there will be less duplication in medical services and greater coordination of care between treating physicians, more widespread use by former L&MPA physicians of evidence-based practices, and greater certainty with respect to the retention of L&MPA physicians. Without the continued presence of L&MPA physicians in the L+M community, patients would have to travel outside of the community and ultimately this will negatively impact access and the health of the community. Access to the combined infrastructure of L&MPA and NEMG will undoubtedly result in added efficiencies. Given the antitrust laws' restrictions against sharing sensitive information, and limitations on planning at this point, the Applicants' are limited in their modeling of cost savings.

As stated by the Applicants, it is the payer who designs health plans and determines the patient's deductible or cost sharing responsibilities. Hyde also decries the development of narrow network products that limit patient choice. As Hyde acknowledges, narrow network products are a vehicle that health insurers used to control costs because they

[14] See Attachment 4 from Hyde's Prefiled Testimony.
[15] See Page 4 of Hyde's Prefiled Testimony.

provide them with greater bargaining leverage over hospitals (through the threat to exclude hospitals from the narrow network). This is not anticompetitive, but rather is a procompetitive way to force hospitals to compete more aggressively to reduce costs that can also result in lower health plan premiums.[16]

Hyde's Statement:

"OHCA should view with skepticism the idea that installation of the EPIC electronic medical record system will generate efficiency or improve quality."[17]

Applicants' Response:

Hyde makes statements critical of the Applicants purchase of Epic and plan to have affiliated entities on a common electronic health record platform. To support this position, he cites the implementation at other systems in other states, but that experience is inapposite – it is Yale New Haven Health's experience that is relevant. Yale New Haven Health's implementation of Epic was on time and nearly $10 million dollars under budget. More importantly, having a single, integrated electronic health record ("EHR") across multiple care settings is the key to enhancing quality and safety. A single platform for clinical care and revenue cycle operations affords synergies and economies of scale across the broad range of clinical services and geographic regions. These economies enable even smaller community hospitals in Yale New Haven Health to immediately access the clinical content developed in concert with its largest academic medical center. This would not be possible for a freestanding community hospital on its own. Yale New Haven Health has already reduced cost and made improvements by efficiently creating pathways, evidence-based decision support, and analytics tools that power the clinical decision making of the entire care team – Yale New Haven Health has created it once rather than multiple times, for a uniform, high standard of care. Specifically, it is this success and an effective clinical, business and analytics platform that Yale New Haven Health can offer to L+M at a cost they cannot achieve on their own even with another EHR vendor. What many, including Hyde, fail to realize is that greater than 80-85% of the cost of implementations is in the people – in Yale New Haven Health's case 29,000 doctors, nurses, and staff who collaborated on local decisions in configuration decision and training. None of this is achievable by L+M on its own.

Hyde's Statement:

"That access to primary and advanced specialty care will be greatly enhanced for the citizens of the Lawrence and Memorial hospital service area through the acquisition. This argument is contradicted by…[t]he example of Windham Hospital's acquisition by Hartford HealthCare…."[18]

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[16] Hyde also fails to acknowledge the driving force behind the merger – Connecticut state law requires that health systems may have only one medical foundation. Compliance with the law certainly constitutes "clear public need."

[17] See Page 5 of Hyde's Prefiled Testimony.

[18] See Page 5 of Hyde's Prefiled Testimony.

Applicants' Response:

Yale New Haven Health and Harford HealthCare do not operate in the same manner, nor do they conspire to develop the same "playbook." It is completely irrelevant to discuss Windham Hospital in the context of this proceeding. Windham Hospital historically and currently is a very different hospital than L+M - it is in a different geographic area and not at all comparable in breadth and depth of services. Dr. Hyde's obsession with Windham Hospital is perhaps the result of his own tenure there, but OHCA should not allow his repeated references to Windham to obscure the fact that the affiliation before it involves a very different hospital and a very different health system.

Hyde's Statement:

"Changing governance and control will render local officials and L+M itself incapable of protecting local services."[19]

Applicants' Response:

This statement by Hyde demonstrates his misunderstanding of hospital governance and the terms of this transaction. Decisions regarding community services will only be made upon the approval of L+M. As a matter of governance, after the affiliation most significant decisions must emanate from the L+M board before the YNHHSC board can act. Hyde continues to approach this application as if it were based upon nonexistent terms to the affiliation. It is also contrary to Yale New Haven Health's culture and philosophy to direct patients away from their community to Yale-New Haven Hospital for care that these patients can receive locally. Yale-New Haven Hospital has not done that with Bridgeport Hospital or Greenwich Hospital, nor does it have the capacity to take on the volume of patients that Hyde suggests in his prefiled testimony.

Hyde's Statement:

"Patient choice will be severely compromised, if not eliminated."[20]

Applicants' Response:

Quite the contrary, the entire proposal is about maintaining the financial stability and strength of L+M. Without the proposal, access to care in the L+M community will be restricted and only then, will patient choice be severely compromised.

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[19] See Page 6 of Hyde's Prefiled Testimony.
[20] See Page 6 of Hyde's Prefiled Testimony.

Hyde's Statement:

"All of the hypothetical $300 million appears to be contingent on future programs being consistent with the YNHHSC strategic plan, mutually agreed upon (between YNHHS and L+M), and displaying a positive return on investment. In other words, there would be no new investment in the Greater New London community's health unless that investment earns Yale-New Haven Health System a profit....In fact, some or all of the $300 million is supposed to come from efficiencies that lead to lower expenses in L+M's future operations...The application assumes that L+M will eliminate more than 200 jobs and more than $130 million in wage and benefit expense during the first three years."[21]

Applicants' Response:

The notion that the affiliation will result in 200 job eliminations in the first year is inaccurate. The drop in FTEs noted on the document attached to Hyde's testimony is in part due to L&MPA becoming part of NEMG. These FTEs are not being eliminated, but instead are being transferred to another company (in this case NEMG). Another reason for the decline in FTEs, and subsequent stabilization in the out years, is that when the CON was filed it was based on the assumption that the affiliation would take place mid-year FY 16. Therefore, the number of employees transferred is only counted at 50% in that first year.

Regarding the supposed loss of $130 million in wages and benefits, it appears Hyde is misinterpreting the financial statements from the Applicants' CON filing. Adding the columns for salary and benefits for the first three years after the transaction (note: given the timing, the columns for FYs 16, 17, and 18 really represent only 2 ½ years) found in the attachment to his testimony, the affiliation actually adds $5.4 million in wages and benefits, rather than reducing them by $130 million.

All information relative to the sources and uses has been outlined in the initial CON, and subsequent Completeness Question Filings.

$85 million in investments by Yale New Haven Health will be made entirely independent of financial performance at L+M, or the generation of any "profit". $41 million of this investment will be spent in the following areas as stated in the Completeness Question Responses on January 5, 2016 (see response 28 a.).

[21] See Page 7 of Hyde's Prefiled Testimony.

Break-down of $41 Million	Description
$14 million	Epic installation and other IT investments
$10 million	Population health infrastructure and related services
$15 million	Development of clinical programs and services for eastern CT and western Rhode Island
$2 million	Rebranding and communication initiatives

Total: $41 million

Of the initial $85 million investment, the remaining $44 million will be invested in further clinical programs in the L+M service area. Decisions regarding service programming will take place after the proposed affiliation is approved as part of the joint strategic planning process. The amount of detail that will be reviewed during that process will require the understanding of the strategic plan of L+M which cannot legally be shared prior to the proposed affiliation.

The programs invested in as part of the $44 million will require mutual agreement. While a return on investment analysis will be performed, the services are not necessarily expected to generate a "profit" in the initial years, or at all - rather, the agreement requires only that the analysis be performed and that Yale New Haven Health and L+M have a multiyear understanding of the financial impact made during these investments. $41 million of the $85 million will come directly from existing funding at Yale New Haven Health.

After this initial $85 million investment, an additional $215 million will be made. The $215 million investment will go to the further development in the Eastern Connecticut region. This can come in the way of new clinical programs, capital development, or any other use deemed consistent with improvement to care for our patients. While the detail of this spending will be developed during the strategic planning phase, the potential areas of investment were also shared during the Completeness Question Responses on January 5, 2016.

The sources of the $215 million will be generated from the improved cash flow of L+M inclusive of the synergies generated by affiliating with Yale New Haven Health. It is for this reason that this funding will be dependent upon financial performance. Given the information we have today, the investment will be made in its entirety, but as payment models and sources of funding continue to change in our industry the future availability of these funds are uncertain. In the event that economic forces drive down the cash flows expected to fund these investments, the two organizations will work to either identify other sources of funding, or change the investment to best meet the missions of both organizations and the community at large. The notion that the entirety of the $300 million will only be made if Yale New Haven Health generates a profit is entirely inaccurate. Rather, the parties will look to whether the business plan makes sense for L+M overall, in light of its then-current financial condition.

Conclusion:

Hyde seems to lay all the problems in our current health care system at the feet of hospital and health system consolidation generally, and consolidation at Yale New Haven Health in particular. Hyde pays little heed to the effect of declining governmental reimbursement, increased hospital taxes and the financial challenges posed by changes in health care reimbursement. It would appear that Hyde is trying to drive forward while following a path he sees in the rear view mirror. Health system consolidation is a response to these challenges and an attempt to meet the need for improved care at a lower cost, not a cause of further instability. Applicants believe that they have provided sufficient context to allow OHCA to assess Hyde's exaggerated, false, irrelevant, and inflammatory statements in his prefiled testimony. Having done so, it is our hope that OHCA can rightfully focus on the facts and the clear public need for the proposed affiliation rather than be distracted by misdirected personal agendas.

I adopt this supplemental Prefiled Testimony as my own.

Bruce D. Cummings
President & CEO
Lawrence + Memorial Corporation

I adopt this supplemental Prefiled Testimony as my own.

Marna Borgstrom
President & CEO
Yale New Haven Health

CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the foregoing documents were sent via electronic mail the 6th day of July, 2016 to:

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, CT 06105
hfmurray@lapm.org

Joan W. Feldman

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, July 06, 2016 3:50 PM
To: Lazarus, Steven; Carney, Brian; Ciesones, Ron
Cc: Greer, Leslie
Subject: FW: L & M / YNHHS
Attachments: 2016 7-6-Response to Pre-Filed Testimony of Dr Monica Noether.pdf; intervenors cover letter response_20160706104112669.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Henry F. Murray [mailto:hfmurray@lapm.org]
Sent: Wednesday, July 06, 2016 3:13 PM
To: Martone, Kim; Hansted, Kevin
Cc: jfeldman@goodwin.com
Subject: L & M / YNHHS

Please find attached Intervenor's Response to the Pre-File testimony of Dr. Monica Noether.

Hank Murray

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

C-126

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
EMAIL:hfmurray@lapm.org

July 6, 2016

Via Email and First Class Mail

Kimberly Martone, Director of Operations
Kevin Hansted, Hearing Officer
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, CT 06106

Re: Certificate of Need Applications,
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and Northeast Medical Group, Inc. and,
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation

Dear Ms. Martone and Mr. Hansted:

Attached please find the Intervenor's response to the Applicants' Pre-file Testimony. Thank you.

Very truly yours,

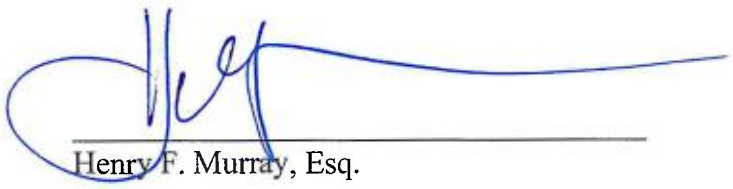
Henry F. Murray

HFM:vds
Enclosure

CERTIFICATION

This certifies that the Intervenors' Response to the Applicants' pre-file testimony was sent via email and First Class Mail, pre-paid, on July 6, 2016, to the following counsel of record:

Joan W. Feldman, Esq.
SHIPMAN & GOODWIN LLP
One Constitution Plaza
Hartford, CT 06103-1919
jfeldman@goodwin.com



Henry F. Murray, Esq.

Comments and Response to Pre-Filed Testimony of Monica Noether, PhD.

Fred Hyde, M.D.
57 Main Street
Ridgefield, CT 06877

July 6, 2016

Price Information, Historical Challenges in Examining Hospital Mergers

Dr. Noether's pre-filed testimony and published articles discuss price information, the difficulty of obtaining that information, and of knowing what it means. This difficulty reflects the challenges facing OHCA generally in the evaluation of this application: the complexity of the field, the difficulties facing researchers in the field, but also the unwillingness of applicants (such as those now before OHCA) to share what they are able to. Dr. Noether noted this problem almost thirty years ago in a major report done with staff at the Federal Trade Commission.[1] Unfortunately, however, Dr. Noether's testimony does not recognize more modern work, in fact "breakthrough" information about hospital monopoly prices.

New Information on Hospital Prices

Major changes have taken place in the intervening three decades since Dr. Noether's original work in this field.

First, Medicare payments have become available to the press and public, through the efforts of the Association of Health Care Journalists working with the Centers for Medicare and Medicaid Services. These comparisons have been offered by the Intervenor.[2] No mention is made of these differences in Medicare payments by Dr. Noether in her testimony.

Second, a major study of information gathered by the Health Care Cost Containment Institute[3] shows price disparities in payments by commercial health insurers. Dr. Noether faults this Cooper study[4] for not including Blue Cross information. Unfortunately, Blue Cross information which would complement that available through the Health Care Cost Containment Institute is not available. Dr. Noether does not dispute a finding of the Cooper report pertinent to this application, namely that New Haven, Connecticut, the home of the Yale-New Haven Health Services Corporation, is an *epicenter of extraordinarily high prices in both the private sector and for Medicare.*

[1] Noether, M., "Competition Among Hospitals," Staff Report of the Bureau of Economics, Federal Trade Commission, 1987
[2] Exhibit Two,, Pre-Filed Testimony, Fred Hyde, MD
[3] Cooper, Z., et al, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER Health Care Pricing Project, December 2015
[4] Noether, M., "Commentary on 'The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured,'" Charles River Associates, January 7, 2016

Third, information from the Department of Social Services in Connecticut will shortly be made available to a task force studying certificate of need in Connecticut. This information will directly impact one question, namely, to what extent does the State of Connecticut pay Medicaid rates which reflect monopoly pricing by Yale-New Haven?

Finally, Section 2(c) of PA 15-146 requires the Connecticut Department of Public Health and the Department of Insurance to have transmitted lists of the fifty most common inpatient and outpatient diagnoses and procedures and the twenty-five most common outpatient surgical and imaging procedures in the State to the Health Insurance Exchange and to the public. Under section 2(d), the Exchange is required to publish reports from insurance carriers showing prices – both billed and allowed amounts – for these procedures broken down by specific payer by specific provider on January 1, 2017.

The applicant therefore has two choices to demonstrate that it has been responsive to the information required by OHCA. The first would be to make known its prices, including those paid by Blue Cross. The second would be to voluntarily defer action until the hearing record can be completed. If the applicant takes neither route, we recommend that OHCA hold the public hearing record open until January to obtain the data that the applicant is not providing.

In summary, Dr. Noether's comments concerning pricing reflect challenges to regulators and the public generally, as well as to economists. Information made available more recently has been either not included in her testimony, or has been refuted on grounds (Blue Cross) of its incompleteness. Dr. Noether's concerns with regard to prices have been reflected in her writings over three decades, not however fully accommodating more recent information. The statute requires OHCA to make written findings to determine whether the applicant has "satisfactorily demonstrated that any consolidation resulting from the proposal will ***not*** adversely affect health care costs or accessibility to care." Given the volume of literature on the relationship between consolidation, provider prices and health care costs, OHCA's responsibility to obtain current information which will reflect the impact of monopoly pricing is clear.

New Studies on Hospital (and Physician) Monopoly Behavior

Dr. Noether has written that separate negotiations need not necessarily lead to monopolist behavior. However, again, Dr. Noether has not taken into account more recent work (see paper in Exhibit One by Gowrisankaran). Dr. Noether, a speaker at a February 2015 Federal Trade Commission and Department of Justice conference in which Gowrisankaran and colleagues presented their findings, does not address those findings or refute them.

Parenthetically, Dr. Noether's career-long writing is critical of certificate of need[5], that is, that prices seem to be higher and/or increase in states with certificate of need. Her hypothesis has been that regulation creates market barriers and allows price increases to exceed what otherwise would have taken place. However, there is no legitimate control with which to evaluate that hypothesis, or "counterfactual." In addition, there are plausible alternative hypotheses: for example, that prices are higher in certificate of need states because the extent of that price

[5] Noether, M., "Competition Among Hospitals," Staff Report of the Bureau of Economics, Federal Trade Commission, 1987

differential has created the political climate which made possible the passage of certificate of need legislation, and/or protection against CoN repeal by those who would rely on "market forces."

In evaluating monopoly behavior, Dr. Noether, in support of the application, appears to take a position contrary to the majority of economists who have studied the merger of non-profit hospitals. The Intervenor has submitted an exhibit with extensive evidence that other economists have evaluated hospital mergers with traditional tools.[6]

Even current and former colleagues of Dr. Noether have taken the opposite position. For example, Seth Sacher of Charles River Associates and Michael G. Vita of the U.S. Federal Trade Commission have written on "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study." In that paper, in which non-profit competitors were reduced from three to two, Sacher and Vita found the following: "We find that the transaction resulted in significant price increases; we reject the hypothesis that these price increases reflect higher post-merger quality."[7] Sacher and Vita indicate that "Studies using data from the mid-1980s and after" present this general relationship: "a *positive* relationship between concentration and price."[8] In this paper, further reference to case studies indicated price increased for medical-surgical services of as much as 9%.

Moreover, Dr. Noether has commented[9] on the favorable results from a reduction in concentration. In a paper written during Dr. Noether's tenure at the FTC, she says that reduction in concentration "may lead to an increase in both price and quality competition."[10] [The word "quality" in Dr. Noether's reports "is used to refer to all non-price aspects of competition," not as we generally refer to quality in hospital and regulatory discussions today.[11] She notes "an increase in 'quality' is not necessarily welfare-enhancing…] In this paper, Dr. Noether goes on to note that "when concentration is reduced, prices (per unit of output, not adjusted for quality) are prevented from rising by a concomitant increase in price competition. This result implies that, for a given level of quality, price is lower in areas with less concentrated markets." She concludes that "the hospital industry can be analyzed, for the most part, like other industries when, for example, applying the anti-trust laws.[12] In her conclusion, Dr. Noether writes that, "The results suggest that hospital margins rise and expenses fall with increases in hospital industry concentration."[13] Addressing one of the changes already underway by the 1987 publication of the FTC report, Dr. Noether writes that "This study also provides no evidence to support the conjecture that managed and system hospitals are more efficient than independent ones. Expenses for both former types appear to be greater."[14]

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[6] Exhibit Two, Pre-file Testiomony, Fred Hyde, M.D.
[7] Vita, M. and S. Sacher, "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study," 1999, page one
[8] Ibid, page six
[9] Noether, M., "Competition Among Hospitals," Journal of Health Economics, 7, 1988, 259-284
[10] Ibid, at. Pg. 260
[11] Ibid, page one
[12] Ibid, page three
[13] Ibid, page 81
[14] Ibid, page 83

Questions remain that are not addressed in Dr. Noether's testimony. The first is: Will health plans be able to offer a marketable network to residents in the New London area that for whatever reason excludes Yale-New Haven Hospital, the Northeast Medical Group, the Yale Medical Group, and the other Yale-New Haven Health System entities? The Intervenors would answer unequivocally, "No."

Also, this question: Are there additional market factors that tip the balance of negotiating power in favor of the Yale-New Haven Health System? The Intervenors' answer to this question is, "Yes."

Indeed, the applicants have signaled that eliminating competition may be one of the goals of their transaction, for example, by cancellation of the Lawrence + Memorial affiliation with the Dana-Farber Institute, Partners' best-known cancer hospital.

New research (for example, the Dafny, Ho and Lee paper included in those submitted by the Intervenor) has analyzed the impact of cross-market mergers on prices.[15] Their findings are as follows:

> *We find that hospitals gaining system members in-state (but not in the same geographic market) experience price increases of 6 – 10 percent relative to control hospitals, while hospitals gaining system members out-of-state exhibit no statistically significant changes in price. The former groups are likelier to share common customers and insurers. This effect remains sizeable even when the merging parties are located further than 90 minutes apart. The results suggest that cross-market, within-state hospital mergers appear to increase hospital systems' leverage when bargaining with insurers.*[16]

In summary, the proposed acquisition would appear to fit all of the criteria that Dafny, Ho and Lee find most closely associated with the risk of higher prices, that is, Yale-New Haven and Lawrence + Memorial occupy immediately contiguous markets, the anchor hospitals are less than 90 miles apart, they share common insurers who value both systems, and they share common customers who value both systems.

In fact, three of the organizations intervening in this transaction are themselves common customers of the two systems under these authors' definitions.

This research (Dafny, Ho, Lee) was presented at a conference organized by the Federal Trade Commission and the Department of Justice in February 2015. Dr. Noether, also a speaker at the conference, did not acknowledge this work in her pre-filed testimony. The weight of this paper, as well as the work of Cooper and Gaynor, makes clear that private sector pricing is the factor which best explains the continued unsustainable growth of U.S. health care costs.

Dr. Noether reflected some aspects of this issue in comments at the FTC/DoJ seminar[17] when she said that "patients who are using those hospitals don't overlap, and they're not going to travel

[15] Dafny, L., et al, "The Price Effects of Cross-Market Hospital Mergers," NBER, March 18, 2016
[16] Ibid, page 1
[17] FTC Workshop Transcript, February 25, 2015, page 117

from one market to another. On the other hand, if they're both employed- and Leemore Dafny mentioned this- by the same employer, and that employer is looking for a single payer to cover all of its employees, then maybe the customer in this case is the employer or the plan who is contracting with the employer. And you need to kind of think about the whole market definition a little bit differently."

Other Issues

Finally, with regard to the "companion" application concerning physicians, Dr. Noether indicated in the February 25, 2015 FTC conference[18] that "a lot of those questions are relevant within what we would normally consider a single geographic market, when you've got a system, and – is there a bundled or tying kind of issue. And it can also happen between hospitals and physicians for example as well." The potential for tie-in pricing—more services, more "linked services," at higher prices—would be the result.

Another issue not addressed in Dr. Noether's testimony is narrow networks and tiering, that is, the prospect that insurers would be compelled - - if these applications were approved - - to charge additional amounts for entry into the most favorable tier.

At the FTC/DoJ conference, Dr. Noether observes, "Of course, you need to have something that controls the providers from saying, you have to take me…But I think like in any kind of exclusive contract situation, if you've got competition to be part of that exclusive or narrow network, then that can certainly work."[19] She points to the effectiveness of these narrow networks "for price-sensitive customers where they're willing to forgo complete freedom of choice in return for having lower premiums." It isn't clear what Dr. Noether's advice would be to those in New London who, for reasons of insurance, transportation or socioeconomic immobility, would be unable to participate in the new networks.

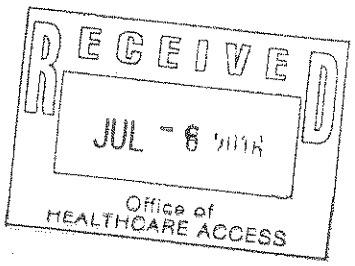
[18] Ibid, page 117
[19] Ibid, page 130

YALE NEW HAVEN HEALTH

LEGAL & RISK SERVICES DEPARTMENT

From:

☑ **YNHHS LRSD Location**
789 Howard Ave 2 Howe Street 3rd Floor
New Haven, CT 06519
203-688-6307
203-688-3324 (Fax)



☐ **YNNHH LRSD Location**
20 York Street Clinic Building – CB230
New Haven, CT 06519
203-688-2291 (Phone)
203-688-3162 (Fax)

Date: July 8th, 2016

To: Kevin Hansted
(Name)

State of CT, Dept. Public Health, Office of Health Care Access
(Organization)

860-418-7053
(Fax Number)

 # OF PAGES: (including this sheet): 3

SENT BY: Gianna Roberts on behalf of Jennifer Willcox

COMMENTS:

Please see the attached two (2) Notices of Appearance regarding Docket No's: 15-32033-CON
15-32032-CON

Thank you.
- Gianna Roberts

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE NEW HAVEN HEALTH SERVICES CORPORATION	:	Docket No. 15-32033-CON
	:	July 8, 2016

NOTICE OF APPEARANCE

Please enter the appearance of Jennifer Willcox of the Yale New Haven Health Legal and Risk Services Department on behalf of Yale-New Haven Health Services Corporation in the above entitled proceeding.

Respectfully Submitted,

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____

Jennifer Willcox
Jennifer.Willcox@ynnh.org
Deputy General Counsel
Yale New Haven Health
Legal and Risk Services Department
789 Howard Avenue
New Haven, CT 06510
Tel: 203-688-9966
Fax: 203-688-3162
Its Attorneys

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

IN THE MATTER OF THE	:	Docket No. 15-32032-CON
PROPOSAL FOR MERGER OF	:	
L&M PHYSICIAN ASSOCIATION, INC.	:	
AND NORTHEAST MEDICAL GROUP, INC.	:	July 8, 2016

NOTICE OF APPEARANCE

Please enter the appearance of Jennifer Willcox of the Yale New Haven Health Legal and Risk Services Department on behalf of Northeast Medical Group, Inc., in the above entitled proceeding.

Respectfully Submitted,

NORTHEAST MEDICAL GROUP, INC.

By: _____

Jennifer Willcox
Jennifer.Willcox@ynhh.org
Deputy General Counsel
Yale New Haven Health
Legal and Risk Services Department
789 Howard Avenue
New Haven, CT 06510
Tel: 203-688-9966
Fax: 203-688-3162
Its Attorneys

Greer, Leslie

From: Martone, Kim
Sent: Monday, July 11, 2016 10:05 AM
To: Riggott, Kaila; Carney, Brian
Cc: Greer, Leslie
Subject: FW: Intervenor Pre-file
Attachments: ohca maritza bond testimony_20160711095928164.pdf

Importance: High

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Henry F. Murray [mailto:hfmurray@lapm.org]
Sent: Monday, July 11, 2016 10:05 AM
To: Hansted, Kevin; Martone, Kim; Lazarus, Steven
Cc: jfeldman@goodwin.com
Subject: Intervenor Pre-file
Importance: High

Please see attached letter and brief two-page pre-file testimony of Maritza Bond that was inadvertently not included in the Intervenor's pre-file testimony on July 1.

Hank Murray

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

LAW OFFICES

LIVINGSTON, ADLER, PULDA, MEIKLEJOHN & KELLY, P.C.

557 PROSPECT AVENUE • HARTFORD, CONNECTICUT 06105-2922

TELEPHONE: (860) 233-9821 • FAX (860) 232-7818

WWW.LAPM.ORG

C-126

DANIEL E. LIVINGSTON
GREGG D. ADLER
THOMAS W. MEIKLEJOHN
MARY E. KELLY
HENRY F. MURRAY
NICOLE M. ROTHGEB*

OF COUNSEL
PETER GOSELIN

*ALSO ADMITTED IN MASSACHUSETTS

RUTH L. PULDA
1955-2008

WRITER'S DIRECT DIAL:
(860) 570-4635
EMAIL:hfmurray@lapm.org

July 11, 2016

Via Email and Hand Delivery

Kimberly Martone, Director of Operations
Kevin Hansted, Hearing Officer
Office of Health Care Access
Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, CT 06106

Re: Certificate of Need Applications,
OHCA Docket No. 15-32032-CON, Merger of L & M Physicians Association and Northeast Medical Group, Inc. and,
OHCA Docket No. 15-32033-CON, Affiliation of Lawrence & Memorial Corporation and Yale New Haven Health Services Corporation

Dear Ms. Martone and Mr. Hansted:

Attached please find the pre-file testimony of Maritza Bond, Executive Director of Eastern Connecticut Health Education Centers. Ms. Bond's testimony was inadvertently left out of the Intervenor's pre-file testimony submitted on July 1, 2016. We ask that OHCA accept the testimony. Ms. Bond is prepared to adopt this pre-file testimony at today's hearing or submit it at that time. Thank you.

Very truly yours,

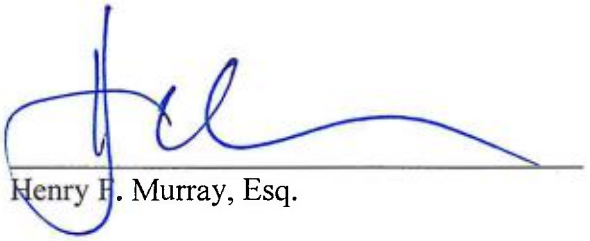
Henry F. Murray

HFM:vds
Enclosure

CERTIFICATION

This certifies that the foregoing was sent via email July11, 2016, to the following counsel of record:

Joan W. Feldman, Esq.
SHIPMAN & GOODWIN LLP
One Constitution Plaza
Hartford, CT 06103-1919
jfeldman@goodwin.com



Henry F. Murray, Esq.

Mailing address:

AHEC Eastern Connecticut

Eastern Area Health Education Ctrs.
Eastern AHEC, Inc.
165 State Street, Suite 313
New London, CT 06320
Phone: 860-465-8281
Fax: 860-724-2568
www.easternctahec.org

Eastern Area Health Education Ctrs.
Eastern AHEC, Inc.
872 Main Street, Lower Level
Willimantic, CT 06226
Phone: 860-465-8281
Fax: 860-724-2568
www.easternctahec.org

TO: Kimberly Martone, Director, Office of Healthcare Access
Kevin Hansted, Hearing Officer

RE: Proposed Yale New Haven (YNH) acquisition of L+M Hospital, OHCA Docket #15-32032, and 32033

DATE: July 1, 2016

Dear Ms. Martone and Mr. Hansted,

As a local nonprofit organization who implements programs that aim to *enhance access to culturally and linguistically appropriate healthcare education and increase the diversity, quality, and distribution of future healthcare professionals within Eastern Connecticut*, I urge your agency to take the necessary steps to ensure that communities of New London County will not be negatively affected by the proposed Yale and Lawrence & Memorial Hospital merger. This community is primarily comprised of low socioeconomic status' including veterans and urban Hispanic residents who are primarily Spanish speaking. Regionalizing healthcare is not an adequate means to quality and equitable care.

Reducing, eliminating, our outsourcing health services is detrimental to communities' ability to access adequate and timely care, impact our health care workforce, and worsen health disparities among underserved communities. In Windham, we are already experiencing the impact of what can occur when hospital services are reduced following a merger. This past fall, a woman in her early 50s, with limited English proficiency suffered a minor stroke. When transported to Windham Hospital, the family was told they could not provide the care she needed because they did not have a neurologist on site. Instead, the woman was put in a Life Star helicopter and transported to Hartford Hospital. Thankfully, this woman's story didn't end tragically. The community in Windham County deserves quality health care that is delivered in a culturally and linguistic appropriate manner. Transporting patients to facilities over 30 minutes away can be catastrophic. In particular, the ability for ambulatory care to effectively communicate with patients that experience language barriers is nonexistent. With the CCU closed, patients are traveling long distances by ambulance, private car or even helicopter for urgently needed care that used to be available at Windham.

I raise this issue because when Hartford HealthCare bought Windham their application strongly suggested that they would not reduce services. Windham selling out to Hartford was supposed to "increase the services and technology offered locally," and to "decrease the out-migration of patients."[i] Hartford also said that "currently they will not be terminating any services." But they also left the door open to reducing "duplicate" services. At the end, Hartford's original CON was filled with broken promises.

Now, Yale is using almost identical language. We're told the acquisition will bring expanded access to clinical programs, and that there are no "planned" reductions in services. But we're also told that there may be a need to reduce "duplicate" services. Again, no guarantees, no real commitments.

It is critical your department carefully reviews this upcoming merger to ensure that communities within New London county's health are not compromised. Thank you for the opportunity to submit public comment for the Health Care cabinet meeting. If you wish to discuss the detrimental impact hospital mergers, call (860) 465-8281 ext. 402 or bond@easternctahec.org

Thank you for your consideration.

Sincerely,

M. Bond

Maritza Bond
Executive Director

[i] Office of Health Care Access, Certificate of Need Application, Final Decision. "Integration of Windham Community Memorial Hospital, Inc., into Hartford Health Care Corporation, Inc." p. 6-7.

Greer, Leslie

From: Rosana Garcia <rgarcia@universalhealthct.org>
Sent: Monday, July 11, 2016 1:07 PM
To: User, OHCA
Cc: Lazarus, Steven; Frances Padilla; Jill Zorn; Lynne Ide; Adam Chiara; Stephanye Clarke
Subject: Public Comment for CON Hearing on L+M & Yale (Dockets 15-32032-CON & 15-32033-CON)
Attachments: FINAL - L+M & YNHHS July 11 2016 Testimony (UHCF).pdf

To: Office of Health Care Access
From: Universal Health Care Foundation of Connecticut
Date: July 11, 2016
Re: Public Comment for CON Hearing on L+M & Yale (Dockets 15-32032-CON & 15-32033-CON)

Please see attached (and text inline below) for Universal Health Care Foundation of Connecticut's testimony in regards to the CON Hearing on L+M & Yale (Dockets 15-32032-CON & 15-32033-CON).

Thank you,

Rosana Garcia | **Policy Associate**
Universal Health Care Foundation of Connecticut
203.639.0550 ext. 314 | rgarcia@universalhealthct.org
290 Pratt Street, Meriden, CT 06450

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UNIVERSAL HEALTH CARE
FOUNDATION OF CONNECTICUT

Testimony Concerning the L+M Hospital / Yale New Haven Health System Proposed Deal
Frances G. Padilla, President
Universal Health Care Foundation of Connecticut
July 11, 2016

Like politics, all health care is local. This is even truer in Connecticut, with our 169 towns and municipalities, and our parochial attitudes about local control. Health care is also intensely personal.

The Office of Health Care Access (OHCA) has an enormous responsibility in reviewing Certificate of Need applications, especially ones such as this, where one health system and medical group (L+M Hospital & Medical Group) is proposing to affiliate with another, larger, system (Yale New Haven Health & Northeast Medical Group).

As this Certificate of Need application is reviewed, it is important to consider the both parties' answers to the following questions:

- How will this affiliation between L + M and YNHHS help the greater New London community?
- How will the city of New London and its surrounding region be better off in terms of health care services, health outcomes, employment, and the social determinants of health?
- How will Lawrence and Memorial Hospital's ability to meet its mission and serve its community be strengthened?
- How will L + M remain connected to its community as a resource for health and health care?

We ask that OHCA consider the conditions urged by local residents and leaders. L + M and Yale must not only listen to the community, but satisfactorily demonstrate that they are addressing the concerns underlying the proposed conditions. The community has serious concerns about this proposed deal. As L + M should ultimately be accountable to the people and community it serves, this community deserves measures in place to directly address their concerns.

- Members of the community are worried they may lose essential services like behavioral and reproductive health. Where will decision-making about service elimination or addition reside, in the local community, informed by local priority needs and members of the community, or in the board room in New Haven?
- Population health should be the driving force behind affiliations and mergers, and OHCA's decision-making. Hospitals should use local health needs assessments as a roadmap for improved community health. Accountability should be built into any approval, so that the hospital(s) must demonstrate clearly and publicly what they have done to make a positive difference in the priorities identified by the needs assessment.
- Health care in Connecticut is unaffordable to many, many people. Hospital costs are a big part of this. How will affiliation demonstrably address affordability to the patient?
- Lower income people, the elderly, families with only one car, and others, struggle with transportation in Connecticut. Public transportation is unreliable. Auto insurance is expensive, particularly in low income urban areas. Health care reform has shifted delivery of care from inpatient to outpatient, often requiring travel and reliable supports to get you back and forth from procedures and appointments. Providing financial support for creative transportation solutions (in the short-term) and using hospitals' lobbying influence for improved public transportation should become an integral component of "community benefit." Moreover, accessibility to the target population must be a prime consideration of locational decisions.
- Local people do not trust that these institutions have their interests at heart. It is incumbent on the institutions to acknowledge and genuinely address this mistrust. Whether affiliated or merged, every hospital should have a robust local board of directors with true governance power. In L + M's case, their governing board must also be able to effectively influence the YNHHS board and not merely have an insignificant seat at the table. Moreover, the local hospital board should be accountable to an independent community body for demonstrated results on community benefit, progress on local needs assessment priorities and hospital financial stability. That independent community body should represent a cross-section of the public, private, nonprofit and resident population of the community.

SENATOR MARTIN M. LOONEY
PRESIDENT PRO TEMPORE

Eleventh District
New Haven, Hamden & North Haven

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591

132 Fort Hale Road
New Haven, Connecticut 06512

Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420

www.SenatorLooney.cga.ct.gov

July 7, 2016

Hon. George Jepsen
Attorney General, State of Connecticut
55 Elm St.
Hartford CT 06106

Hon. Dr. Raul Pino
Commissioner of Public Health
410 Capitol Ave., P.O Box 340308
Hartford, CT 06134

Dear Attorney General Jepsen and Commissioner Pino:

When the two applications were filed in regard to the affiliation between Yale New-Haven and Lawrence and Memorial, I (as well as several other legislators) urged OHCA not to proceed on the applications unless it was able to review both comparative prices between L+M and the Yale-New Haven System Hospitals, and prices at St. Raphael's, Bridgeport and Greenwich Hospitals before and after Yale-New Haven's acquisition of those facilities. I was pleased that OHCA in fact requested this data. Since that time, the Governor issued Executive Order 51 which creates a task force on Certificate of Need and restricts OHCA's ability to allow mergers and acquisitions until the Task Force has made its recommendations.

The Executive Order, among other things, seeks to "coordinate the state's regulatory oversight of its health care delivery systems with the broader goals of maintaining open, transparent, and competitive health care markets in the state that enhance access and quality of care and improve affordability without losing sight of the economic development impact of the hospital systems." These goals are impossible without access to hospital pricing and other hospital data. It is my understanding that Yale-New Haven has refused to provide the requested information and is claiming that risk adjusted prices do not exist, and that if they did exist, YNHH would refuse to provide them because they are proprietary. The claim that the data does not exist lacks credibility. Without such data, OHCA cannot achieve the goals of the Executive order and cannot plausibly find that the Applicant "has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care," as required by section 19a-639 (a)(12), in effect as of the date of the applications.

It would appear that under the terms of the Governor's Executive Order 51 OHCA could not decide either case until at least January 15, 2017 or it would be required to deny the applications if the statutory calendar requires a decision prior to that time. Regardless of the outcome of the Governor's Task Force, I believe that OHCA should not approve these applications at any point in the absence of credible price data. PA 14-168 and PA 15-146 strengthened the standards for review of the impact of the change of ownership of health systems, hospitals and physician practices to ensure that transactions like these by our state's biggest market actors are scrutinized to protect patients in terms of cost, quality and provider choice. This proposed merger would have an extraordinary effect on our health care system and the state must ensure that any allowed merger is in the best interests of our citizens.

Sincerely,

Martin M. Looney

Martin M. Looney
State Senate President Pro Tempore

State of Connecticut
SENATE

SENATOR PAUL FORMICA
TWENTIETH SENATE DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
CAPITOL: (800) 842-1421
E-MAIL: Paul.Formica@cga.ct.gov
WEBSITE: www.SenatorFormica.com

SENATE MINORITY WHIP

RANKING MEMBER
ENERGY & TECHNOLOGY COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
PUBLIC SAFETY COMMITTEE

July 11, 2016

To whom it may concern;

I write in my role as the State Senator of the 20th Senatorial District, which includes the main campus of the Lawrence and Memorial Healthcare System infrastructure in New London and its Cancer Center in Waterford.

The States position regarding funding cuts and excessive taxes on healthcare and hospitals in particular, have created an extraordinarily difficult problem for hospitals in our state.

Hospitals provide crucial health and related services to its local community, are large job creators with a highly skilled and trained workforce and attempt to do so in an industry that already faces many challenging and complex problems. The need to create efficiencies that result in service improvements and fiscal stability has seen many permitted mergers, affiliations and acquisitions here in Connecticut including 25 of our states 28 hospitals.

The proposed affiliation between Yale and L/M is being structured as an affiliation rather than a takeover or a merger in an effort to preserve its local identity in both of the communities in which they serve.

There are always concerns when service providers of any nature get larger; and hospitals are no exceptions. The need to preserve existing jobs to the extent possible by maintaining access and affordability to all the current services provided in both markets are of great concern. This seems to be addressed here as these two systems already have 6 clinical affiliations that work well and compliment each other while providing an expanded service portfolio to SE CT. Though there may be efficiencies created that combine some departments, there are assurances that the existing negotiated union agreements will continue. In addition, the infusion of a multi-million dollar capital investment and access to Yale's advanced technology would indicate a long term stabilizing win for L/M and our region.

If this affiliation were to be approved, I remain confident in the long term viability of L/M: that they will be able to continue to be locally controlled and managed with jobs sustained and services that remain both affordable and convenient to our residents. It is for these reasons I express my strong support.

Additionally I would offer to participate and/or facilitate in any discussions that work to satisfy those affected by this affiliation.

On a personal note my family has had the benefit one of L/M's partnerships with Yale. My wife was in need of complex cardiac care that resulted in trips to New Haven for treatments of a more specialized nature. We were grateful for that opportunity.

Thank you for your thoughtful service and for considering my comments.

Paul M Formica
State Senator
20th District

July 19, 2016

Ms. Kim Martone
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

To Whom It May Concern:

I write today to strongly support the proposed affiliation between L&M/Westerly Hospitals and Yale New Haven Health System. As a member of the local community, I have personally witnessed the extraordinary work performed at L&M for friends, coworkers, and family members. As president of a local community bank that serves the same market area as L&M and Westerly, I have personally witnessed the tremendous impact the hospitals have on our local community, both economically and socially. As a member and officer of the L&M Healthcare's Board of Directors, I have witnessed personally the impact of changes in the national and in-state healthcare environment at large on our hospitals, and believe strongly that the key to our success in the future is through this affiliation.

I cannot put into words how impressed I have been with everyone I have come into contact with at L&M and Westerly hospitals. They are professional, compassionate, and innovative. They are dedicated first and foremost to their patients. In spite of their extraordinary efforts, the forces of change in healthcare that they face every day are such that going it alone seems impossible. I believe that the combination of two well-managed, locally focused hospitals, with access to the talent and resources available to a world-class organization like Yale New Haven Health is a powerful combination and a role model for the future of healthcare.

I strongly urge you to approve this affiliation as soon as possible to help strengthen our local healthcare system and our community.

Sincerely yours,

B. Michael Rauh, Jr.
Resident of Mystic, CT
President & CEO, Chelsea Groton Bank
Secretary/Treasurer, L&M Healthcare

July 20, 2016

Ms. Kimberly Martone, Director
Mr. Kevin Harsted, Hearing Officer
Office of Health Care Access
410 Capital Avenue
Hartford, CT 06106

Reference: Certificate of Need Application, Docket # 15-32032 & Docket # 15-32033; Yale NH Affiliation

Dear Ms. Martone/Mr. Harnsted,

Lawrence & Memorial and Yale New Haven Hospital deserve great respect for what they do. I know many doctors who have provided extraordinary service and I know of many patients who have received extraordinary service from L & M and Yale NH. This should be the most important thing to continue because we can't live without it.

Having said that, there is great concern in modern economics about health care. I have been following health care since I wrote my thesis in 1973 – that thesis was on the unsustainable inflation in health care cost. At that time however, the concerns in economics did not include the impact we are living with today, of the loss of some 60,000 manufacturing facilities nationwide, thousands in Connecticut. The modern problem of not being able to pay our current health care bills has been severely compounded by the loss of these factories, where growth in income has lagged way behind growth in health care expense. Robert Kraft, the billionaire owner of the Patriots, in advocating for a Casino in Foxboro, spoke of the cultural changes resulting from closed factories, where a person once could get a job, buy a house, and join a community forever. Those days, he lamented, are gone with the hope a casino that can't be moved overseas, might replace some of that. Paul Krugman, the noted Princeton economist, has stated the continued extreme growth in health care expense will bankrupt this country.

While this is not the focus of this application, this awareness should present to local officials that how we manage health care going forward is critical and this affiliation could be critical in that as we deal in total with the cost of health care, this affiliation could result in the loss of L & M altogether. Why? Should we become part of Yale NH and they are forced to cut service, you can imagine they would cut services in Southeastern CT first.

With the above in mind, I want to make the following suggestions that reflect the thoughts of many, and would help to improve the confidence that this merger currently lacks:

1) The affiliation needs to include and give authority to a community Board of Directors governing L & M alone. The current L&M Bylaw changes give Yale NH Health total authority over L&M including the right to control the Board by having the right to provide and therefore control the list from which Board Members can be elected.
2) The Board of Directors should be defined by the State and should have authority over the actions of L&M even if the affiliation is approved. We cannot have a Board that can legally serve only the self-interest of the administration or Yale NH. Therefore a Board must include the

Administrator, Doctors, Employee representatives and Community members. The community members should be representatives from the Towns primarily served by the hospital as they have a very strong interest in making sure the hospital provides full and quality service at prices that reflect the local economy. The Board should also include an expert representative from the State since they represent the primary funding source.

3) The current administration and Board should recuse themselves from the negotiation to improve confidence.
4) Our Southeast Connecticut community needs the services and employment of L & M. This need includes the Doctors, administrators, nurses and technicians in full. We cannot afford transfer of services and employment to Yale NH.
5) The hospital needs to include the community need as its primary goal as with or without the merger - it is a basic need that we can't live without. Whether it returns to being a community based hospital or not, it will serve basic community needs without which it cannot and would not exist.
6) L & M assets total hundreds of millions of dollars that should not be turned over to Yale without restrictions that would return the assets to the community should Yale NH be found not to be serving the interests of the Southeast CT community.
7) Surplus funds created through operations should be returned to the community in the form of reduced rates, development of assets in the community, or other benefits approved by the Board.
8) The need to affiliate has not been proven. There is no evidence that supports any conclusion that L&M is losing money.

This affiliation represents a great risk of the loss of assets built over many years and loss of service and employment in Southeastern CT. Yale NH was written up in a Time magazine article titled 'Why Medical Bills are Killing Us' where they were included as a not-for-profit hospital, behaving as 'for profit', running up the bills and rewarding administrators much like a Wall Street corporation. Last count there were nine Yale NH administrators making over $1 million a year.

Oddly many of the comments I have heard from people who have worked with L&M for decades suggest the current L & M administration has been behaving in the same manner as Yale NH administration. This country cannot afford to have the bills run up any more. The middle income group has suffered tremendous income loss due to the competition of cheap foreign labor based on favorable and sometimes manipulated currency exchange rates. While the banking industry is strong in NYC, and that has indirectly benefitted southwestern CT, the vast majority of middle income workers nationwide have suffered extremely and that includes Southeastern CT. As an example of this I can point to the small government entity I work for where our health insurance cost has gone from $30,000 per month in 2008 to $71,000 in 2017, over 200% growth. At the same time annual wage increases averaged just 3% and mostly covered the increase in the employee share of the health insurance premium. This is repeated in every town, every business, and is very much the reason for the unstable budgeting our state is suffering. If you do the math where will we be in another 8 years.

I hope the regional New London community will recognize the need to be proactive in protecting Southeastern Connecticut's very important asset, and with that in mind request the L &M / Yale NH affiliation be disapproved.

Sincerely,

Alfred Fritzsche
15 Ice House Lane
Mystic, CT 06355
860-984-8338
afritzsche4@gmail.com

Sheila Oddi
310 Boston Post Rd #38
Waterford, CT 06385-1965
(860) 941-4093
July 22, 2016

Kimberly Martone
Office of Healthcare Access,
Dept. of Public Health
410 Capital Ave. MS. #13 HCA
P.O. BOX 340308
Hartford, CT 06134-0308

Dear Ms. Martone,

I am writing to you concerning the proposed merger/affiliation of L+M Hospital and Yale-New Haven Health system. Please excuse that this letter is hand-written, as I am penniless and have no computer access.

You ABSOLUTELY CANNOT allow this merger to happen and this is why: It will only make what they did to me even easier for them to do to others. I was a victim of diabolical medical malpractice and horrific patient abuse that occurred at both hospitals and was deliberately covered up by everyone involved. The lawyer I went to, Beth Hogan, failed to inform me that she was on L+M's corporate board and therefore had a conflict of interest. She pretended to take my case while actually working for the

other side, actually helping to make sure they would never get sued. They "cleaned-up" my medical records and threw away anything that could ever be used against them. Meanwhile, I could not get ANY follow-up care because I had become a "hot potato," no doctor connected with L+M would have anything to do with me. I am a medicaid patient, I am assigned to an area and can only go to the doctors in that area and connected to that area hospital. Their refusal to help me resulted in further malpractice including the development of multiple, progressive neurological conditions, one of which will eventually cause me to lose the use of my hands, arms, legs, lose control of bladder and bowels, and eventually work its way up my spinal nerve and shut down my breathing and kill me. To this day it is still not being properly treated because they don't want to admit it is caused by the two feet of bent, crooked, twisted rods in my spine. For about 12 or 13 years no doctor would even lift up the back of my shirt and LOOK at it no matter what symptoms I complained of, they just prescribed more narcotic pain pills even though they were already prescribing WAY beyond the prescribing guidelines. They would not send me to any specialists or order any tests even when I developed VERY RAPIDLY progressing neurological symptoms* because

* including trouble breathing

they did not want to generate any evidence. They were hoping I would overdose on opiates because only then would THEIR problem go away. I did not.

Beth Hogan waited out the two years of pretending to be my lawyer and then mailed me a letter saying she has decided not to take the case, with no explanation. This of course left me no time to get another lawyer. Incidentally, she is now running for State representative. A true politician indeed, since her illegal actions are costing the taxpayers ALOT of money due to the fact that I now continue to qualify for medicaid, food stamps, (housing voucher, too, but lost that because nobody in this state can do their job correctly) and the extra malpractice is driving up the cost of my healthcare for the rest of my life.

She overlooked one detail: because she prevented a lawsuit, I never signed a non-disclosure agreement. Interesting. Very... (For the hospitals, it was never really about the money, it was about preventing the bad publicity from getting out. I wonder if they still care about that?)

To fully understand the gravity of the situation, you need to know the extent of my injuries and exactly what the mal practice and abuse was, and the toll it has taken.

The car accident resulted in a major concussion, several broken ribs, lung injury, temporarily paralyzed left arm due to a brachial plexus injury (doctors said it would be completely healed in about one year), and approximately 12 spinal fractures including a broken neck. At L+M they were not following proper procedures at all, re-injured my shoulder and now it will never fully heal. My shoulder is permanantly partialy paralyzed, and although I have use of my hand and arm (due to extensive physical therapy) it is very painful and weak and will deteriorate.

At Yale they put two feet of bent, crooked, twisted rods in my spine. Rods are literally poking right out of my back. After I was awoken from the surgery I spent two days without any pain medication because they put the button for the pain meds in my paralyzed hand, did not tell me about it, and I could not look because of the neck brace. I kept complaining of excruciating pain but they would not do anything about it.* Next the brace specialist brought the back brace, telling me, "This is for physical therapy next week, try it on to make sure it fits," but he forgot to bring the tools to adjust it. He put it on me anyway. It shoved my head Ten inches too far forwards injuring my broken neck (this is why I now have CONSTANT migraines). Then he told me to tell the nurse to remove the brace

* then I would pass out from the pain. Repeatedly this happened.

and change me back into the neck brace and he left. The nurse refused to do that and proceeded to literally TORTURE me for the next six, or seven hours or so, so severely that I now have PTSD. She even claimed that because I asked her to remove the brace that I was supposedly trying to harm myself, using that as an excuse to HANDCUFF me to the bed. I literally thought I died and went to hell. None of this is in my records because they realized they were wrong by morning, when her shift ended and the doctors showed up and asked why I was wearing a physical therapy brace in bed* when I don't start PT until next week - just like I had been saying all night, she just wouldn't listen because she was too busy TORTURING me.

(I'm just giving you the highlights, a lot more bad things happened, but you get the idea).

After being released from Yale I could not get follow-up care. At one doctor's office, Dr. Radin, in New London, where I was to have x-rays because the neck bone was so close to the nerve it could paralyze me from the neck down and I would die from not breathing - I was turned away. They said, "You're not his patient, he's not your doctor, you have to leave." Dr. Kelly, also of NL, refused to operate on a bunion even though I explained three times that it was interfering with my

*PT brace is NOT supposed to be worn lying down, in bed.

ability to do physical therapy for my arm because they were all standing resistance excersizes with excersize bands, and because my toes are completely crossed I would just wobble and fall over. He got up and walked out while I was mid-sentence. Some of the metal in my back stuck out so far I would actually knock things off of shelves behind me with them! that actually happened numerous times. The rods should have been taken out within a year or so of putting them in but these people did not want any other doctor to see what had been done for fear I would go to another lawyer. So they colluded to cover it all up. More than a dozen years later I went to a surgeon at L+M, Dr. Samuels, and she claimed removing the rods wouldn't help me. She did everything she could to talk circles around me.

Recently I went to a GOOD surgeon, Dr. Paonessa, at Backus Hospital, who DID perform another surgergy on my back. There was a long delay in even scheduling the surgery because we could not get the records we needed from Yale Hospital. Dr. Paonessa had to guess at which set of tools to use to remove the rods because Yale destroyed my records because they did not want to get sued, and consequently we could not get the right tools. Some of what is in my back, the worst of it, cannot be removed because we cannot identify the manufacturer of the

tools we need to do it, and the original surgeon refuses to return his calls. Some of the metal cannot be removed because so much time has passed that bone has grown over it and now it is too late. Bone will eventually grow over the rest as well if that first doctor never tells us what we need to know. My fate is already sealed.

Before this happened, I was working as a proffessional seamstress and hairdresser, had tons hobbies, grew apple trees from seed, had a social life, wanted to volunteer at animal shelters, could bake the best christmas cookies and cakes ever, and was about to start teaching bellydance. Now I am permanently disabled, weigh 88 pounds, live on about $8,000 a year, take 16 different prescriptions, can't afford to buy food or anything else, have constant migraines, insomnia, nightmares, agonizing pain, two kinds of progressive neuropathy, my digestive system no longer works because of both the neuropathy and because I have been on narcotic pain drugs for 15 years, have depression, anxiety, and PTSD, and I'm not even going to include all the other medical problems I had before this.

Please, I am begging you, do not let them do this to anyone else. I have met DOZENS of other people who told me, "They did the same thing to me!" This is actually the root cause of the heroin epidemic - it starts with an injury or bad surgery and some type of medical malpractice which is ALWAYS

covered up because they dont want to get sued. They don't want the bad publicity and whoever screwed up does not want to be held responsible and lose their job. Better to cause still more suffering to the innocent victim than **have the guilty be held responsible**, right? It's not like it's costing society untold BILLIONS of dollars or anything. EXcept that it IS. Will anyone EVER do the right thing?

It's too late for me, I'm already going to die because of what those monsters did to me just because they did not want to be held accountable for their actions, but remember this could happen to ANYONE,* ANYTIME they enter ANY hospital for ANYTHING.

If L+M and Yale are merged, it will only be easier for them to do this, and shut people out of follow-up care like they did to me. Please don't let them do that.

Sincerely,

Sheila Oddi

P.S. It's too bad no one will ever be held accountable for what they did to me, at least, not until they die and go to Hell for all eternity - and they surely will.

*but it is much MORE Likely to happen to THE POOR. They know we have NO Rights, NO recourse: because I have no internet access, no one has heard my story. YET.

June 17, 2016

Written Testimony Concerning Lawrence and Memorial Hospital and Yale New Haven Hospital Merger

To Whom It May Concern:

I am submitting testimony today to express my concern about the Lawrence and Memorial Hospital and Yale New Haven Hospital takeover. I am very concerned with the cost of care and how it will affect New London County, if this merger happens. Also, I have my own personal concerns on this matter.

I am concerned with the Yale New Haven Hospital Administration's practice of placing liens on client's homes for nonpayment of medical bills. Yale New Haven Hospital is a very profitable. I would prefer seeing this hospital focus its attention on working with its clients to create manageable budget plans. Many people in New Haven County have lost their homes for nonpayment. We do not want to see people in New London County losing their homes over nonpayment of medical bills.

I have worked at Lawrence and Memorial Hospital as a Registered Nurse for almost thirty years and have seen many positive changes. However, I have also seen many changes in business practices recently to cut costs to benefit upper management's salaries, while the workers and patients suffer. I believe this will be the case if there is a merger. Many thoughts are going through my mind regarding this possible merger. Will this merger bring less autonomy to the community hospital administration to effect decisions in the boardroom? Will the administration and local unions have less power to affect change in the workplace? I am very concerned with the quality of bedside care for my patients as well as my own financial future and future retirement opportunities as a result of this merger.

The outcome of this merger is not only important to me personally and professionally, but it will have a dramatic impact to the community in New London County. This is why I am passionate about being involved to create the best possible outcome for everyone in this area. Thank you for allowing me to share my testimony.

Sincerely,

Christina Chapman

Christina Chapman, RN, BSN, CRRN

7/26/16

L&M/Yale Merger Public Hearing

Dear Attorney Hanstead,

I am respectfully writing to you as a representative of Riverfront Children's Center, Inc. which is a non-profit child care program in Groton, CT. We have been following the merger on behalf of our 144 clients, and have a few concerns regarding the effects that a merger between Yale and L&M could have on our region.

L&M recently merged with Westerly Hospital, so that if Yale merged with L&M, all the Hospitals from New Haven up the coastline and into RI would be run by 1 entity. My experience with centralization is it causes a kind of monopoly on services. Thus, with no local competition for pricing, the cost generally goes up to consumers. Our concern with that is that the majority of our low to middle income clients (144 children) use the emergency room as their primary care medical home. A needs assessment study was recently done I believe by Ledge Light Health District and L&M Hospital and when I attended the meeting summarizing the findings of that report, it showed that a higher proportion of SECT families were seeking their primary care directly at the ER than anywhere else in the state. With many clients going off of HUSKY August 1, 2016 (especially parents), we fear that they will no longer get the health care they need and put off preventative care because of rising costs. With behavioral mental health and adult mental health in the high level of crisis that it is already in for our region, we fear that the outcome would be disastrous if the costs of medical care became prohibitive to our clients. Even small increases would prevent them from seeking care once they are off HUSKY.

In addition, we have noticed that in the past 2 years that more and more of the children and elderly needing medical care at L&M have had to be sent to Yale, CCMC, Hartford Hospital or another larger hospital more than 1 hour away for their care for things that might have previously been handled locally at less of a stress on the children and families. Personally, we were almost sent to Hartford for our daughter's broken arm because there may not have been a children's specialist available that day. After already driving to L&M by ambulance, we were lucky that the specialist was available, because our child suffers from high anxiety and would not have done well with an additional hour long transport after sitting with a broken arm for 2 hours. It is a concern that with the merger, more patients will be transported to the larger hospital hubs and fewer personnel (especially specialists) will be here locally at the L&M facilities. That could also mean lost jobs and economic impact that would hurt our clients who fill the roles of the service industry locally.

Overall, though we acknowledge that there could also be benefits from a merger such as this, we fear that the negative impacts will far outweigh the positives for our clients specifically. They are already marginalized, and barely making it by from day to day. Any increases in stress, costs or decreases in their health care would be highly detrimental to their overall life outcomes.

Sincerely,

Susan Corrice

Executive Director

The Riverfront Children's Center, Inc.

869-445-8151

476 Thames Street

Groton, CT 06340

Testimony
July 25, 2016

Dear Attorney Hansted:

My name is Susan Goldman. I have lived in Norwich for 27 years. I am a retiree member of AFSCME (local 2422), and I recently retired from my position as Program Assistant at the city of Norwich Office of Community Development where we administered all of the HUD grant funds.

I want to express my strong opposition to the Yale New Haven – L+M Hospital acquisition as currently proposed.

The City of Norwich, and many of its surrounding communities, are already experiencing significant economic challenges, with municipalities faced with eliminating core human service programs due to budget constraints, residents having difficulties securing good jobs, decent housing and putting food on the table. These issues are real, for families not only from traditionally "low-income" families, but are impacting a growing number of people further along the income spectrum. A few years ago, the United Way released a report on ALICE Households- an acronym for Asset Limited Income Constrained Employed families—powerfully illustrating the challenge for both low income and moderate income families. These families earn more than the US Poverty level, but less than the basic cost of ling for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs. In New London County, out of a population of 105,801 there are 36,681 households struggling with providing basic human needs for their families.

It is within this context that I urge OCHA to be vigilant in their approval of this proposed acquisition. Yale New Haven Hospital and L+M Hospital are vital, critical community institutions providing essential services to the whole of the population residing within their service area. If there are significant changes/increases on cost and prices, access to essential health care services, loss of local control or an overall decline in our community's access to basic services, the impact on an already struggling population could be devastating.

Cost & Price:

It is my understanding that if and when this acquisition goes through, Yale New Haven will have 80% of the market share within the L& M service area. Studies show with this kind of market share, prices increase by at least 20%. This would severely impact access to health care services for a very large percentage of our population. Despite request by legislative and executive branch officials for data on impact of previous mergers on cost & pricing, YNHH has not provided this data. If there is no data, OHCA –given its charge and mission to protect consumers from rising health care costs--cannot reasonably or responsibly approve this proposal.

Local Control:

While YNHH & L+M have both claimed that full control of decision making would remain with the local board, recent review of the proposed by-laws reveal that YNHH would assume that power and authority. This revelation undermines Yale's veracity and commitment to engage in authentic and transparent negotiations with the community.

Local Access to Health Care Services:

What happened at Windham Hospital, through the decisions made by its parent company- Hartford Health Care, has had a chilling impact on many members of this community. We do not want our community hospital to be another Windham. YNHH and L+M must provide concrete guarantees to OHCA, to elected leaders and to community members that local access to health care services will not be impacted by this acquisition.

Accountability:

These vital issues require a signed, legally enforceable community benefits agreement between Yale New Haven and a broad cross-section of our community before we can even consider allowing control of our community hospital to change.

June 16,2016

To whom it may concern,

My name is Victoria Longo , I grew up in New London and have lived in New London. I presently live in Uncasville,Ct. I am a registered nurse and have been employed at Lawrence and Memorial hospital for 35 years.

The hospital has been a fixture in our shoreline community for over100 years, not only do I work there but all of my family members have been patient 's at the hospital at one time or another. Since we are a fairly small town I have seen familiar faces all the time using the services at our local hospital. For many people it is very comforting to see familiar faces when they come into the hospital and to know that while they are at the hospital they are still close to home.

I am cautiously optimistic about our pending affiliation with Yale New Haven Hospital.... I know that in the ever changing healthcare atmosphere certain changes have to be made. However I do not want these changes to be made at the expense of our employees,community, and our local hospital . I am concerned about access to care if services get moved closer to New Haven, and I am also concerned about the cost of procedures etc. going higher because of our affiliation with a larger hospital; as everyone knows healthcare is already very expensive. Our employees are dedicated hard working people who deserve to work for an employer that respects each and everyone of them and values them.

Thank you all for your consideration on the very important matter, I'm sure we all want to do what is in the best interest of everyone involved.

Respectively submitted ,
Victoria Long

Mary Ellen Masciale
Secretary, Local 5051 L+M Hospital LPN/Technical Employee Union
Long term employee in Neurodiagnostics Lab for 26 years
Live with my family in New London, with other relatives in Waterford and East Lyme

Thank you for allowing me to be heard. I am terrified of public speaking, so this is something I feel very strongly and deeply about or I wouldn't be here this evening! I have some concerns about this affiliation and feel like we are being railroaded into it. I have concerns that our patients, and therefore our community, are pawns in a political game that is really about big business.

My department is responsible for performing nerve conductions on patients with peripheral nerve issues. We work closely with a physician who is either a neurologist or physiatrist. We have grown this service steadily over the past 5 years and serve about _____ patients a year. Last year, our main physician left for another state; there was no initiative from the administration to find another to take his place. We were able to get someone to take on the patient volume ourselves. After a year, she is also leaving for another state. There has again been no initiative to hire another doctor; I know this because we asked the physician recruiter. We typically have a 4 week wait for an appointment. Now we are only able to schedule 6 patients a week instead of 24, which will prolong diagnostics to at least a 3 month wait. Administration response to this is to "wait and hope Yale will be able to help us." I am very concerned that this aspect of my department will dwindle over the next 6 months and then get moved off site to Yale when the "affiliation" takes place.

I also have concerns that we will be forced to adopt some questionable clinical practices, which will lead to higher patient costs even if L+M does not fall under Yale's DRG rates. At L+M, and most hospitals, a 30 minute EEG tracing is standard. Yale runs a 63 minute EEG so that they can charge for a higher cost procedure, even if it is not clinically necessary.

I've watched over the last 7 years as this administration has ricocheted from one trend to another with limited commitment and success (durable medical equipment, Dana Farber Cancer Center affiliation, large orthopedic inpatient addition, ideas for outpatient pharmacy, "Pequot South", off site psychiatric facility, etc), and I am concerned that this deal is going to follow suit, but be a done deal.

I urge you to delay your decision on this case until the state has had time to review the laws that govern hospital mergers. There are big changes going on in health care, and once this deal gets done it cannot be undone. Let's make sure it is right for our community first!

Good afternoon,

My name is Kristen Powers. I have been an employee at Lawrence + Memorial Hospital for 29 years. I am also a life-long, local community individual that has entrusted all of my healthcare needs to L+M hospital for nearly 52 years.

I am here today to show support for and, **more importantly**, to encourage you to honor the Governors Executive order of delaying large mergers, affiliations or corporate associations amongst **our** Connecticut hospitals. Let the Governors committee do the work they have set out to do.

I ask this because I have read multiple articles regarding **"associations"** of this sort and **I am** concerned that this "affiliation" will, in the long run, lead to increased costs to our patients and our community.

I believe that if L+M **"affiliates"** with a larger entity like Yale, we, as a community hospital, may be fueling the "ever-growing fire" of rising health care costs. No one can dispute that the cost of healthcare is rising at a ridiculous rate; most people cannot even afford it! If L+M affiliates with Yale, Yale will become the dominant player along the CT shoreline from New York all of the way into RI.
This means that if Yale becomes the dominant "player" in the game in our community, **and this is not a game**, they can set whatever prices they want or claim to need.

I have read many articles over the last several months about "hospital mergers" and have found that even the FTC is "wary of mergers by hospitals." The New York Times[1] and the LA Times[2], among others, have written articles about this subject and have found that, although the goal was to become more efficient and save money by merging or affiliating, costs have actually increased after the "deal was done."

I cannot accept this, you should not accept this, nor should anyone!
It is time to reign in the madness!

I **insist** that you take a very long, hard look at what this "affiliation" will mean to my patients, my community, my family and yours! You may or may not live in this part of CT, but your decision will have great impact and be far reaching for the rest of the citizens of CT.

Kristen Powers
298 Lestertown Rd.
Groton, CT 06340
860-912-3138

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[1] http://www.nytimes.com/2014/09/18/business/ftc-wary-of-mergers-by-hospitals-.html

[2] http://www.latimes.com/hilzik-california-hospitals-20160613-snap-story.html

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Personal story on effects of Yale-New Haven Takeover of L & M

My name is Ken Rowland, and I live in Waterford, CT. I am a UAW member who is lucky enough to be offered decent health care coverage benefits through my employer. Until recently, I have been fortunate enough to say my family's health has been good and therefore healthcare costs were not a big concern. My company provides what would be considered as good coverage, at a fairly reasonable cost. Over the years, that coverage cost has evolved, though. Where once the employee had a small premium and a modest co-pay, coverages have changed to require higher premiums and deductibles. Co-pays are gone, now the employee is responsible for a deductible cost. Out of pocket expenses have increased greatly. That brings me to my story about competition, and why it is vital to the community.

Upon a recent diagnosis of a medical condition, the specialist ordered a CAT scan to provide more detail prior to surgery. Since he is affiliated with L & M, he suggested the test be performed there. I called and scheduled the test and later heard back from the billing department informing me of the anticipated cost. I was shocked to hear that after my insurance paid a portion of the cost, my responsibility for the 10 minute test would be over $1500. That drove me to research what the typical price may be and if the procedure was provided elsewhere in the area. According to a medical cost website, the procedure should average around $600 to $800. I called Southeastern Imaging Center in Waterford to ask their price and their response was that they had been bought out by L & M and the cost would be the same as at the hospital, or the Pequot medical center, all of which had become consolidated under L & M. The procedure would be billed at $2300 before I received the "discounted" rate of $1520.

Under most current healthcare plans, the patient is responsible for a deductible cost, and out of pocket costs are higher than ever. We cannot afford another merger which would give Yale-New Haven Hospital a monopoly of services along a vast region of the shoreline from Rhode Island to New York. Competition is the key to holding down cost, which is either paid by individuals or shared by groups through higher and higher premiums. Recent studies have shown that high cost rather than excessive healthcare usage is the major driver in rising healthcare costs. More competition not less is needed to put the cost of services in line with market costs; less competition only lines the pockets of the Board of Directors at those mega healthcare institutions.

This is one facet of the story; monopolistic healthcare entities would also be free to move low returning procedures and facilities out of the communities they have served for decades. Let's keep Lawrence and Memorial a true Full Service Community Hospital.

To Whom It May Concern,

I am submitting testimony today to express concerns of the proposed Yale/ L&M take over.

I currently work at this community hospital. I currently use this community hospital. This is why I am writing to you. To help give a voice to the families and patients I serve at L&M Hospital. We do not want to become another Windham Hospital. We want to use our community hospital in our community. When referencing Windham Hospital, what I am referring to is the closing of the ICU/CCU. This was not part of the plan or CON process when originally looked at by Hartford Healthcare. Somehow they were able to close these 2 units without another CON process. This leaves those families stuck vulnerable. If their loved one needs increased care many can't travel to Hartford.

As a nurse, I have cared for many patients that start out on a regular, some type of complication, change in status occurs and we transfer them to the ICU/CCU. Depending on the status of the pt. Stay may be short, long or their last. Just imagine you loved one coming to the hospital without an ICU/CCU. First few shifts are uneventful, nightshift comes along. Change in status, your loved one now needs to be life flighted to Yale. You now can't go visit because you usually take the bus to L&M. The change in condition is so great your loved one goes from a full code to comfort measures only. Now your loved one is 50 minutes away from you only to die alone.

What I am asking is for you to have Yale/ L&M have answers. So far we have had community forums and came up with what we want to hold this takeover accountable for.

1) Accountability
2) Community Access and Well Being
3) Affordability
4) Workforce

Respectfully Submitted,

Jeanne Wehling

Uncasville Ct

Testimony Regarding Yale New Haven Hospital Takeover of Lawrence and Memorial Hospital

July 26, 2016 Public Hearing

My concerns regarding Yale New Haven's takeover of L&M is in regards to Yale's indication that the local board will retain control of L+M. I would like to know how that is possible. Doesn't Yale approve all board appointments? If so, can't Yale fire any local board member without cause? Doesn't the CEO work "at the pleasure" of Yale? Doesn't Yale retain the authority to make and/or approve all important decisions?

I would like see an open and true conversation about the future of our community hospital. Yale must give the community concrete, written, legally enforceable commitments.

Sincerely,

JoAnn Merolla-Martin

46 Clifton Place

Norwich, CT 06360

Testimony of Tom Swan, Executive Director of the Connecticut Citizen Action Group (CCAG)

On the proposed takeover L & M Hospital by the Yale Health Services Corporation

7/26/16

Good evening, my name is Tom Swan and I am the Executive Director of the CT. Citizen Action Group. My testimony today is on behalf of our members, including hundreds living in the L & M service area. CCAG has been working on health care issues for 45 years and has been very active on health care issues, including recent hospital consolidations.

CCAG strongly opposes the proposed takeover and urge you to reject it as Connecticut continues to work to design an adequate regulatory framework for a 21st Century health care system. The legislature has taken some positive steps over the past few years, but they are not enough to guarantee that people can get the care they need at a price they can afford.

I want to thank you for giving us the opportunity to address this proposed takeover. It is important for us to look at this in a larger context. Regulators and health care policy analysts are increasingly voicing alarm at the trend towards increased consolidation in health care. Just yesterday, the Guardian published a piece entitled: "Healthcare mega-mergers drive income inequality. They must stop." The piece pointed out that "since the mid-1990s more than 1,200 hospital mergers have resulted in larger hospital systems, which wield their market power to extract excessive prices."

It also referenced a recent report that estimated that in areas with significant hospital concentration, which the resulting corporation from

this proposal would have for virtually all of the Route 95 corridor in CT, hospitals charge prices that are 15 % higher than prices in more competitive markets. If this takeover is approved as proposed, we can expect significantly higher costs due to not just L & M being taken over, but also the increased control by the Yale New Haven Health Services Corporation of physician practices - particularly specialists.

The fact that the applicants have refused to share with you pricing data - that they will need to make available in less than 6 months – should be enough of a reason for you to reject this deal.

On a related note, I would like to point out that the US Department of Justice announced its intention to sue to block two large health insurance mergers on anti-trust grounds just last week. Attorney General Jepsen signed onto the Anthem-Cigna suit due to concerns about consolidation in the Connecticut health care landscape and its impact on cost. These same concerns must be part of any review of this transaction.

In closing, I want to touch on the loss of local control as another reason to reject this takeover. Input should not be confused with control and Yale New Haven Health Services Corporation saying otherwise is dishonest and needs to be rejected. Eastern Connecticut is already suffering the effects of a hospital conglomerate making promises to get a deal approved and then turning around and slashing services as we are witnessing with Windham Hospital. Our future regulatory framework needs to have our hospitals be more accountable to our communities not less.

Thank you for your consideration.

Testimony for Hospital Merger or Affiliation or Take Over

I'd like to start by thanking everybody involved in this process to help all of us determine what direction the healthcare industry is going. The future of our community health care system is in the balance as this committee weighs the effects on our care and the need for these corporate takeovers to continue to take shape.

The facts aren't as clear for the general public about certain subjects when it involves healthcare choices. We try to understand the information presented by the pros and cons of affiliations and mergers, in our mind, not knowing but relying on others to help guide us. The facts aren't as clear when we see the fighting which takes place over the interests of profitability for Hospitals and Health Care Systems and the well being of Patients and the Services which are being provided.

The public has been lead to believe that our Community Hospital L&M is in good shape when we see the purchase of Westerly Hospital. The interesting part is we have a **NON PROFIT HOSPITAL** but a **For Profit** group running the Corporate, daily practices of Lawrence and Memorial in New London. I have yet to understand how that actually works. Then we see a bitter labor dispute, millions of dollars spent and lost, along with patient confidence deteriorating. The Management of L&M Hospital has driven some Doctor's in our community away to other hospitals along with bulling and strong arming them into a group practice called LMMG in order to survive. The concept of LMMG may be a necessity but were the Doctors even given a chance to be represented as to how they think things should be formulated? The hospital management took a building on Howard Street, renovated it

and told the doctors, "Staff is interchangeable here's your cubicle and your sharing it with a few other Doctors". I find this practice to be a very indignant act. These are people who provide the care and medical attention to our community. Doctors work long hours they are constantly giving and sacrificing themselves to patient care and I doubt any CEO or Corporate Executive would be delighted to sit and dictate reports or consult with clients and other team officers and corporate staff in a cubicle the size or a closet.

I see these quality care givers as our front line warriors. Their staffs are more than likely understaffed, overworked and probably underpaid due to fixed pricing for their services. The constant corporate mentality of work harder with less and our numbers will increase to streamline or services by paying our executives more bonuses and compensation is a normal modern day practice. I need not exam the true nature of miss information or the bitterness I felt when the Hospital three plus years ago refused to negotiate as the term goes "bargaining in good faith" in a contract negotiation with employees of L&M Hospital. What will happen next time with the interchangeable mentality of Corporate Health Care Systems? Will our Caregivers once again be put out in the streets to settle for less and pay in more money for their health benefits themselves? This has been the formula for Corporations all over our country.

I have done some homework as to the ever changing landscape of healthcare with mergers, takeovers or affiliations. The Yale Health Care Industry Symposium which took place this April of 2016 addresses the industry's Consolidation, Integration, and Competition. This is a great area for the public to review. I have read and re-read about the transformation of Hospitals acquiring other Hospitals as well as Doctors

practices. What troubles me more is they are also acquiring Insurance Businesses. They also seem to look at the management of all sectors of healthcare. The mentality of monopolizing all areas of health care services and looking at our health not as individual patients but in a model format is a bit troubling. The statement of fee-for-service and accountable care practice models are driving a market of Insurance mergers. Insurance companies are arguing their own mergers are necessary to counterbalance the excessive and growing **POWER of Hospitals**. The laws that legislators have created are in place to protect us as patients and to keep a free market in order for us to choose what's best for our health. I have seen what deregulation has done and its track record is quite clear. The Power Industry or the Cable and Phone Industry all have created increased wealth with mergers and takeovers and the public pays the price. The fact our choices are reduced and we have fewer options at higher costs seem to be a normal occurrence.

The question here is will consolidation improve patient care? The other question I ask is will the patient care and services be decrease in our Community hospital? The merging of departments and the corporate comfort words of streamlining and reduction of patient care and services are evident in many areas. Profitability with bigger corporate players leads to a lack of diversity in the health care industry. The bigger the corporation, the more layers of problems persist. The front line caregivers are the constant recipient of layoffs and increased health care premium increases. The pools of premiums with more group coverage should bring the rates down but this is not a guarantee. The fact is we see Departments in smaller Community Hospitals either closed or downsized due to profitability and don't think for one second

that all of this data isn't gathered before the takeover is even attempted. The outlook for health care remains hotly contested as stated in the reviews I've read. The statements I seem to read all focus on basic industry survival techniques. We are hearing that health care is in a crisis but the jury is still out. Economists and Industry leaders are at odds over the outcome of these changes Industry leaders see the modern move not only as necessary but beneficial to consumers and industry alike while economist critique consolidation for raising prices while reducing consumer choices and failing to improve outcomes. We also see little information about market changes on the most vulnerable populations, the everyday patient experience or the average physician and the scientific research and development within health care.

The completeness of the transformation of mergers needs to be an all or nothing proposal mostly due to cost and that many providers don't have the stomach or the resources to do what needs to be done. The cultural changes that are required for the Accountable Care approach may not be the kind of change that can happen in small steps or integrating old methods with new. This new model for profitability is here and we're in the middle of the road trying to not get run over on the superhighway of health care as it evolves. The complex issues of profitability in the Hospital Industry are quite perplexing. The Non- Profit to for Profit intermingling of Health Care groups and the laws governing anti-trust and Monopolies are even more confusing for the lay person. The "Horizontal Consolidations" and the "Vertical Integration" mergers across the board only better confuse the issues more than clarify the subjects involved in caring for the patients and families of those who are sick and infirmed. The Health Care Systems

seem to swallow their competition as the total population approach to care marches on. The fact Accountable Care is a difficult thing to measure only reflects on how prudent we should be to advocate such mergers. I would like to share some basic facts about the Industry leader in this merger and some research areas I have reviewed before I wrote my testimony today.

I've read various internet articles coming from "The Yale Health Care Industry Symposium, Chris Cheney Health Leaders media article, the Beckers Hospital Review, the Hartford Business Journal, the Yale New Haven Health Facts and Figures, along with the Yale New Haven Health Service Corporation Financials for the filling with the State of Connecticut.

1. $3.4 billion dollar Health Care System
2. $4.2 billion in assets
3. 27.1% of market share in the State now
4. 31.4 % with L&M and Milford mergers
5. 1.6 million people or 46% of state population is in YNHHS region
6. 150 million in spending cuts last year
7. CEO of Yale New Haven Health System (YNHHS) compensation and fringe benefits $**3,520,872** dollars

9.6 mill dem

These are a few of the items that make me wonder if bigger is better. I have only one real concern and that is will we be cared for with dignity and respect or will the **Money and Profits** run this new model of Health Care. We have an obligation to each other to speak up and question this type of Affiliation or Merger or Takeover. This will affect our families and the future of our Doctors and Staff in each institution

that provides **PROFIT CARE for People IN NON-PROFIT COMMUNITY HOSPITALS**

Thank you for your time in addressing these critical matters which face our community

Respectfully Submitted,

Shawn Powers

Testimony
Submitted by State Representative Ernest Hewett, District 39, New London
July 26, 2016

Good afternoon Attorney Hansted:

My name is Ernest Hewett, State Representative for District 39, representing the City of New London. As you can imagine, I have been keenly interested and concerned about the impact of this acquisition on the individuals and families that live and work in this city. Several months ago, I expressed my support for the Yale/L+M affiliation, based upon the facts and information at the time. Most importantly, I was concerned about the negative impacts this merger might have had on working families, and those employed at L+M Hospital. I agreed to support the proposed deal when I received assurances from the union and the hospital that job protections would be in place and secure.

Since that time, I have received new information that raises significant concerns about the benefits of this acquisition to the community, specifically related to local control, cost & price and sustained access of health care services to our community.

Local Control:
In initial statements by Yale New Haven and L+M management, we were assured that a local board of directors will control L+M. I have recently learned that, in fact, according to the proposed by-laws for L+M Health Corporation, Yale New Haven is designated as the "sole corporate member" of L+M Health. In other words, Yale New Haven will have total control over membership, and will ultimately have control over the decisions made about our community hospital.

It is essential we have an honest, upfront conversation about what this acquisition means for our community. This newly revealed information about the power and authority held by Yale over our community hospital undermines our trust in the key players within this proposed deal, and calls into question Yale New Haven and L+M's commitment to transparency and authentic dialogue with this community.

Cost & Pricing:
According to a report released at the beginning of this year, if this acquisition is approved Yale will control 60% market share from NY to RI, and more than 80% in L+M's primary service area. Consolidation in such markets can lead to price increases of 20% or more. This would be a significant blow to our community, and would further exacerbate challenges to accessing affordable health care services.

I understand that OCHA has asked Yale New Haven Hospital to provide data on how previous Yale New Haven mergers impacted prices in the case of Bridgeport, Greenwich and St. Raphel's acquisitions, helping us to potentially dispel some of these concerns. To date, Yale has not provided this data. It does not make sense for OCHA to move forward with this acquisition without this crucial data.

Access to local services:
My colleagues who represent constituents in the Windham area recently briefed me on the changes made to critical health care services at Windham hospital. Several years ago, Hartford Hospital promised improvements and no cuts to services within that community. These promises were not kept

and Windham Hospital closed its critical care unit, necessitating patients to drive and fly on helicopters to get normal hospital care. What assurances do we have that this will not be our fate as well?

L+M Hospital is a vital and crucial institution within the community, and its continued service to the individuals and families residing throughout the New London area must remain secure. In order for me to have confidence in supporting this proposal, these issues must be addressed.

I strongly urge OHCA to require Yale New Haven Hospital and L+M Hospital to enter into a signed, legally enforceable community benefits agreement negotiated with a broad cross-section of our community before we move forward with allowing any kind of change in our community hospital.

On July 11, 2016 I gave a brief oral testimony regarding the excellent care I have received from the L&M medical system based out of New London, CT in both Connecticut and Rhode Island. To say that I would take all day to describe in detail this quality, in stark contrast to the deplorable medical care I received from other medical agencies, particularly in rhode island, was understandable, and after talking with the board am fulfilling their request to put this detail in writing to be better understood.

I was born in Vermont and grew up in Connecticut, Rhode Island, New York, and Vermont and have additionally lived in Massachusetts, with my immediate family having owned residential property in Greenwich, CT, Yonkers and Westchester county NY, and Shelter Harbor and Bradford, RI. My paternal grandfather and namesake ran two medical facilities in Yonkers and Mount Vernon, NY from the 1940's until his death of tuberculosis on January 4, 1968. I attended Waterford High School from 1993-6, after being expelled from chariho school system in rhode island in 1992 and meeting further problems at harmony hill and briggs in the same state 1992, and I am familiar with the excellent reputation CT has in terms of quality of life, as that change of placement, and subsequent sojourns in New London county CT, have helped me greatly in times of crisis.

It was on August 3, 2013 that I first experienced the excellent quality of the L&M medical system. I had been released from prison in rhode island after serving a 7 2/3 month sentence, including 5 months in solitary confinement where I had lost ¼ of my body mass. On that particular morning I was found around 3:30 AM passed out at the MGM Grand at Foxwoods. Three hours later I took the seat bus to exit 92 and began walking south down Rt 2 in Stonington. After a half hour of walking slowly then pain I was experiencing was so intense as soon as I arrived at the Henny Penny I asked the clerk to call 911. Paramedics and the Stonington PD arrived, and being shocked at my physical state, transported me to L&M's hospital in Westerly. I was greeted in the emergency room by Dr. Fred Jaccarino, who was familiar with my walks around NL county and my beach workouts. He remained calm, examined me, and noticed that I was experiencing severe dehydration and severe constipation as a result of prison neglect, and for the first time in my life I was put on IV fluids for four hours. Even though I have a long list of allergies to prescription, as well as illicit, drugs, much of that info had been misplaced as the last time I had experienced that type of medical problems was as a juvenile, and my records were under my adopted name, however Dr. Jaccarino prescribed miralax to help with my constipation, and to address any potential effects requested the contact info of Doctors I was already seeing in RI and MA should something occur. Once I was well enough to walk unassisted the staff at L&M Westerly helped me get to the Westerly train station where I boarded a train tor Kingston station.

Several weeks later that month, four days after I began using the miralax, I was experiencing a burning pain in my back around my kidneys. I had an appointment with Dr. Richard Robin that day and went to see him. I had seen dr. Robin first in June 2012 in order to fulfill a court request for a psychiatric evaluation, and on September 28, 2012 Dr. Robin intervened after he noticed I was experiencing complications from a life saving operation performed the previous day in Stoneham, MA to remove an infection from my jaw as the result of a bullet wound from July 21, 2002 which had become seriously infected. It was during that intervention that Dr. Robin made me realize that even though I do not have a major mental illness, I do have situations in my life in which intervention would assist. That afternoon when I experienced that pain and described it to Dr. Robin I found out he was part of the L&M system, the quality of treatment I was receiving from him should have been a tip-off, and he contacted

L&M Westerly and told me to walk to the emergency room there or he would call 911. Once there Dr. Jaccarino noticed I was having an allergic reaction to the miralax, stopped the prescription, and managed to stabilize me.

The quality of treatment in August 2013 made me a L&M patient. Previously I had experienced one incident after another of deplorable medical treatment in rhode island. That included dr. frank gencarelle treating the wrong eye as a juvenile until 1995, and as a result I receive a disability check from the government solely for the visual impairment which I have as a result of this mistreatment. This involved a botched operation on my right foot at Westerly hospital in 1991 long before L&M took it over which required specialized treatment by L&M's Dr. Lawrence in 1992 to correct the damage, and doctors at bradley hospital prescribing medication without properly obtaining my medical records in October 1992 which required treatment in Washington county VT to correct the damage in 1992-3, and attempts by south shore mental health in 1995-6 to coerce me into treatment that was unnecessary at the urging of a stepdad, and this attempt was stopped by Dr. James Greer, with the assistance of the faculty at Waterford High School, in 1996 one it was noticed that the stepdad and I were involved in a dispute over the substantial estate of my biological grandmother/adoptive mother, and bad experiences with court ordered mental health counselling in 2008-9 and 2011-2 before dealing with Dr. Robin.

I later found out to my disgust that L&M subcontracts with south shore in rhode island on November 6, when Dr. Robin's staff noticed I had been in a confrontation with someone I had issues with in prison, and they did an emergency certification to L&M Westerly. I was released after four hours. L&M Westerly helped prevent any adverse experience. They did this by verifying in August 2013 and keeping on their records my association with Dr. William Beeman, my former dpt. Head at brown university. Other mental health agencies claimed my knowing him was a grandiose delusion, however they were able to work with him to verify my statements regarding my history and family, partly as my closest living relatives in America are my relatives from Iran, who were Gilanshahi members of the Imperial Iranian court who have trouble understanding English. By L&M documenting this the staff at south shore was prevented from calling this delusional. They also noted that the inmate I beat up was a violent individual who would create a conflict until compelled to stop, and L&M Westerly has worked with L&M facilities in CT to help me obtain treatment so I do not have to deal with menacing individuals like that.

I also had L&M assist me when I received malicious treatment from thundermist and fellowship rhode island in the summer of 2014. In June 2014 when experiencing pain from unknown marks on my ankles I went to thundermist for treatment. Once they saw the condition of my feet the staff screamed, diagnosed scabies without performing any tests, and wrote a prescription for an overelaborate treatment. The staff at fellowship rhode island, who I had been court ordered to see for mental health counselling by judge jabour in rhode island as part of probation terms to replace Dr. Robin, who had discharged me and most of his patients in November 2013, repeated what thundermist said and tried to coerce me into taking this overelaborate treatment. I sought a second opinion from Dr. Kevin Torres at L&M Westerly in July 2014. Within two minutes of examining my feet and legs he determined that it cound not be scabies as the marks remained under my knees, and the foot injuries L&M Westerly treated me for in May 2014 were healing, which were inconsistent with scabies. When thundermist and fellowship rhode island further attempted to coerce me in August 2014 into this unnecessary treatment, including filing charges after I confronted their attempt to coerce this treatment. L&M

worked with me to successfully beat those charges and to disassociate myself from those organizations who would have harmed me by their incompetence.

I received quality care once again from L&M in 2015. In January 2015, after a Cranston detective and doctors matthews and ottowicz at fatima hospital lied to judge hastings, who stated on the record that she would allow hearsay testimony, at a mental health court hearing in rhode island and gave me drugs which continue to cause me serious health problems, the people at L&M worked to get me discharged from that facility. When I experienced severe chest pain and breathing trouble as a result of the drugs given to me at fatima hospital shortly after being discharged there Dr. Keith Hilliker stabilized me and stopped the prescription that was given to me at fatima, particularly as the staff at fatima would not release the names of all drugs given to me there. I did experience problems when L&M attempted to discharge me, as it was 6PM, I can not get a drivers license in RI because of my visual impairment, then last bus leaving Westerly in RI had left, all buses in CT were going to the casinos, I could not get a ride, and the pain I was experiencing was to severe I asked the staff "not to discharge me too soon" upon which they brought someone from south shore mental health who could not understand my request and had me transported to butler hospital. I spent one week there with violent patients who the staff had to keep away from me, making the work Dr. Furman did with me more difficult, however once he noticed I was not seeking conflict he concurred with Dr. Hilliker and released me. Had L&M in rhode island not affiliated itself with a deplorable association I would not have been deprived of my freedom simply because someone could not understand a simple phrase.

I received excellent care from L&M again from May-December 2015 for a foot infection I received in April 2015 while serving 30 days in rhode island prison for beating up the arsonist who destroyed the place I was staying at. When Dr. Torres saw me in the L&M Westerly emergency room on May 3-4 he focused on my stabilizing my heart which was experiencing a serious palpitation, yet noted the condition of my foot. From then until September 2015 the staff at L&M New London, Stonington, and Westerly worked to stabilize my foot, even dealing with the staff at Backus Hospital when I was brought there on labor day weekend after having a bad fall on a greyhound bus, and with Quinnipiac Medical, as the student intern from there who examined me at L&M Westerly helped solve the problems I had finding a podiatrist and in obtaining the prescriptions I needed to treat the foot, the former by tirelessly and creatively working to arrange an appointment for my treatment, the latter by calling up the pharmacy I was to obtain my prescription from, as L&M Westerly has no dispensary, and form me to receive the prescription upon my ID being verified in order to prevent prescription theft/fraud. The podiatrist that student intern referred me to worked successfully with me, and when treatment became disjointed in December 2015 the staff at L&M Stonington worked not only to see that my foot was healed by the end of that month.

The treatment became disjointed after an incident on a bus in rhode island, two days after receiving successful treatment for that foot injury on November 11, 2015 where my foot brace snagged on some punk's backpack, and the bus driver called 911 claiming I tried to assault that punk. As the bus had stopped on the uri campus when this occurred the campus pd pulled me off the bus and beat me while handcuffed, causing me to experience a narcoleptic attack later that night, and when campus pd brought me to south county hospital they continued to beat me while handcuffed to the stretcher. Even though the prison staff noted the marks on me as a result of the beating they did nothing to treat me. Even though the L&M podiatrist was the only physician to respond in a timely manner to the court, it was enough to demonstrate I had a medical condition which effected my actions during that incident and that imprisonment would only make things

worse, securing my release. The day after my release the staff at mario's pizzeria noticed I had trouble eating, and when I went into the nearby cumberland farms to use the bathroom I was on the toilet for over 30 minutes, and when I got up there was blood everywhere, and as that store was crowded I rushed across the street and called 911. I was brought to L&M Westerly where Dr. Wendy Witt and her nurses treated my condition. They were able to restore my digestion, noting I had been dehydrated and as the food I had was with me they examined it and noted it was not the cause of my troubles. When I had to use the bathroom they brought a commode over and had me use it while they watched. Dr. Witt noted the blood in my shit was small, however a contusion from the beating I received at south county hospital while handcuffed was bleeding profusely and had been neglected in prison and they treated that injury stopping the bleeding. When I tried following through with my primary care Dr. stuart he was more worried about the fact I had to walk over a mile in pouring rain to the stop than about the injury. I reported his behavior to L&M Westerly, who referred me to L&M Stonington, who assisted me with follow on treatment and referred me to Dr. Brandon Luk with my first appointment on March 1, 2016. Even though Dr. Luk is new, he has been working with me to obtain all my medical information, the only problem at this time his being overbooked and as a result not being able to get info from all my doctors, and ones I have and continue to have malicious experiences with respond rapidly and inaccurately.

Having described the good quality of treatment I shall now elaborate on the deplorable treatment I mentioned briefly earlier. I shall first describe the bad experience I continue to have with gateway health, as I am currently on probation in rhode island on two charges, one which expires in September, the other expires in December, and I have been court ordered to undergo mental health counseling on the former sentence, which has become a frequent practice in rhode island that people like myself who do not have a major mental illness are asked to undergo this as a preventative measure, yet it only has created more problems for those undergoing the counseling. I had mentioned earlier how L&M had worked with fatima hospital to get me discharged, especially after RI mental health advocate Jackie Burns learned how I was behaving violently as a result of the drugs given to me at fatima, and noting prominently that I had not been violent until given those drugs worked with fatima on psychiatric referrals. The staff at fatima made me an appointment with someone at gateway in Johnston before L&M could respond, and L&M advised me to at least visit them, and if things became bad they would work on finding another referral. Once at gateway the doctors were over insistent on my taking drugs even before I had signed my releases. Once I signed the releases I knew the doctors at gateway were lying, as they claimed that Dr. Robin had prescribed medication for me when in fact he never had, partly because of my physical health issues, and that they obtained my records from the providence center, when in fact I had obtained all my records from there in 2007, nine years after I terminated my services with them. The only reason I remained with gateway was I ended up on probation in April 2015, and part of the terms was court ordered counseling, and the staff at L&M only said to contact them for a referral if problems persisted with gateway, and as they have I brought them to Dr. Luk's attention. Even though he does not have all my medical records yet, he did note that gateway was not working with ALL my doctors and that after spending five days doing an emergency move after walking from Stonington to Richmond on the Sunday before Memorial Day Dr. Luk noted that gateway should have examined me more thoroughly.

I should also note the treatment at fatima I received there prior to my bad experience at gateway had been the most malicious I have yet received as a adult. I noted earlier how a

Cranston detective had lied to do an emergency certification on me, and dr.s veronica matthews and bill ottowicz would not allow me to sign medical releases for essential information. When dr. matthews filed a mental health court petition it occurred around the same time she had to leave fatima hospital. Not only did dr. ottowicz continue her petition he blatantly lied in court, even claiming my being shot in the head in July 2002 was a delusion, despite the fact that the bullet wound on my nose is visible once my prescription glasses are removed, and I had to have the other would operated on by Dr. Hamid Esbah in Stoneham, MA on September 27, 2012 when it became infected, and I am currently working working with Dr. Mohammed Mobasherat of Medford, MA as I require specialized followup care. As it turned out I was not the only patient who experienced maltreatment by dr. ottowicz, as another patient, a paralyzed Vietnam veteran named Craig Sampson who had served with Rob Simmons, had been treated so badly that he and I talked with other patients about notifying our next of kin if we were to die, and I notified Rob of what I and Craig experienced when I saw him again in October 2015. As it turned out the deplorable treatment I, Craig, and others received at fatima led to that hospital being sold, and a check of their website shows that ottowicz and matthews are no longer there, and I already detailed how Dr. Hilliker, then later Dr. Furman agreed that I received unnecessary treatment there. However as a result I have continued to experience violent palpitations, and narcoleptic attacks, and my vision has become worse.

Prior to that I had another involuntary experience at roger williams hospital in providence on May 3, 2014. I had been swarmed by the ppd based on malicious lies they had spread about me, even claiming I was homeless when I was living in Watertown, MA. Once at roger williams dr peter kirk refused to deal with the staff at L&M regarding my records and had me restrained, then drugged. Once on the unit Dr. Findley was able to verify my address in Watertown and prove that the ppd acted on lies, and had me released, however I continued to have adverse effects from those drugs.

Even though the other bad mental health experiences I had mentioned above were brief the bad treatment I received as a juvenile needs mention. In 1991 my stepdad had me see the staff at south shore mental health around the time my biological grandmother/adoptive mother was dying, and the staff there recommended I keep seeing them. In October 1992 when facing assault charges I was placed in bradley hospital, where dr grapentine and dr neeper put me on a thorazine treatment which almost killed me, partly because they neglected to note the behaviors of my stepdad and biological father, the latter having a lengthy criminal history, much of it drug related, in New York, Vermont, Connecticut, and Rhode Island. It was the interventions first of my teachers at Waterford High School in 1993, then when my stepdad placed me in RI DCYF custody the actions of Dr. Alan Mark at the Kent Center and Dr. James Greer at the Providence Center that determined that the problems was due to my being in a hostile environment caused by my stepdad, and that treatment was unnecessary as I suffered from no major mental illness.

Also I received malicious treatment to my eyes as a juvenile from dr. francis gencerella, who from 1993-5 deliberately treated the wrong eye. This mishap was caught by Dr. Harry Pass of Providence, in 1998, and as a result I have been receiving a disability check solely for this visual mishap, and I continue to use Dr. Pass's clinic.

Now I will describe my concerns about Yale-New Haven. In April 2014 I had to get a former classmate of mine under control who was overintoxicated, and part of it involved telling her I would find out what happened to an elementary school High Incentive teacher we had, Joanne Holberton, partly as many had not seen her in almost two decades and many assumed she was still alive. Finding her obituary was a shock. I had known about her heart transplant and her

retiring after her husband died, however the fact that she was maltreated by assisted living/daycare staff, promised excellent treatment at Yale New Haven, and not only did not get it but due to maltreatment at YNH died there on June 20, 2001. It should be noted that Joanne was a direct descendant of Roger Williams and started RRI's first High incentive program for elementary school students, and could not get essential treatment in RI. Just as shocking was the fact she died exactly ten days after my fiancée was murdered by a doctor and she was buried in a location I had passed by thousands of times without realizing she was there, and only located her burial spot because of her husband's WWII service record. When I broke the news to our former classmates they shared my distress.

I have also felt unsafe and insulted while on Yale campus by the behavior of the students and faculty. There the students regularly ride bikes, skateboards, scooters, and other objects into people with clear physical disabilities and nothing is done to stop them. When attending a conference at the Middle East studies dpt the staff had to separate me from a professor who made a slanderous remark about one of my ancestors, despite the fact the speaker had studied under my former dpt. Head at Brown and noted it during the conversation leading up to that confrontation. If one thinks I am alone in feeling this way consider the fact that few people venture onto Yale campus because they feel unsafe there.

In conclusion, the treatment I have received at L&M has been excellent, partly because whenever something happens they work to fix the issue. This makes them unique in rhode island and is one reason for the patient overload there, specifically people fleeing the deplorable treatment in the rest of the state. I was glad to learn that L&M is upgrading it's info sharing network to prevent me and other people experiencing medical mishaps. I do express concern that L&M in rhode island has subcontracted with south shore, as many continue to get horrendous treatment there, and would be better sending people to New London for evaluations, as the staff there are more professional. Were L&M to merge with Yale New Haven that would give YNH a presence in a community bitter at their maltreatment of a beloved teacher. Even though L&M would get immediate cash relief from YNH, it would not address the nunderlying issues and cause long term damage.

Peter Zendran II
780 Reservoir Ave # 181
Cranston, RI 02910

August 18, 2016

The Honorable Raul Pino
Commissioner of Public Health
410 Capitol Avenue
PO Box 340308
Hartford CT 06134

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access

Attorney Kevin Hansted
Hearing Officer
Office of Health Care Access

Dr. Pino, Ms. Martone, Attorney Hansted:

The undersigned constitute a majority of the New London City Council. We write to urge you to ignore the September 8 expiration of the Federal Trade Commission's approval in your deliberations on the proposed acquisition of L+M Health Corporation by the Yale New Haven Health Services Corporation and the merger of L+M Physicians Association into Northeast Medical Group.

Yale CEO Marna Borgstrom told the media that if the state doesn't approve the proposed takeover of our community hospital immediately, she'll have to spend $250,000 getting re-approval from the federal government, and that will hurt patient care.

The FTC's approval is expiring for one reason only: Ms. Borgstrom and L+M Health CEO Bruce Cummings have stonewalled the Office of Health Care Access for 8 months, refusing to produce price data from the two hospitals so you and the public can understand the potential threat to consumers' wallets.

Yale says the data doesn't exist, and they wouldn't produce it anyway, even though their prices become public next year. The first claim lacks credibility. The second insults patients who depend on L+M.

Renewing FTC approval takes all of 30 days, and the deal sailed through last time. As for spending $250,000 so you can make sure we won't face price gouging, Yale can afford it – that's less than one month of Ms. Borgstrom's $3.6 million annual compensation.

We also have unanswered concerns that Yale refuses to guarantee there will be no future service cuts, that most of Yale's supposed $300 million "investment" is to be generated by L+M's own future profits, and the lack of specifics on how they will spend whatever they do invest. Finally, Yale's continued insistence that L+M will be locally controlled, when Mr. Cummings' sworn testimony and the plain language of their proposed bylaws directly contradict these claims, remains a mystery.

In the end, L+M and our community may benefit from an acquisition. But far too many important questions remain. The future of our hospital and health system is too important to be rushed. OHCA should insist on seeing all the data before making a decision, and take whatever statutory time is necessary to thoroughly evaluate all the information before it. Let Yale worry about the FTC.

Erica L. Richardson, City Council President

Michael J. Tranchida, City Council President Pro Tem

Martha E. Marx, City Councilor

Don Venditto, Jr., City Councilor

Efrain Dominguez, Jr., City Councilor

Anthony L. Nolan, City Councilor

John D. Satti, City Councilor

City of New London
Office of the Mayor
181 State Street • New London, CT 06320 • Phone (860) 447-5201 • Fax (860) 447-7971

August 25, 2016

The Honorable Raul Pino
Commissioner of Public Health
410 Capitol Avenue
PO Box 340308
Hartford CT 06134

Ms. Kimberly Martone
Director of Operations
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford CT 06134

Attorney Kevin Hansted
Hearing Officer
Office of Health Care Access
410 Capitol Avenue
PO Box 340308
Hartford CT 06134

Dear Dr. Pino, Ms. Martone, and Attorney Hansted:

I am writing to express my appreciation for your consideration of the proposed affiliations of Yale New Haven Health Services Corporation with the L+M Health Corporation and Northeast Medical Group with L+M Physicians Association. You may recall that I testified at the first day of your public hearing in New London. I hope your deliberations, so critical to the delivery of healthcare in our city and region and to the future of our community hospital, will not be influenced or rushed by the September 8 expiration of the Federal Trade Commission's approval of the affiliation.

I am hopeful that an affiliation between Yale-New Haven and L+M will only strengthen the delivery of healthcare in the region and benefit our community hospital. However, I believe the intervenors have raised valid questions that should be answered and significant concerns that must be resolved by your commission. Evaluating the terms of the proposed affiliation is too important to be rushed.

Sincerely,

Michael E. Passero
Mayor

cc: Bruce Cummings, President & CEO, L&M

Greer, Leslie

From: Martone, Kim
Sent: Tuesday, July 12, 2016 11:56 AM
To: Hansted, Kevin; Riggott, Kaila; Lazarus, Steven; Carney, Brian
Cc: Greer, Leslie; Olejarz, Barbara
Subject: FW: Docket Number 15-32032-CON and 15-32033-CON Public Information Testimony from Kathleen Stauffer
Attachments: The Arc NLC_Testimony YaleNH 2016 (2) (2).pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Karen Warfield [mailto:kwarfield@thearcnlc.org]
Sent: Tuesday, July 12, 2016 11:02 AM
To: Martone, Kim
Subject: Docket Number 15-32032-CON and 15-32033-CON Public Information Testimony from Kathleen Stauffer

Ms. Martone,

Please see Kathleen Stauffer's written testimony regarding docket number(s) 15-32033-CON and 15-32033-CON. A hardcopy will be mailed to your office at:

Division of the Depart. Of Public Health
410 Capitol Avenue, MS #13 HCA
P.O. Box 340308
Hartford, CT 06134-0308

If you have any questions, please contact me at the email below.

Thank you in advance,

Karen Warfield

Executive Assistant
The Arc-NLC
125 Sachem Street
Norwich, CT 06360

T:860.889.4435 x126
E: kwarfield@thearcnlc.org

www.thearcnlc.org

The Arc New London County
125 Sachem Street
Norwich, CT 06360

T 860.889.4435
F 860.889.4662
www.thearcnlc.org

The Arc
New London County

Achieve with us.

11 July 2016

TESTIMONY RE: PROPOSED MERGER OF YALE NEW HAVEN HOSPITAL WITH L+M HOSPITAL

1. THANK YOU. The Arc New London County **thanks the panel for the opportunity to offer testimony.**

2. WHO WE ARE. The Arc New London County is **a 64-year-old, grassroots agency in Southeastern Connecticut founded by families** to support **loved ones with Intellectual and Developmental Disabilities (I/DD)**. Driven by a philosophy that every person deserves full inclusion, **The Arc walks with people as they live their best lives as independently as possible saving millions of taxpayer dollars each year**. Our sphere of influence – families served, employees, volunteers and Board members – number approximately 2,000 people in New London County.

3. HEALTH AND WELLNESS. **Of critical concern to The Arc NLC is the health and wellness of people with I/DD in Southeastern Connecticut.** *Healthcare supports for the vulnerable residents of SE CT must be measurably enhanced by this merger.* Special populations can be challenging in several respects: Healthcare providers too frequently are untrained in supporting fragile populations whose challenges can present physically, emotionally and behaviorally. It is essential that demonstrating a data-driven suitability and preparedness to serve vulnerable people, specifically people with I/DD, be a critical criterion for approval of this merger.

4. NONPROFIT HOSPITALS AND COMMUNITY WELFARE. The first hospitals in the United States were for-profit enterprises, established by doctors to serve wealthy clients. **As an understanding of public health, sanitation and prevention evolved, nonprofit hospitals were established to serve the public good.** Among the critical services nonprofit hospitals provide to a community:
    - **Community health.** Nonprofit hospitals are less likely to engage in turnkey services, shortening stays inadvisably for quicker profit.
    - **Community research.** Nonprofit hospitals are more likely to invest in research to find cures for disease.
    - **Community well-being.** Nonprofit hospitals readily serve patients whose services are Medicaid reimbursed and provide other critical supports such as community investment, rate caps to hedge against runaway costs, regional economic stability, jobs and facilities investment.

Regrettably, over the last two decades, nonprofit hospitals have increasingly found it necessary to compete with for-profit entities to survive, behaving more like for-profit hospitals. For this reason, the above concerns require established remedies that are measurable, enforceable and ongoing to ensure that this merger benefits New London County and its residents rather than the deal-makers at the top of the healthcare food chain.

5. SOUTHEASTERN CONNECTICUT'S ECONOMIC WELL BEING. As **one of the wealthiest states in America with the second-richest capital city in the nation**, **Connecticut will not be better off if this partnership does not leave New London County better off** economically. **As one of America's 10 most economically distressed regions, New London County must benefit by this merger** in the following, data-driven ways or the merger cannot and should not be permitted to happen: 1) A **significant number of new, quality jobs** must be created and maintained. 2) Demonstrated **facilities investment in the region** must be a part of this plan; 3) A demonstrated **commitment to investment and wellness for the region** for the next decade must be provided by means of a written plan. **Penalties for falling short of these goals** must be clear, enforceable and implemented as appropriate.

Kathleen Stauffer, MPA
Chief Executive Officer
The Arc New London County

Office of Health Care Access
Proposed L+M Health Care and Yale New Haven Health Affiliation
Public Hearing
July 11, 2016

My name is Catherine Zall and I serve on the L+M Healthcare Board. I am here today, however, in my capacity as the Executive Director of the New London Homeless Hospitality Center. In this capacity I have had the opportunity to see first hand the multiple health care challenges that face our neighbors experiencing homelessness. We deal every day with individuals with serious unaddressed health issues often made more acute by homelessness. Every day we also see the precious health care resources that are ineffectively used when people receive high quality medical care but cannot follow up on that care due to the challenges of homelessness.

We are already working with L+M Hospital to address multiple aspects of this issue. With funding from the hospital, we have established a special respite section of our emergency shelter that provides people facing both homelessness and a serious health crisis with access to emergency shelter specifically designed to meet their needs. We are jointly giving people a setting conducive to recuperation, helping people connect to follow-up medical care and providing a setting where people can follow the discharge instructions they receive on release from the emergency room or inpatient care.

This effort represents an important start toward improving health outcomes for a very underserved population. But there is so much more that needs to be done. Drawing on the growing body of evidence generated through population health research, we need to use data to identify individuals experiencing homelessness who could benefit from increase health engagement before they end up in an acute crisis requiring inpatient or emergency room care. We need to apply best practices in reaching people who have chronic conditions to be sure they have access to the basic resources they need to maintain health. We need an even more in-depth partnership between housing and health care providers to address the social determinants of health.

All of these efforts—respite and other health interventions—require access to sophisticated analytical tools and knowledge of population health interventions. Standing alone L+M Hospital has access to some of this expertise. The proposed partnership with the Yale New Haven Health System, however, would allow access far superior support in the effort to improve health outcomes. With help from Yale New Haven, L+M could more effectively utilize data and population health models to address health disparities thereby improving lives and reducing unnecessary costs.

A deeper partnership with Yale New Haven would also streamline care coordination as many of our guests experiencing homelessness touch both the L+M Hospital and the Yale health systems. Being part of a bigger system would allow us

to more effectively collaborate with colleagues in New Haven to test new models of delivering care and develop new best practices that could improve health outcomes across the state for people experiencing homelessness. Finally the proposed affiliation could free up additional community benefit resources that could, in turn, be invested in community based health improvement efforts.

Our neighbors experiencing homelessness need access to new tools to improve health outcomes. We all need to deliver health care more cost effectively by intervening earlier and improving continuity of care. The proposed affiliation would help achieve that goal. I urge the Office of Health Care Access to support the proposed affiliation.

Thank you.

Catherine Zall
Executive Director
New London Homeless Hospitality Center
czall@snet.net

Office of Health Care Access
Proposed L+M Health Care and Yale New Haven Health Affiliation
Public Hearing
July 11, 2016

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Thank you.

Catherine Zall
Executive Director
New London Homeless Hospitality Center
czall@snet.net

The Arc New London County
125 Sachem Street
Norwich, CT 06360

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F 860.889.4662
www.thearcnlc.org

The Arc
New London County

Achieve with us.

11 July 2016

TESTIMONY RE: PROPOSED MERGER OF YALE NEW HAVEN HOSPITAL WITH L+M HOSPITAL

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United Nurses &
Allied Professionals

Linda McDonald, RN
President

Statement to the Office of Health Care Access
Re: CON application regarding Lawrence & Memorial Healthcare and Yale New Haven Health system

July 11, 2016

Hello. My name is Jack Callaci, I live in Cranston, Rhode Island and I represent the employees of Westerly Hospital. I am here to state in the strongest and most unequivocal terms our support for the affiliation of Lawrence and Memorial Healthcare that includes Westerly Hospital with Yale-New Health System. I would like to make three major points.

First, this is not about this one transaction before you. The overwhelming pressures and trends nationwide in the healthcare industry including insurance companies, hospitals, visiting nurse services and doctor practices is towards affiliations and consolidations. The evidence of this is abundant here in Connecticut, in my home state of Rhode Island and around the country. The parties to this affiliation are not creating the nationwide pressures and trends. They are responding to them as best they can.

I wish that the trends did not exist and that we could return to a time of free standing nonprofit hospitals serving each community. Whether we like it or not that time is long gone. So the question is not, in my opinion, whether we can stop this particular transaction and roll back the clock, we can't, but what is the best way for Lawrence and Memorial Healthcare and Westerly Hospital to address these overwhelming pressures.

That brings me to the second point. If this proposal is killed, what is the alternative and is that alternative better than what is before us today? Killing this proposal does not mean that Lawrence and Memorial Healthcare and Westerly Hospital will remain as is. It only means that this particular option is foreclosed. Look at the alternatives out there. I am sad to report on many of the alternatives from our own experience.

Prospect Medical Holdings is about to purchase several hospitals in your state. They are a for profit, out of state entity backed by a venture capital firm. They are aggressively expanding in the east. In Rhode Island, they have reneged on agreements made after demanding and getting tax breaks and governmental benefits. You saw the article in the Manchester newspaper demonstrating the poor quality of care Prospect California Hospitals provide including quality concerns so severe that medicare closed some of their hospital units. Prime Healthcare also a California based for profit expanding in the East coast was recently been indicted for Medicare fraud. Steward Health Care Systems in Massachusetts closed a hospital after agreeing not to do so and have left a hospital and its community in the lurch by endless delays, endless demands on

top of demands and then finally deserting the hospital and its community without notice. My point here is this. Hospital consolidations are going to continue. So the issue is what is the best agreement to make?

I believe that an affiliation with a non-profit, Connecticut based entity with a Board that has members based in our communities and the standing and record Yale-New Haven Health Systems has is by far the best choice.

I have read about and listened to the concerns raised by those opposed to this affiliation. I think many or all of the concerns are legitimate and well thought out. It is those very concerns that lead me to say that those concerns are better addressed in an affiliation such as the one before you rather than killing this affiliation and taking the chances with another entity down the road. Again, perhaps this affiliation can be sunk. But the pressures to affiliate somewhere will not go away. The pressures in fact will build. Don't take my word for it. Look around your state, Rhode Island, Massachusetts and nationwide.

The third and last point I want to make is that with whom you affiliate makes all of the difference in the world. It was only a few years ago that sadly, in my opinion, the Westerly Hospital entered bankruptcy and ceased being the free standing hospital it was. Lawrence and Memorial Healthcare has made good and continues to make good on every commitment they made to the Westerly Hospital, the State of Rhode Island and the Westerly community. Many of those commitments have several more years to run and Yale New Haven Health System committed in writing to honor those commitments. I mentioned earlier Prospect has reneged on its commitments, Steward closed a hospital they committed to keeping open and Prime has been indicted for Medicare fraud.

If one thinks this is a matter of killing this affiliation and freezing all of the national trends in the healthcare industry in this relatively small community, good luck. But if you believe that the industry trends are bigger than all of us and accelerating as I do, then the challenge is what is the best affiliation we can effectuate and to my mind there is no doubt whatsoever that the affiliation of Lawrence and Memorial Healthcare and Westerly Hospital with Yale New Haven Health System is by far the best option for our respective communities and it should be supported.

Sincerely,

John V. Callaci
United Nurses and Allied Professionals
Director of Collective Bargaining

Greer, Leslie

From: Martone, Kim
Sent: Friday, July 22, 2016 9:06 AM
To: Riggott, Kaila; Lazarus, Steven; Carney, Brian
Cc: Greer, Leslie
Subject: FW: Letter to Commissioner Pino RE: Docket No. 15-32033-CON
Attachments: Yale-LM Merger Comptroller Lembo.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Pino, Raul
Sent: Thursday, July 21, 2016 4:02 PM
To: Casagrande, Antony A; Addo, Yvonne; Martone, Kim
Subject: FW: Letter to Commissioner Pino RE: Docket No. 15-32033-CON

FYI

Raul Pino MD/MPH
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone - 860-509-7101
raul.pino@ct.gov

From: Lembo, Comptroller
Sent: Thursday, July 21, 2016 3:43 PM

KEVIN LEMBO
STATE COMPTROLLER

MARTHA CARLSON
DEPUTY COMPTROLLER

STATE OF CONNECTICUT
OFFICE *of the* STATE COMPTROLLER
55 Elm Street
Hartford, CT 06106

July 21, 2016

Commissioner Raul Pino
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Dear Commissioner Pino,

I am writing in regard to the proposed affiliation between Yale New Haven Health Services Corporation (Yale New Haven) and Lawrence & Memorial Hospital (L&M) – Docket No. 15-32033-CON – now before the Office of Health Care Access (OHCA) in the Department of Public Health. The Comptroller's Office administers the state employee health care plan, providing health coverage to over 200,000 members. Any cost increases or service reductions associated with the proposed affiliation between Yale New Haven and L&M will directly impact the state health care plan and its members. I am calling on OHCA to use its authority under the Certificate of Need (CON) review process to ensure that the proposed affiliation between Yale New Haven and L&M results in the retention and expansion of medical services in the L&M service area and does not increase total health care costs.

As you know, Yale New Haven has the largest market share of health care services in the state and is the dominant health system along the Connecticut shoreline. Yale New Haven's significant market share is one factor that has enabled the system to command some of the highest reimbursement rates in Connecticut. The affiliation with L&M will further expand Yale New Haven's market share along the Connecticut coastline. The evidence is clear, greater market concentration of health care providers and hospital facilities results in higher medical costs due to increased reimbursement rates.[1] The affiliation of Yale New Haven and L&M will result in greater bargaining power for Yale New Haven as a whole and L&M particularly.

[1] Dafny, Leemore. Estimation and Identification of Merger Effects: An Application to Hospital Mergers. [Journal of Law and Economics, vol. 52 (August 2009) http://www.kellogg.northwestern.edu/faculty/dafny/Personal/Documents/Publications/2_Dafny_Identification%20and%20Estimation%20of%20Merger%20Effects_2009.pdf; Vogt WB, Town R. How has hospital consolidation affected the price and quality of hospital care? Princeton (NJ): Robert Wood Johnson Foundation; 2009 Feb. http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html

July 19, 2016

Ms. Kim Martone
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, Connecticut 06134

To Whom It May Concern:

I write today to strongly support the proposed affiliation between L&M/Westerly Hospitals and Yale New Haven Health System. As a member of the local community, I have personally witnessed the extraordinary work performed at L&M for friends, coworkers, and family members. As president of a local community bank that serves the same market area as L&M and Westerly, I have personally witnessed the tremendous impact the hospitals have on our local community, both economically and socially. As a member and officer of the L&M Healthcare's Board of Directors, I have witnessed personally the impact of changes in the national and in-state healthcare environment at large on our hospitals, and believe strongly that the key to our success in the future is through this affiliation.

I cannot put into words how impressed I have been with everyone I have come into contact with at L&M and Westerly hospitals. They are professional, compassionate, and innovative. They are dedicated first and foremost to their patients. In spite of their extraordinary efforts, the forces of change in healthcare that they face every day are such that going it alone seems impossible. I believe that the combination of two well-managed, locally focused hospitals, with access to the talent and resources available to a world-class organization like Yale New Haven Health is a powerful combination and a role model for the future of healthcare.

I strongly urge you to approve this affiliation as soon as possible to help strengthen our local healthcare system and our community.

Sincerely yours,

B. Michael Rauh, Jr.
Resident of Mystic, CT
President & CEO, Chelsea Groton Bank
Secretary/Treasurer, L&M Healthcare

Yale New Haven and L&M have stated that the increase in bargaining power will be muted by component contracting in the Yale New Haven Health System, whereby each affiliated hospital facility negotiates reimbursement rates with payers independently. The extent to which separate contracting across facilities will reduce the otherwise clear increase in bargaining power for L&M as a member of Yale New Haven is unclear and may require additional oversight and guarantees.

Yale New Haven and L&M also state that the improved care integration and care management that would result from the affiliation will reduce overall health care costs by changing utilization patterns. Improving care coordination and care management has real potential for improving health outcomes and reducing overall health care costs, however, it is yet unknown if the integration of Yale New Haven and L&M will contribute to better care coordination and management for patients in the L&M service area.

Connecticut statute gives OHCA the ability to place contingent requirements on the approval of any CON application concerning hospital acquisitions or affiliations. An approval of the proposed affiliation should include conditions that ensure health care consumers in Southeastern Connecticut are protected from large health care cost increases driven by higher reimbursement rates at L&M and affiliated facilities.

Essential health care services in the L&M service area must also be protected through the CON process. Yale New Haven and L&M have indicated that no reduction in clinical services is planned as a part of the affiliation, and in fact there are plans to expand certain clinical services at existing L&M facilities. Recently, another major hospital system, Hartford Healthcare, drastically reduced services at Windham Hospital in Willimantic. The reduction in services at Windham Hospital has created significant concern and discontent in the community. Area residents and clinical staff at L&M have expressed concerns that the affiliation with Yale New Haven may eventually result in a similar outcome in the L&M service area. Yale New Haven has stated that their hospital affiliation structure differs from Hartford Health Care as evidence that a similar outcome is less likely. Nonetheless, OHCA can use its regulatory authority to place conditions on the approval of the CON that ensure the planned expansion in services occur and existing critical health care services are maintained.

The costs and access concerns the Yale New Haven and L&M affiliation raise should be directly addressed to the satisfaction of OHCA, the Commissioner of the Department of Public Health and the Attorney General in order for the affiliation to proceed. Separate negotiations by facility are not enough to control the increase in reimbursement rates that result from provider consolidation; OHCA will need to use other mechanisms to protect consumers from unreasonable cost increases. Similarly, OHCA should insist upon adequate protections that will ensure continued and expanded access to essential clinical services by residents in the L&M service area.

The proposed affiliation between Yale New Haven and L&M presents both potential benefits and potential risks for residents in the L&M service area. I am not advocating for the approval or denial of the CON application in front of OHCA, but -- should the application merit approval -- I am advocating any such approval be contingent upon necessary guarantees and protections to protect health care consumers from the risks of increased health care costs and ensure the retention and expansion of health care services for residents in the L&M service area.

I thank you for your consideration.

Sincerely,

Kevin Lembo
State Comptroller

To: Pino, Raul
Subject: Letter to Commissioner Pino RE: Docket No. 15-32033-CON

Subject: Letter to Commissioner Pino RE: Docket No. 15-32033-CON

Dear Commissioner Pino,

Please see attached letter regarding docket # 15-32033-CON.

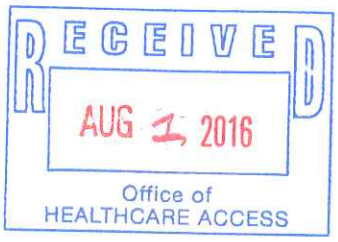
Sincerely,

Kevin Lembo
State Comptroller
860-702-3301

LAWRENCE +MEMORIAL HOSPITAL

365 Montauk Avenue | New London, CT 06320
860.442.0711 | lmhospital.org

July 14, 2016



Kimberly Martone
Director of Operations
Office of Healthcare Access Division
Department of Public Health
410 Capital Avenue
MS 13HCA
P.O. Box 340308
Hartford, CT 06134-0308

I am writing concerning the proposed affiliation between Lawrence + Memorial Hospital and Yale Health Systems.

We have been affiliated with Yale Stroke Service for over eight years. When we began, there was no stroke service, and now we have one of the leading primary stroke centers in the State of Connecticut. Currently, I am the director of the stroke service.

Our relationship has been extremely positive. I note that people have concerns that we be losing patients and business to Yale. Our affiliation with Yale has had the opposite effect. We currently keep 90% of patients that have had strokes at L+M Hospital. The affiliation has increased the quality of medical care for strokes with enhanced laboratory services, x-ray services, interventional radiology and increased rehabilitation services.

I can only speak positively of our affiliation with Yale and encourage that we proceed.

Daniel Moalli MD

Daniel Moalli, MD
Director, Stroke Service

DM:lst

D9.2

PUBLIC HEARING
~~APPLICANT~~ General Public
SIGN UP SHEET
July 11, 2016
3:00 p.m.

Docket Number: 15-32032-CON
Northeast Medical Group, Inc. L&M Physician Association, Inc.
Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

PRINT NAME	Phone	Fax	Representing Organization
John Brady	860-908-9711		AFT Connecticut
MARK KOSNOFF for Ocean Pellett	203-494-8426		UNITED ACTION CT.
NANCY GRANT	860 6257838		—
JANET K. ANDERSON	860.789.9805		
Stephanye R. Clarke	860.984.7155		

Duplicate

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Debbie Wyszocki	860 705 8787	860 537-1322	AFT 5049
MaryEllen Masciale	860 271 9974		AFT 5051
~~Kristen Bowers~~ * written testimony	860-912-3138		AFT 5051
Sharon Palmer	860-447-0662		

Not speaking

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Representing Organization
Nancy Nahas 860 912 0231	Local 217
Tony Rescigno 203-510-7801	New Haven Chamber
Curtis Hill 203-410-3679	Concepts for Adaptive Learning
Jenny Kozlowski 203 7851000	Economic Development Corp of New Haven
Rachel Pond	AFT 5049
Sharon Palmer	AFT/ resident DOL comm.

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Representing Organization
Shawn Powers 298 Lesterbown Rd Groton, CT 06340	Community SELF
Peter Zendan 441-7393	Patient L+M

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Jane Lesser Bohnuff	860-961-7103		/
Tony SHERIDAN	8607019113		Chamber of Commerce Est.
Cherie Poirier	8602086562		Eastern CT AHEC
Thomas A. Moore, Jr	860 467 6834	——	myself
DAN FLANAGAN	203915-1332		TEAMSTERS UNION
DAN BRANNEGAN	8583378673		Self
Tucker Leary	2036764745		self, local resident
(DUPLICATE) John Calleci	401 831 3647		United Nurses & Allied Professionals
Oliver Porter	860 287-2187		self.
CHRIS SOTO	860-501-4800		39th DISTRICT-NL

Northeast Medical Group, Inc. L&M Physician Association, Inc.

PRINT NAME	Phone	Fax	Representing Organization
Jean Jordan	860 439-1423		NL NAACP
Bonnie Stauffer			THC and NLC
Peter Cooper	(914)907-7834		N/A
Dennis Long MD	860 912 9140		Self
Ryan Henowitz	860-705-0891		Democratic Candidate for State Senate
Mitchell Ross	860-437-7994		L+M Techs / AFT-CT 5051
Harry Rodriguez	860-772-2283		L+M Healthcare Workers
Barbara Sadowski	860 549-8145		L+M RN
Dale Cunningham	860-857-0943		L+M RN AFT Local 5049
Lisa D'Andrea	860-389-6620		AFT Local 5049

~~Elected Officials~~ / ~~Agency Reps~~ Pg. 1

PUBLIC HEARING
~~GENERAL~~ PUBLIC OFFICIALS
SIGN UP SHEET
July 11, 2016
3:00 p.m.

Docket Number: 15-32032-CON
Northeast Medical Group, Inc. L&M Physician Association, Inc.
Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

	PRINT NAME	Representing Organization
*	Tomas Reyes	City of New Haven, Mayor's Office
*	Bruce Flax	Town of Groton Mayor
→	Stephen Greene	Westerly Hospital
→	James Mitchell	L+M Hospital Board
	Lisa Konicki	Ocean Community Chamber of Commerce
*	State Rep. Kathleen McCarty	Connecticut General Assembly
*	Scott Mahoney	Watford Chief of Police
→	Dr. Brian Camus	
*	Senator Art Linares	State Senator

not sure how these 3 are elected officials

PUBLIC HEARING
PUBLIC OFFICIAL
SIGN UP SHEET

July 11, 2016
3:00 p.m.

Docket Number: 15-32032-CON
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Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

PRINT NAME	Phone	Fax	Representing Organization
* Erica Richardson	860-910-8207		New London City Council President
* Michael Passero	860-447-5201		Mayor, New London
Martha Marks			city council

PUBLIC COMMENT

NAME	ORGANIZATION	EMAIL
Erica Richardson	New London City Council	ericarichardson32@gmail.com
John V. Callaci	United Nurses	JCallaci@UNAP.org
Jerald Barber	Greater New Haven Clergy Association	jeroldbarber@comcast.net
Bill Kilpatrick	New Haven NAACP	wkilpat@aol.com
Karen Delvecchio	BRBC	
Robert Todin	TCORJ	RJ TOBIN@TCORJ.com
Nancy Grant	Mom	NP6325@gmail.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

July 15, 2016

The Honorable Paul Formica
Senator – 20th District
State of Connecticut
Legislative Office Bldg., Suite 3400
300 Capitol Ave.
Hartford, CT 06106-1591

Re: Certificate of Need Docket Numbers: 15-32033-CON and 15-32032-CON
Yale New Haven Health Services Corporation and L+M Corporation, Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation. Northeast Medical Group, Inc. L&M Physician Association, Inc. acquisition of L&M Physician Association, Inc. by Northeast Medical Group

Dear Senator Formica:

On July 8, 2016, the Department of Public Health ("DPH") received your letter concerning the Certificate of Need ("CON") for the aforementioned dockets.

I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application dockets. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

If you have any further concerns or questions, please feel free to contact Kimberly Martone, Director of Operations for OHCA at (860) 418-7029.

Sincerely,

Janet M. Brancifort

Janet M. Brancifort, MPH, RRT
Deputy Commissioner

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

July 15, 2016

The Honorable Martin M. Looney
President Pro Tempore – 11th District
State of Connecticut
State Capitol
Hartford, CT 06512

Re: Certificate of Need Docket Numbers: 15-32033-CON and 15-32032-CON
Yale New Haven Health Services Corporation and L+M Corporation, Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation. Northeast Medical Group, Inc. L&M Physician Association, Inc. acquisition of L&M Physician Association, Inc. by Northeast Medical Group

Dear Senator Looney:

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I welcome and appreciate your comments regarding this matter. Your letter will be made part of the Office of Health Care Access (OHCA) formal record of the CON application dockets. Please be advised, once a decision has been rendered it will be posted and available on OHCA's website at http:// www.ct.gov/dph/ohca. Meanwhile, OHCA's website maintains status reports that you may review at your convenience.

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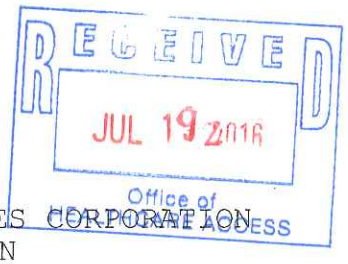
ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS



YALE-NEW HAVEN HEALTH SERVICES CORPORATION
L & M CORPORATION

ACQUISITION OF LAWRENCE & MEMORIAL CORPORATION
BY YALE-NEW HAVEN HEALTH SERVICES CORPORATION

DOCKET NO. 15-32033-CON

AND

NORTHEAST MEDICAL GROUP, INC.
L & M PHYSICIAN ASSOCIATION, INC.

ACQUISITION OF L & M PHYSICIAN
ASSOCIATION, INC. BY
NORTHEAST MEDICAL GROUP

DOCKET NO. 15-32032-CON

JULY 11, 2016

3:15 P.M.

HOLIDAY INN
35 GOVERNOR WINTHROP BOULEVARD
NEW LONDON, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Yale-New Haven Health Services Corporation, L & M Corporation, Acquisition of Lawrence & Memorial Corporation by Yale-New Haven Health Services Corporation and Northeast Medical Group, Inc., L & M Physician Association, Inc., Acquisition of L & M Physician Association, Inc. by Northeast Medical Group, held at the Holiday Inn, 35 Governor Winthrop Boulevard, New London, Connecticut, on July 11, 2016 at 3:15 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. Can everyone hear me? Is this working? In the back, can you hear me okay? Good.

This public hearing before the Office of Health Care Access, identified by Docket Nos. 15-32032-CON and 15-32033-CON, is being held on July 11, 2016 to consider two applications.

One is for Northeast Medical Group, Inc./L & M Physician Association, Inc., the acquisition of L & M Physician Association, Inc. by Northeast Medical Group,

and the second application is Yale-New Haven Health Services Corporation/L & M Corporation for the acquisition of Lawrence & Memorial Corporation by Yale-New Haven Health Services Corporation.

This public hearing is being held pursuant to Connecticut General Statutes, Section 19a-639a, and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Kevin Hansted, and I have been designated as the Hearing Officer for both of these matters.

The staff members assigned to this case are Kaila Riggott, Steven Lazarus and Brian Carney to my right. The hearing is being recorded by Post Reporting Services.

In making its decision, OHCA will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

Yale-New Haven Health Services Corporation and Northeast Medical Group have been designated as parties in this proceeding.

In addition, the Intervenors in this

matter, in both of these matters, with full rights are AFT Connecticut, Connecticut Citizen Action Group, Unite Here Connecticut, National Physicians Alliance in Connecticut, Connecticut Health Policy Project, United Action Connecticut and New England Health Care Employees, District 1199, SEIU, and, again, they've all been designated as Intervenors with full rights.

At this time, I will ask staff to read into the record those documents already appearing in OHCA's two Table of the Records.

All documents have been identified in the Tables for reference purposes. Mr. Lazarus?

MR. STEVEN LAZARUS: Good afternoon. Steven Lazarus. For the record, we're going to enter Exhibits A through U for Docket No. 15-32032-CON and Exhibits A through CC for Docket No. 15-32033-CON.

HEARING OFFICER HANSTED: Counsel, would you identify yourselves for the record, and let me know if you have any objections to either table?

MS. JOAN FELDMAN: Joan Feldman on behalf of the Applicants. I have no objections.

HEARING OFFICER HANSTED: Thank you, counsel.

MR. HENRY MURRAY: Henry Murray for the

Intervenors, and I have no objection.

HEARING OFFICER HANSTED: Thank you, counsel.

MR. MURRAY: Mr. Hansted?

HEARING OFFICER HANSTED: Yes?

MR. MURRAY: May I be heard for one minute?

HEARING OFFICER HANSTED: Yes.

MR. MURRAY: We filed this morning with your office a pre-filed testimony, which was inadvertently left out of our filing, and we would ask that it be included in the record or as an after-filing document.

HEARING OFFICER HANSTED: No, we will include that in the record. Mr. Lazarus, was that one of the ones you included?

MR. LAZARUS: No, it will be included.

MS. FELDMAN: Attorney Hansted, I would like to make an objection. I received that pre-filed testimony at 10:15 this morning, 11 days after it was supposed to be filed, and I believe it's irrelevant, in that, at the end of the pre-filed testimony, it was stated it was for the purpose of the Governor's Health Care Cabinet, so I don't really believe it's relevant to

this proceeding, and it doesn't comply with OHCA's rules.

HEARING OFFICER HANSTED: Okay, counsel, I'll give it the weight it's due, therefore, your objection is overruled, so we'll add it to the record.

MS. FELDMAN: Thank you.

HEARING OFFICER HANSTED: You're welcome. And, this evening, we're doing things a little bit different. We are going to, given the large amount of public in the room, we are going to allow public comment first.

We'll defer to any elected officials that may be present. We'll let them speak first, and then we'll go to the public comment sign-up sheets.

For those of you, who wish to speak, please make sure that you've signed up on the sign-up sheets that are outside of the room, because we will be calling individuals up to speak in the order that you've signed up.

After that, we will first hear the Applicant's presentation under Docket No. 15-32033-CON, followed by the Intervenor's presentation on that same docket number.

Then, when those presentations are done, I'll allow Cross-Examination by both parties. When that

is completed, we will hear from the Applicants on Docket No. 15-32032-CON, followed by the Intervenors' presentation on that docket number and Cross-Examination to follow.

Upon completion of both of those docket numbers, OHCA will have its questions. And, again, once OHCA is completed with its questions, I'll allow another public comment period.

Those folks that are giving comment in the beginning of this hearing may not do so at the end of the hearing.

At this time, I would ask any individuals, who are going to testify here today, not including public commenters, to please stand, raise your right hand, and be sworn in by the court reporter.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER HANSTED: Okay. Would all those folks that were just sworn in please, one-by-one, identify yourselves for the record?

MR. MURRAY: How would you like us to start, Mr. Hansted? On this end?

HEARING OFFICER HANSTED: However you wish. I'd like the Applicants to go first, though,

please, Attorney Murray.

MR. BRUCE CUMMINGS: Bruce Cummings, the CEO from Lawrence & Memorial Healthcare.

MS. MARNA BORGSTROM: Marna Borgstrom, CEO, Yale-New Haven Health System.

DR. TOM BALCEZAK: Tom Balcezak, Chief Medical Officer, Yale-New Haven Hospital.

DR. MONICA NOETHER: Monica Noether, Economist with Charles River Associates.

MR. JOE CRESPO: Joe Crespo, Chairman of the Board of Yale-New Haven Health System.

DR. ROSS SANFILIPPO: Ross Sanfilippo, Lawrence & Memorial Healthcare Board.

HEARING OFFICER HANSTED: Do we have any other folks on this side? I know there were some that stood up. Just feel free to come up to the microphone and just identify yourselves.

MS. FELDMAN: For this application?

HEARING OFFICER HANSTED: Yes, for both of them.

MS. FELDMAN: Oh, for both.

HEARING OFFICER HANSTED: Do it all at once.

MR. CHRIS LEHRACH: Chris Lehrach,

President of the Lawrence & Memorial Medical Group.

DR. PRATHIBHA VARKEY: Prathibha Varkey, CEO, Northeast Medical Group.

DR. ARNOLD DoROSARIO: Arnold DoRosario, Chief Medical Officer, NEMG.

MR. KEITH TANDLER: Keith Tandler, Executive Director Finance, Yale-New Haven Health System.

MR. SETH VAN ESSENDELFT: Seth Van Essendelft. I'm the Chief Financial Officer for L & M.

MR. VINCENT TAMMARO: Vincent Tammaro, Chief Financial Officer for Yale-New Haven Health System.

MS. GAYLE CAPOZZALO: Gayle Capozzalo, Chief Strategy Officer, Yale-New Haven Health System.

MR. WILLIAM ASELTYNE: William Aseltyne, general counsel, Yale-New Haven Health System.

MS. NANCY LEVITT-ROSENTHAL: Nancy Levitt-Rosenthal, Vice President, Yale-New Haven Health System.

DR. ALLEN HSIAO: Allen Hsiao, Chief Medical Information Officer, Yale-New Haven Health System.

MR. BRETT PERRONE: Brett Perrone, Director of Financial Planning, Yale-New Haven Health System.

MR. KEVIN MYATT: Kevin Myatt, Chief Human

Resource Officer, Yale-New Haven Health System.

MS. TINA DiCIOCCIO: Tina DiCioccio, L & M Hospital Corporate Controller.

MR. JIM PULLA: Jim Pulla, Deloitte Transactions and Business Analytics.

MS. DONNA EPPS: Donna Epps, Vice President, Human Resources, Lawrence & Memorial Hospital.

MR. MATTHEW TASSONI: Matthew Tassoni, Deloitte Transactions and Business Analytics.

MS. SHRADDHA PATEL: Shraddha Patel, Director of Planning, L & M Healthcare.

MS. AMY RICHARDS: Amy Richards, Director of Planning, Yale-New Haven Health System.

MS. TARA ESTABROOKS: Tara Estabrooks, Associate Director of Business Development for Yale-New Haven Health System.

MS. AMANDA SKINNER: Amanda Skinner, Executive Director of Clinical Integration and Population Health, Yale-New Haven Health System.

DR. DANIEL RISSI: Daniel Rissi, Chief Medical Officer, L & M Hospital.

MS. AUGUSTA MUELLER: Augusta Mueller, Community Benefits Manager for Yale-New Haven Health.

MS. LYN SALSGIVER: Lyn Salsgiver, Vice

President for Strategic Planning and Community Health Improvement for Yale-New Haven Health System.

MR. ART LINARES: Art Linares, State Senator for the 33rd District.

MS. KATHLEEN McCARTY: Kathleen McCarty, State Representative for the 38th District.

MR. ABE LOPMAN: Abe Lopman, Executive Director of Smilow Cancer Hospital.

MR. STEPHEN GREENE: Stephen Greene, Board Chair, Westerly Hospital.

MS. LISA KONICKI: Lisa Konicki, President, Ocean Community Chamber of Commerce.

MR. JAMES MITCHELL: James Mitchell, L & M Board Member.

MS. JANE LASSEN BOBRUFF: Jane Lassen Bobruff, community member.

MR. TONY SHERIDAN: Tony Sheridan, President of the Chamber of Commerce of Eastern Connecticut.

MR. JACK CALLACI: Jack Callaci, United Nurses and Allied Professionals.

HEARING OFFICER HANSTED: Okay, I think we have everyone on this side. Attorney Murray, do you want to do the same for your side?

Again, the folks that are here for public comment, please do not identify yourself at this time.

DR. FRED HYDE: Fred Hyde for the American Federation of Teachers.

MS. STEPHANIE JOHNSON: Stephanie Johnson, President of the LPN Techs for AFT Connecticut representing L & M Hospital employees and a sleep tech.

MS. ELLEN ANDREWS: Ellen Andrews for Connecticut Health Policy Project.

MS. MARITZA BOND: Maritza Bond, Executive Director for Eastern Area Health Education Center.

MR. JASON PELLETIER: Hi. I'm Jason Pelletier. I am a shop steward for Local 217 Unite Here.

HEARING OFFICER HANSTED: Do you have anyone else, Attorney Murray?

MR. MURRAY: Not on our list of witnesses, Attorney Hansted.

HEARING OFFICER HANSTED: Okay, thank you. At this point, we're going to go to -- actually, before we get to the public comment section, Attorney Feldman, did you want an opportunity -- I'm happy to give you an opportunity to respond in writing to the pre-filed testimony that was filed today with my office. Did you want that opportunity?

MS. FELDMAN: No, thank you.

HEARING OFFICER HANSTED: Okay and, so, we will go to the public comment section at this point, and we'll start with the elected officials. I believe we have a list up here.

And for those of you, who do not hear your name called, just let us know once we get through the sign-up sheet, and we can take you at that time.

MR. TOMAS REYES: Good afternoon. My name is Tomas Reyes, and I'm representing Mayor Toni Harp from New Haven. I serve as her Chief of Staff, and I'm going to read a prepared statement, which I will then leave with you.

I'm here on behalf of Mayor Toni Harp of the City of New Haven to lend our strong support to the proposed affiliation of Lawrence & Memorial Health with the Yale-New Haven Health System.

As a city dedicated to building better lives, we understand the value of developing and sustaining strong working relationships with our employers.

Over the years, we have cultivated a healthy and productive working relationship with Yale-New Haven Hospital and its more than 12,000 employees.

We view this relationship as mutually beneficial, acknowledging that a strong educational and medical foundation has contributed to a stable economic environment and has made New Haven a success story.

For its part, Yale-New Haven has stepped up as a strong and consistent partner with the city and the community. It has been a longstanding supporter of important community-driven programs, such as New Haven Promise, ConnCAT and New Haven Works.

Each of these initiatives provides opportunity for residents of New Haven through access to education and jobs for the future.

Additionally, Yale-New Haven has been an advocate for the City of New Haven. It has sponsored important programs that project the positive image of the city to broader audiences, including their role as a major sponsor of the Connecticut Open Tennis Tournament and a founding partner of Market New Haven.

Yale-New Haven has been a member of our community for nearly 200 years. It has grown with New Haven and provided us with national recognition and local access to exceptional health care.

It has been a catalyst for new development and investment, such as the decision by Alexion to locate

their corporate headquarters in our city. We firmly believe that a strong Yale-New Haven makes the City of New Haven, itself, stronger.

Finally, we recognize that the current environment has provided enormous challenges for health care providers, like Yale-New Haven and Lawrence & Memorial.

Uncertainty and complexity define the future, and that is why affiliations, such as the one you are considering today, are so important.

We are proud of our partnership, and we are here today to support this affiliation. We ask the Office of Health Care Access to approve this application, and we urge you to do so in a timely manner. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. KAILA RIGGOTT: Bruce Flax.

MR. BRUCE FLAX: Thank you. Good afternoon, members of the panel. My name is Bruce Flax. I am the Mayor of the Town of Groton, the single largest municipality in eastern Connecticut.

To say that ours is a diverse community would be an understatement. We are proudly the Submarine Capitol of the world, hosting a U.S. Navy Submarine Base, the USS Nautilus Museum and the world's leading

manufacturer of nuclear submarines and the region's largest employer, the Electric Boat Division of General Dynamics, but there's much more.

The City of Groton is located within the Town of Groton. So is the borough of Groton Long Point and the well-to-do villages of Noank and Mystic.

The City has its own utility company and a large division of Pfizer, the world's largest pharmaceutical company, is also located here.

Different parts of our community are as different as the busy mall line commercial strip in the middle of our town is from the quaint little shops in historic Downtown Mystic.

There are million-dollar homes along the waterfront, and there is subsidized housing. We are a community of marinas and a long-anticipated new water taxi.

We have education at every level, from our seven elementary and magnet schools to a technical school, Fitch High School, home of the undefeated, number one ranked Falcon's girls' softball team, to the Avery Point branch of the University of Connecticut.

I could spend a lot of time going on about so many of the other interesting and different qualities

of our community, but I'll stop there to talk a little bit about what the vast majority of us, young and old, middle age, black, white, Asian and Latino, wealthy and those struggling to make ends meet, organized labor and management at major industry and small business, have in common.

We receive our health care at Lawrence & Memorial. Whether it's L & M's Pequot Health Center just off Interstate 95 here in Groton, one of L & M's primary care practices also located in Groton, the main L & M Hospital campus across the Thames River in New London, where four of my children were born, Westerly Hospital just across the border in Rhode Island, or from the Visiting Nurses Association based in nearby Waterford, most of our town's approximately 40,000 residents rely on L & M for their care.

So, as the Mayor of this town, I get concerned when I learn that our region's leading health care provider and one of its leading employers is experiencing financial difficulty.

As a town suffering through millions in State funding cuts ourselves, we know the challenges associated with this kind of urgent distress, especially when it's something over which we have little or no

control.

We know that, in L & M's case, this downward financial trend cannot continue, especially if those, who have relied on L & M for health care for many years, expect to find the same level of programs, services and staffing available to them, as have been available for generations.

L & M and Yale-New Haven are already affiliated in six different clinical areas; cardiac, cancer, stroke, pediatrics, pediatric emergency and neonatal care.

Some of their physicians practice here, and some of L & M's practice there. A full affiliation would make great sense from every perspective; access to and range of clinical offerings, financial stability, logistical and strategic.

I hope you will concur that this affiliation between two quality health care systems is in the best interests of their employees and the patients they treat from their respective service areas. Thank you.

HEARING OFFICER HANSTED: Thank you.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: At this point,

we have an individual, who needs to testify on behalf of the Applicants and needs to leave, so I'm going to allow that. Attorney Feldman, if you want to give your opening statement on the applications and then present your witness?

MS. FELDMAN: Thank you, Attorney Hansted.

HEARING OFFICER HANSTED: You're welcome.

MS. FELDMAN: As OHCA is well aware, during February, Governor Malloy issued Executive Order No. 51, which directed OHCA to either delay a decision on this application or to make three adverse findings with respect to this application.

The Applicants believe that the Executive Order 51 is void and unenforceable, as it relates to this application, and we strongly believe that the application should be considered and judged against the proper legislatively-prescribed criteria, along with the testimony that you will hear today.

We've heard now almost four hours of oral testimony, and what is very clear is that much of the public testimony and the position of the Intervenors is very consistent with the position of the Applicants.

The Applicants are very invested in making sure there is access in the L & M community, diversity of

providers in the L & M community, that there are efficiencies, that there is a commitment to quality care. None of that is divergent from what we heard today, so I really do not think that there's much controversy with respect to this application.

That having been said, there are multiple agendas here that are completely unrelated to this proceeding and the issues at hand.

It is my hope that this proceeding can focus on the issues that OHCA is legislatively mandated to consider in determining whether or not to grant this application. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. FELDMAN: Mr. Crespo, who is Chairman of the Board of Yale-New Haven Health, would like to give his pre-filed testimony.

HEARING OFFICER HANSTED: Okay, thank you.

MR. CRESPO: Thank you. Good afternoon, Attorney Hansted and members of the OHCA staff.

HEARING OFFICER HANSTED: Good afternoon.

MR. CRESPO: My name is Joe Crespo, and I'm Chairman of the Board of Trustees of Yale-New Haven Health System. I'm a volunteer and dedicate a lot of the time to the governance of the Yale-New Haven Health.

First of all, I would like to adopt my pre-filed testimony, as you have it.

HEARING OFFICER HANSTED: Thank you.

MR. CRESPO: The Boards of our hospital are composed of community, business and position leaders from the communities that they serve. Our Boards are diverse, active and engaged.

These Boards are critical to Yale-New Haven Health's success, as their input helps frame our strategies.

Yale-New Haven Health and L & M are committed to maintaining a local Board that ensures the needs of its community, that the needs of its communities are represented, as well, and well-served when considering both local and system strategies.

Now I want to clarify one point. I understand that there may be some confusion about the governance of L & M if this affiliation is approved, and I would like to take this opportunity to explain our governance philosophy.

As in the case with all the hospitals in Yale-New Haven Health, one Board member will be appointed by the system to the local Board, and that Board member will have one vote, just like the rest of all of the

members on the L & M Boards.

While some decisions that affect the entire system will be made by the Yale-New Haven Health Board, most significant decisions, including regarding clinical problems, will require L & M approval.

L & M has chosen to form a relationship with Yale-New Haven Health that will allow us to address community needs, ensure continued access to leader services, and enhance the efficiency of healthcare systems in the State.

Therefore, I urge you to approve this application and to allow Yale-New Haven Health and L & M to forge a partnership that will be truly beneficial for all involved. Thank you.

HEARING OFFICER HANSTED: Thank you, Mr. Crespo. And, at this point, I want to take a 15-minute break, so please report back here promptly, so we can continue the hearing in 15 minutes. Thank you, all.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're going to get going again here. Okay, Attorney Feldman, if you would like to continue with your case in chief?

MS. FELDMAN: Thank you, Attorney Hansted. Bruce Cummings would like to provide his pre-filed

testimony.

HEARING OFFICER HANSTED: Absolutely.

MR. CUMMINGS: Good evening.

HEARING OFFICER HANSTED: Good evening.

MR. CUMMINGS: Good evening, Attorney Hansted and OHCA staff. I'd like to adopt my pre-filed testimony as my own.

HEARING OFFICER HANSTED: Thank you.

MR. CUMMINGS: My name is Bruce Cummings, and I am the President and CEO of Lawrence & Memorial Corporation, which is the parent entity for Lawrence & Memorial Hospital, the Westerly Hospital in Rhode Island, the L & M Physician Association, and the Visiting Nurse Association of Southeastern Connecticut, collectively known as the L & M Health Care System.

On a personal note, I live in New London. This has been my home for 11 years. L & M is my hospital, and the L & M Medical Group is my physician and that of my wife, and I'm happy to report that one of my grandchildren was born at L & M two years ago, and number two will be born this summer in August, so I'm grateful to have this opportunity to speak with you and to convey my reasons for recommending to you that it approve the CON application now before you, allowing L & M Health

Care to affiliate with Yale-New Haven Health.

We've heard from a number of people in the audience bandying about terms like merger, acquisition, and, certainly, in particular, pejorative takeover, none of which are applicable here in relation to L & M Health Care and Yale-New Haven Health.

It is an affiliation. To be sure, you'll hear later about a proposed merger between the L & M Medical Group and the Northeast Medical Group. That is a true merger, but, for L & M Health Care and Yale-New Haven Health, it is an affiliation, not an acquisition.

The two entities have a long history of clinical collaboration and support. We have complimentary missions, visions, philosophies and values around patient care and community service.

During the past 10 years, L & M has turned to Yale-New Haven Health to provide a number of needed services within the L & M primary service area to promote access, a theme that you'll hear us articulate and restate on a number of occasions about promoting access in the areas of heart and vascular care, medical and radiation oncology, pediatric and neonatal services and neurosurgery and stroke.

You heard this afternoon from Dr. Brian

Cambi, who offered a case study around emergency and elective angioplasty, a capability available in L & M by virtue of our connection to the Yale-New Haven Heart and Vascular Center, but I wanted to mention two others.

A Telestroke Program, we were actually the first community hospital in Connecticut to develop and implement such a program, and that, again, was made possible, because of a relationship with Yale-New Haven Hospital that has resulted in saving literally hundreds of lives, and only late last year new pediatric hospitalist service, at a time when most community hospitals have abandoned completely offering pediatric services, we moved in a different direction, thanks to a relationship with Yale Children's Hospital, Yale-New Haven Children's Hospital, that resulted in a team of well-trained pediatric hospitalists coming to our community and reestablishing hospital-based inpatient pediatric care.

These clinical collaborations have not been sufficient to address all of the challenges in health care today.

Other market forces have created other imperatives for L & M that make this proposal a necessity rather than a luxury.

As health systems undertake this transition from a traditional fee-for-service or volume-driven environment to a value-based or outcome-oriented delivery system, they will need access to all the components of a fully integrated health care delivery model.

This shift that I'm describing requires alternative care models and access to affordable capitol to fund the new generation of technology and resource development, along with data analytics, to improve the health of the population served, a capability that simply we do not have as a small community controlled health system.

When you couple these imperatives with aging infrastructure, a growing population of older and sicker adults and demands for more effective medical treatments and technologies, it becomes clear that the challenges are daunting on many levels, not the least of which is financial.

One significant driving force between L & M's decision to affiliate with Yale-New Haven Health has been our progressively declining financial performance over the past three fiscal years.

During those past three fiscal years, L &

M has experienced a significant decline in its revenues. This decline has been the result of many factors; the State of Connecticut budgetary rescissions and the Medicaid supplemental pool, along with hospital taxes increasing.

This has gone in 2013 from a tax of $1 million to $18 million this past year, with about $5 million restored late in the legislative session, so all together an adverse impact of $13 million on a one-year basis.

There have been no updates, no payment increases for Medicaid since 2008. Indeed, when I came 11 years ago to New London, L & M was paid about 65 to 70 cents on the dollar. Today, it's half that, and, at the same time, the percentage of our patient population has gone from around eight percent on Medicaid to more than 18 percent on Medicaid, a doubling of the population and a halving of the payment levels.

We've seen the 75 percent reduction in federal disproportionate share payments, payers increasing the shift away from fee-for-service to value-based payments, an unwillingness on the part of commercial payers to bear the burden of insufficient government funding, and, last, but not least, reductions

in inpatient hospital utilization. Put plainly, we've seen a huge shift at virtually every hospital, especially in community hospitals, on the part of Medicare moving what used to be considered inpatient acute admissions to observation status.

All of these factors have a cumulative and detrimental impact on our financial status, and, in May of this year, our bond rating was downgraded by Standard & Poor from an A+ rating just three years ago to a triple B+.

S & P's rating agency attributed three factors to that downgrade; the Connecticut State Hospital Tax, inpatient softness with a mix to these observation patients, and a weakened balance sheet.

Unfortunately, our demand for capital to meet our community needs to enhance access is the greatest it has ever been.

Healthcare reform requires innovative responses to meet the demands for higher quality care at lower cost. L & M is without the capacity or the capital to take on such challenges on its own, a conclusion that our Board began to come to in January 2015 and completed its independent internal assessment and ultimate decision to affiliate with Yale-New Haven Health in June of 2015.

Yale-New Haven Health and L & M have agreed on a commitment of $300 million to enhance and support both clinical and operational initiatives, consistent with the needs of the Eastern Connecticut Region.

Without a capital infusion, a financial downward spiral is very likely. Such financial downturn for L & M would be counter-productive, hard to recover from, and negatively impact access to care for the financially disadvantaged and underserved and most vulnerable members of the L & M community.

If approved, the Applicants together intend to meet the needs of the region through a jointly-developed strategic plan, with a focus on greater access to primary care, cost-effective alignment of service lines, such as oncology, cardiology, neurosurgery, emergency medicine, surgery, orthopedics and behavioral health, along with enhancements to operational infrastructure.

Let me take a moment to clear up a misconception that some may hold about this $300 million investment. It is not dependent on Yale-New Haven Health making a profit, rather, 85 million of this 300 million investment is already committed, and the remaining 215

million in investments will be made over five years, based upon mutually agreed upon business plans and the financial performance of L & M.

This is a rational and prudent approach to ensuring the financial stability of L & M and its continued presence in the community.

In the event this application is not approved, it's my opinion and belief that many of the programs discussed in our application will be in serious jeopardy and will force us to make the type of difficult decisions that will inevitably and negatively impact our community benefit program clinical offerings and, consequently, jobs.

For all the reasons discussed in our application and the testimony provided today, I urge OHCA to approve this application without delay.

Let me introduce Dr. Tom Balcezak, the Chief Medical Officer. Are you going next, or Ron is going to go next? Okay. Turn it back to you, Joan.

MS. FELDMAN: Dr. Ross Sanfilippo will provide his pre-filed testimony. He's a member of the L & M Corporation Board of Directors.

DR. SANFILIPPO: Good evening, Attorney Hansted and the OHCA staff.

HEARING OFFICER HANSTED: Good evening.

DR. SANFILIPPO: My name is Dr. Ross Sanfilippo, and I am a member of the Board of Directors of the Lawrence & Memorial Corporation. I adopt my pre-filed testimony as my own.

I am very appreciative of this opportunity to speak to you today on behalf of my fellow Board members and recommend to OHCA that it allow L & M to affiliate with Yale-New Haven Health.

I've been in private practice in New London and on the staff of the Department of Surgery here at L & M for over 20 years.

My family receives healthcare here from both my L & M and Yale-New Haven colleagues, and, like many others, my children were born here at L & M.

Since the passage of the Affordable Care Act, it has become very clear to the Board that past assumptions and approaches to the delivery of health care would no longer serve us well.

We endeavored to reduce expenses, but that was not enough. Given the associated costs with data analytics, IT platforms, population health and coordination of care, our Board knew that we needed access to capital and a greater scale.

L & M has historically enjoyed a very positive working relationship with Yale-New Haven Health Services. We are excited about the potential to be associated with their brand, their quality, their standards and recruit the best and brightest physicians to our L & M community from Yale-New Haven Health System.

If OHCA does not approve this application, I am here to say that there will be negative consequences to our L & M community. Indeed, some of which may not be reversible and may even result in less access to care, less diversity of providers, and, even worse, a less healthy community with programs that have to be cut.

OHCA should also know that the L & M Board will remain in place and continue to govern locally. Our Board is and will remain fully engaged in our community. We live and work here.

I also want to remind everybody that this -- we are very excited about this continuing role, and I must point out that this is in stark contrast to how other systems in the State govern and relate to their community Boards. This is not going to be a Hartford/Windham situation. Our Board made sure of that.

I must tell all of those in the room today that my fellow Board members and I consider ourselves

fiduciary of the community, and we would not be here recommending this proposal if we did not think it was in the best interest of our community with respect to providing not only high-quality, but, also, affordable care.

For all these reasons, I urge OHCA to consider our testimony today and allow us to form this relationship with Yale-New Haven Health, as we are committed to the future and to the success of L & M here in our community. Thank you.

HEARING OFFICER HANSTED: Thank you.

DR. BALCEZAK: Good afternoon, Hearing Officer Hansted and the entire OHCA staff. My name is Tom Balcezak. I'm the Chief Medical Officer at Yale-New Haven.

On a personal note, I'm also a lifelong resident in the State of Connecticut, trained here in both medical school at the University of Connecticut and my residency at Yale-New Haven Hospital and have lots of colleagues at the hospitals across the State of Connecticut.

I ask that you please adopt my pre-filed testimony. As outlined in that pre-filed testimony and as Bruce Cummings just noted, there's a long history of

clinical collaborations between L & M and Yale-New Haven Hospital, but those relationships can only go so far, and if this application is approved, I would look forward to working with my colleagues at L & M to enhance the clinical offerings available in the area, as we have done with both Bridgeport and Greenwich Hospitals.

Yale-New Haven Hospital's interest here is not in filling Yale-New Haven Hospital's beds, nor are we interested in moving clinical programs or patients to Yale-New Haven.

For one, we currently don't have the space. We routinely operate at or above our capacity, and, second, it's not the approach of Yale-New Haven Health, rather, we seek to enhance the clinical offerings in the community, so that we can ensure high-quality patient care provided locally here with these local physicians.

And, again, on a personal note, that's not just our philosophy as an institution. It's also my personal goal, since both my parents live in this community, my brother and his family live in this community and works at Electric Boat.

They get their local care here. They've had procedures here, GI procedures, surgical procedures,

and it is, I believe, in all of their best interests, as well as this community, that we continue to provide that care and continue to enhance it.

I understand that in another context it's been suggested to OHCA that physicians associated with the Yale Medical Group practicing at L & M have been sending patients to Yale-New Haven Hospital for cardiac procedures, rather than performing them at L & M.

We have looked at this, and I want to assure OHCA that we have not seen an increase in cardiac procedures from the New London area and that only those cases that cannot be performed safely at L & M are appropriate and have been transferred to Yale-New Haven Hospital.

That's the principle we currently follow, and it's a principle that we would continue to follow, even if this affiliation is approved.

Transfers to Yale-New Haven would only be appropriate for the most complex and high-risk patients, and given the transition that we are seeing nationally from payment systems that reward volume to those that reward value is, in fact, in Yale-New Haven Health's and Yale-New Haven Hospital's best interest to seek the lowest cost care setting for patients whenever possible.

This point is also demonstrated by our track record in Bridgeport and Greenwich, where we have increased the services available in those communities and collaborated with physicians and executives from those hospitals to improve care and reduce costs.

For this reason, I urge OHCA to approve this application. I would now like to introduce Monica Noether, who is an economist from Charles Rivers Associates and has worked in the field of health care economics for a number of years, and we asked her to provide her expert testimony on this affiliation.

DR. NOETHER: Good evening, Attorney Hansted and members of the OHCA panel. First of all, I adopt my pre-filed testimony as my own, and while I can't claim to be a resident of Connecticut currently, I did go to high school and college here, and my parents actually taught at the University of Connecticut for a couple of decades, so I do have some connections here.

I've been asked to contribute to this proceeding as both a resource to OHCA and to respond to issues related to access, diversity of providers and costs.

I can also explain how the antitrust agencies that have jurisdiction over things like

monopolies and acquisitions or affiliations likely determine that they should not challenge this affiliation.

There are four main points that I'd like OHCA to take from my pre-filed testimony. First, prices will not increase as a result of this transaction. Because Yale-New Haven Health and L & M largely serve different customer bases, their affiliation does not change the competitive landscape significantly.

As you know, they're 50 miles apart, and we've heard how difficult it is to travel between the two and the fact that there isn't that much travel really between the two.

Second, Yale-New Haven is, at least the hospital, is an academic medical center, focusing on high end cases, whereas L & M has traditionally been a community hospital serving the local community.

Second, diversity of health care providers and patient choice will, therefore, not be negatively impacted by the proposed affiliation.

Third, to the contrary, given the increasing financial weakness of L & M, which we've heard quite a bit of testimony about, without the affiliation, residents of L & M service area will likely face reduced

choice and access as L & M is forced to cut services.

And, finally, the affiliation will allow L & M to achieve greater efficiencies, enhanced services, and position itself to meet the challenges of healthcare reform that we've also heard several people talk about this afternoon while maintaining jobs as services are increased.

I also need to rebut three statements made by Dr. Hyde in his response to my pre-filed testimony. Perhaps most importantly, Dr. Hyde's assertions about Yale-New Haven's current crisis and its ability to increase prices through affiliations misplaced.

It's not clear on what basis Dr. Hyde describes, quote, "New Haven as the epicenter of extraordinarily high prices." Certainly, the information presented in the Cooper Study that he references does not support that conclusion.

In fact, New Haven average commercial hospital price is, of 12,300 or so, is over six percent below the national average, which is over 13,000, according to data used by Dr. Cooper and reported in the press, and, on the Medicare side, New Haven ranks 40th for Medicare spend across different hospital referral regions across the country, nor does Dr. Hyde's assertion

that Connecticut Medicaid rates are attributable to, quote, "monopoly pricing by Yale-New Haven" have any basis. Prices are set by the State and, as you well know, do not cover costs.

Hyde also claims that I, quote, "appear to take a position contrary to the majority of economists, who have studied the merger of non-profit hospitals."

That's actually not the case, rather, the literature to which he refers does not apply to the proposed affiliation that OHCA must currently rule upon. That literature is concerned with the effects of mergers that actually enhance market power, and for all the reasons that I outlined just now and in my pre-filed testimony, the proposed affiliation does not create or enhance market power.

The FTC and the DOJ have never challenged affiliations of combinations of hospitals that are 50 miles apart, and, therefore, it's not necessarily surprising that the FTC and the Connecticut Attorney General both closed their investigation of this proposed affiliation about a year ago.

Finally, on price information, Dr. Hyde acknowledges that it's difficult to obtain reliable price information, but then proceeds to disagree with himself

by citing several irrelevant sources. For example, administered prices set by Medicare and Medicaid.

Applicants explain in their supplemental pre-filed testimony why there are no readily available price data that accurately distinguishes the complexity of services provided by academic medical centers, such as Yale-New Haven Hospital.

Dr. Hyde cites a study of mine, in which I use charge data as evidence that price data can be used, but I need to point out that that study was based on data from 1977 and '78, i.e., nearly 40 years ago, when the healthcare world was a bit of a different place.

It was a time when individuals and insurers actually paid consisted multiples of charges, so that charges, in fact, had some meaning to them. In fact, DRGs or any other of the features of Medicare's current payment system on which many private payment systems are also based didn't exist, and managed care was in its infancy everywhere, except perhaps California.

And I think that, with that, that's probably enough, given the hour. I appreciate your time today, and I'm obviously available to answer any questions.

HEARING OFFICER HANSTED: Thank you.

MS. BORGSTROM: Great. Thank you. My notes say good afternoon, but I'll say good evening, Attorney Hansted and the rest of the OHCA staff with incredible stamina.

My name is Marna Borgstrom, and I'm the President and Chief Executive Officer of Yale-New Haven Health Services Corporation. I also adopt my pre-filed testimony as my own and appreciate the opportunity to share with you a couple of points of view, and some of it will build on other testimony that you've had.

The application that we put together is intended to support a value-driven affiliation designed, as was said earlier, to improve access, to enhance the quality of care, and reduce the costs through scale.

In fact, about two years ago, the Yale-New Haven Health System Board adopted the following mission statement. Yale-New Haven Health System seeks to enhance the lives of people we serve by providing access to high value, patient-centered care in collaboration with others, who share our values, and that was a very big move for us and very important, because it recognizes that the world is changing, that volume is not going to be the basis on which we're paid, that we really need to be focusing on how to make our communities stronger and

healthier, and no one organization can do that, so collaboration and partnership is going to be critical if we're really going to start to change the way health care is actually provided.

As a result, the culture and the evolution of the Yale-New Haven Health System has not been and is not to grow for the sake of growth.

When we look at our system, until the acquisition of the hospital of St. Raphael, which was a very different form of transaction, Yale-Haven's size has not changed materially since the 1990s.

Yale-New Haven Hospital formed the Yale-New Haven Health System in 1996. Bridgeport Hospital joined. Bridgeport then and in the subsequent few years, as we were getting the system together, was losing money. They were losing patients. They were losing physicians.

If you fast forward to today, Bridgeport is the lead player in the geography they serve. They have among the highest patient satisfaction, physician satisfaction, and the growth in their patient services has been remarkable, and that is a very poor community.

And part of the way that they've grown is they have brought specialists into the Bridgeport community that they couldn't have brought in previously,

and those specialists are providing care in Bridgeport doing their procedures and their services at Bridgeport Hospital.

Greenwich Hospital joined the Yale-New Haven Health System about a year later in 1997, and, similarly, in addition to cost position improvement, has been home to the expansion of services, notably, the Smilow Cancer Hospital and the Yale-New Haven Heart and Vascular Center.

And I think, if you talk to Board members at both of those organizations, they would say both organizations have been enhanced as a result of their affiliation with the Yale-New Haven Health System, which is identical in form to the one that we're proposing for Lawrence & Memorial.

A different form of transaction, almost four years ago, because it was significantly distressed, Yale-New Haven Hospital actually purchased the Hospital of St. Raphael, and, at the time, and that was a much more difficult transaction to work through with the Federal Trade Commission, there were a number of requirements put on that, and we have met, exceeded all of those.

We were asked to save $250 million in

costs. That has been exceeded. We've realized over $400 million in capital cost avoidance, because Yale-New Haven Hospital, which, as Dr. Balcezak said, has been running full, did not have to build additional facilities.

As important, more important, we've made $100 million investment in infrastructure on the St. Raphael's campus since the acquisition, and, as you heard in public testimony earlier, all 3,000 jobs were preserved on that campus.

Employees benefitted from pension plans and wage increases that they had not enjoyed previously, and, as you've also heard, we have enjoyed a very positive and productive relationship with the Teamsters, who represented a number of employees on that campus.

We can do the same, we believe, for Lawrence & Memorial as we've done for Greenwich and for Bridgeport and as a result of the St. Raphael's transaction and the community served by Lawrence & Memorial, but if we don't have this opportunity, I think you've also heard that it's likely Lawrence & Memorial will face some disruption, some instability and potentially reduced access to care.

And I'd like to just take a minute to address a few of the misconceptions about our system.

Our corporate focus is not one of control, but it is of creating a unified system, a unified strategy. We want to enhance performance, we want to set standards for quality and value, and we want to achieve cost reductions through economies of scale and economies of skill.

Our corporate focus is on local governance, with real authority, and Mr. Crespo spoke to that earlier. The Yale-New Haven Health System has the opportunity to name one member of the Lawrence & Memorial Board, and that person has one vote, and, with the exception of system-based decisions, decisions related to any changes in services, additions, subtractions, changes come from the Lawrence & Memorial Board, not from the Yale-New Haven Health System Board.

It's in no one's interest to drive up cost or increase prices to make healthcare less affordable to consumers. We do not and we have never negotiated rates as a system.

The rates negotiated for Greenwich Hospital, for Bridgeport Hospital and for Yale-New Haven Hospital are separate, independent, and they reflect the cost of doing business at those organizations, and we expect that that will continue with Lawrence & Memorial.

We will work with Lawrence & Memorial to

provide additional primary care and surgical specialists in the area to enhance the medical services available and to reduce the need for patients to travel to New Haven, except for highly-specialized services.

As I mentioned, if you look at what's happened in Greenwich and Bridgeport, in fact, both of those organizations have seen a growth in local healthcare volume, because there is more business being done in those communities that appropriately can stay there.

Finally, I understand that there is concern, and we heard it in some of the public testimony, that this affiliation will have the same effect as some other system activities in this State.

Please remember that we do not negotiate a single price for our system, that we operate in very different local communities, and each one of those communities has specific needs.

In addition, and you've already heard this, it's very difficult to negotiate increased prices anyplace, because the third party payers are finding that, with employees and employers paying more and more of the healthcare bill, they can't afford to do that anymore.

Our health system has worked very hard on cost reduction. Over the last several years, we have saved $300 million on an annualized basis across the health system. The original plan and strategy had been to use that to lower some of the negotiated commercial rates to make certain services more affordable as people were paying more out of pocket.

In the last four years, however, between taxes and payment reductions from the State of Connecticut, we have lost almost $300 million in revenue from the State of Connecticut, and, so, effectively, as we have reduced costs, those have gone to subsidize what would have been provided by the State of Connecticut.

I believe that this application has delayed or denied the opportunity for Yale-New Haven Health to help make a positive difference, and the Greater New London and Westerly communities will be diminished or worse. It could be lost.

Put simply, the alternative to this application may be the eventual closure, the reduction, or termination of services, lost jobs and reduced access to care, so I strongly support OHCA and the Deputy Commissioner of the Department of Public Health approving this application. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. FELDMAN: That completes our pre-filed testimony.

HEARING OFFICER HANSTED: Okay. Attorney Murray, if you want to proceed with your case in chief?

MR. MURRAY: Thanks very much.

HEARING OFFICER HANSTED: You're welcome.

MR. MURRAY: Good evening, Hearing Officer Hansted and staff of the Office of Health Care Access.

As you know, I represent a coalition of Intervenors, who were granted Intervenor status in this particular proceeding.

These specific applications involve the acquisition of Lawrence & Memorial Hospital here in New London and the acquisition by Yale-New Haven Hospital Health Care System and the merger of L & M's physician practices with Yale's Northeast Medical Group.

The Intervenors, as we will more specifically detail in the testimony today and have provided in our pre-filed documents, have raised some serious reservations about the proposed acquisition and merger and believe that they will put at risk Lawrence & Memorial Hospital's patients in the Greater New London area, both from escalating costs of medical care and

decrease in access to affordable and quality medical services that we believe are a result of this acquisition and merger.

In the interest of time, I will actually ask permission. I have a written opening statement, which kind of lays out the theory that the Intervenors have, and I'd just like permission to supply it to you in written format.

MS. FELDMAN: I object.

HEARING OFFICER HANSTED: Would you supply a copy to the Applicants?

MR. MURRAY: Absolutely.

HEARING OFFICER HANSTED: Would you just let them look at it right now before, and then I'll rule on the objection.

MR. MURRAY: Well I can put it on the record.

HEARING OFFICER HANSTED: Why don't you just read it into the record?

MR. MURRAY: Okay. Nothing in the application, in the applications, provide any assurance at all that the interests of low-income, at-risk and minority communities within the Lawrence & Memorial service area will be adequately protected or that they

will be continuing community involvement and oversight of L & M's provision of health and medical care in Southeastern Connecticut.

The Connecticut General Statute 19a-639a-12 requires the Applicants to satisfactorily demonstrate that their resulting consolidation will not adversely affect healthcare costs or accessibility to care in the service areas.

We believe they have failed to do so, and, as a result, OHCA must reject these applications, as currently filed.

Our coalition witnesses today will focus on the serious inadequacies of these applications in addressing these major statutory areas of concern regarding price of, access to and quality of medical care after the proposed mergers and acquisitions, and I'll let our witnesses, basically -- I'm not going to summarize their testimony. I'll let them do it themselves.

In a minute, I want to introduce the members of our coalition to provide evidence for the Department today, as well as adopting their pre-filed testimony.

Each of the witnesses and coalition members will tell you that they share a deep skepticism

that the applications before you satisfy the statutory criteria for approval with respect to both cost and access.

Rather, these witnesses will tell you that the two applications will lead to increases in the price for health care in the L & M service areas, a decrease in access of needed services, including specialty services, and elimination of alternative service providers in Rhode Island and Massachusetts, which are now available to the L & M patient population.

Of particular importance in this process is the unwillingness of the Applicants to provide historic price information from previous acquisitions at Bridgeport and Greenwich Hospitals.

This raises serious concerns that the Applicants cannot meet their statutory burden of demonstrating that the acquisitions and mergers will not adversely affect the healthcare cost in the L & M service areas post-acquisition by the Yale system.

These issues will be more substantially addressed by our witnesses today. There is a document that will be referenced by at least one of our witnesses, which I will either put on the record now or supply to the agency, and I'll represent to you it is a document

that we receive from the Office of the State Controller, and it details for the period of time from May 1, 2014 to April 30, 2015 the cost of certain inpatient and outpatient cost for inpatient and outpatient services provided by Yale-New Haven Hospital and L & M for State employees, who are part of the State Employee Health Care System.

And I know that Dr. Hyde is going to be referring to this. I'm happy to provide this to the Applicants now or do it as a late file exhibit.

HEARING OFFICER HANSTED: Do you have the document with you?

MR. MURRAY: I have copies of it here for both you and the Applicant.

HEARING OFFICER HANSTED: Why don't you let the Applicants review it? Attorney Feldman, let me know if you have any objection.

MS. FELDMAN: At this point, it's very difficult to review a one-page document without knowing the source or the context of the document, where the information came from, or whether it's reliable information, so I'm going to have to object to its entry into the record at this point.

MR. MURRAY: We can certainly provide

testimony. I understand that we may be having another hearing date. We can certainly provide testimony, as to the source of the information and whether or not it's reliable. It was provided by Kevin Lembo.

HEARING OFFICER HANSTED: Okay and you said Dr. Hyde will refer to this document?

MR. MURRAY: He's going to refer to this, but we can put an individual on the next time we have a hearing, who can testify to how they acquired it and how it was given to them by Comptroller Lembo.

HEARING OFFICER HANSTED: Yes, I'd like to have that done. So we won't accept it at this point. As you refer to the second hearing date, we'll take it at that point if you properly introduce the document into the record.

MS. FELDMAN: Yes. Attorney Hansted, I'd also like to object on the basis that, as mentioned in the Intervenor's opening comments, if you read our pre-filed testimony, it becomes very clear that almost 80 percent of our payments are government payers, and I really don't understand the relevance of this document being introduced now at this late date, and I think this whole issue of costs going up post-affiliation is a bit of a guise, in that we made it very clear that we don't

have the ability to negotiate almost 80 percent of our payments from governmental payers.

HEARING OFFICER HANSTED: I can appreciate your position, but, at the same time, I'd like to receive evidence from the Intervenors on what they feel their position is.

Now, as I stated, we're not accepting this document at this time, but if Attorney Murray properly introduces it at the next hearing and we hear testimony on it, I will accept it at that time, and you will be given the opportunity to object at that point.

MS. FELDMAN: Thank you.

MR. MURRAY: Just for the record, also, we are actually not talking about, even though this is the State of Connecticut's Employee Healthcare Plan, which I'm sure all the members up there participated, it's hardly a government payer, as we understand that term in this hearing.

HEARING OFFICER HANSTED: Correct.

MR. MURRAY: It's essentially a third party payer. The State of Connecticut is self-insured and provides those payments for those services that it negotiates with hospitals throughout the State.

HEARING OFFICER HANSTED: Correct. Okay,

so, be prepared to enter it at the next hearing date.

MR. MURRAY: I'll do that. At this time, the Intervenors would like to turn the microphone over to Dr. Fred Hyde.

HEARING OFFICER HANSTED: Okay.

DR. HYDE: Mr. Hansted, members of the panel, ladies and gentlemen, my name is Fred Hyde, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

DR. HYDE: And would like, given the hour, merely to underline parts of it that I think may be of some help to you.

The essence of our presentation is that, as Mr. Murray indicated, we have really two different applications here. One application can be embraced or endorsed by everyone or almost everyone in the room, and that is that Yale-New Haven is a great hospital. Lawrence & Memorial is a gem. People have gotten good services from these hospitals.

All of the efforts that have been put forward by the witnesses can be embraced happily, and the real question is at what cost?

I'm here on behalf of the American Federation of Teachers, whose President, Randi

Weingarten, has embraced the campaign, known as Patients before Profits.

Part of that campaign is to highlight the actions that we all need to take that will attempt to put some brakes on what appears to be a runaway system, a system, which is consolidating into more and more expensive and less and less accessible corporate headquarters.

We have tried to make a line of reasoning or an argument in our pre-filed testimony that goes something like this.

Yale-New Haven has a tremendous position in the market and attachment for, I believe, which is a study of the markets of the various hospitals in South Central and Eastern Connecticut, shows what a tremendous concentration would take place, notwithstanding testimony from the Applicants.

The only recent study that shows concentrated power within the same State concludes that it really doesn't matter if they're overlapping markets.

It's the reason why we think, when Mr. Jon Leibowitz was expressing his frustration as Chairman of the Federal Trade Commission in March of 2012, he said, if you want to get a handle on health costs, you have to

challenge anticompetitive hospital mergers.

Now the Applicants have pointed out that I seem to put all the problems of the healthcare field at the doorstep of this application. I apologize if that appears to be what I did.

What I did was to say this is the application in front of you. It's the one thing we can do something about. It's not all of the problems in the field, but it certainly is a powerful driver of problems in the field, and we'll give you a late file exhibit citing exactly where in-State competition, different markets, exactly where Gaynor and Cooper and exactly where Yale-New Haven's market historically, 75 percent of which is essentially community hospital.

A big part of the way you prosper is to charge academic medical center rates for community hospital services, so we'll pullout from the morass of information. We've given you those things that we think will help.

So we have the two different applications, and it's not up to the Intervenor, if I may say so, to prove that the Applicant is wrong. To the contrary, it's up to the Applicant to prove that there will be, under number 12 of your statutory requirements, there will be

no adverse economic impact on hopefully the State, the hospital, the patients.

Let's take a look at, if you would with me, take administrative notice of the audited financial statements, which are within your possession. Let's take a look at 2015 and see what happened with Lawrence & Memorial.

The hospital made money. It made almost $5 million, and, yet, if you use 19 million of that to transfer to affiliates, the doctors in Westerly, you are going to lose money.

The hospital made money, notwithstanding the fact that it had a very unfortunate recent history. People, who are in positions of authority and responsibility in this field, know that the nurses and clinical personnel are critical. The way you treat them is the way they'll treat the patients, and, so, almost a one, two, three blow.

And if you look at your annual report, you can see that Lawrence and Memorial for the last four years, before 2015, have profits from operations from I believe nine to $22 million.

The one, two, three blow is you tell your nurses they're locked out and you're going to transfer

services. You acquire a bankrupt hospital in a neighboring state, and you subsidize your doctors at the tune of $20 million, which is understandable. If you're the doctors, it works very well.

I won't go into the prices problem, except to acknowledge something, which has been said I think by us, as well as by the Applicant.

Getting price information in this field is astonishingly difficult. It's difficult, because those, who have it, do not want to disclose it, not because somehow it's abstruse.

We can look at the hospital as a whole. If you look at Greenwich and at Bridgeport and at Yale-New Haven and at Lawrence & Memorial, you'll see that the current ratio, a key index of liquidity and, therefore, of solvency, is easily two and a half to four, depending on the year recently.

I do a lot of work in other states. There are many states. New York is one of them, where 1.75 is the statewide average. People would be astonished to find what might be labeled crocodile tears going on with regard to the under reimbursement of Medicaid for hospitals that still have current ratios over two, or two and a half, or three, or four, as was one year with L &

M.

So we're not unmindful of the distress that Lawrence & Memorial has found itself in, but our narrative entertains the theory that it's largely self-inflicted.

Therefore, whatever the remedy might be is within the power of Lawrence & Memorial. There is no case that this acquisition, and that's what it is, when you become the sole corporate member, you acquire control, no matter how many members you have on the Board, and to pretend otherwise is dissimulation.

When you become the sole corporate member and are the controlling body, that's a different kind of fix.

Now what we worry about with Bridgeport and Greenwich is not that they haven't benefitted from Yale-New Haven's participation, but that they've benefitted too much.

If you look at the profitability of these hospitals as far back as your records go and, therefore, as far back as we can deduce, you'll see that they are consistently pretty good performers. How good?

If you were the Applicant, if you were the owner, if you were the system that had responsibility for

these, you could very well put together an adjusted cost per patient day, an adjusted revenue figure that would show very clearly here's the before and here's the after.

You know, I don't have to tell you, but perhaps the audience doesn't know, that the legislature has actually asked for this information to be made public and plans to do so.

We can understand to some extent, if price is a sensitive issue, why, therefore, this application is being rushed along, why it has to get done now, before January 1 of 2017, when all of this information, at least in terms of how the legislature has set things up, will be public.

How do we get expensive? How do we get to be very, very expensive in this field? There's no simple answer. Years ago, I was Vice President for Planning at Yale-New Haven, a long time ago, so long ago we only had five Vice Presidents, and subsequently was the organizing first Director of the Faculty Practice Plan.

It's nobody's fault. These things are not -- they don't happen, because of one particular decision, but we focus on one area for a reason.

When I served as in-house counsel for the Hospital Association, I was irritated at your agency

collecting information about the top 10 compensated officials, because it was meant to be a source of secrecy, privacy. Why would you invade my privacy?

Even one of the witnesses indicated this is irrelevant. It's not irrelevant. Here's why it's not irrelevant.

We need all of us. I don't believe there's anybody in this room, who can say they're thoroughly exposed to the calamity of medical cost. I'm on Medicare. I'm not exposed, but there are people, and you stand for them.

That happens to be your challenge. What do you do with people, who are going to be out of luck financially, avoiding medical care, not just avoiding paying the bills, avoiding medical care, who are immobile for socioeconomic reasons, who might like to go here instead of there, but don't have a doctor, who is here, who are not connected? That's really the audience that's not in the room.

There's a second reason. It's a message. If I tell you, as shown in our attachment eight, that the top 10, and I know you know this, but the audience may not know this, you publish every year the total compensation of the top 10 individuals, whoever they are,

and if I tell you that the compensation of the top 10 individuals at Yale-New Haven is $15 million a year, you can do the math.

If I tell you that it increases faster than other hospitals, you can perhaps appreciate what that looks like, in terms of a message.

One group that gets the message are the doctors. When they discover that paper-pushers are earning more than they are, it adjusts their relative cupidity in some cases. Let's put it that way.

So here's what attachment eight comes down to over a nine-year period. If you are with Bridgeport, you've got a 7.3 percent increase not necessarily in individual, but the top 10 people, most of whom are the same.

If you were in, oh, let's say Greenwich, you had 2.8 percent on average. If you were in Lawrence & Memorial, you had .6 percent on average, .6. If you were at Yale-New Haven, you had 11.2.

I feel like I'm channeling Rob Reiner's mother in Harry Met Sally, when I say I'll take what she's having. It's a motivation. It's not the only motivation, but it's a motivation. It's the American way. We earn as much as we possibly can.

So for those three reasons, that more and more Americans are not insulated, as hopefully all of us in this room are, that it's a message to others, and that if you are -- if your mentality with regard to strategic planning, which is what I teach in Columbia business school, if your mentality is service, let's do a better job here, you're going to act in a certain way.

If your mentality is commercial banking, the ship is not doing too well, let's find someone to sell it to, you're going to act in a different way.

Let me conclude with just a couple of items, in terms of these exhibits. My little variation in Medicare exhibit was criticized and I think in some ways legitimately so.

This is not a peer-reviewed research paper. This is from the top 100 DRGs from the MEDPAR file, some particularly outstanding examples, so that, for example, on the first page, with septicemia, if you were at Yale-New Haven in 2013, the average Medicare payment was $85,000, and, as the patient, you were on the hook for 10,000.

At Lawrence & Memorial, you were on the hook for $721. I think that makes a difference. If the Applicants don't think it makes a difference, that may be

revealing, but I think it makes a huge difference, because the Medicare beneficiary with regard to out-of-network, out-of-pocket deductibles, co-payments and so forth is paying more than $1,000 per hospital discharge, and when we get to the Comptroller's information, you may find that of interest, as well, but I don't pretend that any of this can't be criticized.

I'll tell you, looking through the top 100, there was no place where the Applicants were at the bottom.

Finally, I'd like to close by talking a little about Massachusetts and this attachment, which is --

MS. FELDMAN: I have to object, both on the basis of time and the relevancy of talking about Massachusetts.

HEARING OFFICER HANSTED: I'll overrule the objection, in terms of time. Attorney Murray, do you want to respond, in terms of the relevance of speaking about Massachusetts?

MR. MURRAY: Attorney Hansted, this was part of our pre-file, Dr. Hyde's pre-file. I can't remember what exhibit it is. It's attachment six, which he made reference to, and I think it's just he's just

going to make a brief point, in terms of a study that was done in Massachusetts. It seems to me that the agency needs to take information and lessons learned from as many places as it can.

Dr. Hyde is simply going to point that out, in terms of your staff looking at that particular exhibit that was attached and the lessons that can be learned from that. I think it is relevant.

MS. FELDMAN: In our supplemental pre-file, we objected on the same basis, that it was irrelevant information.

There's an enormous amount of irrelevant and contradictory information being thrown around, and we addressed all of that in our supplemental. I see no relevancy to this hearing today.

HEARING OFFICER HANSTED: I'm going to overrule the objection. We'll give it the weight it's due, Attorney Feldman. Dr. Hyde, please keep this brief.

DR. HYDE: Thirty seconds, Mr. Chairman, and thank you.

HEARING OFFICER HANSTED: I'm not a Chairman, by the way.

DR. HYDE: This particular study shows how the leverage acquired by the Massachusetts

general/partners group has destroyed community hospitals in Massachusetts. Where did that leverage come from?

They've done us a great favor. Their Attorney General found, and everyone should be armed with subpoena power, that when you quiz hospitals, what makes a difference is not how many poor people we have, not how many residents, not how much research, but how much leverage we have.

This application would give the Yale-New Haven Health System more leverage by a very large significant amount, as outlined in the study of monopoly overlap here, and that's the entirety of our point of view.

If you give them more leverage, they will use it, and we will all be incrementally poorer, but some people will be much poorer. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: The Intervenors would like to now call Stephanie Johnson.

MS. JOHNSON: Good evening.

HEARING OFFICER HANSTED: Good evening.

MS. JOHNSON: My name is Stephanie Johnson, and I'm the President of AFT Connecticut, Local 5051, which represents more than 270 LPN techs at the

Lawrence & Memorial Hospital. I am also a hospital employee. I work as a polysomnography technologist, which is just a very fancy way to say sleep tech, and I am a resident of East Lyme, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MS. JOHNSON: You know, it's been very hard here that nobody really on the Union side is coming out and saying I'm absolutely against this, or I'm absolutely for this.

As the President of the Union, I've seen change for good reasons, and I've seen change for the sake of change, and, you know, our community relies heavily on the bus route, and we have a lot of people, who actually walk in on the main streets, which are Ocean and Montauk and surround on Lawrence & Memorial Hospital.

I'm very concerned that these patients will not be able to get the care that they need from their community hospitals, should this acquisition take our community hospital from us.

For years, the Unions at the hospitals have been fighting to keep access to quality service. It's the reason why we went on strike in 2013, but this is not a Union versus management issue. This is about

allowing our community to receive the quality care that we have been delivering for more than 100 years.

Decisions that are going to be made about what care is going to be kept here are going to be made by Yale. I've read the bylaws. I've seen what it says about the member and the member substitution, and I can't be convinced otherwise.

I'm very, very concerned that decisions about what kind of care is going to be kept here at the main campus or at any other affiliate that Lawrence & Memorial has is going to be made from people 50 miles away that don't know what this community is.

I'm concerned that duplicate services will be phased out, since we both are hospitals, and that may include necessary clinical services that have been traditionally performed here by L & M.

I am very concerned that the profitable services will be removed or assumed by Yale, which charges a higher cost than L & M does.

There's been a lot of talk about L & M being in financial distress. L & M Hospital has a healthy margin and always has. It's the corporation, not the hospital, that's not doing well.

It's because the corporation makes poor

business decisions, draining funds from our hospital; $17 million for locking out the employees in 2013, $35 million for buying Westerly Hospital, several million dollars on a now defunct McKesson electronic medical record system, and $20 million per year to LMMG.

All of this money could have and should have been spent on patient care services. A few years ago, we were told that the purchase of Westerly Hospital was so that we could stave off being taken over by a for-profit.

Two years later, we were told that we were going to affiliate with many hospitals in the area to get this purchase buying power that was going to make it so that Yale couldn't take us over, and here we are today.

So transparency is what we're looking for, and these are the reasons that I can't support this CON going forward, as it's currently written.

I ask you to take our concerns and get truthful answers from Yale and L & M about their plans for continuing care here in New London where the $300 million is coming from, what it's going to, and what they're going to do to our little community hospital. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: I'd like to now call Dr. Ellen Andrews, who is the Executive Director of the Connecticut Health Policy Project.

DR. ANDREWS: Good evening.

HEARING OFFICER HANSTED: Good evening.

DR. ANDREWS: I'm Ellen Andrews. I'm the Executive Director of the Connecticut Health Policy Project. We are a non-profit, non-partisan organization advocating for consumers with non-partisan policy analysis consumer education and assistance and capacity building, so that I can retire, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

DR. ANDREWS: We have deep concerns about this acquisition, this application, for a number of reasons, both for the health of this community, especially the underserved, which is a particular emphasis for the Connecticut Health Policy Project.

Medicaid and uninsured and the growing number of people between those two were underinsured. The impact on State resources to support underserved community needs. I've learned that being a consumer advocate I've had to start to be an advocate for taxpayers, because the supports that go for the people I

care about come from the general fund, and, if I don't worry about that, then, the people I care about are not going to get the resources they need.

Consumer choice and access to care, you can't have patient-centered care when there's only one option, and questions about the vague promise to invest $300 million in this community.

First, New London and L & M service area include many fragile and underserved communities and residents that would be placed at risk by this acquisition.

Robert Wood Johnson Foundation estimates that there are 20,598 uninsured residents this year. That's after the Affordable Care Act and the Medicaid expansion in New London County and a growing number of even more people, who are underinsured, people with high deductibles and cost sharing, who are baring the burden of costs directly, at least up until thousands of dollars, and, for many of my clients, it might as well be a million, so that health care is becoming less and less affordable.

You heard in public comment a little about L & M's community health needs assessment, a requirement of the Affordable Care Act, one of the best kept secrets

in the Affordable Care Act. It's required for non-profit hospitals, and they did include a great deal of data collection and engaged the community in identifying priorities.

The report found that one in four families with children in this county are living in poverty, almost one in three in the city. Asthma, diabetes, rates are high and even higher for people of color.

This was really especially important for these proceedings, that between six and 14 percent, depending on the survey, of residents in this area are already delaying care, because of cost. That's before, you know, we see higher deductibles and, also, higher costs, because of an acquisition.

It does say that, quote, "The demographic profile of the L & M service area correlates with a higher incidence of negative health outcomes," and that's before -- that's with the wonderful gem that you heard about already in this community.

The community health needs assessment outlines consensus priority areas for investment, including asthma, diabetes, tobacco use and health status and access, particularly around affordability.

The plan includes a roadmap for

priorities, including social determinants of health, core investment issue areas, and access to care, and resources from that $300 million would go a long way toward making a great deal of important contributions to fixing those problems, but we're hearing that those resources are going to be decided behind closed doors at a strategic planning session after this acquisition is already -- the ink is dry on it, and that's no way to make these decisions.

There already exists a community health needs assessment, and I think they should follow it. The decision should be made by communities rather than behind closed doors.

Let's see. New London area residents are already strapped and cannot afford higher prices for care, more out of pocket costs. If even more people are forced to delay, care prices and taxes for all of us will rise, and that brings me to my second point. We can't afford it either.

The State budget is in very serious deficit. I'm sure that hasn't escaped any State employee lately. And, because of that, as a consequence, over 10,000 working parents are going to lose Husky coverage at the end of this month, in just three weeks. That is

on top of provider cuts, the hospital cuts that you've heard about.

Medicaid has done a lot in the last four years. I have to say this is not a -- Medicaid has done a lot in the last four years to improve access to high-quality care for a rapidly-growing program that now covers 760,000 people.

It has controlled costs, as well. Fewer people are going to the emergency room for non-urgent visits. In the first year, after the shift to a care management system, 32 percent more physicians participated in the program, which is kind of a miracle in Medicaid, but costs went down at the same time, down, not off of trend, but down. They've been trending down every year for the last four years, but, last year, they were down 5.9 percent per person. I can't say that enough.

But the levers to do that will be severely reduced if you allow this market concentration in this application. There's substantial evidence, and I know Dr. Hyde has talked about it at length in his testimony, but that monopolies drive up prices. They do. They just do. We can't afford 15 percent higher costs. Individuals can't, businesses can't, and I know the State

can't.

Every time anybody brings up, you know, we're going to have to pay more for this, we're going to have to pay more for that at the Capitol, I try to translate it into how many more Husky parents have to lose coverage for us to afford whatever it is you want to do?

I mean I think that's the sort of the tradeoff we need to think about, is how many people are going to lose coverage, and how many people aren't going to be able to afford care and are going to delay it?

And the third piece, Yale-New Haven mentioned in their media that they are going to invest $300 million, some of it in HIT, which sounds like it was a bad business decision, but they're not going to say what it's for.

If they want to invest in New London, their community health needs assessment lays out a really good roadmap. There are a lot of needs in this community, and effective solutions are pretty easy to find. They just need money.

Yale-New Haven must be very clear about what investments they will be making, how they're going to make them, who they're going to make them from, and

what they expect, and that should happen now, not later, behind closed doors, without community input.

And taking it from L & M's cash flow is not a net benefit to this community, and it needs to be enforceable, and it needs to be accountable to the community, and it's unfortunate that you're not going to hear from Maritza Bond about what happened in Windham, but a lot of promises were made, and they weren't kept, and that would be a tragic shame, if that happens here.

Healthcare costs -- one other piece I wanted to respond to, the Applicants saying that -- well, first of all, we heard a lot about clinical collaborations that are happening now already, before the acquisition, so I think they need to make a case that this is really necessary for clinical care.

They talked about how it's about value-based purchasing, and I understand that. That's the shiny new toy in healthcare right now. We've had a lot of shiny new toys. It seems every 10 years we get a new one, but this is the one, and it is driving acquisitions.

The problem with this is that it's going to be extremely difficult to unravel. Unraveling managed care was hard enough for Husky. Unraveling this I don't know if we'll be able to, and it is driving -- there's a

lot of pressure to adopt alternative payment models, and those are about risk sharing, risk going on to provider networks, large health systems, and this is going to be a much bigger one, with a lot more members. That's what this is about.

On the other side, acquisition doesn't guarantee clinical integration. There are plenty of instances from Connecticut and elsewhere, where there have been corporate mergers and acquisitions, but, in fact, healthcare systems still don't talk to each other. Physicians can't coordinate care any better than they could before the corporate change. That isn't necessary, nor is it sufficient, for integration.

So I just want you to take a lot of time and think this through, and maybe this isn't the right time for this application. Thank you.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: Our last witness is Jason Pelletier.

MR. PELLETIER: My name is Jason Pelletier. I live in Groton, Connecticut. I'd like to adopt my pre-filed testimony.

Healthcare coverage for me is very important. I work as a steward. I'm also a cook at

Pfizer. I've been there for about 15 years.

Healthcare coverage for us is always about recurring doctor visits and our prescriptions. We're all very concerned about having adequate healthcare coverage. The older people get, the more health issues you get, the more often you have to go to the hospital, and the more expensive things get.

Currently, we are in contract negotiations in Local 217. There are also seven other corporate cafeterias in Connecticut that are operated by Compass, including our brothers and sisters at Electric Boat.

We pay currently 20 percent of our premiums and are trying to reduce that percentage at the bargaining table. The cost of employees' shares went up by about 10 percent last October.

That means that everyone who had coverage had a big bite taken out of the raises that they had negotiated at the bargaining table.

We have a really good healthcare plan and have fought really hard to keep the costs down, but I have co-workers, who are uninsured, or they're on State assistance, they also have children, because they can't afford the premiums.

Before I talk about Yale taking over the

hospital at L & M, I want to tell you how hard our Union works to keep the costs down of our healthcare plan.

Our Unite Here Health is run jointly by our Union and by our employers in our industries. Workers in our Union take leave from their jobs for several weeks to educate our co-workers about keeping costs down on their own; not going to the emergency room for colds and things of that nature.

As a steward, I'm trained to help my co-workers use their healthcare the right way and to help them connect with our healthcare plan if they have any problems. We have healthcare coordinators that are very, very helpful in that regard, but that won't matter if prices for hospitals and doctors go up, because Yale takes over.

Even if we convince our employer to lower the percentage of the premiums that we do pay, if the care, itself, gets more expensive, the premiums will go up, and we'll be paying what we paid before.

Please stop this takeover, or, if it is approved, make Yale-New Haven guarantee in writing that they won't raise prices.

We don't make a lot of money. I make about $16.44 an hour, and I'm one of the better paid

people where I work.

I'm fortunate to have a full-time hour job and a steady paycheck, but none of us can afford to pay more for healthcare. Affordable healthcare insurance has always been important, but where I'm at in my life now I can't afford to do without it. Thank you very much for your time.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: Attorney Hansted, that concludes our testimony.

HEARING OFFICER HANSTED: Okay, thank you. It's getting late, so, at this point, we are going to stop the hearing. We'll continue it for a date to be set, about two weeks out.

For those members of the public, we will post a new date on OHCA's website, and we'll work with the Applicants and the Intervenors on the new date.

Attorney Feldman, did you have something?

MS. FELDMAN: Yes. With respect to this document that was --

HEARING OFFICER HANSTED: We're not accepting it tonight.

MS. FELDMAN: Okay, so, if this is going to be presented at the next hearing date, we'd like to

receive it at least a week before, so that we could understand what this document is, where it came from, unless Attorney Murray can tell us now whether you got that from Comptroller Lembo directly.

MR. MURRAY: Well I didn't get it from Comptroller Lembo, but members of the Intervenors did receive it directly from --

MS. FELDMAN: Without a Freedom of Information request?

MR. MURRAY: I don't know whether it was a Freedom of Information request or not.

MS. FELDMAN: Okay, because my law office has done several Freedom of Information requests, and we have not received any documents, whatsoever, so I'm curious to know how this was obtained.

MR. MURRAY: Well I just told you that it was obtained directly from the Comptroller's office. I don't know whether it would be responsive to the Freedom of Information request that you made or not, because I haven't seen what your Freedom of Information requests are.

MS. FELDMAN: Can you tell me when you received it, or how current this is?

MR. MURRAY: Well it's clearly after that

time period that's there. That particular document, I don't have it in front of me, but, from memory, it takes a look at the payments at Yale-New Haven Hospital and Lawrence & Memorial for inpatient and outpatient procedures for the one-year period from May 1, 2014 to April 30, 2015, and then paid through July 31, 2015, so, clearly, the information was compiled after July 31, 2015.

MS. FELDMAN: But we don't know whether there's any subsequent modifications to the document, whether the document is accurate or not.

HEARING OFFICER HANSTED: Well let's hold the discussion on this document for the next hearing. At the next hearing, will you have the individual, who obtained the information?

MR. MURRAY: Yes, I will.

HEARING OFFICER HANSTED: Okay, so, Attorney Feldman, you can examine the individual, who obtained the document, at that time.

MS. FELDMAN: I need to receive this prior to the hearing, so I can analyze the information and have an opportunity --

HEARING OFFICER HANSTED: This particular document that you have in your hand?

MS. FELDMAN: Right.

HEARING OFFICER HANSTED: Would you like to keep that copy?

MS. FELDMAN: No, no, no, no. I need to understand the context in which this document was derived, what data they used, when they got the data. We can't just look at one piece of paper, based on the entire State employee population.

MR. MURRAY: But this is not the entire State employee population. That is probably well over a couple hundred thousand people. This is admittedly a small sample. This is just --

MS. FELDMAN: Exactly.

MR. MURRAY: -- State employees. Let me finish. These are State employees, who have received those particular services at Yale-New Haven Hospital or Lawrence & Memorial Hospital in that one year period of time and for which payment was made by July 31st, so it's clearly not a sample of every of the several hundred thousand insured lives that the State of Connecticut employees that the State pays for that coverage.

MS. FELDMAN: Is it a sample of every State employee that received care at Yale-New Haven Hospital and every State employee that received care at

Lawrence & Memorial Hospital?

Just like the DRGs were cherry picked, I'd like to know whether these were cherry picked, also.

MR. MURRAY: My understanding is that it is all of the State employees, who received those particular services at those two hospitals during that one-year period of time.

HEARING OFFICER HANSTED: But, again, we're not going to know until the individual, who obtained the information, is here to testify under oath how he or she obtained the information.

MR. MURRAY: And that may not satisfy Attorney Feldman, because --

MS. FELDMAN: Correct.

MR. MURRAY: -- it sounds like she wants to ask the Comptroller to be part of these proceedings.

MS. FELDMAN: Well I'd rather not have this information introduced at this late date anyway. I mean there was plenty of time to submit pre-filed testimony. There was rebuttal to our pre-filed testimony, and it's being introduced now in the abstract, plucked out of the air.

MR. MURRAY: And I provided it. I received it this morning.

MS. FELDMAN: Yeah, well, I also received the pre-file.

HEARING OFFICER HANSTED: She has --

MR. MURRAY: I absolutely understand the point.

HEARING OFFICER HANSTED: Of course, Attorney Feldman, you understand the position I'm in.

MS. FELDMAN: Right.

HEARING OFFICER HANSTED: I don't have the individual here to question, he or she.

MS. FELDMAN: Well I'm asking the Intervenors, if they plan on presenting this at the next hearing, then, prior to that hearing, at least a couple of days before, they should substantiate, you know, we should have access to the person that provided the data, so we could ask questions and appropriately comprehend the context in which this document is derived.

HEARING OFFICER HANSTED: You want access to the individual outside of the hearing before the next hearing?

MS. FELDMAN: That would be fine. If it's the Comptroller, yes. Is that what you're saying?

MR. MURRAY: No. I think we're saying two different things. My understanding is that the Hearing

Officer would like the person, who received this document from the Comptroller, to testify about how they got it from the Office of the State Comptroller.

HEARING OFFICER HANSTED: If it's admitted, I want it properly admitted.

MR. MURRAY: Right. Right. So if they --

MS. FELDMAN: But I --

MR. MURRAY: Let me finish. If they got a business record from the Comptroller that was handed to them and they, in turn, want to proffer it to the hearing, that establishes the chain of custody and authenticates that the document was provided to that individual by the Comptroller.

I hear the Applicant saying something quite different, which they simply want to inquire about the underlying data. I don't represent the Comptroller. I can't produce the Comptroller to talk about that.

MS. FELDMAN: Well it would also be helpful if we could have attachment eight, which was not included in the pre-filed testimony. It was just referenced tonight by Dr. Hyde.

MR. MURRAY: That's actually not accurate. If you take a look at the pre-filed testimony, the eight, it was supplied.

MS. FELDMAN: We don't have it.

MR. MURRAY: Oh. You do have a nine, correct?

MS. FELDMAN: Yes.

MR. MURRAY: Right. Nine is eight.

MS. FELDMAN: Oh. Thank you.

HEARING OFFICER HANSTED: It's just mis-numbered.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: So the question remains what do we do about this document?

MS. FELDMAN: Well we're objecting to it being entered into the record.

HEARING OFFICER HANSTED: It hasn't been entered into the record.

MS. FELDMAN: Potentially.

HEARING OFFICER HANSTED: Potentially.

MS. FELDMAN: So if the person that received this document comes to the hearing, the next scheduled hearing, presumably, you're going to admit it into the record, if all you need to prove is a chain of custody.

HEARING OFFICER HANSTED: If it can be properly admitted.

MR. MURRAY: I mean, essentially, they're asking to authenticate the document, so it can be properly admitted.

HEARING OFFICER HANSTED: Correct.

MR. MURRAY: If what Attorney Feldman wishes us to do is to provide, for example, prior to the hearing an affidavit to both the Hearing Officer and to the Applicant's counsel from the individual, who got the document from the Comptroller's office, laying out exactly what happened, so that it's no mystery, I mean, obviously, it's not at the hearing, but a sworn affidavit about how that came, I don't know if that would satisfy their objection.

MS. FELDMAN: We object to this exhibit, whatever document this is. We don't know whether it represents more than one payer, whether it represents a mixture of governmental payers, plus commercial insurance.

There are State employees that have multiple types of insurance. It's very inaccurate information.

HEARING OFFICER HANSTED: I understand what you're saying. Where was this extrapolated from?

MS. FELDMAN: Right.

HEARING OFFICER HANSTED: Now the individual, who received this, would they know how this was extrapolated?

MR. MURRAY: I think the only thing that they can testify to is what they were told by Comptroller Lembo.

MS. FELDMAN: Are you saying that the Comptroller prepared this document?

MR. MURRAY: I don't know who prepared it. They got it from the Office of the Comptroller.

HEARING OFFICER HANSTED: Well here's what we're going to do. I won't rule on any objection at this time. The objection will stand. I want the individual, who received this document, to be present at the next hearing, and then I'll rule on Attorney Feldman's objection at that time.

MR. MURRAY: Okay.

MS. FELDMAN: I mean it would be very helpful if the person that generated this information or this document would be in attendance at the hearing, otherwise, the person that received the document is not going to be able to respond to any questions we may have about the accuracy of the data.

HEARING OFFICER HANSTED: That's correct,

and that's up to Attorney Murray to make sure he can get this properly admitted and that it can be Cross-Examined with respect to how the information was calculated, because, to me, I agree with Attorney Feldman, that, looking at this document, I don't know where it's derived from.

MR. MURRAY: I understand that.

HEARING OFFICER HANSTED: Aside from you saying that it came from the Comptroller's Office. That's fine to know who generated it, but what information was it generated from, and how was this information calculated from the original database?

MS. FELDMAN: I mean, frankly, I don't think this should be given any greater weight than public testimony at this point.

HEARING OFFICER HANSTED: And it may not. Again, I'm not accepting the document at this time. We will discuss it further at the next hearing, when we actually have an individual here to question.

MS. FELDMAN: Okay, thank you.

HEARING OFFICER HANSTED: I don't want to further question Attorney Murray on this document when he's not the one who produced it.

MS. FELDMAN: Thank you.

HEARING OFFICER HANSTED: Okay. And before we adjourn, is there anyone here from the members of the public that would like to give comment on either of the applications before us? Okay. Hearing and seeing none, counsel, did you have another comment?

MS. FELDMAN: The question really pertains to the second application. Are we going to be hearing the second application at the next hearing date or tonight?

HEARING OFFICER HANSTED: I think we should hear the second application at the next hearing date, just so we can keep the two separate.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: For our purposes, because I want to have the Cross-Examination, whoever has Cross-Examination on this application we heard tonight, we'll start with that.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: Okay? Then we will hear the second application, Cross-Examination, and then OHCA will do its questions after that is completed.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: Okay. Hearing and seeing no one that wants to give additional public

comment, I will adjourn this hearing until the next hearing date. Thank you, all.

MS. FELDMAN: Thank you.

(Whereupon, the hearing adjourned at 8:56 p.m.)

HEARING RE: YALE-NEW HAVEN & NORTHEAST MEDICAL GROUP
JULY 11, 2016

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this18th day of July, 2016.

Paul Landman
President

Post Reporting Service
1-800-262-4102

KEVIN LEMBO
STATE COMPTROLLER

MARTHA CARLSON
DEPUTY COMPTROLLER

STATE OF CONNECTICUT
OFFICE *of the* STATE COMPTROLLER
55 Elm Street
Hartford, CT 06106

July 21, 2016

Commissioner Raul Pino
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Dear Commissioner Pino,

I am writing in regard to the proposed affiliation between Yale New Haven Health Services Corporation (Yale New Haven) and Lawrence & Memorial Hospital (L&M) – Docket No. 15-32033-CON – now before the Office of Health Care Access (OHCA) in the Department of Public Health. The Comptroller's Office administers the state employee health care plan, providing health coverage to over 200,000 members. Any cost increases or service reductions associated with the proposed affiliation between Yale New Haven and L&M will directly impact the state health care plan and its members. I am calling on OHCA to use its authority under the Certificate of Need (CON) review process to ensure that the proposed affiliation between Yale New Haven and L&M results in the retention and expansion of medical services in the L&M service area and does not increase total health care costs.

As you know, Yale New Haven has the largest market share of health care services in the state and is the dominant health system along the Connecticut shoreline. Yale New Haven's significant market share is one factor that has enabled the system to command some of the highest reimbursement rates in Connecticut. The affiliation with L&M will further expand Yale New Haven's market share along the Connecticut coastline. The evidence is clear, greater market concentration of health care providers and hospital facilities results in higher medical costs due to increased reimbursement rates.[1] The affiliation of Yale New Haven and L&M will result in greater bargaining power for Yale New Haven as a whole and L&M particularly.

[1] Dafny, Leemore. Estimation and Identification of Merger Effects: An Application to Hospital Mergers. [Journal of Law and Economics, vol. 52 (August 2009) http://www.kellogg.northwestern.edu/faculty/dafny/Personal/Documents/Publications/2_Dafny_Identification%20and%20Estimation%20of%20Merger%20Effects_2009.pdf; Vogt WB, Town R. How has hospital consolidation affected the price and quality of hospital care? Princeton (NJ): Robert Wood Johnson Foundation; 2009 Feb. http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html

Yale New Haven and L&M have stated that the increase in bargaining power will be muted by component contracting in the Yale New Haven Health System, whereby each affiliated hospital facility negotiates reimbursement rates with payers independently. The extent to which separate contracting across facilities will reduce the otherwise clear increase in bargaining power for L&M as a member of Yale New Haven is unclear and may require additional oversight and guarantees.

Yale New Haven and L&M also state that the improved care integration and care management that would result from the affiliation will reduce overall health care costs by changing utilization patterns. Improving care coordination and care management has real potential for improving health outcomes and reducing overall health care costs, however, it is yet unknown if the integration of Yale New Haven and L&M will contribute to better care coordination and management for patients in the L&M service area.

Connecticut statute gives OHCA the ability to place contingent requirements on the approval of any CON application concerning hospital acquisitions or affiliations. An approval of the proposed affiliation should include conditions that ensure health care consumers in Southeastern Connecticut are protected from large health care cost increases driven by higher reimbursement rates at L&M and affiliated facilities.

Essential health care services in the L&M service area must also be protected through the CON process. Yale New Haven and L&M have indicated that no reduction in clinical services is planned as a part of the affiliation, and in fact there are plans to expand certain clinical services at existing L&M facilities. Recently, another major hospital system, Hartford Healthcare, drastically reduced services at Windham Hospital in Willimantic. The reduction in services at Windham Hospital has created significant concern and discontent in the community. Area residents and clinical staff at L&M have expressed concerns that the affiliation with Yale New Haven may eventually result in a similar outcome in the L&M service area. Yale New Haven has stated that their hospital affiliation structure differs from Hartford Health Care as evidence that a similar outcome is less likely. Nonetheless, OHCA can use its regulatory authority to place conditions on the approval of the CON that ensure the planned expansion in services occur and existing critical health care services are maintained.

The costs and access concerns the Yale New Haven and L&M affiliation raise should be directly addressed to the satisfaction of OHCA, the Commissioner of the Department of Public Health and the Attorney General in order for the affiliation to proceed. Separate negotiations by facility are not enough to control the increase in reimbursement rates that result from provider consolidation; OHCA will need to use other mechanisms to protect consumers from unreasonable cost increases. Similarly, OHCA should insist upon adequate protections that will ensure continued and expanded access to essential clinical services by residents in the L&M service area.

The proposed affiliation between Yale New Haven and L&M presents both potential benefits and potential risks for residents in the L&M service area. I am not advocating for the approval or denial of the CON application in front of OHCA, but -- should the application merit approval -- I am advocating any such approval be contingent upon necessary guarantees and protections to protect health care consumers from the risks of increased health care costs and ensure the retention and expansion of health care services for residents in the L&M service area.

I thank you for your consideration.

Sincerely,

Kevin Lembo
State Comptroller

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTER OF:

Certificate of Need Applications by
Lawrence + Memorial Corporation;
Yale New Haven Health Services Corporation;

Docket Numbers: 15-32033-CON

RULING ON OBJECTION TO ADMISSION OF EXHIBIT LL

On July 29, 2016 the Applicants, Lawrence + Memorial Corporation and Yale-New Haven Health Services Corporation (the "Applicants") filed an objection to the admission of Exhibit LL to the record in this matter. On August 5, 2016 the Intervenors filed a response to the Applicants' objection.

After careful consideration, the Applicants' objection is hereby **SUSTAINED**.

Exhibit LL is hereby stricken from the record in this matter.

8/12/16
Date

Kevin T. Hansted
Hearing Officer

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

IN THE MATTER OF:

Certificate of Need Applications by
Lawrence + Memorial Corporation;
Yale New Haven Health Services Corporation;
L+M Physicians Association; and
Northeast Medical Group, Inc.

Docket Numbers: 15-32033-CON

ORDER REGARDING ADMINISTRATIVE NOTICE

The Office of Health Care Access ("OHCA"), for purposes of analyzing and rendering a decision in the application filed under Docket Numbers 15-32033-CON, is hereby taking administrative notice of the attached letter dated July 21, 2016 from Kevin Lembo, State Comptroller, to Commissioner Raul Pino. The letter will be referenced as Exhibit KK. OCHA is also taking administrative notice of an E-mail, including attachment, dated July 21, 2016 from Kevin Lembo, State Comptroller, to Commissioner Raul Pino. The E-mail, along with the attachment, will be referenced as Exhibit LL.

7/22/16
Date

Kevin T. Hansted
Hearing Officer

Connecticut Department of Public Health

Phone: (860) 418-7001• Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Friday, July 22, 2016 1:29 PM
To: 'hfmurray@lapm.org'; 'Rosenthal, Nancy'; 'jfeldman@goodwin.com'
Cc: Martone, Kim; Lazarus, Steven; Hansted, Kevin; Riggott, Kaila
Subject: information for July 26th hearing
Attachments: 15-32032 & 15-32033 Combined Agenda continuation.doc; 32032 table continuation.doc; 32033 table continuation.doc

Tracking:

Recipient	Delivery	Read
'hfmurray@lapm.org'		
'Rosenthal, Nancy'		
'jfeldman@goodwin.com'		
Martone, Kim	Delivered: 7/22/2016 1:29 PM	Read: 7/22/2016 2:06 PM
Lazarus, Steven	Delivered: 7/22/2016 1:29 PM	Read: 7/22/2016 1:51 PM
Hansted, Kevin	Delivered: 7/22/2016 1:29 PM	
Riggott, Kaila	Delivered: 7/22/2016 1:29 PM	

7/22/16

Attached is information for next week's continuation hearing.

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TENTATIVE AGENDA

Docket Number: 15-32033- CON - Yale New Haven Health Services Corporation L+M Corporation, Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation

And

Docket Number: 15-32032-CON - Northeast Medical Group, Inc. L&M Physician Association, Inc., Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

July 26, 2016 at 3:00 p.m. (continued from July 11, 2016)

I. Convening of the Public Hearing

II. Docket Number: 15-32033-CON

B. Applicant and Intervenors cross-examination

III. Docket Number: 15-32032-CON

A. Applicant and Intervenors Direct Testimony
B. Applicant and Intervenors cross-examination

IV. OHCA's questions

V. Public Comment

VI. Closing Remarks

VII. Public Hearing Adjourned

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Yale New Haven Health Services Corporation**
Lawrence+Memorial Corporation

DOCKET NUMBER: **15-32033-CON**

PUBLIC HEARING: **July 26, 2016 at 3:00 p.m. (continued from July 11, 2016)**

PLACE: **Holiday Inn New London – Mystic Area**
35 Governor Winthrop Boulevard – Ballroom
New London, CT 06320

EXHIBIT	DESCRIPTION
A	Letter from Yale New Haven Health Services Corporation and L+M Corporation (Applicants) dated October 7, 2015 enclosing the Certificate of Need (CON) application for the Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation under Docket Number 15-32033, received by OHCA on October 7, 2015. (602 Pages)
B	Letters of support in the matter of the CON application filed under Docket Number 15-32033, received by OHCA on various dates. (4 pages)
C	OHCA's letter to the Applicants dated November 6, 2015, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32033.(9 Pages)
D	Designation letter dated December 16, 2015 of Hearing Officer in the matter of the CON application under Docket Number 15-32033. (1 page)
E	Applicants responses to OHCA's letter of November 6, 2015, dated January 5, 2016 in the matter of the CON application under Docket Number 15-32033, received by OHCA on January 5, 2016. (262 Pages)
F	Legislative letters in the matter of the CON application filed under Docket Number 15-32033, received by OHCA on January 5 and 8, 2016. (4 pages)
G	Applicants' letter dated January 8, 2016 enclosing additional completenss responses in the matter of the CON application filed under Docket Number 15-32033. Received by OHCA on January 8, 2016. (62 pages)
H	Letter from Senator Looney dated January 6, 2016 in the matter of the CON application filed under Docket Number 15-32033. Received by the Department of Public Health on January 11, 2016. (2 pages)

I	The Department of Public Health's response to Senator Looney's letter of January 6, 2016, dated January 14, 2016, in the matter of the CON application filed under Docket Number 15-32033. (2 pages)
J	OHCA's letter to the Applicants dated January 19, 2016 requesting electronic copies of financial worksheets and Applicants response dated January 21, 2016 enclosing requested financial worksheets in the matter of the CON application filed under Docket Number 15-32033. (6 pages)
K	OHCA's letter to the Applicants dated February 4, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32033.(5 Pages)
L	Legislative letter to DPH and OAG dated January 29, 2016 in the matter of the CON application under Docket Number 15-32033. Received by OHCA on February 3, 2016.(2 Pages)
M	DPH response to January 29, 2016 legislative letter dated February 10, 2016 in the matter of the CON application under Docket Number 15-32033. (2 pages)
N	Letter from the Applicants dated March 3, 2016 informing OHCA that in light of Governor Malloy's Executive Order No. 51, that they plan to proceed, within the applicable statutory and regulatory framework to complete the CON process as it relates to the application in the matter of the CON application under Docket Number 15-32033. Received by OHCA on March 3, 2016. (3 pages)
O	Applicants' letter dated March 16, 2016 to OHCA regarding additional materials requested by OHCA in the matter of the CON application under Docket Number 15-32033. Received by OHCA on March 16, 2016. (262 pages)
P	Applicants's letter to OHCA dated March 30, 2016 enclosing responses to 2nd set of completeness questions in the matter of the CON application under Docket Number 15-32033. Received by OHCA on March 16, 2016. (13 pages)
Q	OHCA's letter to the Applicants dated May 10, 2016 deeming the application complete in the matter of the CON application filed under Docket Number 15-32033. (1 page)

R	OHCA's request for legal notification in *The Day* of OHCA's Notice to the Applicants of the public hearing scheduled for June 15, 2016, in the matter of the CON application under Docket Number 15-32033, dated May 11, 2016. (4 pages)
S	OHCA's request for legal notification in *The Day* of OHCA's Notice to the Applicants of the public hearing rescheduled for June 27, 2016, in the matter of the CON application under Docket Number 15-32033, dated June 2, 2016. (4 pages)
T	OHCA's letter to the Applicants dated June 14, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 15-32033. (4 pages)
U	Coalition Petition for Intervenor Status dated June 17, 2016 in the in the matter of the CON application under Docket Number 15-32033, received by OHCA on June 22, 2016. (2 pages)
V	OHCA's request for legal notification in *The Day* of OHCA's Notice to the Applicants of the public hearing rescheduled for July 11, 2016, in the matter of the CON application under Docket Number 15-32033, dated June 22, 2016. (4 pages)
W	Applicants letter to OHCA dated June 22, 2016 enclosing Notice of Appearance, Objection to the Coalitions's request for Intervenor status and certification that documents have been provided to Coalition attorney, in the matter of the CON application under Docket Number 15-32033, received by OHCA on June 22, 2016. (5 pages)
X	OHCA's Ruling on the Petition of the Coalition to be granted intervenor status in the matter of the CON application under Docket Number 16-32033, dated June 23, 2016. (3 pages)
Y	OHCA's letter to the Applicants dated June 23, 2016 enclosing ORDER for filing the pre-file testimony in the matter of the CON application under Docket Number 16-32033, dated June 23, 2016. (1 page)
Z	Letter from the Applicants to OHCA enclosing Prefile Testimony and responses to issues dated July 1, 2016 in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 1, 2016. (186 pages)
AA	Letter from the Intervenor to OHCA enclosing Prefile Testimony dated July 1, 2016 in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 1, 2016. (155 pages)
BB	Letter from the Applicants to OHCA dated July 6, 2016 enclosing supplemental prefiled testimony rebutting prefile testimony of Fred Hyde on behalf of the intervenors in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 6, 2016. (15 pages)
CC	Letter from the Intervenor to OHCA dated July 6, 2016 responding to Applicants' prefile in the matter of the CON application under Docket Number 16-32033, received by OHCA on July 6, 2016. (5 pages)
	The following came in after table was completed

DD	Letter from the Applicant to OHCA dated July 8, 2016 noticing the appearance of Jennifer Willcox in the matter of the CON application under Docket Number 15-32033, received by OHCA on July 8, 2016. (2 pages)
EE	Letter from the Intervenor dated July 11, 2016 enclosing prefile testimony of Maritza Bond in the matter of the CON application under Docket Number 15-32033, received by OHCA on July 1, 2016. (4 pages)
FF	Testimony of Universal Health Care foundation of Connectcut dated July 11, 2016 in the matter of the CON application under Docket Number 15-32033, received by OHCA on July 11, 2016. (2 pages)
GG	Letters from the public in the matter of the CON application under Docket Number 15-32033. (6 pages)
HH	Public Testimonies in the matter of the CON application under Docket Number 15-32033. (7 pages)
II	Department of Public Healths responses to Senators Formica and Looney dated July 15, 2016 in the matter of the CON application under Docket Number 15-32033 (2 pages)
JJ	Hearing Transcript from the July 11, 2016 hearing in the matter of the CON application under Docket Number 15-32033. Received by OHCA on July 19, 2016 (109 pages)

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

TABLE OF THE RECORD

APPLICANT: **Northeast Medical Group, Inc.**
L&M Physician Association, Inc

DOCKET NUMBER: **15-32032-CON**

PUBLIC HEARING: **July 26, 2016 at 3:00 p.m. (continued from July 11, 2016)**

PLACE: **Holiday Inn New London – Mystic Area**
35 Governor Winthrop Boulevard – Ballroom
New London, CT 06320

EXHIBIT	DESCRIPTION
A	Letter from Yale New Haven Health, Northeast Medical Group, Inc. and L& M Physician Association, Inc. (Applicants) dated October 7, 2015 enclosing the Certificate of Need (CON) application for the merger of L&M Physician Association, Inc. with and into Northeast Medical Group, Inc.under Docket Number 15-32032, received by OHCA on October 7, 2015.(211 Pages)
B	Various letters of in the matter of the CON application filed under Docket Number 15-32032, received by OHCA on various dates. (33 pages)
C	OHCA's letter to the Applicants dated November 6, 2015, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32032.(2 Pages)
D	Applicants responses to OHCA's letter of November 6, 2015, dated January 5, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on January 5, 2016. (22 Pages)
E	OHCA's letter to the Applicants dated February 1, 2016, requesting Additional information and/or clarification in the matter of the CON application under Docket Number 15-32032.(2 Pages)
F	Applicants letter to OHCA dated March 2, 2016 informing OHCA of its plans in light of Executive Order No. 51, received by OHCA on March 2, 2016. (3 pages)
G	Applicants responses to OHCA's letter of February 1, 2016, dated March 30, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on March 30, 2016. (26Pages)

H	OHCA's letter to the Applicants dated May 10, 2016 deeming the application complete in the matter of the CON application filed under Docket Number 15-32032. (1 page)
I	OHCA's request for legal notification in *The Day* of OHCA's Notice to the Applicants of the public hearing scheduled for June 15, 2016, in the matter of the CON application under Docket Number 15-32032, dated May 11, 2016. (4 pages)
J	OHCA's request for legal notification in *The Day* of OHCA's Notice to the Applicants of the public hearing rescheduled for June 27, 2016, in the matter of the CON application under Docket Number 15-32032, dated June 2, 2016. (4 pages)
K	OHCA's letter to the Applicant dated June 14, 2016 requesting prefile testimony and enclosing issues in the matter of the CON application under Docket Number 15-32032. (43pages)
L	Letter from AFT Connecticut, Connecticut Citizen Action Group, UNITE HERE Connecticut, National Physicians Alliance in Connecticut, Connecticut Health policy Project, United Action Connecticut, and New England Health Care Employees, District 1199, SEIU ("Petitioners") to OHCA dated June 17, 2016 requesting intervenor Status in the matter of the CON application under Docket Number 15-32032, received by OHCA on June 17, 2016. (152 pages)
M	OHCA's request for legal notification in *The Day* of OHCA's Notice to the Applicants of the public hearing rescheduled for July11, 2016, in the matter of the CON application under Docket Number 15-32032, dated June 22, 2016. (4 pages)
N	Letter from the Applicants to OHCA dated June 22, 2016 enclosing Notice of Appearince of Shipman & Goodwin, Objection to the Coalitions request for full intervenor status and certification of the documents have been provided to the Coalition's attorney in the matter of the CON application under Docket Number 15-32032, received by OHCA on June 22, 2016. (5pages)
O	OHCA's Ruling on the Petition of the Coalition to be granted intervenor status with full rights in the matter of the CON application under Docket Number 15-32032, dated June 23, 2016. (2 pages)
P	OHCA's letter dated June 23, 2016 to the Applicants enclosing an ORDER regarding filing of Prefile testimony in the matter of the CON application under Docket Number 15-32032. (1 page)
Q	Designation of Hearing Office in the in the matter of the CON application under Docket Number 15-32032, dated June 24, 2016. (1 page)
R	Letter from the Applicants to OHCA dated July 1, 2016 enclosing Prefile Testimony and responses in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 1, 2016. (42pages)

S	Letter from the Intervenor to OHCA dated July 1, 2016 enclosing Prefile Testimony in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 1, 2016. (155 pages)
T	Letter from the Applicants to OHCA dated Jully 6, 2016 enclosing supplemental prefile testimony rebutting prefile testimony of Fred Hyde on behalf of the Intervenors in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 6, 2016. (15 pages)
U	Letter from the Intervenor to OHCA dated July 6, 2016 enclosing response to the prefile testimony of Dr. Monical Noether in the in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 6, 2016. (6 pages)
	The following came in after table was completed for hearing held on July 11, 2016
V	Letter from the Applicant to OHCA dated July 8, 2016 noticing the appearance of Jennifer Willcox in the in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 8, 2016. (2 pages)
W	Letter from the Intervenor to OHCA dated July 11, 2016 enclosing prefile testimony of Maritza Bond in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 11, 2016. (8 pages)
X	Testimony of Universal Health Care dated July 11, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 11, 2016. (2 pages)
Y	Letter from Senator Looney dated July 7, 2016 in the matter of the CON application under Docket Number 15-32032, received by OHCA on July 8, 2016.(1 page)
Z	Letters from the public in the matter of the CON application under Docket Number 15-32032. (6 pages)
AA	Responses to Senators Looney and Formica in the matter of the CON application under Docket Number 15-32032. (2 pages)
BB	Hearing Transcript from the July 11, 2016 hearing in the matter of the CON application under Docket Number 15-32032. Received by OHCA on July 19, 2016 (109 pages)

Greer, Leslie

From: Lazarus, Steven
Sent: Thursday, July 28, 2016 3:47 PM
To: hfmurray@lapm.org; Feldman, Joan (JFeldman@goodwin.com); Carannante, Vincenzo (VCarannante@goodwin.com)
Cc: Greer, Leslie; Hansted, Kevin; Riggott, Kaila; Carney, Brian; Ciesones, Ron
Subject: List Of Late Files Requested by OHCA, DNs 15-32033 & 15-32032
Attachments: List Of Late Files Requested by OHCA.docx

Good Afternoon,

Please see the attached document that was created to help clarify the Late Files dues and other hearing related materials in the above referenced dockets. Please feel free to contact Brian, Ron or myself, if you have any questions at 860-418-7001.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

Office of Health Care Access

Public Hearing held on July 11 & 26, 2016
Docket Numbers: 15-32032 & 15-32033
Late Files Requested by OHCA

- **Late File # 1**: A list of additional services, specialists and/or sub-specialists added / recruited to the L&M service area (post-merger). [DN- 15-32032]

- **Late File # 2**: A list of L&M /commercial payer contracts and the expiration dates of said contracts. [DN- 15-32033]

- **Late File # 3**: Submit separate forms for year- to-date (YTD) actual results through June 2016 for L+M Health System, Lawrence + Memorial Hospital (*hospital only and consolidated*) and Yale-New Haven Health System. Use the same format as used previously a Financial Attachment A of the original application. [DN- 15-32032 & DN-15-32033]

- **Late File # 4**: Provide separate YTD Financial Measurement Indicators through June 2016 for L+M Health System, Lawrence + Memorial Hospital and Yale-New Haven Health System in the same format as previously submitted on page 602 (and resubmitted on page 863) of the application which includes amounts for the prior year time period (June 2016.) [DN- 15-32033]

- **Late File # 5**: A copy of L+M Hospital's most recent DPH licensing survey (July 13, 2016) and all communication between L+M Hospital and DPH regarding said survey. [DN- 15-32033]

Due Dates:

1. All late files are due no later than August 5, 2016.

2. Applicants Objection in writing to OHCA's taking Administrative Notice of Exhibits KK (Letter from State of Connecticut Comptroller, Kevin Lembo), and Exhibit LL (the Milliman Analysis), due no later than July 29, 2016.

3. Intervenors' response to the Applicants Objection to OHCA taking Administrative Notice of Exhibits KK and LL, due not later than August 5, 2016.

GENERAL PUBLIC

(Only persons speaking as general public must put their names on this list)

PUBLIC HEARING-SIGN UP SHEET

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

PRINT NAME	Representing Organization (If applicable) or Self
Peg. Curtin. for → Victoria Longo	Self.
USA D'Abrosca → Kristen Powers	AFT Local 5049.
~~Tom Swart~~ (duplicate)	CCAG.
Daniel Kilburn.	Self & Behalf of. Christina Chapman

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials

Connecticut Department of Public Health

Office of Health Care Access

Public/Elected Officials

(Only elected/appointed officials making a statement)

PUBLIC HEARING-SIGN UP SHEET

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

Docket Number: 15-32032-CON
Northeast Medical Group, Inc. L&M Physician Association, Inc.
Acquisition of L&M Physician Association, Inc. by Northeast Medical Group

PRINT NAME	Phone	Email	Public/Appointed Office Name
Ernest Hewett	860-460-9768	paparileyc@aol.com	State Rep.
~~Anthony Nolan~~	~~860-625-4711~~	~~nolan4NLC@ct.rr.com~~	~~City Council~~
John Satti	860 287.052[illegible]	Jsatti@snet.net	City Council

Office of Health Care Access

GENERAL PUBLIC

(Only persons speaking as general public must put their names on this list)

PUBLIC HEARING-SIGN UP SHEET

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

Docket Number: 15-32032-CON Northeast Medical Group, Inc. L&M Physician Association, Inc. Acquisition of L&M Physician Association, Inc. by Northeast Medical Group	Docket Number: 15-32033-CON Yale New Haven Health Services Corporation L+M Corporation Acquisition of Lawrence + Memorial Corporation by Yale New Haven Health Services Corporation
PRINT NAME	**Representing Organization (If applicable) or Self**
Ken Rowland	U.A.W.
Sue Corrice (READ BY MITCH ROSS)	Riverfront Children's Center
Ann Pratt (Reading for Susan Goldman + Ken Rowland)	AFSCME
NEWMAN MARSILIUS	BRIDGEPORT HOSPITAL, BOARD
~~Mitch Ross~~ (DUPLICATE)	L+M, V.P AFT Local 5051

GENERAL PUBLIC

(Only persons speaking as general public must put their names on this list)

PUBLIC HEARING-SIGN UP SHEET

July 26, 2016 (continued from July 11, 2016)

3:00 p.m.

PRINT NAME	Representing Organization (If applicable) or Self
Hal Levi	Health Care Consumer
Tom Swan	CT Citizen Action Group
Alfred Fritzsche	Citizen
Bud McAllister	Partners in Healthy Communities
Sue Fraser.	Self.
Barbara Sadowski	Self.
~~Anthony Moran~~	
William Schnauder	Self
~~Ken Rowland (DUPLICATE)~~	Self (CT Citizen Action Grp)
Cathy ~~De~~ VanVerdenghem	AFT Local 5051.

General Public: Anyone not associated with the Applicants, Intervenor or Elected/Public Officials

Greer, Leslie

From: Lazarus, Steven
Sent: Wednesday, August 03, 2016 7:14 AM
To: Greer, Leslie
Cc: Hansted, Kevin
Subject: FW: YNHH/L+M Late Files Docket No.-15-32033 and 15-32032
Attachments: Late Files.PDF

Leslie,

Please add to the record.

Thank you,

Steve

Steven W. Lazarus
Associate Health Care Analyst
Division of Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7012
Fax: 860-418-7053

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Tuesday, August 02, 2016 5:51 PM
To: Hansted, Kevin; Carney, Brian; Lazarus, Steven; Riggott, Kaila
Cc: hfmurray@lapm.org; jennifer.willcox@ynhh.org; Aseltyne, Bill; manderson@lmhosp.org
Subject: YNHH/L+M Late Files Docket No.-15-32033 and 15-32032

Attorney Hansted:
Attached you will find an electronic version of the requested late files in connection with the above-referenced dockets. We will hand-deliver a hard copy of the late files in the a.m.
Many thanks.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

August 2, 2016

Via E-Mail

Kevin T. Hansted
Staff Attorney/Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Kevin.Hansted@ct.gov

Re: Late files - Affiliation of Lawrence + Memorial Corporation with Yale-New Haven Health Services Docket No. 15-32033 and Proposal for Merger of L&M Physician Association, Inc. and Northeast Medical Group, Inc. Docket No. 15-32032

Dear Attorney Hansted:

Attached you will find the late files requested by OHCA in connection with the above-referenced applications. Please let me know if you have any questions.

Respectfully submitted,

Lawrence + Memorial Corporation
Yale New Haven Health Services Corporation

By _____
Joan W. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103
Tel: (860) 251-5104
Email: jfeldman@goodwin.com
Their Attorneys

4980384v1

CERTIFICATE OF SERVICE

I hereby certify that the foregoing was served by e-mail on August 2, 2016 to the following counsel of record:

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.
557 Prospect Avenue
Hartford, CT 06105-2922
(e-mail: HFMurray@lapm.org)

Joan W. Feldman

Connecticut Department of Public Health

Office of Health Care Access

Public Hearing held on July 11 & 26, 2016
Docket Numbers: 15-32032 & 15-32033
Late Files Requested by OHCA

- **Late File # 1**: A list of additional services, specialists and/or sub-specialists added / recruited to the L&M service area (post-merger). [DN- 15-32032]

- **Late File # 2**: A list of L&M /commercial payer contracts and the expiration dates of said contracts. [DN- 15-32033]

- **Late File # 3**: Submit separate forms for year- to-date (YTD) actual results through June 2016 for L+M Health System, Lawrence + Memorial Hospital (*hospital only and consolidated*) and Yale-New Haven Health System. Use the same format as used previously a Financial Attachment A of the original application. [DN- 15-32032 & DN-15-32033]

- **Late File # 4**: Provide separate YTD Financial Measurement Indicators through June 2016 for L+M Health System, Lawrence + Memorial Hospital and Yale-New Haven Health System in the same format as previously submitted on page 602 (and resubmitted on page 863) of the application which includes amounts for the prior year time period (June 2016.) [DN- 15-32033]

- **Late File # 5**: A copy of L+M Hospital's most recent DPH licensing survey (July 13, 2016) and all communication between L+M Hospital and DPH regarding said survey. [DN- 15-32033]

Due Dates:

1. All late files are due no later than August 5, 2016.

2. Applicants Objection in writing to OHCA's taking Administrative Notice of Exhibits KK (Letter from State of Connecticut Comptroller, Kevin Lembo), and Exhibit LL (the Milliman Analysis), due no later than July 29, 2016.

3. Intervenors' response to the Applicants Objection to OHCA taking Administrative Notice of Exhibits KK and LL, due not later than August 5, 2016.

Late File #1

Yale New Haven Health / Lawrence + Memorial Health
Affiliation CON Hearing
Docket Number: 15-32032-CON

Late File #1: A list of additional services, specialists and/or sub-specialists added / recruited to the L&M service area (post-merger). [DN- 15-32032]

Yale New Haven Health System will support the enhancement of clinical services in L+M's service area in the following disciplines subject to community need and the opportunity to provide these services locally at a lower cost over a five-year period:

- Primary care (6)
- Surgical specialties (e.g., cardiovascular, women's and children's, neurosurgery, etc.) (9)
- Medical specialists (e.g., oncology, cardiology, etc.) (10)
- Behavioral health (1)

Late File #2

Lawrence + Memorial Healthcare
Commercial Payer Contracts as of 07/29/2016

Hospital	Insurer	Latest FPA	Latest Rate Amendment	Next Potential Rate Change	Underlying Contract / LOA Term
L&M	Aetna	1/1/1998	12/1/2001	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Anthem	10/1/2012	10/1/2015	To be negotiated on 10/1/17	9/30/2017
L&M	Cigna	4/15/1996	3/16/1999	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Connecticare	9/1/1997	1/1/2014	In negotiations currently	In negotiation
L&M	Harvard Pilgrim	3/1/2015	3/1/2015	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Healthy CT	1/1/2014	1/1/2014	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Multiplan	3/1/2008	3/1/2008	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	Pequot Plus	3/20/2008	3/20/2008	Low volume. % of charges. No specific target date for renegotiation	Evergreen
L&M	United	10/1/2015	2/1/2016	Rates outlined until 9/30/17 with agreed upon annual inflation neutral to charges on 10/1/2016	Original LOA 03/01/1997;. Current contract expires 9/30/2017 with auto renewals

*FPA = Facility Participation Agreement

1. Evergreen contracts have no termination dates built into language but minor annual adjustments comparable to inflation increases

Late File #3

LINE	Total Entity: LMC	FY 2016 YTD Thru June 30
	Description	
A.	OPERATING REVENUE	
1	Total Gross Patient Revenue	849,188,142.00
2	Less: Allowances	$505,735,966
3	Less: Charity Care	4,622,724.97
4	Less: Other Deductions	8,225,838.00
	Net Patient Service Revenue	$330,603,613
5	Medicare	$119,815,016
6	Medicaid	$35,748,799
7	CHAMPUS & TriCare	$9,249,077
8	Other	($8,225,838)
	Total Government	$156,587,053
9	Commercial Insurers	$160,234,793
10	Uninsured	$0
11	Self Pay	$7,397,505
12	Workers Compensation	$6,384,262
13	Other	$0
	Total Non-Government	$174,016,560
	Net Patient Service Revenue[a] (Government+Non-Government)	$330,603,613
14	Less: Provision for Bad Debts	$11,223,286
	Net Patient Service Revenue less provision for bad debts	$319,380,327
15	Other Operating Revenue	$13,910,987
17	Net Assets Released from Restrictions	$0
	TOTAL OPERATING REVENUE	$333,291,314
B.	OPERATING EXPENSES	
1	Salaries and Wages	$164,399,926
2	Fringe Benefits	$46,210,874
3	Physicians Fees	$20,689,449
4	Supplies and Drugs	$55,635,875
5	Depreciation and Amortization	$21,428,431
6	Provision for Bad Debts-Other[b]	
7	Interest Expense	$2,634,953
8	Malpractice Insurance Cost	$10,561,456
9	Lease Expense	$4,520,641
10	Other Operating Expenses	$21,244,899
	TOTAL OPERATING EXPENSES	$347,326,504
	INCOME/(LOSS) FROM OPERATIONS	($14,035,190)
	NON-OPERATING REVENUE	$1,615,307
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	($12,419,883)
	Principal Payments	$1,325,962
C.	PROFITABILITY SUMMARY	
1	Hospital Operating Margin	-4.2%
2	Hospital Non Operating Margin	0.5%
3	Hospital Total Margin	-3.7%
D.	FTEs	2,797
	FTE reduction is a transfer to NEMG see separate CON	
E.	VOLUME STATISTICS[c]	
1	Inpatient Discharges	11,878
2	Outpatient Visits	544,086
	TOTAL VOLUME	555,964

LINE	Total Entity:L+M Hospital	FY 2016 YTD Thru June 30
	Description	
A.	OPERATING REVENUE	
1	Total Gross Patient Revenue	$639,076,340
2	Less: Allowances	$378,126,336
3	Less: Charity Care	$3,961,358
4	Less: Other Deductions	$8,225,838
	Net Patient Service Revenue	$248,760,808
5	Medicare	$87,731,433
6	Medicaid	$27,790,034
7	CHAMPUS & TriCare	$8,309,418
8	Other	($8,225,838)
	Total Government	$115,605,047
9	Commercial Insurers	$123,632,348
10	Uninsured	$0
11	Self Pay	$3,905,445
12	Workers Compensation	$5,617,968
13	Other	$0
	Total Non-Government	$133,155,761
	Net Patient Service Revenue[a] (Government+Non-Government)	$248,760,808
14	Less: Provision for Bad Debts	$8,431,606
	Net Patient Service Revenue less provision for bad debts	$240,329,202
15	Other Operating Revenue	24,016,927
17	Net Assets Released from Restrictions	$0
	TOTAL OPERATING REVENUE	$264,346,129
B.	OPERATING EXPENSES	
1	Salaries and Wages	$ 106,932,067
2	Fringe Benefits	$ 41,209,855
3	Physicians Fees	$ 18,388,808
4	Supplies and Drugs	$45,975,704
5	Depreciation and Amortization	$17,266,207
6	Provision for Bad Debts-Other[b]	
7	Interest Expense	$2,634,617
8	Malpractice Insurance Cost	$3,608,118
9	Lease Expense	$2,472,284
10	Other Operating Expenses	$ 20,847,477
	TOTAL OPERATING EXPENSES	$259,335,137
	INCOME/(LOSS) FROM OPERATION	$5,010,992
	NON-OPERATING REVENUE	$979,682
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$5,990,674
	Principal Payments	$1,325,982
C.	PROFITABILITY SUMMARY	
1	Hospital Operating Margin	1.9%
2	Hospital Non Operating Margin	0.4%
3	Hospital Total Margin	2.3%
D.	FTEs	1,832
E.	VOLUME STATISTICS[c]	
1	Inpatient Discharges	10,095
2	Outpatient Visits	326,180
	TOTAL VOLUME	336,275

NON-PROFIT

Applicant: Yale New Haven Health System

Financial Worksheet (A)

LINE	Total Entity:	(1) FY 2016 YTD June Actual Results
	Description	
A.	OPERATING REVENUE	
1	Total Gross Patient Revenue	$9,307,350,000
2	Less: Allowances	$6,340,612,000
3	Less: Charity Care	$98,443,000
4	Less: Other Deductions	$92,233,000
	Net Patient Service Revenue	$2,776,062,000
5	Medicare	$884,333,150
6	Medicaid	$312,433,610
7	CHAMPUS & TriCare	$9,776,156
8	Other	($136,500,000)
	Total Government	$1,070,042,916
9	Commercial Insurers	$1,593,360,493
10	Uninsured	$0
11	Self Pay	$98,796,901
12	Workers Compensation	$13,861,689
13	Other	$0
	Total Non-Government	$1,706,019,084
	Net Patient Service Revenue[a] (Government+Non-Government)	$2,776,062,000
14	Less: Provision for Bad Debts	$72,481,000
	Net Patient Service Revenue less provision for bad debts	$2,703,581,000
15	Other Operating Revenue	$89,275,000
17	Net Assets Released from Restrictions	$18,900,000
	TOTAL OPERATING REVENUE	$2,811,756,000
B.	OPERATING EXPENSES	
1	Salaries and Wages	$1,119,083,000
2	Fringe Benefits	$298,679,000
3	Physicians Fees	$451,991,000
4	Supplies and Drugs	$385,268,000
5	Depreciation and Amortization	$143,361,000
6	Provision for Bad Debts-Other[b]	$0
7	Interest Expense	$20,623,000
8	Malpractice Insurance Cost	$20,900,000
9	Lease Expense	$25,828,000
10	Other Operating Expenses	$243,080,000
	TOTAL OPERATING EXPENSES	$2,708,813,000
	INCOME/(LOSS) FROM OPERATIONS	$102,943,000
	NON-OPERATING REVENUE	$30,600,000
	EXCESS/(DEFICIENCY) OF REVENUE OVER EXPENSES	$133,543,000
	Principal Payments	$0
C.	PROFITABILITY SUMMARY	
1	Hospital Operating Margin	3.6%
2	Hospital Non Operating Margin	1.1%
3	Hospital Total Margin	4.7%
D.	FTEs	16,429
E.	VOLUME STATISTICS[c]	
1	Inpatient Discharges	84,974
2	Outpatient Visits	1,433,289
	TOTAL VOLUME	1,518,263

[a]Total amount should equal the total amount on cell line "Net Patient Revenue" Row 14.

[b]Provide the amount of any transaction associated with Bad Debts not related to the provision of direct services to patients. For additional information, refer to FASB, No.2011-07, July 2011.

[c]Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Note to table:

The updated financial information above reflects the impact of material transactions that are anticipated to be included in the September 30, 2016 year end audited financial statements.

Late File #4

Late File #4 Provide monthly financial reports that include statistics for the current month, and year to date and comparable month from the previous year for the following:

	L&M Hospital				L+M Corporation (Consolidated)			
	YTD	YTD	MTD	MTD	YTD	YTD	MTD	MTD
Monthly Financial Measurement/Indicators								
A. Operating Performance:	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15
Operating Margin	1.36%	1.63%	13.46%	3.92%	-4.21%	-1.29%	5.65%	1.31%
Non operating Margin	NA	NA	NA	NA	NA	NA	NA	NA
Total Margin	1.72%	4.82%	14.12%	32.28%	-3.73%	1.98%	6.31%	21.60%
Bad Debt as % of Net Revenue	5.73%	6.46%	4.17%	4.00%	5.37%	5.89%	4.14%	3.97%
B. Liquidity:	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15
Current Ratio	2.8	3.5	2.8	3.5	3.4	4.0	3.4	4.0
Days Cash on Hand	113.8	144.7	113.8	144.7	127.5	152.7	127.5	152.7
Days in Net Accounts Receivable	41.2	38.5	41.2	38.5	36.9	37.6	36.9	37.6
Average Payment Period	60.7	56.2	60.7	56.2	57.6	56.2	57.6	56.2
C. Leverage and Capital Structure:	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15
Long-term Debt to Equity	89.9%	71.2%	89.9%	71.2%	41.4%	37.0%	41.4%	37.0%
Long-term Debt to Capitalization	46.0%	40.4%	46.0%	40.4%	28.2%	26.1%	28.2%	26.1%
Unrestricted Cash to Debt	96.9%	118.7%	96.9%	118.7%	144.9%	167.8%	144.9%	167.8%
Times Interest Earned Ratio	2.7	5.9	17.5	35.4	-3.7	3.6	9.8	30.0
Debt Service Coverage Ratio	2.8	3.8	2.8	3.8	1.3	3.5	1.3	3.5
Equity Financing Ratio	0.36	0.44	0.36	0.44	0.50	0.55	0.50	0.55
D. Additional Statistics:	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15
Income from Operation	3,595,629	4,383,117	4,307,722	1,182,420	(14,035,190)	(4,459,584)	2,419,606	559,877
Revenue Over/(Under) Expense	4,575,311	12,925,878	4,519,186	9,725,181	(12,419,883)	6,874,703	2,702,080	9,212,158
EBITA	23,496,453	24,317,418	6,493,637	3,380,999	10,028,194	19,344,610	5,188,638	3,227,771
Patient Cash Collected	NA	NA	NA	NA	NA	NA	NA	NA
	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15	Jun-16	Jun-15
Cash and Cash Equivalents	5,002,627	5,989,197	5,002,627	5,989,197	15,518,776	16,566,226	15,518,776	16,566,226
Net Working Cash	99,050,177	129,563,076	99,050,177	129,563,076	166,832,875	201,559,545	166,832,875	201,559,545
Unrestricted Assets	90,882,751	127,734,763	90,882,751	127,734,763	217,782,094	259,079,233	217,782,094	259,079,233
Credit Ratings (S&P, Fitch, Moody's)								

Fitch A with Stable

S&P BBB+ with Developing

ate File #4: Yale New Haven Health System

	Yale New Haven Health			
	Jun-16 YTD	Jun-15 YTD	Jun-16 MTD	Jun-15 MTD
Monthly Financial Measurement/Indicators				
. Operating Performance:				
Operating Margin	3.60%	4.36%	3.13%	6.79%
Non operating Margin	N/A	N/A	N/A	N/A
Total Margin	4.74%	5.73%	1.74%	6.99%
Bad Debt as % of Net Revenue	2.66%	2.50%	2.59%	3.15%
. Liquidity:				
Current Ratio	3.3	3.2	3.3	3.2
Days Cash on Hand	201.0	191.0	201.0	191.0
Days in Net Accounts Receivable	41.1	41.8	41.1	41.8
Average Payment Period	65.2	67.5	65.2	67.5
. Leverage and Capital Structure:				
Long-term Debt to Equity	50.2%	50.0%	50.2%	50.0%
Long-term Debt to Capitalization	33.4%	33.3%	33.4%	33.3%
Unrestricted Cash to Debt	160.1%	164.4%	160.1%	164.4%
Times Interest Earned Ratio	7.5	9.6	3.1	11.2
Debt Service Coverage Ratio	5.1	6.5	5.1	6.5
Equity Financing Ratio	0.45	0.46	0.45	0.46
). Additional Statistics:				
Income from Operations	102,943,000	117,683,000	10,352,000	20,406,000
Revenue Over/(Under) Expense	133,543,000	154,670,000	5,755,000	20,986,000
EBITA	297,527,000	312,434,000	24,574,000	37,507,000
Patient Cash Collected	N/A	N/A	N/A	N/A
Cash and Cash Equivalents	139,260,000	212,913,000	139,260,000	212,913,000
Net Working Cash	1,416,866,000	1,250,273,000	1,416,866,000	1,250,273,000
Unrestricted Assets	1,861,952,000	1,801,765,000	1,861,952,000	1,801,765,000
Credit Ratings (S&P, Fitch, Moody's)				
Fitch	AA- with Stable			
S&P	A+ with Positive			
Moody's	Aa3 with Stable			

Note to table:

The updated financial information above reflects the impact of material transactions that are anticipated to be included in the September 30, 2016 year end audited financial statements.

Late File #5

CMS
Centers for Medicare & Medicaid Services
Office of the Regional Administrator

Boston Region I
JFK Federal Building, Room 2325
Boston, MA 02203-0003
FAX #: 443-380-8871

Confidential Facsimile Transmittal

To: **Bruce Cummings, President & CEO**
Company:
Fax: 8604444788
Phone

From: **Kathy Mackin**
Fax: 443-380-5597
Phone: (617) 565-1211
E-mail: kathy.mackin@cms.hhs.gov

Date and time: Thursday, July 21, 2016 9:41:58 AM

Number of pages: 43

cc:

NOTES: Advanced copy of notice of findings

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

July 21, 2016

Mr. Bruce Cummings, President & CEO
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Re: CMS Certification Number: 070007
Survey ID: 7ZQQ11, 07/13/2016

Dear Mr. Cummings:

Section 1865 of the Social Security Act (the Act) and Centers for Medicare & Medicaid Services (CMS) regulations provide that a provider or supplier accredited by a CMS-approved Medicare accreditation program will be "deemed" to meet all of the Medicare Conditions of Participation (CoPs) for hospitals. In accordance with Section 1864 of the Act, State Survey Agencies may conduct at CMS's direction, surveys of deemed status providers on a selective sampling basis, in response to a substantial allegation of noncompliance, or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance. CMS uses such surveys as a means of validating the accrediting organization's survey and accreditation process.

A survey conducted by the State of Connecticut Department of Public Health (State Survey Agency) at Lawrence & Memorial Hospital on July 13, 2016 found that the facility was not in substantial compliance with the following Conditions of Participation (CoPs) for hospitals:

42 C.F.R. §482.12 - Governing Body
42 C.F.R. §482.13 - Patient's Rights
42 C.F.R. §482.22 - Medical Staff
42 C.F.R. §482.23 - Nursing Services

As a result, effective July 13, 2016, your facility's deemed status is being removed and survey jurisdiction has been transferred to the State Survey Agency.

A listing of all deficiencies found is enclosed (Form CMS-2567, Statement of Deficiencies and Plan of Correction). You are not required to submit a plan of correction (PoC) for these deficiencies, but you may do so voluntarily. Copies of the Form CMS-2567, including copies containing a facility's PoC, are releasable to the

public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. §401.133(a). As such, if you choose to submit a PoC, it should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names.

The State Survey Agency will conduct an unannounced full survey of your facility to assess compliance with all the applicable Medicare conditions. If that survey indicates your facility is in substantial compliance with all of the applicable conditions, CMS will restore your deemed status and notify you in writing of this. If that survey indicates your facility is not in substantial compliance with one or more of the applicable conditions, then CMS will initiate action to terminate your Medicare agreement and will notify you in writing of this, including your opportunity to make timely correction of deficiencies identified.

In accordance with 42 CFR §498.3(d), this notice of findings is an administrative action, not an initial determination, and therefore formal reconsideration and hearing procedures do not apply.

If you have any questions, please contact Kathy Mackin at (617) 565-1211.

Sincerely,

for J. William Roberson
Associate Regional Administrator
Northeast Division, Survey & Certification

Enclosure: CMS-2567

cc: CT State Survey Agency
The Joint Commission (TJC)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070007	A. BUILDING _____ B. WING _____	C 07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE & MEMORIAL HOSPITAL	365 MONTAUK AVE NEW LONDON, CT 06320

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A 000	INITIAL COMMENTS An authorized substantial allegation survey commenced on 6/30/16 and concluded on 7/13/16 in response to complaint # CT 20210 at Lawrence and Memorial Hospital 365 Montauk Avenue New London, CT 06320 The following Conditions of Participation were reviewed as they pertain to the complaint 482.12 Governing Body 482.13 Patient Rights 482.21 QAPI 482.22 Medical Staff 482.23 Nursing Staff 482.25 Pharmacy Services The Conditions of Participation for Governing Body, Patient Rights, Medical Staff, Nursing Staff and were not met. The census in Lawrence and Memorial Hospital 159 Patient records sampled 12	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery, history of chronic pain and receiving analgesia. (Patient #1), the governing body failed to be accountable for the quality of care provided to the patient including emergency treatment/assessments when the patient had expired and/or failed to ensure that the hospitalist's contract was reviewed and implemented to provide ample coverage on the off shifts. (See A49 and A84)	A 043		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery history chronic pain and receiving analgesia, (Patient #1), the medical staff failed to be accountable for the quality of care provided to the patient. The findings include. 1. a. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain and was a Full Code Status. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety	A 049		

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A 049	Continued From page 2	A 049		

disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.

Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol.

Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10 45 am, Miralax 17 grams at 10 45 am, and Senokot 17.2 milligrams at 10 45 am (laxative medications), in addition, Relistor for narcotic induced constipation was administered at 11.12 am. Although multiple medications were administered to promote bowel activity, an abdominal x-ray was not obtained until 2.47 pm on 6/27/16. The impression of the x-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milliliters at 3.52 pm and a soap suds enema at 6 02 pm. Nursing notes dated 6/27/16, 6.02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and procedure.

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A 049	Continued From page 3 Further review of the nursing flowsheets dated 6/27/16 at 12.10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12 04 pm. At 1 00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1 00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2 47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6 02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement per the physician. Patient #1 also received Roxicodone 10 mg at 7.20 pm with indications to reassess in one hour. At 7 22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9 00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status. Interview with Registered Nurse (RN) #1 on 7/6/16 identified that he/she had gone into Patient #1's room after 9 30 pm to obtain his/her blood sugar and noticed the patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9.45 pm, he/she returned to Patient #1's room and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the	A 049		

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A 049	Continued From page 4 door and found Patient #1 hanging by a bed sheet tied around a shower rod. RN #1 indicated that he/she had called for help, checked for a pulse while a Code 8 was called at 9 50 pm. b. Review of the progress notes dated 6/27/16 identified that, although an abdominal assessment was documented by MD #3 at 11.30 am, the clinical record failed to identify any additional assessment conducted by a physician and/or a licensed independent practitioner when the patient had a change in condition including an assessment when the patient coded and expired. Additionally, the medical record lacked documentation to reflect an assessment by MD #2 when the patient coded and expired. Review of the Discharge Summary dated 7/17/16 identified that Patient #1 started presenting with increasing abdominal pain as well of periods of burping. Further review indicated that abdominal x-ray was done to evaluate for possible complications/obstruction/aspiration however it continued to show the ileus. Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code from the Emergency Department and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Review of the clinical record with MD #2 failed to identify a progress note had been written indicating MD #2's assessment and reason not to proceed with resuscitative efforts, although the	A 049		

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A 049	Continued From page 5	A 049		

clinical record identified that the patient was a full code. Further interview with MD #2 identified that he/she did not document the assessment in the progress note as he/she was instructed by administration that this was a police matter.

Interview with Pastoral Care Representative on 7/5/16 identified that he/she had visited with Patient #1 on 6/27/16 in the afternoon. Further interview identified that Patient #1 was lying on his/her side, scrunched over and groaning so loudly that you could hear him/her throughout the unit. In addition, the Pastoral Care Representative indicated that he/she had not seen anyone struggling and in so much pain.

Interview with Pharmacy Manager on 7/6/16 identified that laxatives are to be discontinued prior to administering Relistor. In addition, use is contraindicated in patients with known or suspected GI obstruction or at increased risk of recurrent obstruction.

Interview with MD #1 on 7/13/16 identified that he/she was aware of Patient #1's suicidal and psychiatric history, however, it was never communicated to the nursing staff and/or had no psychiatric consult was completed. Further interview with MD #1 on 7/13/16 identified that he was aware that MD #2 had not documented in the medical record regarding assessments and code response however he/she was told to wait until DPH finished their investigation.

Interview with MD #6 on 7/13/16 identified that he/she was aware of Patient #1's being on multiple psychiatric meds and previous psychiatric history from reviewing previous admissions however, did not feel the patient

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A 049	Continued From page 6 needed for a psychiatric consult while in the hospital. Review of hospital policy identified that each patient has an initial assessment by a medical staff member who assesses the physical, psychological and social status of the patient and identifies appropriate care of the need for further assessment. The medical staff member is the leader of the patient care team in the planning and provision of care throughout the continuum. Review of hospital patients' rights policy identified that patients will receive information about pain and symptom management. It further identified that "As healthcare professionals and concerned staff, we are committed to pain prevention and management and want to respond quickly to your reports of pain and related symptoms." Review of hospital policy identified that the Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s. and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is initiated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician. The cardiopulmonary resuscitation record is completed and the original becomes part of the patient record. c. Review of the physician orders dated 6/18/16	A 049		

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A 049	Continued From page 7 identified that Patient #1 was to receive Oxycontin 10 mg every twelve hours for pain to be renewed every seven days. On 6/25/16, Patient #1's medication was due to be renewed, however, the hospitalist never renewed the medication. Patient #1 had not received the scheduled Oxycontin for 36 hours. On 6/26/16, the 7-3 nurse noticed the pain medication was not renewed and called the physician for a new order. Review of hospital policy identified that all Schedule II narcotic ordered will automatically be removed for the Medication Administration Record at 12 midnight on the seventh day if not renewed. Interview with MD #6 on 7/13/16 identified that he/she was not aware and/or educated of an alert on the computer identifying that a patients narcotics were up for renewal. Interview with the Pharmacy Manager on 7/1/16 identified that pharmacy staff have no process in place to monitor when narcotics need to be renewed after seven days if the provider fails to renew the order. Further interview identified that the pharmacy relies on the provider to renew the narcotic when a purple tab in the computer that notifies the provider a narcotic needs to be renewed otherwise the narcotic order just drops off. Review of hospital documentation dated 7/13/16 (16 days later) identified that a memo went out to all providers to remind them of renewing Schedule II Controlled Substances every 7 days per state law.	A 049		
A 084	482.12(e)(1) CONTRACTED SERVICES	A 084		

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A 084	Continued From page 8 The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by Based on review of hospital documentation and contracts, the hospital failed to provide hospitalist coverage based on the contract. The findings include Review of hospital documentation and the contracted service for hospitalist coverage identified that from 6/2016-7/2016 indicated that on 11 00 pm-7 00 am one physician, one on-call physician for the intensive care unit and one physician extender were covering the entire hospital. Review of the hospitalist contract identified that on 11 00 pm - 7 00 am shift, the hospital shall be staffed at night with no fewer than one FTE physician assigned to the intensive care unit and one FTE physician assigned to the hospital inpatient units. In addition, review of hospital documentation identified that on 6/25/16-6/27/16 the range of hospital census was from 190-199 and from 5.00 pm -7 00 am, one physician covering the ED, codes and intensive care unit and one Advanced Practice Registered Nurses covering the entire hospital. Further review failed to identify an on-call physician for the intensive care unit. Interview and review of the hospitalist contract with the Chief Hospitalist on 7/13/16 identified that he/she was not aware of what coverage was needed per the contract. Further interview identified that they had one physician who covered the intensive care unit leave and the hospital was providing coverage with one.	A 084		

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A 084	Continued From page 9 physician and a physician extender (APRN) on the overnight shift.	A 084		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by. Based on review of clinical records, hospital policies and procedures and interviews for one of twelve sampled patients (Patient # 1) with a Full Code status, the hospital failed to ensure that cardiopulmonary resuscitation (CPR) was initiated and/or when a patient presents with a risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and receiving analgesia, the facility failed to ensure that the patient received care in a safe setting. See (A 130, A144)	A 115		
A 130	482.13(b)(1) PATIENT RIGHTS.PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by Based on review of clinical records, hospital policies and procedures and interviews for one of twelve sampled patients (Patient # 1) with a Full code status, the hospital failed to ensure that cardiopulmonary resuscitation (CPR) was initiated when the patient presented without pulse and/or respirations. The findings include. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with a chief	A 130		

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A 130	Continued From page 10	A 130		

complaint of abdominal pain and diagnoses that included small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and use of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, and Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.

Physician orders dated 06/17/16 at 6:33 PM identified that the patient's code status was discussed with Patient #1 who requested a Full Code. The Full Code status was consistent with the code status identified on previous hospital/ED admissions.

Interview with RN #1 on 7/6/16 identified that, on 06/28/16 at approximately 9:30 PM he/she had gone into Patient #1's room to obtain a fingerstick blood glucose and noticed the patient was in the bathroom with the water running and the door shut. RN#1 indicated that he/she thought that the enema, previously administered, had been effective, and the patient was in the bathroom having a bowel movement. RN #1 decided to return in fifteen minutes. Further interview with RN #1 identified at 9:45 pm, he/she returned to Patient #1's room. The door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging by a bed sheet around the shower curtain rod. RN #1 identified that he/she had called for help, and checked for a pulse while a Code 8 was called.

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A 130	Continued From page 11 Interview with RN #7, the intravenous therapy (IV) nurse, on 07/06/16 at 2.45 PM identified that he/she was charting at the nursing station adjacent to the unit when he/she heard screaming and went to the patient's room to investigate. At the same time, RN #10, a nurse from the adjacent unit, was coming out of the room, heading towards the nursing station. RN #7 identified that he/she believed that RN #10 was going to call a Code 8. RN #7 entered the patient room and observed the clinical manager, RN #1, looking into the bathroom. RN #7 then entered the bathroom and observed Patient #1 suspended from the curtain rod. RN #7 checked the patient for movement, palpated the left and right carotid arteries for pulse, checked for respirations, assessed the pupils as fixed and dilated, and observed a dried substance consistent with blood at the right corner of the patient's mouth. RN #7 further identified that a staff member had reported that Patient #1 was a full code and RN #7 responded that the patient had expired and directed the staff not to touch Patient #1, but notify the Assistant Director of Nursing (ADNS), security, and the physician. RN #7 then left the room and observed many staff members coming down the hallway towards the room. RN #7 further identified that, based on his/her professional experience, the patient and his/her environment had become part of a crime scene. Interview with MD #2 on 07/06/16 identified that he/she had been in the ED when summoned by the Code 8 to Patient #1's room. Patient #1 presented with mottling his/her soles of feet were white and multiple abrasions were visible around his/her neck. The body was already cooled and	A 130		

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A 130	Continued From page 12 The patient appeared to have expired some time ago. Death was pronounced at 10 00 PM. Further interview with MD # 2 on 7/6/16 identified that he/she had been directed by administration not to document at that time and, therefore, failed to document the time of death, circumstances of death, and/or physical assessment in the clinical record. MD #2 returned to the ED. Interviews with the Director of Patient Care Services (PCS) on 07/06/16 at 10 00 AM and 7/13/16 that on 06/28/16 at approximately 10.00 PM he/she had received a call from the Director on Call, who identified the circumstances of Patient #1's death. The PCS arrived at the hospital by 10.30 PM. The police had arrived and the PCS did not enter the room as it was considered to be a crime scene. According to the PCS, RN #7 had responded to the Code 8 and directed that the situation represented a crime scene and MD #2 agreed with that approach. In a later interview, the PCS identified that he/she had directed the staff to step out of the room so it could be secured as it was a crime scene. Patient #1 was not removed from the hanging position at that time. Interview with the Director of Risk Management on 07/07/16 at 3 00 PM identified that once the police cleared the scene, they removed the patient with assistance of the hospital's public safety staff and the body was removed by a representative of the Medical Examiner's office sometime before 2 00 AM on 06/29/16. Interview with RN #5 on 07/05/16 identified that the code cart had been brought into the patient's room, however CPR was never initiated. The hospital policy entitled Cardiopulmonary	A 130		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 130	Continued From page 13 Resuscitation identified that CPR is initiated on all patients unless the physician records a "Do Not Resuscitate" order. The Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s. and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is imitated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician.	A 130		
A 132	482.13(b)(3) PATIENT RIGHTS. INFORMED DECISION The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates) This STANDARD is not met as evidenced by: Based on review of clinical records, hospital policies and procedures and Interviews for one of one sampled patient (Patient # 1) with a Full Code, the hospital failed to ensure that cardiopulmonary resuscitation (CPR) was initiated when the patient presented without pulse and/or respirations. The findings include. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with a chief complaint of abdominal pain and diagnoses that	A 132		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 132	Continued From page 14 included small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and use of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, and Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus. Physician orders dated 06/17/16 at 6:33 PM identified that the patient's code status was discussed with Patient #1 who requested Full Code. The Full Code status was consistent with the code status identified on previous hospital/ED admissions. Interview with RN #1 on 7/6/16 identified that, on 06/28/16 at approximately 9:30 PM he/she had gone into Patient #1's room to obtain a fingerstick blood glucose and noticed the patient was in the bathroom with the water running and the door shut. RN#1 indicated that he/she thought that the enema, previously administered, had been effective, and the patient was in the bathroom having a bowel movement. RN #1 decided to return in fifteen minutes. Further interview with RN #1 identified at 9:45 pm, he/she returned to Patient #1's room. The door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging from the shower curtain rod. RN #1 identified that he/she had called for help, and checked for a pulse while a Code 8 was called.	A 132		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

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A 132	Continued From page 15 Interview with RN #7, the intravenous therapy (IV) nurse, on 07/06/16 at 2:45 PM identified that he/she was charting at the nursing station adjacent to the unit when he/she heard screaming and went to the patient's room to investigate. At the same time, RN #10, a nurse from the adjacent unit, was coming out of the room, heading towards the nursing station. RN #7 identified that he/she believed that RN #10 was going to call a Code 8. RN #7 entered the patient room and observed the clinical manager, RN #1, looking into the bathroom. RN #7 then entered the bathroom and observed Patient #1 suspended from the curtain rod. RN #7 checked the patient for movement, palpated the left and right carotid arteries for pulse, checked for respirations, assessed the pupils as fixed and dilated, and observed a dried substance consistent with blood at the right corner of the patient's mouth. RN #7 further identified that a staff member had reported that Patient #1 was a full code and RN #7 responded that the patient had expired and directed the staff not to touch Patient #1, but notify the Assistant Director of Nursing (ADNS), security, and the physician. RN #7 then left the room and observed many staff members coming down the hallway towards the room. RN #7 further identified that, based on his/her professional experience, the patient and his/her environment had become part of a crime scene. Interview with MD #2 on 07/06/16 identified that he/she had been in the ED when summoned by the Code 8 to Patient #1's room. Patient #1 presented with mottling. His/her soles were white and multiple abrasions were visible around his/her neck. The body was already cooled and the patient appeared to have expired some time	A 132		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 132	Continued From page 16 ago. Death was pronounced at 10 00 PM. Further interview with MD # 2 on 7/6/16 identified that he/she had been directed not to document at that time and, therefore, failed to document the time of death, circumstances of death, and/or physical assessment in the clinical record. MD #2 returned to the ED. Interviews with the Director of Patient Care Services (PCS) on 07/06/16 at 10 00 AM and 7/13/16 that on 06/28/16 at approximately 10 00 PM he/she had received a call from the Director on Call, who identified the circumstances of Patient #1's death. The PCS arrived at the hospital by 10.30 PM. The police had arrived and the PCS did not enter the room as it was considered to be a crime scene. According to the PCS, RN #7 had responded to the Code 8 and directed that the situation represented a crime scene and MD #2 agreed with that approach. In a later interview, the PCS identified that he/she had directed the staff to step out of the room so it could be secured as it was a crime scene. Patient #1 was not removed from the hanging position at that time. Interview with the Director of Risk Management on 07/07/16 at 3 00 PM identified that once the police cleared the scene, they removed the patient with assistance of the hospital's public safety staff and the body was removed by a representative of the Medical Examiner's office sometime before 2 00 AM on 06/29/16. Interview with RN #5 on 07/11/16 identified that the code cart had been brought into the patient's room, however CPR was never initiated. The hospital policy entitled Cardiopulmonary Resuscitation identified that the	A 132		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 132	Continued From page 17 Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s, and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is imitated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician.	A 132		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by Based on clinical record review, review of policies and procedures and interviews with facility personnel for one of twelve sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that the patient received care in a safe setting. The findings include Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25	A 144		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 144	Continued From page 18	A 144		

micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.

Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol.

Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10:45 am, Miralax 17 grams at 10 45 am, and Senokot 17.2 milligrams at 10 45 am (laxative medications). In addition, Relistor for narcotic induced constipation was administered at 11.12 am. Although multiple medications were administered to promote bowel activity, an abdominal X-ray was not obtained until 2 47 pm on 6/27/16. The impression of the X-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milliliters at 3.52 pm and a soap suds enema at 6.02 pm. Nursing notes dated 6/27/16, 6.02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and procedure.

Further review of the nursing flowsheets dated 6/27/16 at 12 10 pm identified that Patient #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070007	A. BUILDING _____ B. WING _____	C 07/13/2016

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A 144	Continued From page 19	A 144		

pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12.04 pm. At 1.00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1.00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2.47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6 02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxicodone 10 mg at 7 20 pm with indications to reassess in one hour. At 7 22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9 00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.

Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room at 9 30pm to obtain his blood sugar and noticed the patient was in the bathroom with the water running and the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9.45 pm, he/she returned to Patient #1's room and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging from the shower rod. RN #1 indicated that he/she had called for help, checked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 144	Continued From page 20	A 144		

for a pulse while a Code 8 was called at 9 50 pm. Further review identified that the nursing staff failed to initiate CPR.

Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Review of the clinical record with MD #2 failed to identify a progress note had been written indicating MD #2's assessment and reason not to proceed with resuscitative efforts, although the clinical record identified that the patient was a Full Code. Further interview with MD #2 identified that she/he did not document the assessment in the progress note as he/she was directed it was a police matter by Administration.

Interview with Pastoral Care Representative on 7/5/16 identified that he/she had visited with Patient #1 on 6/27/16 in the afternoon. Interview identified that Patient #1 was lying on his/her side, scrunched over and groaning so loudly that you could hear him/her throughout the unit. In addition, the Pastoral Care Representative indicated that he/she had not seen anyone struggling and in so much pain.

Interview with RN #6 on 07/06/16 at 2.00 PM identified that although he/she was not assigned to care for Patient #1 on 06/28/16, he/she had a patient assignment on the same unit and observed RN #1 and RN #5 frequently responding to the patient's needs. Additionally, he/she heard the patient calling out and moaning

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 144	Continued From page 21 loudly throughout the shift. Interview with Pharmacy Manager on 7/6/16 identified that laxatives are to be discontinued prior to administering Relistor. In addition, use is contraindicated in patients with known or suspected GI obstruction or at increased risk of recurrent obstruction. Review of hospital patients' rights policy identified that patients will receive information about pain and symptom management. It further identified that "As healthcare professionals and concerned staff, we are committed to pain prevention and management and want to respond quickly to your reports of pain and related symptoms."	A 144		
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery history chronic pain and receiving analgesia, (Patient #1), the medical staff failed to be accountable for the quality of care provided to the patient including emergency treatment/assessments when the patient had expired. (See A347)	A 338		
A 347	482.22(b)(1), (2), (3) MEDICAL STAFF ORGANIZATION & ACCOUNTABILITY The medical staff must be well organized and	A 347		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 347	Continued From page 22 accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. (3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following (i) An individual doctor of medicine or osteopathy. (ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located. (iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located. This STANDARD is not met as evidenced by Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel for one of twelve sampled patients who had a history of suicidal ideation, extensive abdominal surgery history chronic pain and receiving analgesia, (Patient #1), the medical staff failed to be accountable for the quality of care provided to the patient. The findings include 1a. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous	A 347		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 347	Continued From page 23 surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus. Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol. Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10.45 am, Miralax 17 grams at 10.45 am, and Senokot 17.2 milligrams at 10 45 am (laxative medications). In addition, Relistor for narcotic induced constipation was administered at 11 12 am. Although multiple medications were administered to promote bowel activity, an abdominal x-ray was not obtained until 2 47 pm on 6/27/16. The impression of the x-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milliliters at 3 52 pm and a soap suds enema at 6 02 pm. Nursing notes dated 6/27/16 at 6.02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and	A 347		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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A 347	Continued From page 24 procedure. Further review of the nursing flowsheets dated 6/27/16 at 12 10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12 04 pm. At 1 00 pm, Patient #1's pain level was a 7/10 as shooting, unbearable. MD #1 was notified at 1.00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2 47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patent #1 received another dose of Dilaudid 1.0 mg IV at 6.02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement per the physician. Patient #1 also received Roxicodone 10 mg at 7 20 pm with indications to reassess in one hour. At 7 22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9.00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status. Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room after 9 30 pm to obtain his blood sugar and noticed the patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9 45 pm, he/she returned to Patient #1's room and the door was still shut so he/she	A 347		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 347	Continued From page 25 knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging by a bed sheet around the shower rod. RN #1 indicated that he/she had called for help, checked for a pulse while a Code 8 was called at 9:50pm. 1b. Review of the progress notes dated 6/27/16 identified that although an abdominal assessment was documented by MD #3 at 11:30 am, the clinical record failed to identify any additional assessment conducted by a physician and/or a licensed independent practitioner when the patient had a change in condition including an assessment when the patient coded and expired. Additionally, the medical record lacked documentation to reflect an assessment by MD #2 when the patient coded and expired. Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code from the Emergency Department and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10.00 pm. Review of the clinical record with MD #2 failed to identify a progress note had been written indicating MD #2's assessment and reason not to proceed with resuscitative efforts, although the clinical record identified that the patient was a full code. Further interview with MD #2 identified that he/she did not document the assessment in the progress note as he/she was instructed by administration that this was a police matter. Interview with Pastoral Care Representative on	A 347		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

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A 347	Continued From page 26 7/5/16 identified that he/she had visited with Patient #1 on 6/27/16 in the afternoon. Further interview identified that Patient #1 was lying on his/her side, scrunched over and groaning so loudly that you could hear him/her throughout the unit. In addition, the Pastoral Care Representative indicated that he/she had not seen anyone struggling and in so much pain. Review of the Discharge Summary dated 7/17/16 identified that Patient #1 started presenting with increasing abdominal pain as well of periods of burping. Further review indicated that abdominal x-ray was done to evaluate for possible complications/obstruction/aspiration however it continued to show the ileus. Interview with Pharmacy Manager on 7/6/16 identified that laxatives are to be discontinued prior to administering Relistor. In addition, use is contraindicated in patients with known or suspected GI obstruction or at increased risk of recurrent obstruction. Interview with MD #1 on 7/13/16 identified that he/she was aware of Patient #1's suicidal and psychiatric history, however, it was never communicated to the nursing staff and/or had no psychiatric consult completed. Further interview with MD #1 on 7/13/16 identified that he was aware that MD #2 had not documented in the medical record regarding assessments and code response however he/she was told to wait until DPH finished their investigation. Interview with MD #6 on 7/13/16 identified that he/she was aware of Patient #1's being on multiple psychiatric meds and previous psychiatric history from reviewing previous	A 347		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

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A 347	Continued From page 27 admissions however, did not feel the patient needed for a psychiatric consult while in the hospital. Review of hospital policy identified that each patient has an initial assessment by a medical staff member who assesses the physical, psychological and social status of the patient and identifies appropriate care of the need for further assessment. The medical staff member is the leader of the patient care team in the planning and provision of care throughout the continuum. Review of hospital patients' rights policy identified that patients will receive information about pain and symptom management. It further identified that "As healthcare professionals and concerned staff, we are committed to pain prevention and management and want to respond quickly to your reports of pain and related symptoms." Review of hospital policy identified that CPR is initiated on all patients unless the physician records a "Do Not Resuscitation" order. The Physician-in-Charge/Adult Hospitalist directs the resuscitation efforts from ECG interpretation until final disposition. The I.V. Nurse/Critical Care Nurse/Staff Nurse is in charge of starting I.V.'s, and the Staff Nurse initiates CPR, calls for help, established respiratory support, and prepares equipment for cardiac monitoring and defibrillation. Cardiopulmonary resuscitation is initiated on all patients unless the physician records a DNR order. Resuscitation efforts are only terminated by the decision of the physician-in-charge or the attending physician. The cardiopulmonary resuscitation record is completed and the original becomes part of the patient record.	A 347		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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A 347	Continued From page 28	A 347		

1c. Review of the physician orders dated 6/18/16 identified that Patient #1 was to receive Oxycontin 10 mg every twelve hours for pain to be renewed every seven days. On 6/25/16, Patient #1's medication was due to be renewed, however, the hospitalist never renewed the medication. Patient #1 had not received the scheduled Oxycontin for 36 hours. On 6/26/16, the 7:00 AM-3:00 PM nurse noticed the pain medication was not renewed and called the physician for a new order.

Review of hospital policy identified that all Schedule II narcotic ordered will automatically be removed for the medication administration record at 12 midnight on the seventh day if not renewed.

Interview with MD #6 on 7/13/16 identified that he/she was not aware and/or educated of an alert on the computer identifying that a patient's narcotic was up for renewal.

Interview with the Pharmacy Manager on 7/1/16 identified that pharmacy staff have no process in place to monitor when narcotics need to be renewed after seven days if the provider fails to renew the order. Further interview identified that the pharmacy relies on the provider to renew the narcotic when a purple tab in the computer that notifies the provider a narcotic needs to be renewed otherwise the narcotic order just drops off.

Review of hospital documentation dated 7/13/16 (16 days later) identified that a memo went out to all providers to remind them of renewing Schedule II Controlled Substances every 7 days per state law.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 385	Continued From page 29	A 385		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by Based on clinical record review, review of policies and procedures and interviews with facility personnel for one of twelve sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that a nursing admission assessments, comprehensive nursing care plans, pain assessments, physician notification with a change in condition and Cardiopulmonary Resuscitation were conducted per hospital policy. (See A395 and A396)	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by Based on review of clinical record, review policies and procedures and interviews with facility personnel, the facility failed to ensure that pain assessments were completed for three of twelve patients (P#1, #2 and #6) and/or for one of one sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that a nursing admission assessment was	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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A 395	Continued From page 30 conducted when the patient was admitted to the hospital and/or the physician was notified when the patient had a change in condition and/or failed to perform CPR. The findings include 1a. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus. Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol. Review of the nursing flowsheets dated 6/17/16-6/27/16 identified that Patient #1 had no bowel movement since 6/17/16 (10 days). On 6/27/16, Patient #1 was administered Lactulose 60 milligrams at 10 45 am, Miralax 17 grams at 10 45 am, and Senokot 17.2 milligrams at 10 45 am (laxative medications). In addition, Relistor for narcotic induced constipation was administered at 11 12 am. Although multiple medications were administered to promote bowel activity, an abdominal X-ray was not obtained until 2 47 pm on 6/27/16. The impression of the X-ray identified in part, a nonspecific bowel gas pattern with no obvious small bowel or colonic	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
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A 395	Continued From page 31	A 395		

distension. Further review identified that Patient #1 also received Magnesium Citrate 300 milliliters at 3.52 pm and a soap suds enema at 6 02 pm. Nursing notes dated 6/27/16, 6 02 pm indicated that 1000 cubic centimeters of fluid was infused with the soap suds enema with yellow colored fluid returned. Abdominal assessments were being conducted in accordance with the policy and procedure.

Review of the nursing flowsheets dated 6/27/16 at 12 10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12.04 pm. At 1 00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1 00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2 47 pm, the patient's pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6.02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxicodone 10 mg at 7 20 pm with indications to reassess in one hour. At 7 22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9 00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status.

Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room at 9.15 pm to obtain his/her blood sugar and noticed the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 32 patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9.45 pm, he/she returned to Patient #1's room and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging by a bed sheet from the shower rod. RN #1 indicated that he/she had called for help; checked for a pulse while a Code 8 was called. Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code and found Patient #1 hanging with a bed sheet around a shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Nursing staff failed to initiate CPR when the patient was found hanging from the shower rod. Review of hospital policy identified that at the time of admission, each patient has their needs assessed by a registered nurse and must be completed within eight hours of admission. Interview with Nurse Manager #1 on 7/1/16 identified that the nursing admission assessment was completed by two nurses at the change of shift, however, it was never saved in the computer. 1b. Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
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A 395	Continued From page 33	A 395		

bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxytocin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus.

Review of the nursing flowsheets dated 6/27/16 at 12.10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12 04 pm. At 1 00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1 00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2.47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6.02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxicodone 10 mg at 7 20 pm with indications to reassess in one hour. At 7 22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9 00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Further review failed to identify that pain reassessments were completed per hospital policy. The clinical record failed to reflect that the patient's pain was reassessed within one hour of the intervention in accordance with hospital policy. Review of the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 34 pain policy directed that the patient's pain should be reassessed within 30 minutes of receiving an IV medication to determine efficacy of the intervention. 2. Patient #2 was admitted to the facility on 6/26/16 with chronic back pain, abdominal pain, nausea and vomiting. Review of a physician's order directed Dilaudid 4 milligrams (mg.) intravenously every four hours as needed for pain. Review of the clinical record dated 7/2/16 at 7.44 PM identified that the patient rated pain as a four (4) on a scale of 1-10 (10 being the worst possible pain). Review of the Medication Administration Record dated 7/2/16 at 9 40 PM identified that Dilaudid 4 mg IV was administered. The clinical record failed to reflect that the patient's pain was reassessed within one hour of the intervention in accordance with hospital policy. The next documented pain assessment was recorded on 7/3/16 at 12.34 AM (2 hours, 54 minutes later). Review of the pain policy directed that the patient's pain should be reassessed within 30 minutes of receiving an IV medication to determine efficacy of the intervention. 3. Patient #6 was admitted on 7/1/16 at 8.00 PM with right lower leg cellulitis. Review of the pain assessments for the period of 7/1/16 through 7/3/16 failed to reflect that pain assessments were completed every shift per the policy. Review of the record indicated that the first pain assessment was completed on 7/3/16 at 10 44 AM. Interview with the Clinical Coordinator on 7/3/16 at 10:55 AM stated pain levels should be assessed every shift. Review of the pain policy directed that a baseline pain assessment should be completed every shift with reassessments completed at least every shift.	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by Based on clinical record review, review of policies and procedures and interviews with facility personnel for one of one sampled patients (Patient #1) who was at risk for suicidal ideation and/or had an extensive history of abdominal surgeries, chronic pain and was receiving analgesia, the facility failed to ensure that a comprehensive plan of care was completed for the patient on admission to the hospital. The findings include Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxycontin 10 milligrams every 12 hours prior to admission to the hospital. Patient #1 was transferred to a medical floor pursuant to a CT scan 6/17/16 which identified a possible small bowel obstruction/ileus. Review of the nursing admission assessment dated 6/17/16 failed to identify that an assessment including the patient's risk for suicidal ideation was completed upon admission per the facility's protocol. Review of the nursing plan of care failed to indicate the patient's suicidal	A 396		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 36 risk and/or pain management issues including interventions. Review of the nursing flowsheets dated 6/27/16 at 12 10 pm identified that Patient #1's pain level was a 7/10 as acceptable and aching. Patient #1 received Roxicodone 10 mg at 12.04 pm. At 1.00 pm, Patient #1's pain level was a 7/10 as shooting and unbearable. MD #1 was notified at 1 00 pm regarding increased abdominal pain and Patient #1 was medicated for nausea and a new Fentanyl patch was applied. At 2 47 pm, pain level was 10/10 and "unbearable." MD #1 was notified and gave an order for Dilaudid IV 1.0 mg. Patient #1 received another dose of Dilaudid 1.0 mg IV at 6:02 pm with the understanding that Patient #1 would not be able to receive anymore Dilaudid IV until after he/she had a bowel movement. Patient #1 also received Roxicodone 10 mg at 7 20 pm with indications to reassess in one hour. At 7.22 pm, Patient #1's pain level was 8/10 as sharp and unbearable. At 9.00 pm, Patient #1 vomited 200 cc of undigested food and continued to have "unbearable pain." Although review of the clinical record identified a change in condition, further review failed to identify that the physician was notified regarding the patient's current status. Interview with RN #1 on 7/6/16 identified that he/she had gone into Patient #1's room at 9 30 pm to do his blood sugar and noticed the patient was in the bathroom with the water running with the door shut. RN#1 indicated that he/she thought the enema had worked and the patient was in the bathroom having a bowel movement so he/she decided to come back in fifteen minutes. Further interview with RN #1 identified at 9 45 pm, he/she returned to Patient #1's room	A 396		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070007	A. BUILDING _____ B. WING _____	C 07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE & MEMORIAL HOSPITAL	365 MONTAUK AVE NEW LONDON, CT 06320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 37 and the door was still shut so he/she knocked on the door with no answer. RN #1 indicated that he/she opened the door and found Patient #1 hanging with a bed sheet around a shower rod. RN #1 indicated that he/she had called for help, checked for a pulse while a Code 8 was called at 9 50pm. Interview with MD #2 on 7/5/16 identified that he/she was first called regarding Patient #1 by responding to the code and found Patient #1 hanging from the shower rod. MD #2 indicated that his/her assessment was that Patient #1 had expired "a while ago" so the decision was made based on his/her assessment not to resuscitate the patient and the patient was pronounced at 10 00 pm. Review of hospital policy identified that the patient plan of care serves as a rapid reference for the active problems, interventions and measurable goals the care team addresses. In addition, the plan of care is reviewed at least every 24 hours and revised as necessary. Interview with Nurse Manager #1 on 7/1/16 identified that the plan of care did not address the patient ' s history of suicidal ideation and pain management including narcotic usage concerns.	A 396		
A 494	482.25(a)(3) PHARMACY DRUG RECORDS Current and accurate records must be kept of the receipt and distribution of all scheduled drugs. This STANDARD is not met as evidenced by Based on a review of the clinical record, review of hospital policies and procedures and interviews with facility personnel for one of twelve sampled patients (Patient #1), the pharmacy failed to ensure that narcotic renewals were monitored	A 494		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070007	A. BUILDING _____ B. WING _____	C 07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE & MEMORIAL HOSPITAL	365 MONTAUK AVE NEW LONDON, CT 06320

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A 494	Continued From page 38 and reordered if necessary. The findings include Patient #1 was admitted to the Emergency Department (ED) on 6/17/16 with abdominal pain. Patient #1's admitting diagnosis was a small bowel obstruction/ileus. Patient #1's history included abdominal surgeries (14 previous surgeries), congestive heart failure, diabetes, anxiety disorder, depression, suicidal ideation (on a 10/25/15 previous ED admission), and usage of multiple narcotics, including Fentanyl 25 micrograms every 72 hours, Oxytocin 10 milligrams every 12 hours prior to admission to the hospital. Review of the physician orders dated 6/18/16 identified that Patient #1 was to receive Fentanyl 25 micrograms every 72 hours and Oxycotin 10mg every 12 hours for pain to be renewed every seven days. On 6/25/16, Patient #1's medication was due to be renewed, however, the hospitalist never renewed the medication. Patient #1 had not received the scheduled Oxycotin for 36 hours. On 6/26/16, the 7 00 am - 3.00 pm nurse noticed the pain medication had not been renewed and called the physician for a new order. Review of hospital policy identified that all Schedule II narcotic ordered will automatically be removed for the Medication Administration Record at 12 00 am on the seventh day if not renewed. Interview with MD #6 on 7/13/16 identified that he/she was not aware and/or educated of an alert on the computer identifying that a patient's narcotic medications was up for renewal. Interview with the Pharmacy Manager on 7/1/16	A 494		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	070007	A. BUILDING _____ B. WING _____	C 07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE & MEMORIAL HOSPITAL	365 MONTAUK AVE NEW LONDON, CT 06320

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A 494	Continued From page 39 identified that pharmacy staff have no process in place to monitor when narcotics need to be renewed after seven days if the provider fails to renew the order. Further interview identified that the pharmacy relies on the provider to renew the narcotic when a purple tab in the computer that notifies the provider a narcotic needs to be renewed otherwise the narcotic order just drops off. Review of hospital documentation dated 7/13/16 (16 days later) identified that a memo went out to all providers to remind them of renewing Schedule II Controlled Substances every 7 days per state law.	A 494		

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM

DEMOGRAPHIC DATA – All Facilities

FACILITY INFORMATION:

Type of Facility: ☐ Chronic Disease Hospital ☒ General Hospital/Children's Hospital	☐ Hospital for Mentally Ill Persons ☐ Hospital for the Care of Hospice Patients ☐ Maternity Hospital ☐ Outpatient Surgical Facility
Facility Name and Address: Lawrence + Memorial Hospital 365 Montauk Avenue New London, CT 06320	License Number: 0047 Sequential Report Number: 0047-16- 08
Reporter's Name: Tina Loarte-Rodriguez, MSQAc, BSN, BS, RN, CIC, CPPS	
Contact Person: Name: Tina Loarte-Rodriguez	Telephone Number:860-442-0771 ext. 4906

PATIENT INFORMATION:

Medical Record Number: M0001435	Age 64	Date of Admission: June 17, 2016
Patient's Billing Number: V014015453	Sex ☒M ☐F	Date and Time of Event: Date: June 27, 2016 Time: Unknown
		Date and Time Event First Known: Date: June 27, 2016 Time: 2150
Date of Patient Death (if applicable): June 27, 2016		
Admission Diagnosis: Acute on Chronic Abdominal Pain		

Phone: (860) 509-7400
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DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

Sequential Report Number
0047 -16 - 08

DEMOGRAPHICS – Hospitals Only

☒ Inpatient ☒ Hospital Based ☐ Off Campus Satellite Site Name:_____ Address_____	☐ Outpatient ☐ Hospital Based ☐ Off Campus Satellite Site Name:_____ Address_____
LOCATION OF OCCURENCE: ☐ Medical Intensive Care ☐ Neonatal Intensive Care ☐ Surgical Intensive Care Unit ☒ Adult Medical ☒ Adult Surgical ☐ Ambulatory Surgical ☐ Cardiac Cath Lab ☐ Cardiac Care ☐ Dialysis ☐ Emergency Department	☐ Obstetrical /Gynecological ☐ Operating Room ☐ Outpatient Services - Specify Type _____ ☐ Pediatrics ☐ Psychiatric ☐ Diagnostic Services – Specify Type: _____ ☐ Rehabilitative Services – Specify Type: _____ ☐ Other_____

NOTIFICATIONS:

PATIENT AND/OR AUTHORIZED REPRESENTATIVE NOTIFIED OF EVENT: Y☒ Date notified June 28, 2016 N ☐

DID THE PATIENT EXPIRE? Y☒ N ☐
If yes: June 27, 2016

MEDICAL EXAMINER NOTIFIED Y ☒ N ☐ CASE NUMBER (if applicable): 16-70495	AUTOPSY PERFORMED (if applicable) Y ☒ N ☐ Unknown ☐ LOCATION: Not Applicable

At the time of this report, were any other entities known to have been notified of this event?

Check all that apply: ☐ Centers for Medicare/Medicaid Services ☐ Department of Children and Families ☐ Food and Drug Administration ☐ Joint Commission on the Accreditation of Health Care Organizations	☒ Local/State Police ☐ Office of Protection and Advocacy for Persons with Disabilities ☐ State Fire Marshal ☐ Department of Social Services, Protective Services ☐ Unknown to reporter at time of report

DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

Sequential Report Number
0047-16-08

"CUT & PASTE" DESCRIPTION OF EVENT HERE FROM LIST

NQF 3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

Facts of Event and Status of Patient Condition:

Patient is a 64 year old male with extensive past medical history of chronic abdominal pain, chronic obstructive pulmonary disease, pulmonary embolism, congestive heart failure, coronary artery disease, anxiety, diabetes mellitus, irritable bowel syndrome, traumatic brain injury, pancreatitis, small bowel obstruction, recurrent ileus, appendectomy, cholecystectomy, splenectomy and multiple abdominal surgeries secondary to adhesions and obstruction, who presented to the ED on June 17, 2016 at 1627 with sudden onset diffuse abdominal pain, nausea, and vomiting requesting pain control. CT scan revealed some nondescript gaseous distention of the transverse colon with some gas and fluid in the ascending colon. Patient was admitted under hospitalist service on June 17, 2016 with a plan to keep patient NPO, IV fluids, and pain control. Surgical consult assessment and plan consist of treating conservatively with strict NPO, intravenous fluids, intravenous antibiotics via PICC and rule out ischemia. Patient refused NG tube. Over hospital stay, patient diet advanced to clear liquids and then to full liquids. Patient bowel sounds returned as well as flatus, but negative bowel movement since admission. Patient transitioned from IV pain medication to PO pain medication in anticipation of discharge.
On June 26, 2016 patient cleared by surgery for discharge, pending bowel movement and hospitalist service.
On June 27, 2016 patient had increased pain, nausea, and vomiting. IV pain medication given as well as soapy suds enema. Last documented assessment at 1902. Patient last visualized at 2115. Patient found asphyxiated at 2145.

Immediate Plan of Action

6/27 Immediate call for assistance from other 6.2 nursing staff. CODE 8 called. CODE 8 team responded. No pulse palpated. MD pronounced. Director and Administrator on call notified. Security notified and contacted NLPD. Scene secured. NLPD responded. Medical Examiner contacted and responded.

6/30 Suicide Education with staff

Crisis debrief

Huddle with unit clinical coordinators regarding audit of patients on unit for nursing admission assessment saved in EMR, risk/safety assessment concerns incorporated into nursing care plan, documentation of last bowel movement, and nursing assessments documentation completed once a shift.

FOR DPH USE ONLY

Date Report Received- Emergent	
Date Report Received	
Date Corrective Action Plan Received	

DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

CORRECTIVE ACTION PLAN (CAP)

Facility: Lawrence + Memorial Hospital 365 Montauk Avenue New London, CT 06320	Sequential Report Number for which this plan is being submitted: 0047-016-08
Patient Billing Number:	Date CAP Submitted:

Event being addressed:

NQF 3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

Findings:

Corrective Action Plan to prevent reoccurrence:

Does JCAHO require a root cause analysis for this event? Y ☒ N ☐

Time line for implementation: Not applicable	Completion date for CAP: Not applicable
Identification of staff member, by title, who has been designated the responsibility for monitoring CAP implementation: Not applicable	
Submitted by: Tina Loarte-Rodriguez, MSQAc, BSN, RN, CIC, CPPS	Date:

Henriques, Jennie

From: Henriques, Jennie
Sent: Tuesday, July 19, 2016 9:27 AM
To: Caron, Heidi
Subject: Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <Heidi.Caron@ct.gov> wrote:

> Hi Jenni,
> I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.
> Thanks,
> Heidi

Henriques, Jennie

From: Henriques, Jennie
Sent: Tuesday, July 26, 2016 5:04 PM
To: 'Heidi.Caron@ct.gov'
Subject: RE: additional documents not received

Hi Heidi:

We are working on finalizing our CAP and while reviewing the CMS report, there are a couple of items we need to add to our CAP. It is my understanding that our CAP is due 30 days from date of incident which would be tomorrow. I was wondering if it would be possible to give us until Friday to finalize and submit our CAP?

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

From: Caron, Heidi [mailto:secureMailer.d-f384194e5e2e4fd682aebccf33dcf758@ct.gov] **On Behalf Of** Caron, Heidi
Sent: Tuesday, July 19, 2016 11:31 AM
To: Henriques, Jennie
Subject: RE: additional documents not received

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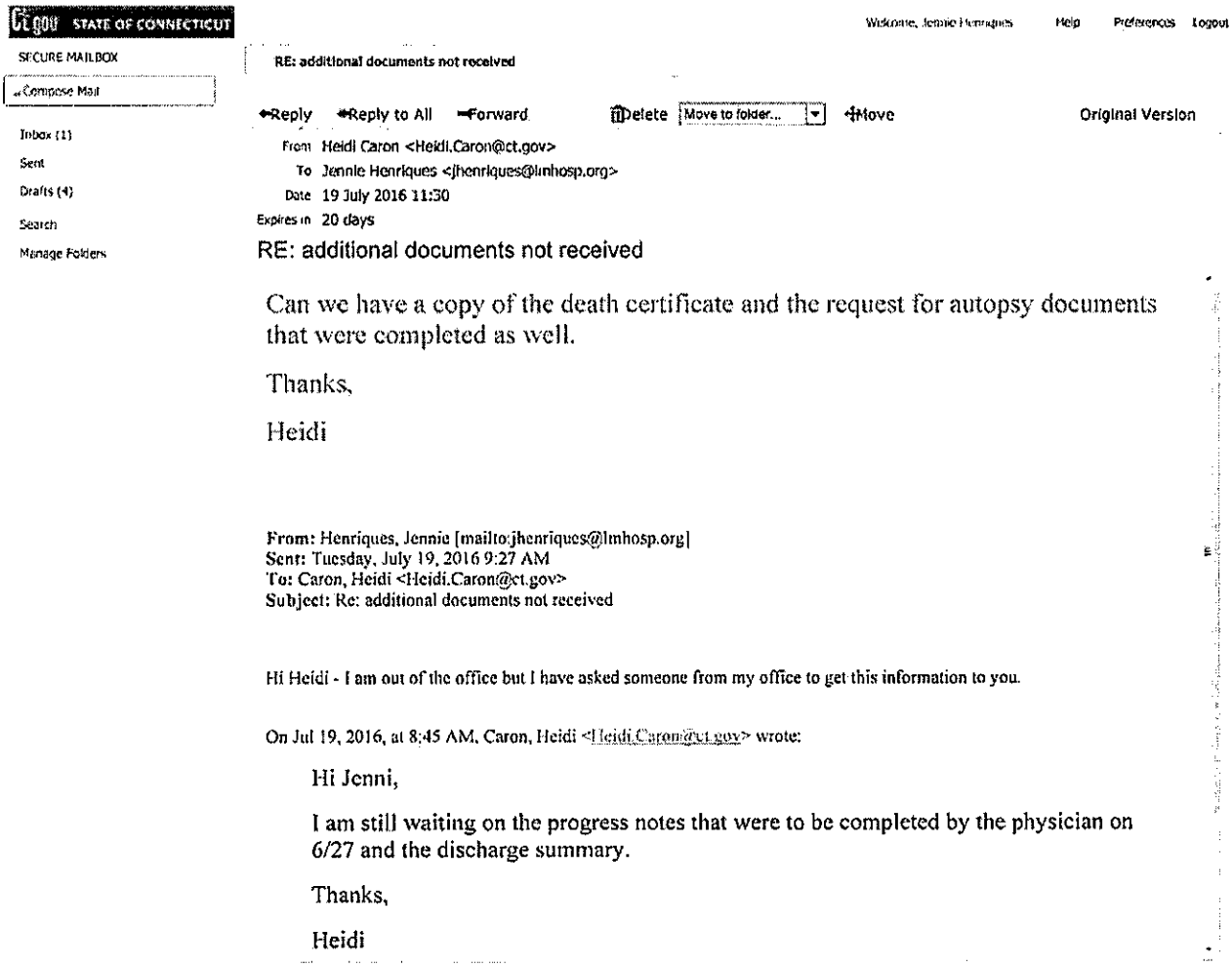
Secure Message Delivery

From: "Caron, Heidi" <Heidi.Caron@ct.gov>
Subject: RE: additional documents not received

View Message

Message available online until 08/18/2016. Use your password to access the message.



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RE: additional documents not received

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From: Heidi Caron <Heidi.Caron@ct.gov>
To: Jennie Henriques <jhenriques@lmhosp.org>
Date: 19 July 2016 11:30
Expires in: 20 days

RE: additional documents not received

Can we have a copy of the death certificate and the request for autopsy documents that were completed as well.

Thanks,

Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Tuesday, July 19, 2016 9:27 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: additional documents not received

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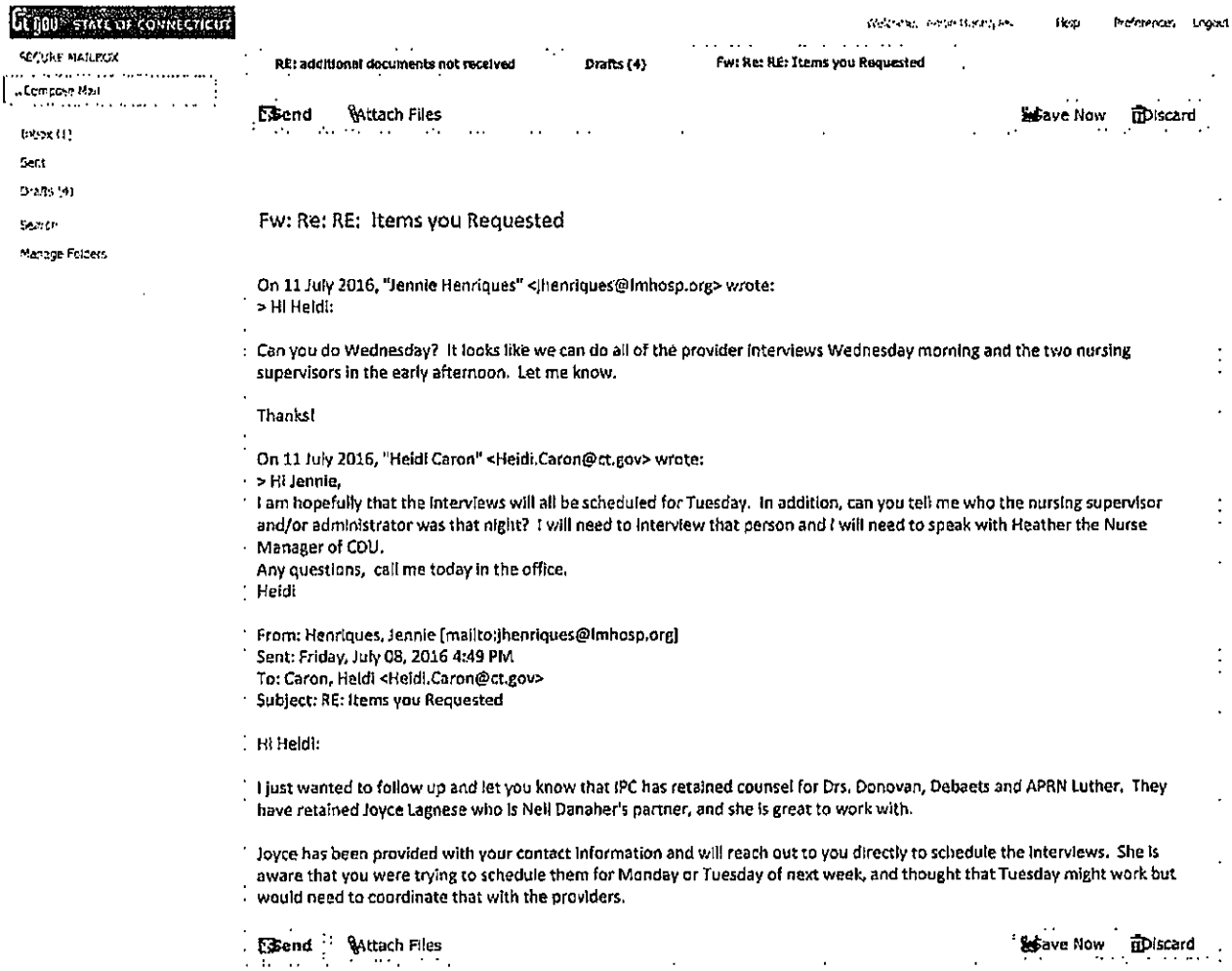
>
> Heidi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Send
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Discard
Fw: Re: RE: Items you Requested
On 11 July 2016, "Jennie Henriques" <jhenriques@imhosp.org> wrote:
> Hi Heidi:
Can you do Wednesday? It looks like we can do all of the provider interviews Wednesday morning and the two nursing supervisors in the early afternoon. Let me know.
Thanks!
On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> Hi Jennie,
I am hopefully that the interviews will all be scheduled for Tuesday. In addition, can you tell me who the nursing supervisor and/or administrator was that night? I will need to interview that person and I will need to speak with Heather the Nurse Manager of CDU.
Any questions, call me today in the office.
Heidi
From: Henriques, Jennie [mailto:jhenriques@imhosp.org]
Sent: Friday, July 08, 2016 4:49 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: RE: Items you Requested
Hi Heidi:
I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.
Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.
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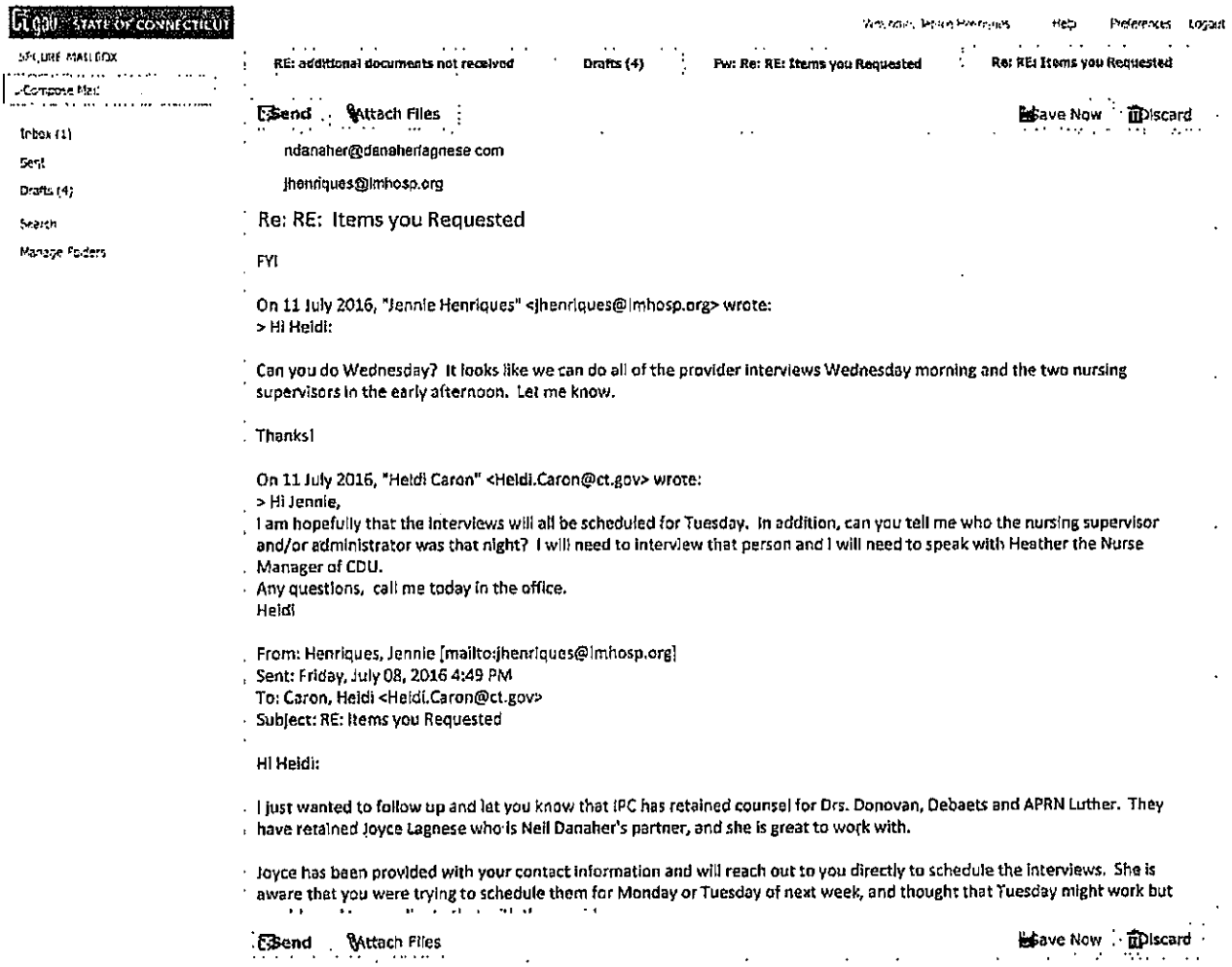
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Drafts (4)
Fw: Re: RE: Items you Requested
Re: RE: Items you Requested
Send
Attach Files
Save Now
Discard
ndanaher@danaherlagnese.com
jhenriques@lmhosp.org
Re: RE: Items you Requested
FYI
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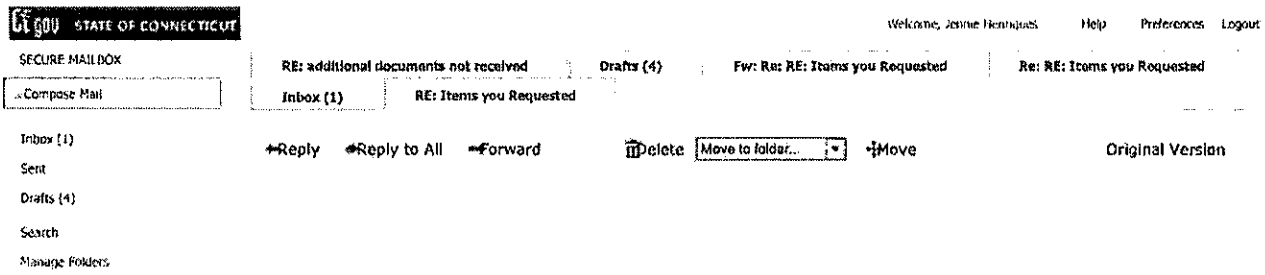


Hi Jennie,

If you can provide the info that would be greatly appreciated.

Thanks,

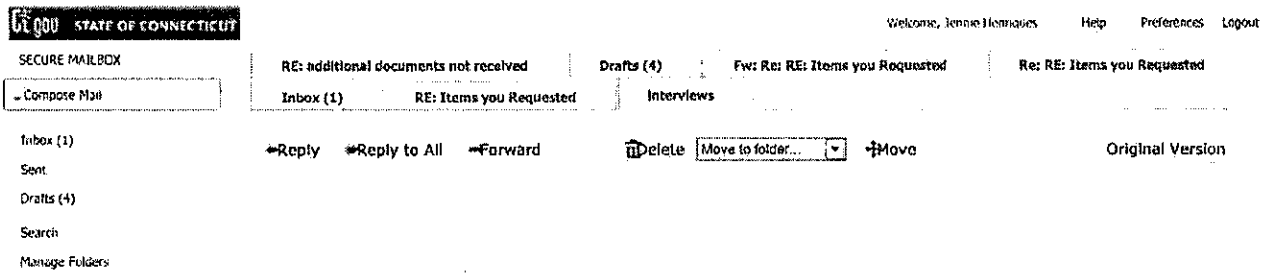
Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Wednesday, July 06, 2016 7:16 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Items you Requested
Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.



Hi Jeannie,

Can these interviews with the physicians and APRN be scheduled on Monday or Tuesday next week?

Thanks,

Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Wednesday, July 06, 2016 7:16 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Items you Requested
Importance: High

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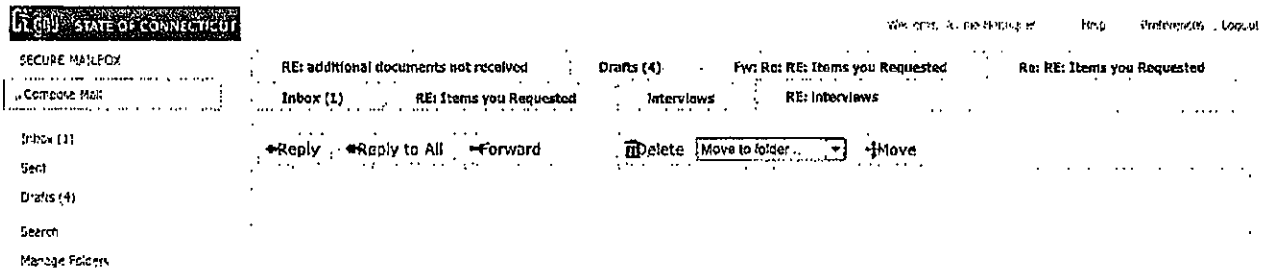
You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted



Can you add the admin or manager that was on that night and who from admin came in after the event?
Thanks,
Heidi

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer.d-234986572498 47e2ab65035a8925d09f@ct.gov] On Behalf Of Jennie Henriques
Sent: Thursday, July 07, 2016 1:40 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: interviews

Hi Heidi:

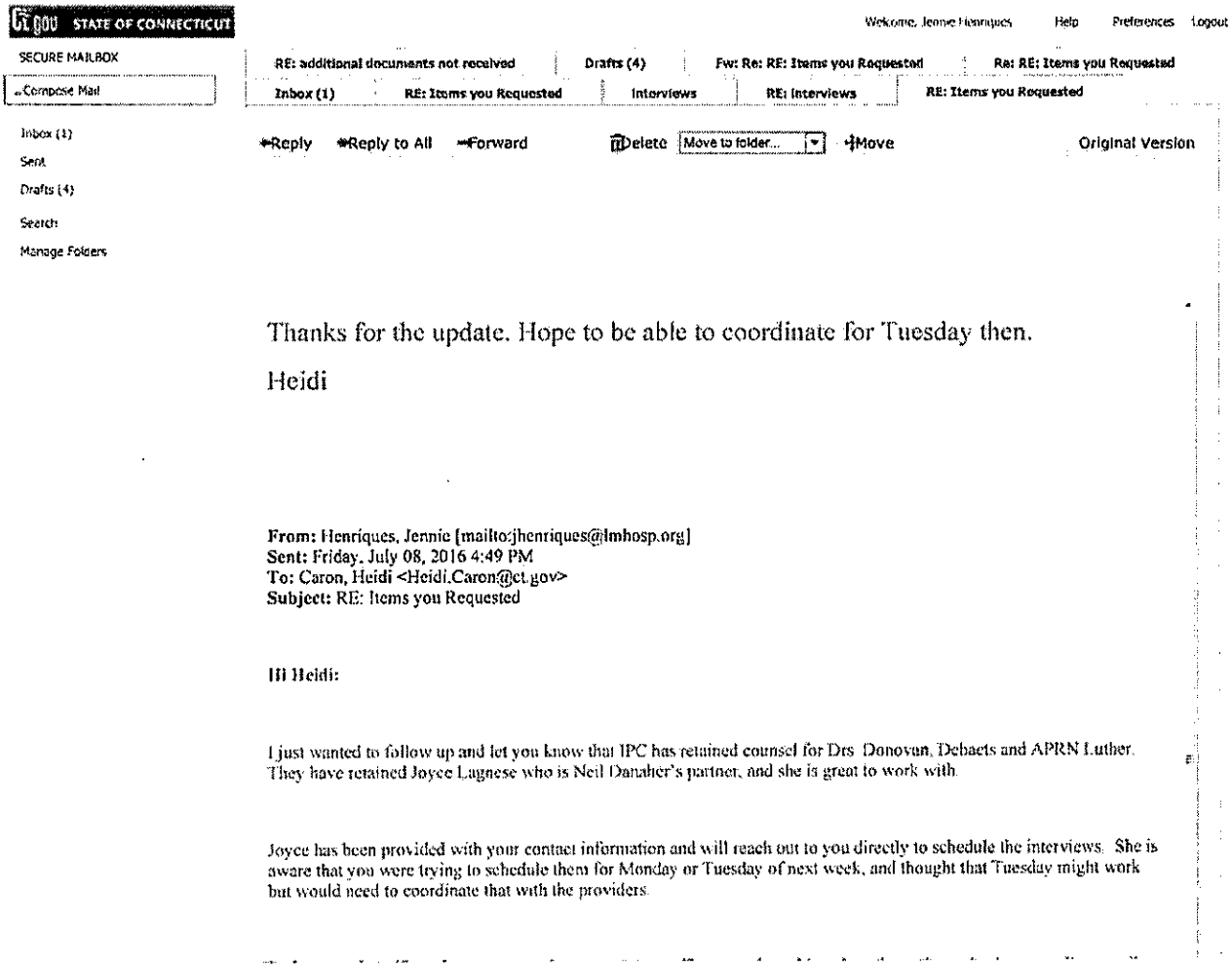
I put a call into to check and see if we can make it happen. I am hoping we can, and will reach out to you by tomorrow morning

Have a great day!

On 7 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> Hi Jeannie,
Can these interviews with the physicians and APRN be scheduled on Monday or Tuesday next week?
Thanks,
Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Wednesday, July 06, 2016 7:16 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Items you Requested
Importance: High

Hi Heidi



Thanks for the update. Hope to be able to coordinate for Tuesday then.

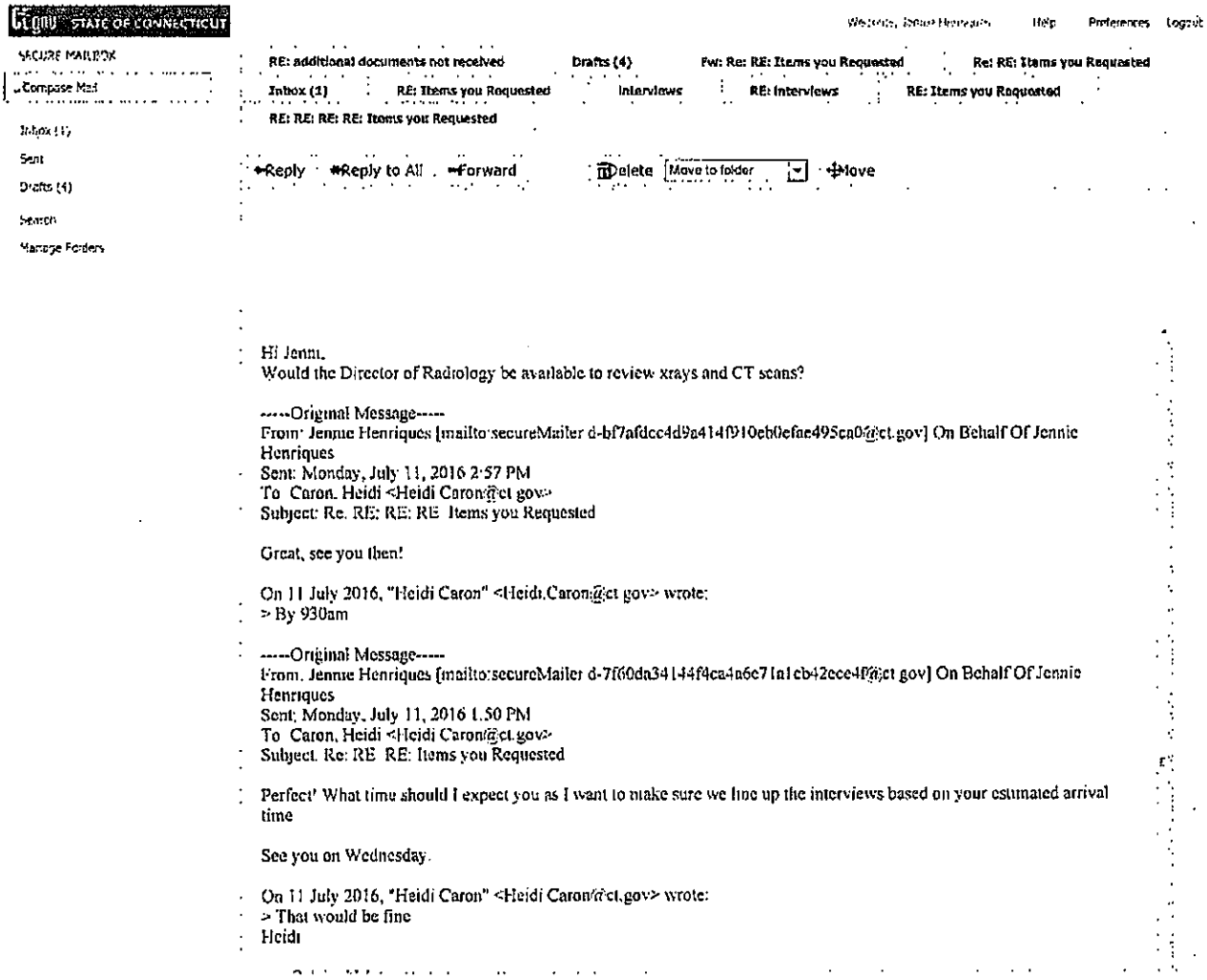
Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Friday, July 08, 2016 4:49 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lugnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.



Hi Jenni,
Would the Director of Radiology be available to review xrays and CT scans?

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer d-bf7afdcc4d9a414f910eb0efae495ca0@ct.gov] On Behalf Of Jennie Henriques
Sent: Monday, July 11, 2016 2:57 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: RE: RE: RE: Items you Requested

Great, see you then!

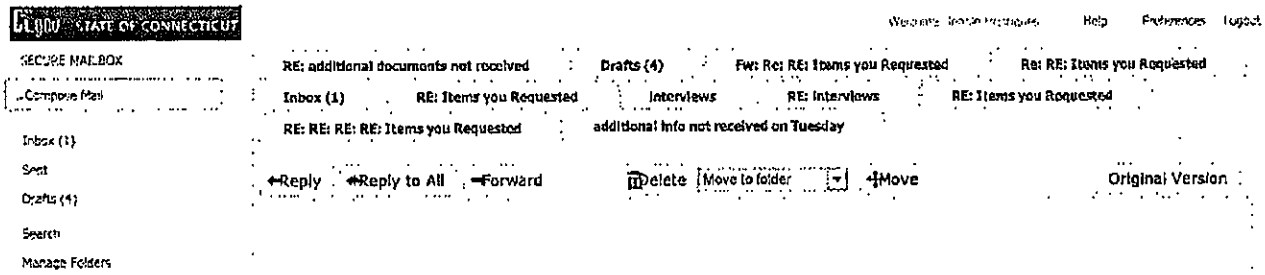
On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> By 930am

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer d-7f60da3414f4ca4a6e71a1cb42ece4f@ct.gov] On Behalf Of Jennie Henriques
Sent: Monday, July 11, 2016 1:50 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: RE: RE: Items you Requested

Perfect! What time should I expect you as I want to make sure we line up the interviews based on your estimated arrival time

See you on Wednesday.

On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> That would be fine
Heidi



Hi Jenni,

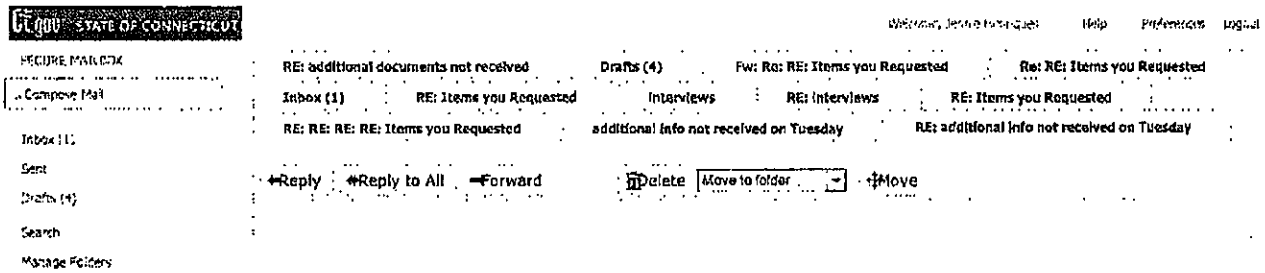
These are a few pieces of info I did not receive on Tuesday.

1. On Call List for 6/2016 and 7/2016
2. Privileges for Donovan, Wolf, Debaets and Luther.

Please fax asap to 8605097543.

Thanks,

Heidi



Can you email it to me?

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer d-72b309d3b1b1422ca0d0e6bd7e057dd8@ct gov] On Behalf Of Jennie Henriques
Sent: Friday, July 15, 2016 3:10 PM
To: Caron, Heidi <Heidi Caron@ct gov>
Subject: Re. additional info not received on Tuesday

Hi Heidi

We have tried to fax over the documents several times but it keeps telling us no answer Can you confirm the fax machine is working It is a large document 62 pages total

Thanks

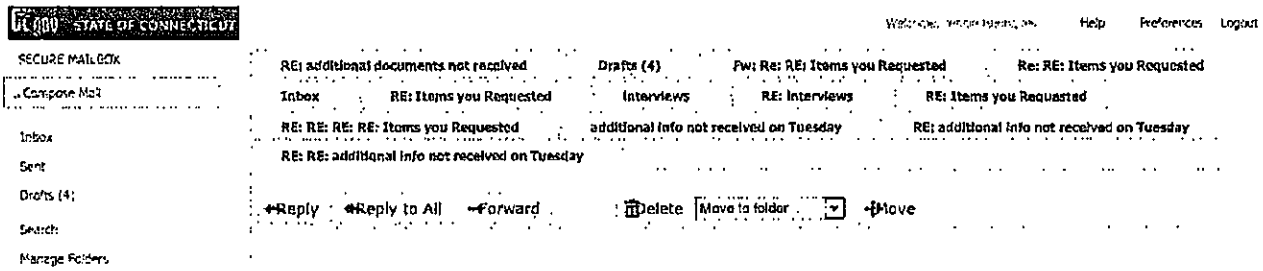
Jennie

On 15 July 2016, "Heidi Caron" <Heidi Caron@ct gov> wrote.
> Hi Jenni,
> These are a few pieces of info I did not receive on Tuesday.

> 1 On Call List for 6/2016 and 7/2016

> 2 Privileges for Donovan, Wolf, Debaets and Luther.

> Please fax asap to 8605097543
> Thanks,
> Heidi



I have received it
Thanks,
Heidi

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer-d-3c68c3031bca47cd99f753652406e1e6@ct.gov] On Behalf Of Jennie Henriques
Sent: Monday, July 18, 2016 10:39 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: RE: additional info not received on Tuesday

Hi Heidi,

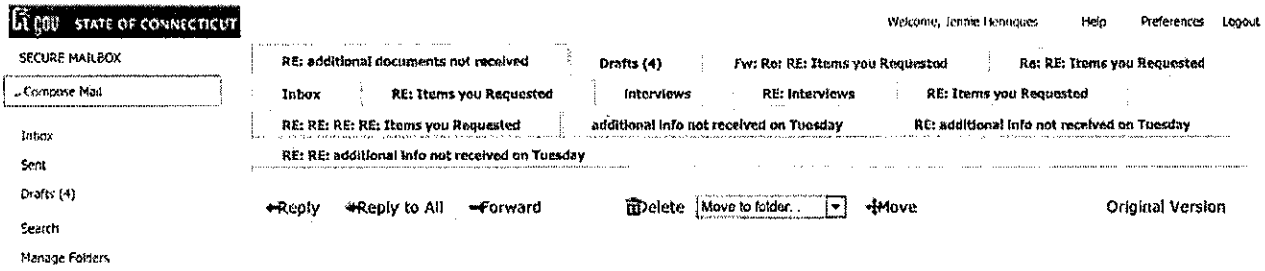
We were able to fax it over this morning. Can you please confirm that you received it?

On 18 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote
> Can you email it to me?

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer-d-72b309d3b1b1422ca0d0e6bd7e057dd8@ct.gov] On Behalf Of Jennie Henriques
Sent: Friday, July 15, 2016 3:10 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: additional info not received on Tuesday

Hi Heidi:

We have tried to fax over the documents several times but it keeps telling us no answer. Can you confirm the fax machine is working. It is a large document 62 pages total.



Can we have a copy of the death certificate and the request for autopsy documents that were completed as well.

Thanks,

Heidi

From: Henriques, Jennie [mailto:jhenriques@lmhosp.org]
Sent: Tuesday, July 19, 2016 9:27 AM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <Heidi.Caron@ct.gov> wrote:

> Hi Jenni,
>
> I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.
>
> Thanks.

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Welcome, Jennie.Henriques@ct.gov Help Preferences Logout

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RE: additional documents not received Sent Re: RE: additional info not received on Tuesday

Reply Reply to All Forward Delete Recall Move to folder... Move

Hi Heidi:

We were able to fax it over this morning. Can you please confirm that you received it?

On 18 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> Can you email it to me?

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer.d-72b309d3b1b1422ca0d0e6bd7e057dd8@ct.gov] On Behalf Of Jennie Henriques
Sent: Friday, July 15, 2016 3:10 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: additional info not received on Tuesday

Hi Heidi,

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Thanks

Jennie

On 15 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> Hi Jenni,
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1. On Call List for 6/2016 and 7/2016

2. Privileges for Donovan, Wolf, Debaets and Luther.

Please fax asap to 8605097543.
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Jennie

On 15 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
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Please fax asap to 8605097543
Thanks,
Heidi

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RE: additional documents not received Sent Re: RE: additional info not received on Tuesday

Re: additional info not received on Tuesday Re: additional info not received on Tuesday

Reply Reply to All Forward Delete Recall Move to folder Move

Hi Heidi:

It is being faxed right now. Please let me know that you have received it

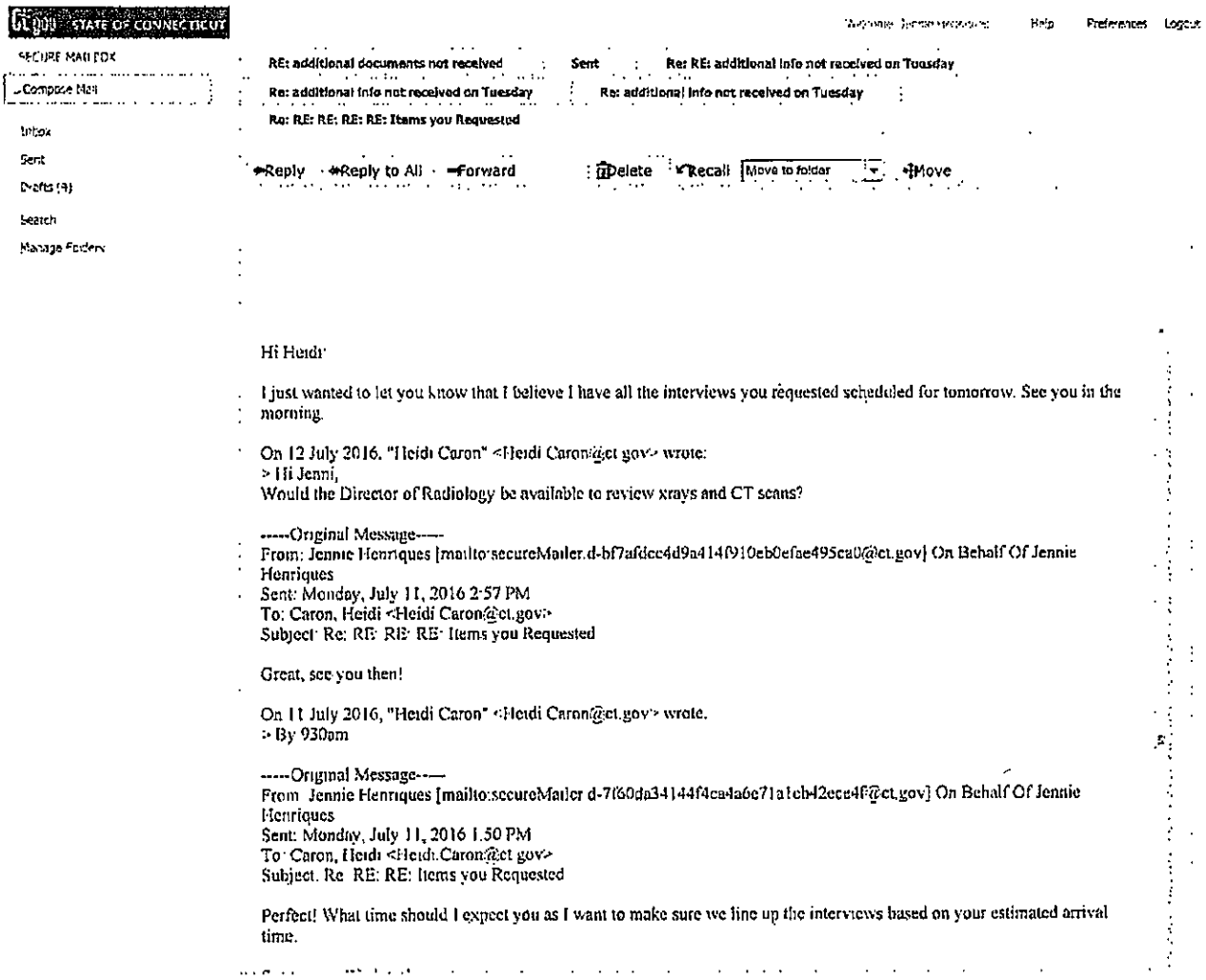
Thanks!

On 15 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote
> Hi Jenni,
> These are a few pieces of info I did not receive on Tuesday.

1. On Call List for 6/2016 and 7/2016

2 Privileges for Donovan, Wolf, Debaets and Luther

Please fax asap to 8605097543
Thanks,
Heidi



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RE: additional documents not received : Sent : Re: RE: additional info not received on Tuesday

Re: additional info not received on Tuesday Re: additional info not received on Tuesday

Re: RE: RE: RE: RE: Items you Requested

Reply Reply to All Forward Delete Recall Move to folder Move

Hi Heidi

I just wanted to let you know that I believe I have all the interviews you requested scheduled for tomorrow. See you in the morning.

On 12 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> Hi Jenni,
Would the Director of Radiology be available to review xrays and CT scans?

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer.d-bf7afdcc4d9a414f910eb0efae495ca0@ct.gov] On Behalf Of Jennie Henriques
Sent: Monday, July 11, 2016 2:57 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: RE: RE: RE: Items you Requested

Great, see you then!

On 11 July 2016, "Heidi Caron" <Heidi.Caron@ct.gov> wrote:
> By 930am

-----Original Message-----
From: Jennie Henriques [mailto:secureMailer.d-7f60da34144f4ca4a6e71a1eb42ecc4f@ct.gov] On Behalf Of Jennie Henriques
Sent: Monday, July 11, 2016 1:50 PM
To: Caron, Heidi <Heidi.Caron@ct.gov>
Subject: Re: RE: RE: Items you Requested

Perfect! What time should I expect you as I want to make sure we line up the interviews based on your estimated arrival time.

Henriques, Jennie

From: Henriques, Jennie
Sent: Wednesday, July 13, 2016 4:05 PM
To: 'Heidi.Caron@ct.gov'
Subject: RE: RE: RE: RE: Items you Requested
Attachments: DPC Prescriber Education 7-16.doc

Hi Heidi:

Attached please find the communication that is going out to providers. Please let me know if you have any questions.

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

From: Caron, Heidi [mailto:secureMailer.d-f6bae7ca55f64e8d9afb88f75b34f223@ct.gov] **On Behalf Of** Caron, Heidi
Sent: Tuesday, July 12, 2016 11:38 AM
To: Henriques, Jennie
Subject: RE: RE: RE: RE: Items you Requested

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Secure Message Delivery

From: "Caron, Heidi" <Heidi.Caron@ct.gov>
Subject: RE: RE: RE: RE: Items you Requested

View Message

Message available online until 08/11/2016. Use your password to access the message.

LAWRENCE +MEMORIAL HOSPITAL

365 Montauk Avenue | New London, CT 06320
860.442.0711 | lmhospital.org

TO: All Providers

FROM: Daniel Rissi, MD, VP/Chief Medical & Clinical Operations Officer
Kenneth Donovan, MD, Chair, Department of Medicine
Robert Lincer, MD, Chari, Department of Surgery

DATE: July 13, 2016

This memo is to serve as a reminder of the CT state law mandates Schedule II Controlled Substance orders for inpatients expire after 7 days, and to increase awareness of the fact that these orders must be renewed or they will fall off the patient's profile.

Please see the below screenshots which are found on the orders tab of Mckesson HEO CPOE system. Once in the orders screen, you will see the fourth tab from the left on the bottom screen called **"Renew"**. In the event that there is an order that needs to be renewed, this tab will be colored bright pink. To renew the expiring order(s), simply click on the tab and renew the orders.

While renewing orders is primarily a provider responsibility, both nursing and pharmacy staff will take measures to remind providers of orders soon to expire. The following methods will be utilized:

1. Nursing will incorporate review of expiring Schedule II orders with notification to prescriber as part of nightly chart check.
2. Pharmacy will incorporate this review as part of interdisciplinary rounds on all units pharmacy currently rounds on, which has been expanded to include CDU.
3. Once the Epic system is implemented in October 2016, a custom report will be available and run daily that lists all expiring controlled substance orders. The pharmacy will plan on running this report daily and communicating with prescribers regarding expiring orders.

Please contact the pharmacy at extension 2513 if there are any questions.

Patient with 2 narcotics about to expire within the next 24 hrs (2:59 am 7/14 to be exact):

- LORazepam tablet [ATIVAN] 0.5 mg oral every 4 hr prn x30 days for anxiety »Jul 07 03:00...Aug 6 02:59
- morphINE Inj 2 mg iv every 4 hr prn x7 days for severe pain scale 8-10 »Jul 07 03:00...Jul 14 02:59
- oxyCODONE 5 mg - acetaminophen 325 mg [PERCOCET] 1 tablet oral every 6 hr prn x7 days for pain scale 4-7 may repeat x 1 within 1 hr xcomment 2 ngth constant). »Jul 07 03:00...Jul 14 02:59
- sodium chloride 0.9% flush 5 ml iv as directed »Jul 07 23:00...
- sodium chloride 0.9% flush 10 ml iv as directed »Jul 07 23:00...
- zolpidem tablet [AMBIEN] 5 mg oral at bedtime prn x30 days for sleep »Jul 07 03:00...Aug 6 02:59

:V fluids -

[PN orders

)ther interventions

- WOUND CONSULT wound wound type/location toe »Jul 07 01:57...

.aboratory tests -

Henriques, Jennie

From: Henriques, Jennie
Sent: Friday, July 08, 2016 4:49 PM
To: 'Heidi.Caron@ct.gov'
Subject: RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.

In the meantime, if you have any questions, concerns, or if you need anything else, please do not hesitate to call or email me.

Sincerely,

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

From: Henriques, Jennie
Sent: Wednesday, July 06, 2016 7:16 AM
To: 'Heidi.Caron@ct.gov'
Subject: Items you Requested
Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital

365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

Henriques, Jennie

From: Henriques, Jennie
Sent: Wednesday, July 06, 2016 7:16 AM
To: 'Heidi.Caron@ct.gov'
Subject: Items you Requested

Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

Henriques, Jennie

From: Henriques, Jennie
Sent: Tuesday, July 19, 2016 9:27 AM
To: Caron, Heidi
Subject: Re: additional documents not received

Hi Heidi - I am out of the office but I have asked someone from my office to get this information to you.

On Jul 19, 2016, at 8:45 AM, Caron, Heidi <Heidi.Caron@ct.gov> wrote:

> Hi Jenni,
> I am still waiting on the progress notes that were to be completed by the physician on 6/27 and the discharge summary.
> Thanks,
> Heidi

Goodson, Marcia

From: Henriques, Jennie <jhenriques@lmhosp.org>
Sent: Friday, July 29, 2016 4:30 PM
To: 'Susan.Newton@ct.gov'
Subject: secure FINAL DPH CAP 7 30 16 Site Survey June 30 through July 1 2016 (Incident date June 27 2016)
Attachments: FINAL DPH CAP 7 30 16 Site Survey June 30 through July 1 2016 (Incident date June 27 2016).docx

Hi Sue:

Attached please find our CAP for Adverse Event dated June 27, 2016, Sequential Report Number 0047-16-08/DPH Survey. As we discussed, you had agreed to an extension until today, July 29, 2016. Please confirm that you have received this email.

If you have any questions or concerns, please do not hesitate to call or email me.

Jennie C. Henriques, CPHRM, CHPC
Director of Risk Management, Patient Safety & Quality Innovation
Interim Compliance + Privacy Officer
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
1	**Compliance with completing Nursing Admission Assessment for inpatients.**	Associate Chief Nursing Officer	a.	**Review** policies titled "Documentation, Patient" and "Assessment & Reassessment of Patients" to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	June 30, 2016	P3 Committee (Policy, Procedure, Protocol) Patient Care Services
		CDU Nurse Manager	b.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **CDU**.	June 30, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		CDU Manager	c.	**AUDIT:**Compliance with completing nursing Admission Assessment to include suicide risk assessment questions on all **CDU** patients.	July 1, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance. 100% of charts will be audited	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**Educate** nursing staff on compliance with policies titled "Documentation, Patient" and "Assessment &	July 8, 2016	Monitoring: 100% of nursing staff will be educated and	August 5, 2016	Patient Safety Quality

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Reassessment of Patients" on **all adult inpatient units excluding NICU and Perioperative Services.**		signoff on education.		Council
		Associate Chief Nursing Officer	e.	**AUDIT** Compliance with nursing admission assessment audit on **all adult inpatient units excluding NICU and Perioperative Services.**	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. 5 charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council
		ED Nurse Managers ED Crisis Manager	f.	**Educate** ED nursing & ED Crisis staff on policy titled "Delivery of Care for ED Patients" and "Management of Behavior Patient" at main ED and PEQ ED.	July 8, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		ED Crisis Manager	g.	**Educate** Inpatient Psychiatric Unit staff on policy titled "Levels of Observation, Inpatient Psych".	August 15, 2016	Monitoring: 100% of nursing staff will be educated and signoff on	September 15, 2016	Patient Safety Quality Council

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						education.		
		ED Nurse Managers ED Crisis Manager	h.	**Audit** compliance with Emergency Dept. Room record (includes ED Crisis) for suicide screening documentation.	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) ED records each at Main ED and PEQ per week ED Crisis: 100% of patients charts will be audited.	November 8, 2016	Patient Safety Quality Council
2	**Compliance with completing assessment and reassessment of pain**	Associate Chief Nursing Officer	a.	**Review and revise** policy titled "Pain Management" to ensure policy reflects current practice.	July 30, 2016	Policy will be reviewed every three years **or** when changes are needed to reflect	August 15, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						evidence based practice.		
		CDU Manager	b.	**Educate** nursing staff on compliance with policy titled "Pain Management" on **CDU**. Education will reinforce assessment and reassessment of pain before and after interventions.	August 10, 2016	Monitoring: 100% of CDU nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council
		CDU Manager	c.	**AUDIT** Compliance with completing nursing assessment and reassessment of pain before and after interventions on **CDU**.	September 10, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance. **CDU:**100% of charts will be audited.	January 10, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**Educate** nursing staff on compliance with policy titled "Pain Management" on **all adult inpatient units, emergency room and crisis ED. (excluding NICU and Perioperative Services)**. Education will reinforce	August 10, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				assessment and reassessment of pain before and after interventions.				
		Associate Chief Nursing Officer	e.	**AUDIT** compliance with completing nursing assessment and reassessment of pain before and after interventions on **all adult inpatient units and emergency rooms (Includes Main and PEQ; excludes NICU and Perioperative Services)**	September 10, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) ED records each at Main ED and PEQ per week. ED Crisis: 100% of patients charts will be audited.	January 10, 2016	Patient Safety Quality Council
3	**Compliance with completing psychosocial assessment on inpatient nursing**	CDU Nurse Manager	a.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **CDU**.	June 30, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	flowsheet(s).							
		CDU Manager	b.	**AUDIT** Compliance with completion of psychosocial documentation on nursing flowsheet for **CDU.** • If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).	July 8, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	c.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **all adult inpatient units.**	July 8, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**AUDIT** Compliance with completion of psychosocial documentation on nursing flowsheet for **all inpatient units.** • If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
4	**Compliance with completing Personalized Care Plan**	Associate Chief Nursing Officer	a.	**Review** policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	June 30, 2016	Patient Safety Quality Council
		CDU Manager	b.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **CDU**.	June 30, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		CDU Manager	C.	**AUDIT** compliance with completing Nursing personalized care plan based on patient assessmenton all **CDU** patients.	July 1, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance. 100% of charts will be audited.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**Educate** nursing staff on compliance with policies titled "The Document,	July 8, 2016	Monitoring: 100% of nursing	August 5, 2016	Patient Safety

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Patient" and "Assessment & Reassessment of Patients" on **all adult inpatient units (excludes ED &Perioperative)**		staff will be educated and signoff on education.		Quality Council
			e.	**AUDIT** compliance with nursing personalized care plan audit on **all adult inpatient units, inpatient psychiatry (excludes ED, ED Crisis & Perioperative)**.	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council
5	**Compliance with Schedule Class II narcotic medication order.**	Director of Pharmacy	a.	**Review and revise** "Controlled Substance" Policy to ensure compliance with current evidence based practice and current state regulations.	July 30, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	August 5, 2016	Pharmacy and Therapeutics
			b.	**Educate** nursing staff on compliance with policy "Controlled Substance" on **all adult inpatient units.**	August 10, 2016	Monitoring: 100% of nursing staff will be	September 10, 2016.	Patient Safety

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						educated and signoff on education.		Quality Council
		Director of Pharmacy & Chief of Medicine	c.	**Educate** medical staff regarding current electronic medical record renewal process of Schedule Class II narcotic orders and renewal alert via email communication.	July 13, 2016	Monitoring: Ongoing	July 13, 2016	Quality Council
		Director of Pharmacy	d.	**Process:** Pharmacy will review daily report of medication profiles for CDU, specifically ScheduleClass II narcotic order(s) and renewal(s) to ensure compliance with policy.	July 6, 2016	Ongoing	Ongoing	Patient Safety Quality Council
		CDU Nurse Manager / Clinical Coordinator Director of Pharmacy	e.	**Implement** nursing daily chart review for Schedule Class II narcotics scheduled to automatically discontinue with notification to licensed independent practitioners.	July 8, 2016	Ongoing **or** until a report can be created to transition monitoring to pharmacy department.	Ongoing **or** until a report can be created to transition monitoring to pharmacy department.	Patient Safety Quality Council
6	**Review of CDU Scope of**	Associate Chief Nursing Office	a.	**Review** of: a. CDU Staffing model, staffing	July 1, 2016	**Monitoring:** On-going	On-going	Nursing Leadership

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	Services.			orientation and competency, b. leadership expertise and competency to reflect current evidence based practice. No changes to current structure needed at this time.				Meeting
7	**Governing Board minutes**	Special Project Coordinator & Executive Assistant	a.	Governing Board minutes to include actions taken by the board as follows: review of Quality Council Minutes, Patient Safety Minutes, and Board agreement and/or identify opportunities with Quality & Patient Safety activities.	August 1, 2016	Ongoing	Ongoing	N/A
8	**Quality Council Minutes**	Director of Risk Management, Patient Safety & Quality	a.	Quality Council minutes to include actions taken by the council as follows: review of Patient Safety Minutes, and identify opportunities with Quality & Patient Safety activities that are reviewed and discussed at	August 1, 2016	Ongoing	Ongoing	Governing Board

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				each Quality Council meeting.				
9	**Physician Documentation related to patient change in condition**	Director of Risk Management, Patient Safety & Quality	a.	**Continuing Education** for medical staff regarding medical record documentation standards and best practices.	October 31, 2016	Ongoing	November 15, 2016	Quality Council
		Director of Risk Management, Patient Safety & Quality	b.	**Audit** compliance of medical records to ensure completeness of medical record. Identified opportunities for improvement will be reported to physician leaders.	August 15, 2015	**AUDITS:** four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	December 15, 2016	Quality Council
10	**Provide emergency treatment/assessment**	Associate Chief of Nursing	a.	**Review and revise** Cardiopulmonary Resuscitation policy.	August 15, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	September 15, 2015	Patient Safety Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
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Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
		Associate Chief of Nursing	b.	**Educate** on Cardiopulmonary Resuscitation policy.	September 20, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	October 15, 2016	Patient Safety Quality Council
		Associate Chief of Nursing Critical Care Committee	c.	**Audit** all Code 8s will be reviewed for compliance with Cardiopulmonary Resuscitation policy.	October 15, 2016	100% of Code 8 with 90% or greater compliance to policy.	February 15, 2016	Patient Safety Quality Council
11	**Patient Rights: Care in a safe setting**	Chief Medical Officer Associate Chief of Nursing	a.	**Educate** medical and nursing staff on updating patient problem list to reflect patients with a known history of suicide ideation.	August 15, 2016	**AUDITS:** four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	December 15, 2016	Patient Safety Quality Council
			b.	**Audit** Patients identified with history of suicide ideation will have history listed on problem list.	August 15, 2016	**AUDITS:** four (4) consecutive months with 90% or greater	December 15, 2016	Patient Safety Quality

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						compliance. Five (5) charts per inpatient unit per week.		Council
12	**Hospitalist Coverage**	Chief Medical Officer	a.	**Audit** Compliance with Hospitalist coverage pursuant to contract.	August 1, 2016	**AUDITS:** four (4) consecutive months with 90% or greater compliance.	December 1, 2016	Governing Board

Goodson, Marcia

From: Henriques, Jennie <jhenriques@lmhosp.org>
Sent: Wednesday, July 06, 2016 7:16 AM
To: Heidi.Caron@ct.gov
Subject: Items you Requested

Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

Goodson, Marcia

From: Henriques, Jennie <jhenriques@lmhosp.org>
Sent: Friday, July 08, 2016 4:49 PM
To: Heidi.Caron@ct.gov
Subject: RE: Items you Requested

Hi Heidi:

I just wanted to follow up and let you know that IPC has retained counsel for Drs. Donovan, Debaets and APRN Luther. They have retained Joyce Lagnese who is Neil Danaher's partner, and she is great to work with.

Joyce has been provided with your contact information and will reach out to you directly to schedule the interviews. She is aware that you were trying to schedule them for Monday or Tuesday of next week, and thought that Tuesday might work but would need to coordinate that with the providers.

In the meantime, if you have any questions, concerns, or if you need anything else, please do not hesitate to call or email me.

Sincerely,

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

From: Henriques, Jennie
Sent: Wednesday, July 06, 2016 7:16 AM
To: 'Heidi.Caron@ct.gov'
Subject: Items you Requested
Importance: High

Hi Heidi:

I wanted to follow up on some of the things you requested yesterday afternoon.

You had requested to meet with Dr. Donovan, Kelley Luther, APRN and Dr. Debaets. Please be advised that they have opted to have legal counsel present and those interviews will need to be coordinated through their legal counsel. I will provide your contact information to their attorney. If you have any questions or concerns, please do not hesitate to call me.

Sincerely,

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320

Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

Goodson, Marcia

From: Henriques, Jennie <jhenriques@lmhosp.org>
Sent: Friday, July 01, 2016 11:01 PM
To: Cass, Barbara
Cc: Newton, Susan
Subject: Re: [not-secure]

We will be doing audits daily.

Sent from my iPhone

> On Jul 1, 2016, at 9:26 PM, Cass, Barbara <Barbara.Cass@ct.gov> wrote:
>
> Hello Jenny
> Thank you, what is the frequency of the audits for completion of assessments?
>
> Sent from my iPhone
>
> On Jul 1, 2016, at 9:14 PM, Henriques, Jennie <jhenriques@lmhosp.org<mailto:jhenriques@lmhosp.org>> wrote:
>
> Hi Barbara:
>
> Attached please find our Corrective Action Plan. I am heading home but will be available by cell. Please do not hesitate to call me at 401-595-9707 with any questions.
>
> Jennie C. Henriques, CPHRM
> Director of Risk Management, Patient Safety & Quality Innovation
> Interim Compliance + Privacy Officer Lawrence + Memorial Hospital
> Westerly Hospital
> 365 Montauk Avenue, New London, CT 06320 Direct 860.442.0711 EXT. 2161
> | Fax 860.444.4788 | Cell 401.595-9707
> EMAIL: jhenriques@lmhosp.org<mailto:dthomas@westerlyhospital.org>
>
>
> This message (and any included attachments) is from L+M Healthcare,Inc. and is intended only for the addressee(s). The information contained herein may include privileged or otherwise confidential information. Unauthorized review, forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you received this message in error, or have reason to believe you are not authorized to receive it, please promptly delete this message and notify the sender by e-mail.
> <CAP Site Survey June 30, 2016 through July 1, 2016 (incident dated
> June 27, 2016).docx>

Goodson, Marcia

From: Henriques, Jennie <jhenriques@lmhosp.org>
Sent: Friday, July 01, 2016 9:15 PM
To: barbara.cass@ct.gov
Cc: susan.newton@CT.gov
Subject: Corrective Action Plan
Attachments: CAP Site Survey June 30, 2016 through July 1, 2016 (incident dated June 27, 2016).docx

Hi Barbara:

Attached please find our Corrective Action Plan. I am heading home but will be available by cell. Please do not hesitate to call me at 401-595-9707 with any questions.

Jennie C. Henriques, CPHRM
Director of Risk Management, Patient Safety & Quality Innovation
Interim Compliance + Privacy Officer
Lawrence + Memorial Hospital
Westerly Hospital
365 Montauk Avenue, New London, CT 06320
Direct 860.442.0711 EXT. 2161 | Fax 860.444.4788 | Cell 401.595-9707
EMAIL: jhenriques@lmhosp.org

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
1	**Admission assessment for inpatient was not completed on Clinical Design Unit (CDU).**	Associate Chief Nursing Officer	1. Policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" reviewed to ensure compliance with current evidence based practice. 2. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" at safety huddles and change of shift on CDU. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" at safety huddles and change of shift on all adult inpatient units and emergency room. 3. AUDIT: Implement nursing admission assessment audit of all patients on Clinical Design Unit (CDU). 4. AUDIT: Implement nursing admission	June 30, 2016 June 30, 2016 July 8, 2016 July 1, 2016 July 8, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance	Patient Safety Committee Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			assessment audit on all adult inpatient units emergency room.			

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
2	**Incomplete assessment and reassessment of patients with a history of suicide ideation and pain management on the Clinical Design Unit (CDU).**	Associate Chief Nursing Officer	1. Policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" reviewed to ensure compliance with current evidence based practice. 2. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" at safety huddles and change of shift on CDU. 3. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" at safety huddles and change of shift on all adult inpatient units and emergency room. 4. AUDIT: Implement nursing admission assessment audit of all patients on Clinical Design Unit (CDU). 5. AUDIT: Implement nursing admission	June 30, 2016 June 30, 2016 July 8, 2016 July 1, 2016 July 8, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance	Patient Safety Committee Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			assessment audit on all adult inpatient units and emergency room.			

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
3	**Nursing care plan not updated to reflect change in patient condition on CDU.**	Associate Chief Nursing Officer	1. Policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" reviewed to ensure compliance with current evidence based practice. 2. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" at safety huddles and change of shift on CDU. 3. Educate nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" at safety huddles and change of shift on all adult inpatient units and emergency room. 4. AUDIT: Implement nursing care plan audit of all patients on Clinical Design Unit (CDU). 5. AUDIT: Implement nursing care plan	June 30, 2016 June 30, 2016 July 8, 2016 July 1, 2016 July 8, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance	Patient Safety Committee Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			assessment on all adult inpatient units and emergency room.			

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
4	**Overview of unit to determine appropriateness of staffing composition and oversight to ensure both clinical needs and patient care needs are met.**	Associate Chief Nursing Office	Staffing model, staffing orientation and competency, leadership expertise and competency, patient mix and ratios all reviewed to reflect current evidence based practice. No changes to current structure needed at this time.	July 1, 2016	N/A	N/A

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
5	**Order management of narcotic medication**	Chief of Medicine Chief of Surgery Director of Pharmacy Associate Chief Nursing Officer Director of Risk Management, Patient Safety & Quality	1. Review of Controlled Substance Policy to ensure compliance with current evidence based practice and current state regulations. 2. Provide education to licensed independent practitioners regarding electronic medical record renewal process of narcotic medication orders and renewal alert. 3. Weekday Interdisciplinary Team Rounds to commence on CDU to include review of narcotic pain medication order(s) and renewal(s). An order to discontinue narcotic medications will be written when a renewal is not indicated. 4. Review and revise "Controlled Substance" policy. 5. <u>AUDIT:</u> Compliance of review of narcotic pain medication order(s) and renewal(s)	July 8, 2016 July 8, 2016 July 6, 2016 July 30, 2016 July 5, 2016	**<u>AUDITS:</u>** Four (4) consecutive months with 100% compliance	Patient Safety Committee Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

#	Opportunity for Improvement	Responsible Party	Corrective Action	Date Implemented	Audit & Monitoring Plan:	Where Reported
			at weekday Interdisciplinary Team Rounds.			
			6. Implement nursing daily chart review for controlled substances scheduled to automatically discontinue with notification to licensed independent practitioners.	July 8, 2016		
			7. AUDIT: Implement audit of nursing daily chart review for completeness.	July 8, 2016		

Lawrence & Memorial Hospital
Date of Submission: July 1, 2016

Site Survey: June 30, 2016 – July 1, 2016
Corrective Action Plan

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
1	**Compliance with completing Nursing Admission Assessment for inpatients.**	Associate Chief Nursing Officer	a.	**Review** policies titled "Documentation, Patient" and "Assessment & Reassessment of Patients" to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	June 30, 2016	P3 Committee (Policy, Procedure, Protocol) Patient Care Services
		CDU Nurse Manager	b.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **CDU**.	June 30, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		CDU Manager	c.	**AUDIT:**Compliance with completing nursing Admission Assessment to include suicide risk assessment questions on all **CDU** patients.	July 1, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance. 100% of charts will be audited	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**Educate** nursing staff on compliance with policies titled "Documentation, Patient" and "Assessment &	July 8, 2016	Monitoring: 100% of nursing staff will be educated and	August 5, 2016	Patient Safety Quality

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Reassessment of Patients" on **all adult inpatient units excluding NICU and Perioperative Services.**		signoff on education.		Council
		Associate Chief Nursing Officer	e.	**AUDIT** Compliance with nursing admission assessment audit on **all adult inpatient units excluding NICU and Perioperative Services.**	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. 5 charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council
		ED Nurse Managers ED Crisis Manager	f.	**Educate** ED nursing & ED Crisis staff on policy titled "Delivery of Care for ED Patients" and "Management of Behavior Patient" at main ED and PEQ ED.	July 8, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		ED Crisis Manager	g.	**Educate** Inpatient Psychiatric Unit staff on policy titled "Levels of Observation, Inpatient Psych".	August 15, 2016	Monitoring: 100% of nursing staff will be educated and signoff on	September 15, 2016	Patient Safety Quality Council

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						education.		
		ED Nurse Managers ED Crisis Manager	h.	**Audit** compliance with Emergency Dept. Room record (includes ED Crisis) for suicide screening documentation.	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) ED records each at Main ED and PEQ per week ED Crisis: 100% of patients charts will be audited.	November 8, 2016	Patient Safety Quality Council
2	**Compliance with completing assessment and reassessment of pain**	Associate Chief Nursing Officer	a.	**Review and revise** policy titled "Pain Management" to ensure policy reflects current practice.	July 30, 2016	Policy will be reviewed every three years **or** when changes are needed to reflect	August 15, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						evidence based practice.		
		CDU Manager	b.	**Educate** nursing staff on compliance with policy titled "Pain Management" on **CDU**. Education will reinforce assessment and reassessment of pain before and after interventions.	August 10, 2016	Monitoring: 100% of CDU nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council
		CDU Manager	c.	**AUDIT** Compliance with completing nursing assessment and reassessment of pain before and after interventions on **CDU**.	September 10, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance. **CDU:**100% of charts will be audited.	January 10, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**Educate** nursing staff on compliance with policy titled "Pain Management" on **all adult inpatient units, emergency room and crisis ED. (excluding NICU and Perioperative Services)**. Education will reinforce	August 10, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	September 10, 2016	Patient Safety Quality Council

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				assessment and reassessment of pain before and after interventions.				
		Associate Chief Nursing Officer	e.	**AUDIT** compliance with completing nursing assessment and reassessment of pain before and after interventions on **all adult inpatient units and emergency rooms (Includes Main and PEQ; excludes NICU and Perioperative Services)**	September 10, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) ED records each at Main ED and PEQ per week. ED Crisis: 100% of patients charts will be audited.	January 10, 2016	Patient Safety Quality Council
3	**Compliance with completing psychosocial assessment on inpatient nursing**	CDU Nurse Manager	a.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **CDU**.	June 30, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	flowsheet(s).							
		CDU Manager	b.	**AUDIT** Compliance with completion of psychosocial documentation on nursing flowsheet for **CDU.** • If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).	July 8, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	c.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **all adult inpatient units.**	July 8, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**AUDIT** Compliance with completion of psychosocial documentation on nursing flowsheet for **all inpatient units.** • If change in psychosocial is identified, has the Care Plan been personalized to reflect intervention(s).	July 8, 2016	**AUDITS:** Four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
4	**Compliance with completing Personalized Care Plan**	Associate Chief Nursing Officer	a.	**Review** policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" to ensure compliance with current evidence based practice.	June 30, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	June 30, 2016	Patient Safety Quality Council
		CDU Manager	b.	**Educate** nursing staff on compliance with policies titled "The Document, Patient" and "Assessment & Reassessment of Patients" on **CDU**.	June 30, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	August 5, 2016	Patient Safety Quality Council
		CDU Manager	C.	**AUDIT** compliance with completing Nursing personalized care plan based on patient assessmenton all **CDU** patients.	July 1, 2016	**AUDITS:** Four (4) consecutive months with 100% compliance. 100% of charts will be audited.	November 8, 2016	Patient Safety Quality Council
		Associate Chief Nursing Officer	d.	**Educate** nursing staff on compliance with policies titled "The Document,	July 8, 2016	Monitoring: 100% of nursing	August 5, 2016	Patient Safety

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				Patient" and "Assessment & Reassessment of Patients" on <u>all adult inpatient units (excludes ED &Perioperative)</u>		staff will be educated and signoff on education.		Quality Council
			e.	<u>AUDIT</u> compliance with nursing personalized care plan audit on <u>all adult inpatient units, inpatient psychiatry (excludes ED, ED Crisis & Perioperative)</u>.	July 8, 2016	<u>AUDITS:</u> Four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	November 8, 2016	Patient Safety Quality Council
5	**Compliance with Schedule Class II narcotic medication order.**	Director of Pharmacy	a.	<u>Review and revise</u> "Controlled Substance" Policy to ensure compliance with current evidence based practice and current state regulations.	July 30, 2016	Policies will be reviewed every three years <u>or</u> when changes are needed to reflect evidence based practice.	August 5, 2016	Pharmacy and Therapeutics
			b.	<u>Educate</u> nursing staff on compliance with policy "Controlled Substance" on <u>all adult inpatient units.</u>	August 10, 2016	<u>Monitoring:</u> 100% of nursing staff will be	September 10, 2016.	Patient Safety

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						educated and signoff on education.		Quality Council
		Director of Pharmacy & Chief of Medicine	c.	**Educate** medical staff regarding current electronic medical record renewal process of Schedule Class II narcotic orders and renewal alert via email communication.	July 13, 2016	Monitoring: Ongoing	July 13, 2016	Quality Council
		Director of Pharmacy	d.	**Process:** Pharmacy will review daily report of medication profiles for CDU, specifically ScheduleClass II narcotic order(s) and renewal(s) to ensure compliance with policy.	July 6, 2016	Ongoing	Ongoing	Patient Safety Quality Council
		CDU Nurse Manager / Clinical Coordinator Director of Pharmacy	e.	**Implement** nursing daily chart review for Schedule Class II narcotics scheduled to automatically discontinue with notification to licensed independent practitioners.	July 8, 2016	Ongoing **or** until a report can be created to transition monitoring to pharmacy department.	Ongoing **or** until a report can be created to transition monitoring to pharmacy department.	Patient Safety Quality Council
6	**Review of CDU Scope of**	Associate Chief Nursing Office	a.	**Review** of: a. CDU Staffing model, staffing	July 1, 2016	**Monitoring:** On-going	On-going	Nursing Leadership

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
	Services.			orientation and competency, b. leadership expertise and competency to reflect current evidence based practice. No changes to current structure needed at this time.				Meeting
7	**Governing Board minutes**	Special Project Coordinator & Executive Assistant	a.	Governing Board minutes to include actions taken by the board as follows: review of Quality Council Minutes, Patient Safety Minutes, and Board agreement and/or identify opportunities with Quality & Patient Safety activities.	August 1, 2016	Ongoing	Ongoing	N/A
8	**Quality Council Minutes**	Director of Risk Management, Patient Safety & Quality	a.	Quality Council minutes to include actions taken by the council as follows: review of Patient Safety Minutes, and identify opportunities with Quality & Patient Safety activities that are reviewed and discussed at	August 1, 2016	Ongoing	Ongoing	Governing Board

Lawrence & Memorial Hospital
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DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
				each Quality Council meeting.				
9	**Physician Documentation related to patient change in condition**	Director of Risk Management, Patient Safety & Quality	a.	**Continuing Education** for medical staff regarding medical record documentation standards and best practices.	October 31, 2016	Ongoing	November 15, 2016	Quality Council
		Director of Risk Management, Patient Safety & Quality	b.	**Audit** compliance of medical records to ensure completeness of medical record. Identified opportunities for improvement will be reported to physician leaders.	August 15, 2015	**AUDITS:** four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	December 15, 2016	Quality Council
10	**Provide emergency treatment/assessment**	Associate Chief of Nursing	a.	**Review and revise** Cardiopulmonary Resuscitation policy.	August 15, 2016	Policies will be reviewed every three years **or** when changes are needed to reflect evidence based practice.	September 15, 2015	Patient Safety Quality Council

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
Sequential Report Number: 0047-16-08

#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
		Associate Chief of Nursing	b.	**Educate** on Cardiopulmonary Resuscitation policy.	September 20, 2016	Monitoring: 100% of nursing staff will be educated and signoff on education.	October 15, 2016	Patient Safety Quality Council
		Associate Chief of Nursing Critical Care Committee	c.	**Audit** all Code 8s will be reviewed for compliance with Cardiopulmonary Resuscitation policy.	October 15, 2016	100% of Code 8 with 90% or greater compliance to policy.	February 15, 2016	Patient Safety Quality Council
11	**Patient Rights: Care in a safe setting**	Chief Medical Officer Associate Chief of Nursing	a.	**Educate** medical and nursing staff on updating patient problem list to reflect patients with a known history of suicide ideation.	August 15, 2016	**AUDITS:** four (4) consecutive months with 90% or greater compliance. Five (5) charts per inpatient unit per week.	December 15, 2016	Patient Safety Quality Council
			b.	**Audit** Patients identified with history of suicide ideation will have history listed on problem list.	August 15, 2016	**AUDITS:** four (4) consecutive months with 90% or greater	December 15, 2016	Patient Safety Quality

Lawrence & Memorial Hospital
Date of Submission: July 29, 2016
DPH Corrective Action Plan
Site Survey: June 30, 2016 – July 1, 2016 and July 3, 2016 – July 6, 2016
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#	Opportunity for Improvement	Responsible Party	Action	Corrective Action	Date Implemented	Audit & Monitoring Plan	Date Completed	Where Reported
						compliance. Five (5) charts per inpatient unit per week.		Council
12	**Hospitalist Coverage**	Chief Medical Officer	a.	**Audit** Compliance with Hospitalist coverage pursuant to contract.	August 1, 2016	**AUDITS:** four (4) consecutive months with 90% or greater compliance.	December 1, 2016	Governing Board

ORIGINAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

YALE-NEW HAVEN HEALTH SERVICES CORPORATION
L & M CORPORATION

ACQUISITION OF LAWRENCE & MEMORIAL CORPORATION
BY YALE-NEW HAVEN HEALTH SERVICES CORPORATION

DOCKET NO. 15-32033-CON

AND

NORTHEAST MEDICAL GROUP, INC.
L & M PHYSICIAN ASSOCIATION, INC.

ACQUISITION OF L & M PHYSICIAN
ASSOCIATION, INC. BY
NORTHEAST MEDICAL GROUP

DOCKET NO. 15-32032-CON

JULY 26, 2016

3:00 P.M.

HOLIDAY INN
35 GOVERNOR WINTHROP BOULEVARD
NEW LONDON, CONNECTICUT

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. . .Continued verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Care Access, in the matter of Yale-New Haven Health Services Corporation, L & M Corporation, Acquisition of Lawrence & Memorial Corporation by Yale-New Haven Health Services Corporation and Northeast Medical Group, Inc., L & M Physician Association, Inc., Acquisition of L & M Physician Association, Inc. by Northeast Medical Group, held at the Holiday Inn, 35 Governor Winthrop Boulevard, New London, Connecticut, on July 26, 2016 at 3:00 p.m. . . .

HEARING OFFICER KEVIN HANSTED: Good afternoon, everyone. Welcome back. This is the second half of a hearing that we started on July 11, 2016 to consider two applications, one under Docket No. 15-32032-CON and the other under 15-32033-CON.

I would remind everyone that took the oath at the first hearing that you are still under oath, and I believe we completed Cross-Examination last time. I'm sorry. Direct Examination last time. If that's incorrect, please let me know.

MR. HENRY MURRAY: I believe it -- is this on? I think it is, isn't it? Okay. I believe it was, Mr. Hansted, but we had two individuals, who had submitted pre-filed testimony, Maritza Bond and Dr. Steven Smith, who were unable to be here, because of the length of the public testimony last time, and I just thought we would like them to be able to testify on Direct, also, to provide -- make them available, obviously, for the Applicants to Cross-Examine them, also.

HEARING OFFICER HANSTED: Okay, is this on 15-32033?

MR. MURRAY: Yes, it is.

HEARING OFFICER HANSTED: Okay. Okay. I'm going to allow that.

MS. JOAN FELDMAN: I'm going to have to object.

HEARING OFFICER HANSTED: Okay. Based upon what?

MS. FELDMAN: Well there are rules that I would expect to be adhered to. I understand that one of the witnesses was here and chose to leave, so --

HEARING OFFICER HANSTED: Okay. I'm going to allow them to testify. I'll also allow you to Cross-

Examine those folks.

But just before we get started with the hearing again, for those folks that weren't here last time, we had an opportunity for the public and elected officials to give comment on both applications at the beginning of the hearing last time.

This time, I will allow for public comment again. It will be at the end of today's hearing, so after we finish Direct Examination, complete Cross-Examination, any Redirect we might have, and after OHCA's questions, then we will go to the public comment portion of the hearing.

MS. FELDMAN: Attorney Hansted, before we begin, we do have three additional folks that might be able to provide some answers to any questions that we would like to have sworn in.

HEARING OFFICER HANSTED: Okay, that's fine. Attorney Murray, do you have any additional individuals that need to be sworn in?

MR. MURRAY: No, not for the Intervenors. Well, yes. I believe, Maritza, you took the oath last time. Okay, so, Dr. Smith is the only one that hasn't been sworn in.

HEARING OFFICER HANSTED: Okay. If I

could have those folks please stand and raise your right hand and be sworn in by the court reporter?

(Whereupon, Dr. Steven Smith, Christopher O'Connor, Lisa Stump, Laurel Holmes and Pat McCabe were duly sworn in.)

HEARING OFFICER HANSTED: Okay, thank you, all. And, just for the record, would you please identify yourselves one at a time into a microphone, those, who just took the oath?

DR. STEVEN SMITH: Dr. Steven Smith.

HEARING OFFICER HANSTED: Thank you.

MR. CHRISTOPHER O'CONNOR: Christopher O'Connor.

MS. LISA STUMP: Lisa Stump.

HEARING OFFICER HANSTED: Okay, thank you, all.

MS. LAUREL HOLMES: Laurel Holmes.

MR. PAT McCABE: Pat McCabe.

HEARING OFFICER HANSTED: Thank you. Did you get that, court reporter? Thank you. Okay, Attorney Murray, if you want to have the two individuals that you referenced earlier provide their testimony, I'll take that now.

MR. MURRAY: Okay, thank you very much,

Mr. Hansted.

HEARING OFFICER HANSTED: Hold on.

MS. FELDMAN: Hold on. During the interval since the last hearing and today, there were several documents that were given administrative notice. I would like to know whether or not you're going to discuss that before we begin the testimony, or are we just going to plan on proceeding from this point?

HEARING OFFICER HANSTED: I won't specifically be discussing it, but if you want to comment on it, I'll take comment on it.

MS. FELDMAN: Before I comment, I would like some clarification, in terms of the weight that the e-mail from Comptroller Lembo and the Milliman Study, which we objected to at the last hearing, will be given with respect to the record.

HEARING OFFICER HANSTED: I really can't make that determination at this point until I look at the entire record as a whole. I can't tell you what percentage I would give it, as to weight.

MS. FELDMAN: Okay, well, for the record, just looking at Connecticut General Statute, Section 4-178, which refers to evidence in contested cases, it lays out the criteria for introducing these documents into

evidence and having greater weight than perhaps the public testimony, and I point your attention to items one and six.

Item one says that, if the information is irrelevant, immaterial, or unduly repetitious evidence, it should not be introduced, or item six, notice may be taken of judicially cognizable facts and of generally recognized technical or scientific facts within the agency's specialized knowledge.

With respect to the Milliman report, I believe at the last hearing I objected on the basis that I thought that the document, itself, was completely unreliable, irrelevant.

And if you look at the first two pages that were not present on July 11th, but that were part of the e-mail that Comptroller Lembo sent, even Milliman, itself, states that on page two of three that any third party recipient of Milliman's work product, who desires professional guidance, should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to specific needs.

There's also other disclaimers in the first two pages of the document. In fact, I think there's a typo, because they said they relied on

Milliman's health cost guideline grouping mythologies.

In addition, we don't think the data is relevant, in that it does not take into effect the acuity of the patient or the other factors that they, themselves, identified, in terms of various cost, geographic areas, catastrophic claims, and quality of care.

So we don't know whether this is complete data, we don't think it's reliable data, and, for those reasons, we object to it being introduced as evidence that would have any weight, other than public testimony, beyond that of public testimony.

HEARING OFFICER HANSTED: Okay. I would ask that you put your objection in writing, and I'll rule on it in writing.

MS. FELDMAN: Okay. Can I also object to Comptroller Lembo's letter? I would have assumed that this letter would have been similar to any other letters that OHCA would receive, and that this, too, would not be given any additional weight beyond that of public testimony.

There is, interestingly, an e-mail that accompanies the Milliman data, which seems to be at odds with the position that the Comptroller took in this

letter.

He seems to be comfortable with the fact that, in the e-mail, he states that he understands now that this is not a merger that this application describes, but that it is an affiliation, so I think a lot of what he says in his letter is irrelevant.

HEARING OFFICER HANSTED: Okay, thank you.

MR. MURRAY: Mr. Hansted?

HEARING OFFICER HANSTED: Yes.

MR. MURRAY: If Attorney Feldman is going to put her objection in writing, would we be given an opportunity to weigh in on that, or would you like our comments now?

HEARING OFFICER HANSTED: No, I'll allow you an opportunity to weigh in in writing.

MR. MURRAY: Okay.

HEARING OFFICER HANSTED: So, Attorney Feldman, I would ask that your objection be filed by -- let's see. Today is Tuesday. By Friday. Does that give you enough time?

MS. FELDMAN: Sure.

HEARING OFFICER HANSTED: By Friday. And, Attorney Murray, a response by you by the following Friday.

MR. MURRAY: That's fine. Thank you.

HEARING OFFICER HANSTED: Okay.

MR. MURRAY: Mr. Hansted, just before we move on, just for the record, when the comment that -- I think, if one carefully reads the Milliman report, you'll see that page two is often what we would refer to as risk analysis of language, in the sense that I believe it's probably for Milliman's protection, so that they're not quoted.

It has nothing to do with the reliability of the information, but I'll put that in writing.

HEARING OFFICER HANSTED: Thank you. Counsel, anything further?

MS. FELDMAN: No.

HEARING OFFICER HANSTED: Okay. Attorney Murray, if you want to have your two witnesses present their evidence?

MR. MURRAY: Yeah. The Intervenors would call Maritza Bond.

MS. MARITZA BOND: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MS. BOND: My name is Maritza Bond. I am the Executive Director for Eastern Area Health Education Center, and I adopt my pre-filed testimony.

HEARING OFFICER HANSTED: Thank you.

MS. BOND: Our local non-profit organization, which implements services within Windham and New London County, our mission is to ensure that access to quality healthcare services are delivered in a culturally and linguistic manner. This includes equitable distribution of the healthcare workforce. I am also a coalition member of both Windham and New London.

Today, I am here in the interest of underserved communities, whose voices are not able to be heard, and to share what I am witnessing in the Windham community upon the Hartford HealthCare merger.

In Windham, we are already experiencing the impact of what can occur when hospital services are reduced following a merger.

This past year, a woman in her early fifties with limited English proficiency suffered a stroke. When transported to Windham Hospital, the family was told they could not provide the care she needed, because they did not have a neurologist on site.

Instead, the woman was put in a Life Star helicopter and transported to Hartford Hospital. This was detrimental to both the patient and the family members, who were left to drive over 30 minutes to be by

her side.

There were no language services provided or offered, and there was no way to effectively communicate with this patient. Thankfully, this woman's story did not end tragically.

During the Hartford HealthCare merger, promises were made that services were not going to be reduced, nor eliminated.

Nonetheless, this is not the case. With the CCU now being closed, patients are traveling long distances by ambulance, private car, or even helicopter for urgently-needed care that used to be available at Windham. At the end, Hartford's original CON was filled with broken promises.

If this acquisition is a necessity for improving efficiency, then I would request that the CON application have clear provisions in place that will protect the community of New London and surrounding areas.

We must ensure that access to healthcare would not be reduced, outsourced, or eliminated, services will be affordable to all patients from all social economic backgrounds and cultural background, and to ensure that local healthcare workforce are not eliminated

or replaced, due to this new regionalization of healthcare phenomenon that is happening in the state and across the country.

It is my hope that this acquisition truly leads to improving health outcomes of this community and not just the bottom line of improving the financial status of an organization.

Thank you for the opportunity to provide testimony before you today.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: The Intervenors would like to call for testimony of Dr. Steven Smith.

DR. SMITH: Thank you. Good afternoon, Attorney Hansted and OHCA staff.

HEARING OFFICER HANSTED: Good afternoon.

DR. SMITH: I'd like to adopt my pre-filed testimony as my own.

My name is Steven Smith. I'm a family physician, and I practice at the Community Health Center here in New London. I'm also Professor Emeritus of family medicine at the Warren Alpert Medical School at Brown University, and I served as Associate Dean of Medicine at Brown University for 25 years.

I also taught an undergraduate health

policy course during that time, and after scouring and critically reviewing the literature, one lesson is very clear.

By and large, hospital mergers are not good for the public. Most of the time, prices end up rising. Most of the time, quality does not improve, and safety does not improve.

The often mentioned efficiencies often never materialize, and, worst of all, as Ms. Bond has just testified, local access to vital services sometimes are terminated. The other thing is that, when hospitals acquire physician practices, productivity plummets.

This article, which is in our Exhibit 2, just came out a few weeks ago, June 16th, in New England Journal, by McWilliams, et al, and it's the first report of early performance of Accountable Care Organizations in Medicare.

And the article states that savings are achieved only by independent physician primary care practices, not by hospital-owned practices.

One wonders whether the dire call for more capital by the Applicants might, in fact, just be used to acquire more physician practices and increase the hegemony over physician services here in Southeastern

Connecticut.

In my opinion, hospital mergers can only be justified if there are no other available options to save a financially-distressed hospital, and we know from publicly-available documents that L & M operates in the black and is not financially-threatened.

If any other benefits are being suggested as a justification for a merger or whatever you want to call it, but these benefits can be achieved by some other way, then a merger should not really be considered.

Just such a claim is being made by the Applicants, in terms of close clinical coordination. What I want to testify is that, in fact, close clinical coordination can be achieved without legal acquisition, merger affiliation, whatever you want to call it.

As a physician at the Community Health Center in New London, I have instant access to the records at L & M through a portal, so I can get x-ray reports, I can get laboratory reports, I get hospital admissions and discharge summaries only at the touch of a key.

Emergency room physicians, if they're seeing some of our patients in the hospital through a procedure that we've established with the hospital, can

guarantee that those patients are seen within 24 hours, and our Community Health Center and L & M are completely separate, independent institutions.

In terms of ER, I mean my relationships with physicians at Yale, they're excellent. In fact, recently, with the patient with the severe pulmonary disease, another patient with vascular problems, I'm on the phone with the specialists in New Haven, and they can ask me to see the patients, order tests in between, without any need for formal merger between the two.

The neonatal intensive care unit at L & M is, in fact, manned, staffed by neonatologists, who are employees at Yale-New Haven, without the need for any kind of merger.

Again, babies, who are discharged from the NICU can be seen in my clinic within 24 hours with arrangements we've made with them.

Community hospitals like L & M should maintain close clinical coordination with a tertiary care hospital like Yale, and they've managed to do so, without the need for a formal affiliation.

I believe they should continue to do what they've done for years and adopt those kinds of close cooperations, without the need for formal merger. That

will benefit our patients here in Southeastern Connecticut and maintain our independent community hospital. Thank you very much.

HEARING OFFICER HANSTED: Thank you, Doctor.

MR. MURRAY: Attorney Hansted, that concludes the testimony for the Intervenors.

HEARING OFFICER HANSTED: Okay, thank you, Attorney Murray. Attorney Feldman, do you have any Cross-Examination?

MS. FELDMAN: I do.

HEARING OFFICER HANSTED: Okay.

MS. FELDMAN: I would like to Cross Mr. Hyde. Mr. Hyde, are you referred to as Dr. Hyde, or Attorney Hyde, or Mr. Hyde? I want to make sure I refer to you properly.

DR. FRED HYDE: Dr. Hyde will do.

MS. FELDMAN: Dr. Hyde? And are you a doctor of economics?

DR. HYDE: No, no. My degree in medicine is an MD from Yale.

MS. FELDMAN: Okay, very good. Mr. Hyde, is it true, is it not, that since 1981 you have been engaged as a consultant with respect to the management of

healthcare facilities?

DR. HYDE: Yes.

MS. FELDMAN: Okay. As part of your consultancy, you served as CEO of various hospitals, including Windham and Winsted?

DR. HYDE: Two hospitals, Windham and, in Western Pennsylvania, Aliquippa. When I was Chief Executive of the Winsted Health Center Foundation, it had closed as a hospital and reopened as a community health center.

MS. FELDMAN: Okay, thank you. Is it also true that, while you were serving as CEO of Windham Hospital, that Attorney General Blumenthal initiated an investigation of the misuse of endowment funds while you were CEO, and, as a result of that investigation, there was a settlement agreement, which was reached between the AG's office and Windham Hospital, which required you to refund or reinvest $1.8 million back into the endowment?

DR. HYDE: Yes.

HEARING OFFICER HANSTED: And just for the benefit of the public, the AG's office is the Attorney General's office.

MS. FELDMAN: And, as part of your consultancy, is it fair to say that you've been engaged

by and testified on behalf of community hospitals in opposition to their acquisition by a larger hospital system?

DR. HYDE: I believe that's true, but if you ask me about a specific, I could be more accurate.

MS. FELDMAN: Okay, well, let me ask you this question. Have you ever, at any time, testified in favor of the acquisition of a small community hospital by a larger health system or hospital?

DR. HYDE: I don't believe so.

MS. FELDMAN: Okay, so, to date, it seems as if your position has been pretty much negative with respect to such acquisitions, and, so, I want to bring your attention to an article written in the Hartford Courant, an editorial written by you on January 11, 2009, where you criticize the -- the title of it is This Merger is Malpractice, Bad Deal, In Perils, UConn Facilities Mission. Did you write that editorial?

DR. HYDE: I'd have to take a look at it. It's been seven years from the date you cite.

MR. MURRAY: I'd like an opportunity to look at that.

HEARING OFFICER HANSTED: Sure.

DR. HYDE: Yes, that's correct.

MS. FELDMAN: Is it fair to say that the list of horribles that you describe in that article cannot be generalized to all affiliations?

DR. HYDE: Could you repeat your question, please?

MS. FELDMAN: Well, in your testimony in this proceeding and your pre-filed testimony and your response to Dr. Noether's pre-filed testimony, you take a rather negative stance with respect to this proposed application, and you do the same in that editorial you submitted to the Hartford Courant regarding Hartford HealthCare and its affiliation with UConn Health Center.

Is it accurate to say that the horribles that you describe cannot be generalized with respect to every affiliation by a large system and a small community hospital?

DR. HYDE: I think it would be accurate to say at least three things from a review of this article. First, that my views haven't changed. My clients find me, because of my views. I don't alter them to fit my clients.

Secondly, that the John Dempsey Hospital, which continues today as an independent institution, would, in all likelihood, not continue, not have

continued, but for the effort of the Unions that represented employees and the faculty to oppose a Hartford takeover.

Third, that fundamental in the examination of the takeover were specifics concerning prices. I recall, for example, members of the legislature asking officials from the University of Connecticut Health Center specific questions, as opposed to generalities, about budgets and prices.

So those three things I think would be my summary, quickly reviewing this. My views haven't changed. I believe that the medical faculty and the Unions, who opposed a takeover of Dempsey by Hartford at the time, were correct, and that many of the issues discussed by the executive leadership were discussions that were taking place in the absence of close examination of the facts.

MS. FELDMAN: Would it be fair to say that you would object to any acquisition by a large healthcare system of a small community hospital?

DR. HYDE: It would be fair to say that we have, as a nation and what I attempted in 14 years of teaching to pass along to students, extraordinary problems with access, that we've gone from 60, 200

independent hospitals in modern times before the DRG revolution to 4,900 hospitals, that, as a consequence and with another 500 or so in periled and rural areas, that, as a consequence, access to small hospital services, which might be either guaranteed by their assumption by large hospitals or by strengthening their independence, I've always believed in the latter.

MS. FELDMAN: When you were CEO of Windham Hospital, was Windham Hospital a sole community hospital not affiliated with Hartford HealthCare?

DR. HYDE: No. At the time, it was not.

MS. FELDMAN: Okay and when you left Windham Hospital, is it true that Windham Hospital was financially $6 million in the red?

DR. HYDE: Windham was actually in reasonably good position in comparison to other Connecticut hospitals. We had rebuilt the hospital entirely.

My successor, Mr. Brvenik, did an even better job in operations and used the new facilities to restore complete financial health.

In fact, for the three years prior to 2008, when Hartford first became involved, Windham was doing fine.

MS. FELDMAN: In your pre-filed testimony, I believe this was attached as an exhibit. It's Hospital Market Concentration in Connecticut, the Impact of Yale-New Haven Health Systems Expansion. I just have a simple question.

DR. HYDE: You're referring to Exhibit 4 or Attachment 4, and which page, if any, would you like me to address?

MS. FELDMAN: Just generally, did you -- could you tell me who prepared this, who wrote this?

DR. HYDE: I had no role in writing this, but I have relied on this document for a statement I made in my testimony.

MS. FELDMAN: Okay, thank you.

DR. HYDE: If I may complete my answer, Mr. Hansted?

HEARING OFFICER HANSTED: Go ahead.

DR. HYDE: I stated that Yale-New Haven and Lawrence & Memorial were important competitors, a statement contested by Dr. Noether.

In fact, a reference to a bond issue footnote in this document confirms that 80 percent of Yale-New Haven's work is as a community hospital from its primary service area.

Fifteen percent is from its so-called referral service area, which, of course, includes the entirety of Lawrence & Memorial service area. Five percent is beyond that.

I don't say that to diminish the role of Yale-New Haven in providing primary and secondary care to its community, but, rather, to emphasize that the markets that are perceived by Yale-New Haven to be part of its primary responsibility overlap with those of Lawrence & Memorial.

MS. FELDMAN: No further questions for Mr. Hyde.

HEARING OFFICER HANSTED: Attorney Murray, do you have any Redirect?

MR. MURRAY: Just give me a second. No Redirect.

HEARING OFFICER HANSTED: Okay. Attorney Feldman, did you have Cross for any of his other witnesses?

MS. FELDMAN: No, I don't.

HEARING OFFICER HANSTED: Okay. Attorney Murray, do you have any --

MR. MURRAY: I just wanted to make a comment on the last round of questioning that Attorney

Feldman did, in terms of the report that she was referring to.

If OHCA would like that, the Intervenors -- that report was written by someone, an analyst. She was an employee of one of the Intervenors. We can certainly provide, if OHCA wants it, all of the data files, in which that report was based.

HEARING OFFICER HANSTED: No. Thank you, Attorney Murray. That will be fine.

MR. MURRAY: Okay.

HEARING OFFICER HANSTED: Do you have any Cross-Examination?

MR. MURRAY: Yes, I do, of a couple of the Applicant's witnesses. Let me just get my notes here.

Yes, I have questions for Dr. Sanfilippo. Good afternoon, Doctor.

DR. LOUIS SANFILIPPO: Good afternoon.

MR. MURRAY: You're a member of the Lawrence & Memorial Board of Directors, correct?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and in both your pre-filed testimony and the testimony here on July 11th you stated that the L & M Board of Directors made sure that, as a result of the acquisition by Yale-New Haven Health

System, L & M Board would remain in place and continue to govern locally, is that correct?

DR. SANFILIPPO: That is correct.

MR. MURRAY: Okay. You even asserted that the acquisition by Yale-New Haven Health System was in stark contrast, and I'm quoting that, that was in your testimony, to how other systems in the State govern locally, is that correct?

DR. SANFILIPPO: That is correct.

MR. MURRAY: Okay and, in fact, you even drew a distinction between this acquisition and Hartford Hospital, Hartford HealthCare's acquisition of Windham Hospital, correct?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and, finally, I believe in your testimony you asserted that the Board of L & M made sure, and, again, that's in quotes, that's in your testimony, that there wouldn't be a loss of local control, is that correct?

DR. SANFILIPPO: That's correct.

MR. MURRAY: Okay, now, as part of the application, you and the L & M Board have final proposed amended corporate bylaws that will govern the future operation of L & M, correct?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and, as part of the due diligence as a Board member and in your words from your July 11th testimony as fiduciary to the community, when you and the other Board members reviewed the changes in the corporate governance, did you understand that Yale-New Haven Health System would become the sole member of the L & M Corporation?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and under the proposed new bylaws for the L & M Corporation, there are two classes of trustees on the Board, correct, elected trustees and ex officio trustees?

DR. SANFILIPPO: Yes.

MR. MURRAY: And the ex officio trustees consist of the President/CEO of L & M and the Board Chairs for each of its affiliates, correct? L & M Hospital, Westerly Hospital and the VNA?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and, also, the President/CEO of the sole corporate member, Yale-New Haven Health System, correct?

DR. SANFILIPPO: And I believe the President of the medical staff, as well.

MR. MURRAY: Okay. I may have missed that in reading. Okay and, as the sole corporate member of the L & M Corporation, you're aware, aren't you, that, under Section 3.2 of the proposed bylaws --

MS. FELDMAN: I think he's going to need to look at the bylaws.

MR. MURRAY: I'll give you the citation. It's page 186 of the Certificate of Need application.

DR. SANFILIPPO: Okay, go ahead with your question.

MR. MURRAY: Okay. Let me repeat the question. As the sole corporate member of the L & M Corporation, you're aware, aren't you, that, under Section 3.2 of the proposed bylaws, that Yale-New Haven has the sole authority to select or elect, depending on the word that's used in the bylaws, the elected trustees to the L & M Corporation Board?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and you're aware, aren't you, that under the proposed post-acquisition bylaws, that Yale-New Haven Health System, as the sole corporate member, has the power to reject nominees proposed by the trustees of the L & M Corporation Board? That's Section 3.4 of the proposed bylaws.

DR. SANFILIPPO: Yes. We were also advised by Bridgeport and Greenwich Hospitals on how the operation would take place.

MR. MURRAY: Okay, so, if I understand it, you were advised that this is the same corporate governance model that both Bridgeport and Greenwich have, is that correct?

DR. SANFILIPPO: It is comparable, yes.

MR. MURRAY: Okay, but my question was simply that you were aware that if Yale-New Haven Health System, as a sole corporate member, did not like the candidates being proposed by the L & M Board, that it had the sole power to reject those and elect whoever it chose fit to be on the Board?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay, now --

DR. SANFILIPPO: We were also parenthetically advised that both Bridgeport and Greenwich had never had any of their Board selections rejected.

MR. MURRAY: Okay, but we're talking about L & M, aren't we?

DR. SANFILIPPO: Yes, we are.

MR. MURRAY: Okay and you're also aware,

aren't you, that under the proposed post-acquisition bylaws, that the L & M Board would no longer have the power to appoint the President and CEO?

DR. SANFILIPPO: Yes.

MR. MURRAY: But that power would reside solely in the sole corporate member?

DR. SANFILIPPO: Yes, we were aware of that.

MR. MURRAY: Okay and it's true, isn't it, that under that bylaw provision, the bylaws state explicitly that the President and CEO of Lawrence & Memorial Corporation serves at the pleasure of the member and not at the pleasure of the L & M Board?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay, now, I want to ask you a couple of questions. We just talked about the elected Board members, and I just have a couple of questions to ask you about the ex officio members of the Board.

Now the remaining three ex officio members of the Board, which are the L & M Hospital, Westerly Hospital and the VNA, those Boards are all selected by the sole corporate member now of the L & M Corporation, which is the L & M Board, correct?

DR. SANFILIPPO: Yes, and there's no plans

to change that.

MR. MURRAY: Okay, but, as the sole corporate member, Yale-New Haven Hospital would be in a position to change the composition of those particular Boards if it chose to, couldn't it?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay, now, Dr. Sanfilippo, as a Board member, did you read the proposed L & M post-acquisition bylaws, including Exhibit A and Exhibit B to those bylaws, which can be found on pages 197 to 198 of the application?

MS. FELDMAN: Say those pages again?

MR. MURRAY: 195 to 198.

MS. FELDMAN: Just one second.

DR. SANFILIPPO: Yes, we reviewed this.

MR. MURRAY: Okay and you would agree with me, wouldn't you, that, if you read Exhibit A, it sets out, doesn't it, that virtually every management action by the L & M Board can only be taken with the approval of the sole corporate member?

DR. SANFILIPPO: We realize that this would all be -- first of all, this document was mutually agreed upon, and, second of all, we do agree that these would be joint decisions.

MR. MURRAY: I'm sorry. I couldn't hear what you said.

DR. SANFILIPPO: These would be joint decisions.

MR. MURRAY: Well I understand that. That may have been the assurances, and that may have been what you said. I'm simply asking you isn't it true that Exhibit A provides for the fact that every major decision must have the approval of the sole corporate member?

DR. SANFILIPPO: Those decisions cannot be made without the approval of the local Board.

MR. MURRAY: Okay and Exhibit B in the bylaws gives the sole corporate member the --

MS. FELDMAN: Just one second.

MR. MURRAY: I'm sorry.

DR. SANFILIPPO: Go ahead with your question.

MR. MURRAY: Yeah. Exhibit B gives the sole corporate member, Yale-New Haven Health System, the retained authority to set budget targets, incur debt on behalf of L & M, and control the liquid assets, appoint auditors, and, if it chooses, designate any activity a major activity requiring its approval before L & M or any of its affiliates can take action?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay.

DR. SANFILIPPO: This is what we understand is how a system would work, since we already are a system. We're just going by how we've done things, and this is how the system would work.

MR. MURRAY: Right, so, in other words, the way the system operates, in terms of Lawrence & Memorial Corporation, the Lawrence & Memorial Corporation, is that you have lots of retained authority as the sole member for all the other affiliates, L & M Hospital, the Physicians' Association and the VNA, correct?

DR. SANFILIPPO: And Westerly Hospital.

MR. MURRAY: Excuse me. And Westerly Hospital. And what would change under these bylaws is that that power that the L & M Corporation currently has would now be retained and exercised by the sole corporate member, which is the Yale-New Haven Health System, correct?

MS. FELDMAN: Can you restate the question, please?

MR. MURRAY: Okay. It's a long question. As it is right now, Lawrence & Memorial Corporation

retains certain authority with respect, as the sole corporate member, retains authority with respect to your other affiliates, L & M Hospital, Westerly Hospital and the VNA, correct?

DR. SANFILIPPO: At a high level, yes.

MR. MURRAY: Okay and when Yale-New Haven Health System becomes the sole corporate member of the L & M Corporation, it will retain the authority that L & M currently exercises now, correct?

DR. SANFILIPPO: Somewhat, yes.

MR. MURRAY: Well somewhat. The powers retained by the sole corporate member in Exhibit A and Exhibit B are pretty clear, aren't they, Dr. DeFilippo? Sanfilippo. Pardon me.

DR. SANFILIPPO: No, I would disagree with that. Exhibit A and B reflect joint governance.

MR. MURRAY: Joint governance. Joint governance is a situation, where someone can make -- would you agree with me that situations of joint governance is where one party can't take an action, unless it has the approval of the other party?

DR. SANFILIPPO: Yes.

MR. MURRAY: Okay and nothing in the proposed bylaws does it indicate that Lawrence & Memorial

Board of Directors can take an action without the approval of the sole corporate member or that the Lawrence & Memorial Board can veto any of the actions taken by the sole corporate member?

MS. FELDMAN: Can you restate the question?

DR. SANFILIPPO: I don't understand the question.

MR. MURRAY: Okay. I prefaced it by saying that joint governance is a situation, and you agreed with me, where one party can't act without the approval of another party, correct?

DR. SANFILIPPO: With respect to the specifics in Exhibit A, yes, I would agree.

MR. MURRAY: Okay, but, in Exhibit A and Exhibit B and elsewhere in the proposed bylaws it's pretty clear that Yale-New Haven Health System, as a sole corporate member post-acquisition of the L & M Board, retains the authority to take actions without the approval of the L & M Board and, conversely, that the L & M Board can't take any actions without Yale-New Haven Health System's approval, isn't that true?

DR. SANFILIPPO: I would say no.

MR. MURRAY: Okay.

DR. SANFILIPPO: That's incorrect.

MR. MURRAY: Okay. Can you point to where in any of the proposed bylaws post-acquisition the Lawrence & Memorial corporate trustees retain the power to act against the expressed consent of the sole corporate member?

DR. SANFILIPPO: We retain the power for local day-to-day operations, clearly, in this.

MR. MURRAY: So local day-to-day operations. Would you agree with me, then, that major decisions, major financial, clinical, strategic decisions are ones, which the sole corporate member retains the authority on?

DR. SANFILIPPO: No.

MR. MURRAY: And, again, can you point anywhere in the bylaws that it indicates that governance is joint governance, as opposed to governance by a sole member?

MS. FELDMAN: I'm going to object. These questions are very broad in scope and confusing. With respect to the last question regarding control over clinical, I don't even know what that means, and I think he's leading my witness.

HEARING OFFICER HANSTED: Counsel?

MR. MURRAY: I'm simply -- you know, the Applicants put in quite a thick number of volumes, including the proposed bylaws of the corporation.

The bylaws are very clear on what a sole corporate member's powers are. The literature, you know, the law review literature about what it is to be apparent as the sole corporate member is very voluminous, and we're happy to submit them, but I don't think we need to.

All I'm simply saying is that these are their documents. I think we have a right to ask questions.

MS. FELDMAN: We don't need to look at law review articles to understand corporate governance. And I agree with Attorney Murray, that this document is crystal clear. I'm afraid that he doesn't understand the document and how it's intended to work, and he keeps restating the same question in a way that's trying to put words in my witness's mouth.

MR. MURRAY: I'm not going to take umbrage with saying that I don't understand the document. That's okay. I'm not the witness. I don't need to understand the document.

MS. FELDMAN: Well you do if you're going to ask questions that are meaningful.

MR. MURRAY: Well, Attorney Feldman, I think you just betrayed the issue that we have here, and I'm going to say something.

You said the intent of the documents. I'm talking about the black and white words of the document, and that's why I intended to ask the question of the witness.

The documents are crystal clear about the power and the retained power of the sole corporate member. Whether the Lawrence & Memorial Board of Trustees was told something different in a sotto voce conversation, I don't know, but the documents are pretty clear.

MS. FELDMAN: I think I would agree that the documents are very clear, and I think that Exhibit A articulates those types of decisions that need to be made jointly by L & M Corporation and Yale-New Haven Health System.

I don't think we need to belabor them. They're very clear, and they're very limited, so I don't understand the questioning.

HEARING OFFICER HANSTED: Attorney Murray, I'm going to sustain the objection. I think the document speaks for itself.

MR. MURRAY: I was about to end my questioning of Dr. Sanfilippo.

HEARING OFFICER HANSTED: Thank you. We'll move on from this line of questioning.

MR. MURRAY: Okay. I have no other questions, Doctor. We have some questions for Marna Borgstrom. Good afternoon.

MS. MARNA BORGSTROM: Good afternoon.

MR. MURRAY: Ms. Borgstrom, during the application process, OHCA repeatedly asked for price information related to Yale-New Haven's contracts with commercial insurers for common diagnoses and procedures.

The Applicants have refused to provide this information, citing both the confidential and proprietary nature of the data sought.

On January 1st of 2017, all of this information related to the actual prices received from such commercial insurers or other third party payers will become public.

In light of this development and the inevitable disclosure of this information within the next six months, the Applicant's arguments to prevent the release of information now seems to be out of step with this movement towards transparency.

Given these facts, why won't the Applicants release the price information requested by OHCA?

MS. FELDMAN: I have to object, because I believe that he misstated the request of OHCA. OHCA requested risk adjusted data, and the Applicants responded by stating that that data is in the hands of the payers and was not available to us, nor did we have the capability, just like any other hospital system in the state or presumably nationally, have the capability of producing that data, and that is not the same data that was produced in the Milliman exhibit that was introduced by the Intervenors.

HEARING OFFICER HANSTED: Attorney Murray, response?

MR. MURRAY: I guess I'm going to go to the January 1, 2017 disclosures. Ms. Borgstrom, you would agree with me that the data, in terms of the prices actually paid by providers, will be available on January 1st, correct?

MS. FELDMAN: We're unaware. I'm not sure what he's referring to.

MR. MURRAY: Through the Health Exchange.

MS. FELDMAN: The Health Exchange? Okay.

I don't know if this is appropriate for me to say. I think you mean the All-Payer Claims Database?

MR. MURRAY: That's correct.

MS. FELDMAN: I happen to be counsel for the All-Payer Claims Database, and that is not information that's available and will not be available as of January 1, 2017.

MR. MURRAY: In objecting to my question before, Attorney Feldman said that the Applicants claim that this data, that data was in the hands of the payers. Can you point to specifically where the Applicants make that claim?

MS. FELDMAN: Well what data are we talking about here, because it's unclear to me?

MR. MURRAY: The data that OHCA requested.

MS. FELDMAN: That's risk adjusted data?

MR. MURRAY: Yeah.

MS. FELDMAN: I would like to have our expert, Dr. Noether, explain why that information cannot be readily produced. Is that possible, for me to have that done?

HEARING OFFICER HANSTED: Is that okay with you, Attorney Murray.

MR. MURRAY: That would be fine.

HEARING OFFICER HANSTED: It sounds like he might be the best witness.

MR. MURRAY: She.

MS. FELDMAN: Dr. Noether, yes.

HEARING OFFICER HANSTED: I'm sorry, she.

DR. MONICA NOETHER: So there are data available that insurers would have that include what they pay for particular services inpatient or outpatient, however, even those data do not completely reflect variation in patient severity or complexity and, therefore, the underlying cost of treating patients.

Therefore, it's not surprising that different hospitals are paid different amounts for patients, who are classified into the same DRG, or the same CPT code, or the same APC code, or whatever particular acronym you want to apply to a particular claim.

In order to accurately adjust, in terms of adjusting for risk, as it's often called, or patient severity, would be another way of doing it, that's a methodology that is still I don't want to say in its infancy, but still in the process of being developed.

There are a lot of people doing research on trying to figure out good ways to do severity

adjustment, but I don't think anybody has developed the Gold Standard. There is no standard methodology for doing that, so, for that reason, I think it's difficult when you are comparing prices for anything, but really routine commodity services to be able to know that you are, in fact, comparing apples-to-apples, as opposed to apples-to-watermelons.

MR. MURRAY: Just give me one minute.

HEARING OFFICER HANSTED: Sure.

MR. MURRAY: OHCA has put into the record a document, which I know the Applicants are going to object to, which is I'll call it the Milliman report. Have you seen that report, Ms. Borgstrom?

MS. FELDMAN: Just a second.

MS. BORGSTROM: I have seen it, yes.

MR. MURRAY: Okay and, in that report, the consultant compares a series of inpatient and outpatient charges in a one-year period for a universe of patients in the State Employee Healthcare System that were seen at both L & M and at Yale-New Haven Hospital, isn't that correct?

MS. FELDMAN: Just give her a second.

MS. BORGSTROM: I believe that's correct.

MR. MURRAY: Okay and the report

chronicles the fact that the payment for several inpatient or outpatient settings, depending on what the procedure was, was higher at Yale-New Haven Hospital than at L & M, is that correct?

MS. FELDMAN: I'm going to have to object again, because this is beyond the scope. She didn't testify about this. We objected to its introduction into evidence. We don't think it's relevant. We don't think it's accurate. We don't even know the source of the data. We don't know whether it's complete, so I don't understand why she's being Crossed if she hasn't provided Direct testimony on this.

MR. MURRAY: My question is not on necessarily the report.

MS. FELDMAN: Oh, I thought it was.

MR. MURRAY: The report is a foundation. My question is, and I'll ask the question, and, if you want to object to it, go ahead, are the prices reported in this report for procedures, inpatient and outpatient procedures, at Yale-New Haven Hospital, and this report represents that these are the actual prices paid by the State Employee Health System, are these comparable to the prices paid by commercial insurers for these services at Yale-New Haven Hospital?

MS. BORGSTROM: I would have no way of knowing that.

MR. MURRAY: Okay. Ms. Borgstrom, in the application and the responses provided to OHCA, the Applicants have been reluctant to specify exactly where the $216 million of the alleged $300 million investment in L & M will come from.

In the application and the completeness responses, the claim is that the amount will come from synergies and efficiencies achieved at L & M post-acquisition and from L & M's cash flow.

In response to OHCA, the Applicant said that the $300 million is not a cash commitment. Is that correct?

MS. BORGSTROM: The $300 million is a commitment over a period of time to enhance services, infrastructure operations at Lawrence & Memorial.

A portion of that will come in the future, based on the improved operational performance at Lawrence & Memorial Hospital, but a significant amount of this are committed investments in things like a new information technology service, investment in population health infrastructure to better allow these communities to prepare for and manage value-based payment, as well as

investments in recruiting and building out certain clinical areas that were determined by the Lawrence & Memorial and Westerly communities to be under-supported right now, such as primary care, surgery, behavioral health, women and children's services, emergency critical care services, so the first $85 million of this are hard investments made by the Yale-New Haven Health System.

MR. MURRAY: Okay, but the subsequent -- I was asking about the $216 or $215 million that is supposed to happen after the initial investments.

In the completeness answers and application, the Applicants say that --

MS. FELDMAN: Can we have a page reference?

MR. MURRAY: -- the amount is dependent upon the performance of both Yale-New Haven Health System and L & M and business and strategic plans that achieve, and this is the quote from the application, "A positive return on investment."

So I guess my question is, based on these representations, would you agree with me that $216 million number isn't really a hard number?

HEARING OFFICER HANSTED: Attorney Murray, just for purposes of the record, what pages are you

referencing?

MR. MURRAY: Well, on page 224, there's a reference to the $300 million commitment will come out of L & M's base operating cash flow.

MS. FELDMAN: Just one second. We have to find it. I'm sorry. Can you repeat the page?

HEARING OFFICER HANSTED: 224.

MR. MURRAY: 624.

HEARING OFFICER HANSTED: 624.

MS. FELDMAN: Oh, 624. Okay, hold on. And just give us a second, so she could review it.

HEARING OFFICER HANSTED: Absolutely.

MS. BORGSTROM: Okay, thank you. I had a chance to take a look at this.

MR. MURRAY: Okay. My question was a more general question, which is that the total dollar amount being talked about in the application of a $300 million investment is not a completely hard number, is it?

MS. BORGSTROM: Well it depends on the definition of what a hard number is, but we have made a hard commitment of the first $85 million of this and have identified funding sources.

The funding sources for the remaining $215 million will come as a result of improved business

operations and business plans for identified needed services that I couldn't define or articulate right now.

MR. MURRAY: All right and, for example, in answer to some of OHCA's questions, and it was on that page 624, the Applicants say that $163 million of the $300 million commitment will come out of L & M's base operating cash flow, isn't that correct?

MS. BORGSTROM: Yes.

MR. MURRAY: Okay and this amount, this is in addition to the incremental cash flow from efficiencies and synergies that the Applicants estimate will be about $68 million, is that correct?

MS. BORGSTROM: Yes.

MR. MURRAY: Okay, now, in answer to another OHCA question, the Applicants detailed a five-year table for what it called capital investments in equipment and facilities, correct? That's on page 625?

MS. BORGSTROM: Pardon?

MR. MURRAY: On page 625, the Applicants detailed and actually put a table out, talking about what it called the capital investment in equipment and facilities?

MS. BORGSTROM: Um-hum.

MR. MURRAY: Over a five-year period of

time? Isn't that correct?

MS. BORGSTROM: Yes.

MR. MURRAY: Okay and if you sum up that five-year expenditure, as set forth in this table for capital improvement, that comes to $163 million, doesn't it?

MS. BORGSTROM: You know, I will confess I'm not intimately familiar with these numbers and tables, and if we want to pursue this, I would like to ask that our senior finance representative here come and respond to those questions. I don't feel that I can do that reliably.

MR. MURRAY: All right. I understand you're obviously given the opportunity. I'm just really asking a simple mathematical equivalent.

If that table, if you sum up the amount put forth for capital improvement over five years, it comes up to $163 million, and, earlier on that page in the response to OHCA, the Applicants say that $163 million will come from the cash flow of L & M over the five years.

I guess my question is does that mean that L & M's cash flow is actually funding the capital improvements over those five years?

MS. FELDMAN: Do we want the truth, or, if we want accurate and helpful information to explain it and respond to your question, I think Ms. Borgstrom indicated that she doesn't feel like she is the best person to answer the question. We'd be happy to answer it and elucidate on it and respond to your question.

HEARING OFFICER HANSTED: That's an interesting way to put it, Attorney Feldman. Do we want the truth? I've never heard an attorney say that. (Laughter)

I will say, unequivocally, yes, we want the truth.

MS. FELDMAN: Okay, great.

MR. MURRAY: It's in the job description.

HEARING OFFICER HANSTED: And I think, also, to be fair, Ms. Borgstrom already stated that she's not intimately familiar with that. It's a fair statement.

If she didn't present or if she didn't prepare the table, let's hear from the person, who prepared the table, so we can get down to more specifics about the table.

MR. MURRAY: That's fine with me.

HEARING OFFICER HANSTED: Okay.

MS. FELDMAN: Keith, you want to come here and look at the -- do you have the application? Take a second. Do you need to review it?

MR. KEITH TANDLER: Okay.

MS. FELDMAN: Can we restate the question?

MR. MURRAY: Okay. My question was, taking a look at the capital investments in that table on page 625, over a five-year period of time, the capital infrastructure expenditures amount to $163 million, correct?

MR. TANDLER: Correct.

MR. MURRAY: And, earlier, in one of the responses to OHCA in the previous page, the Applicants indicated that $163 million of the estimated $215 million investment was going to happen over a five-year period of time from the operating cash flow of Lawrence & Memorial Hospital, isn't that correct?

MR. TANDLER: That's correct.

MR. MURRAY: Okay and that amount, that $163 million from the operating cash flow at L & M is the equivalent of what the Applicant's estimate is going to be spent on capital improvements, correct?

MR. TANDLER: Yes, that appears correct.

MR. MURRAY: Okay. I guess my question

was does that mean that, as this is structured, the operating cash flow at L & M is going to finance the capital improvements, infrastructure improvements over that five-year period of time?

MR. TANDLER: So what we described in the application is the first $85 million is a hard commitment. Following the first $85 million, there are ongoing investments that will be based on the success of those synergies, those operating improvements as the business, as the organization is reorganized.

We'll be able to accomplish synergies and back office operations. Like we described, population health, bringing access to the community, physician recruitment. All those investments we do anticipate will bring a positive ROI.

Now we did use the term ROI broadly. It's not strictly a financial return that we're looking at. Yes, we do have to bring the business to financial stability. That's one element of our entire portfolio of strategic pillars that we manage at the health system, but there are other forms of ROI.

Those include improvements in quality. Those include improvements in patient satisfaction. And as we continue to navigate the shift from volume to

value, we'll be measuring those metrics not only from a financial standpoint, but, also, in our program service accomplishments.

MR. MURRAY: Let me ask you about that, if you're the correct person to ask this question to, about that initial investment of $85 million.

Forty-four million of that is targeted to support clinical programs than physician recruitment, is that correct?

MR. TANDLER: All of the details of the $85 million I don't have in front of me, but physician recruitment is a substantial component of it, yes.

MR. MURRAY: Okay and, in fact, at some point, in response to OHCA, the Applicants made a statement that, of the $44 million, half of that $44 million was targeted for physician recruitment. Do you recall that?

MR. TANDLER: I believe it was responsed 30.

MS. FELDMAN: What page?

MR. TANDLER: On page 628.

MS. FELDMAN: I'd like to point out for OHCA that there was another set of completeness questions, as you know, that elaborated and clarified

some of the earlier similar questions, and those are on page 871.

MR. MURRAY: Did you see that answer, where it says launch funding for new position recruits, 50 percent. Others, such as staff augmentation and clinical support, 50 percent, and it was in response to the $44 million?

MR. TANDLER: You're referring to page 628?

MR. MURRAY: 628, in response to question 30.

MR. TANDLER: I do see that, yes.

MR. MURRAY: Okay, so, the Applicant's response said that half of the $44 million is targeted for new position recruit.

My question is a very simple one. Is the money targeted for new physician recruit for actually bringing new physicians to the New London area to work at L & M or the L & M affiliates, or is this targeted for the acquisition of community physician practices?

MS. BORGSTROM: That is to bring new physicians to the Lawrence & Memorial and Westerly communities.

MR. MURRAY: So just so it's clear, so

that money is not to be used for the acquisition of community physician practices?

MS. BORGSTROM: I don't believe that that's ever been the intention of those resources.

MR. MURRAY: Could those resources be allocated, could be earmarked for that, if it needed to?

MS. BORGSTROM: You're asking a hypothetical. I don't know the community. I don't know the needs. I can tell you what the intent was, is that there have been expressions of interest and concern in getting more primary care physicians recruited to the New London and Westerly communities, more support for maternal and child health, and then there are some surgical subspecialties, where the volume and the demand in these communities would not allow an individual hospital to recruit physicians and appropriate on-call and backup.

It wouldn't be economically feasible, and, so, this is to recruit physicians, who can meet those needs in the community that are not being met now. They're new providers.

MR. MURRAY: And the other part of the initial $85 million is $41 million earmarked for the support of, at least the Applicants indicate in its

filings, it's about 13 or 14 potential clinical programs for support. Do you recall that?

MS. BORGSTROM: Yes.

MR. MURRAY: Okay. Is there any guarantee given to L & M about which programs that that money will be spent on, or is that something that's only going to be decided on after the acquisition with a strategic planning process?

MS. BORGSTROM: You know, I'll give you an example of how this will be done, based on what we've actually done in the past with Bridgeport and Greenwich and continue to do to this day, is they are looking to develop more clinical services in those communities, and it's a very fluid process, because it's based on needs, it's based on, in many cases, unanticipated retirements, or the departure of certain physicians, but this is something that's a collaborative process.

There's no way that we at the health system would have the ability to go in and define what's going to be most appropriate and the greatest need in the Lawrence & Memorial and Westerly communities.

That is something that our planning and clinical leaders will do in collaboration with their colleagues in Lawrence & Memorial and Westerly.

MR. MURRAY: And why wasn't, as part of the process of this acquisition, why wasn't that planning process done prior to the actual completion of the acquisition, so that the community could know where those dollars were going to be spent by Yale?

MR. TANDLER: Like Marna just indicated, we did not want to get too far ahead of the process. This is a true collaboration. Many of the ideas have been generated locally.

For us to come in and just run a script or a playbook of all the answers to all the financial and other operational issues would be, in our mind, gun jumping, getting ahead of the process.

MR. MURRAY: Perhaps my question was unclear, and I apologize for that. I wasn't suggesting that you come in and prescribe which clinical programs get the $41 million and which don't.

The question I asked was why didn't the joint collaborative planning take place prior to the application process, so that the community and OHCA would know exactly what clinical programs were going to receive the infusion of cash and which weren't?

MS. BORGSTROM: You know, this is a fluid dynamic process. We're trying to be in this for the long

term. This is not all based on data you can collect right now and come up with the answer. This is going to evolve, as it has over, you know, 18 and 20 years with Greenwich and Bridgeport.

We are committed for the long term to the success of these communities and the success of these organizations, and, you know, frankly, you know, to get in there and begin to engage people in a detailed planning process for right now, when, you know, we've got a lot of things in front of us to get this approval, wouldn't have made sense and could have appeared to be heavy-handed.

This is going to be an iterative process. It's going to take time, but I think that you could talk to the leaders, clinical and otherwise, and the other communities in which our system operates, and they would describe a process that's ongoing, that's collaborative, and that's based on demonstrated need.

MR. TANDLER: I would just add that we are honoring certain regulatory parameters that guide what we can and cannot do.

MR. MURRAY: The regulatory parameters, is that because you were concerned about the competitive nature of the affiliation?

MS. FELDMAN: Can you rephrase the question? I don't know what the question is.

MR. MURRAY: Is one of the parameters that you were concerned about was anti-trust concerns?

MS. FELDMAN: Correct. This is -- I don't think it's fair to ask the witnesses legal questions. They've been advised by counsel throughout the process.

MR. MURRAY: Just I guess one last question, Ms. Borgstrom. You're aware, aren't you, that there's a community health needs assessment going on in New London right now?

MS. BORGSTROM: I'm aware that all of the acute care hospitals perform community health needs assessments.

MR. MURRAY: Okay and is there any reason why the Applicants couldn't have waited for the completion of the community health needs assessment to have a better sense of what the actual needs were within the community before going ahead with the acquisition?

MS. BORGSTROM: I'm a little confused by the question and by the previous questions, because, on one hand, we've been asked why it wasn't all specified and determined, and, on the other hand, to wait.

These community needs assessments are done

regularly. They are updated. They cover a whole lot of things, only a piece of which may be the direct clinical services and human power, clinical planning in these communities, so, you know, I don't think that, you know, I think these are fruits and vegetables.

I think the community health needs assessment is very relevant. It will be very helpful, but it is not and would not be the sole determinant of how investments are made.

MR. MURRAY: We have no other questions of Ms. Borgstrom. We do have questions of Mr. Cummings.

HEARING OFFICER HANSTED: Okay.

MR. MURRAY: Good afternoon, sir.

MR. BRUCE CUMMINGS: Good afternoon.

MR. MURRAY: Mr. Cummings, there's nothing in the application submitted to OHCA or in the agreement between L & M and Yale-New Haven Health System that prevents the elimination, consolidation, moving, or closing of any current medical services at L & M, is there?

MR. CUMMINGS: Well, as you've already pointed out, there's a joint approval process, because the local Board retains fiduciary responsibility, so any major new service, or, the flip side, any termination or

substantial diminution of an existing service would require approval by both Boards, and, for that matter, the Office of Health Care Access has jurisdiction over specific services that would require the Applicant to seek permission.

MR. MURRAY: Okay.

MR. CUMMINGS: So, for example, under regulation, any material change in inpatient psychiatry, for example, requires that there be a filing with an approval by OHCA, so there are governing body responsibilities at both the local and parent level and regulatory oversight.

MR. MURRAY: Okay. I appreciate that. My question was a slightly different one, which was that there's nothing in the agreement or the application that guarantees the current level of services, correct?

MR. CUMMINGS: It's in the bylaws under Exhibit A.

MS. FELDMAN: I think the bylaws are a part of the agreement.

MR. MURRAY: Can you point out where in Exhibit A that is?

MR. CUMMINGS: On page 196, Item I, as in Irene, approval of major new programs and clinical

services of this corporation or any affiliate or discontinuation or consolidation of such program.

MR. MURRAY: That deals with who makes the decisions, correct?

MS. FELDMAN: Can you rephrase your question?

MR. MURRAY: My question was that there's nothing in the application or in the agreement between Yale-New Haven Health Systems and L & M's current Board that guarantees the current level of services.

MS. FELDMAN: I'm going to have to object, because I think we already said that the affiliation agreement is part of the application and that the bylaws are a part of the affiliation agreement, which is also part of the application.

MR. MURRAY: So is that yes or no to my --

HEARING OFFICER HANSTED: No, she's objecting to your question.

MR. MURRAY: Okay.

HEARING OFFICER HANSTED: Do you have a response to that?

MR. MURRAY: I think it's an appropriate question. I want to know whether or not there's -- whether the current level of services are going to be

maintained post-affiliation.

HEARING OFFICER HANSTED: Well your question was whether or not the documents reference the current level of services and guarantee that they will be maintained, and we said earlier in the hearing that the document speaks for itself.

MR. MURRAY: Okay.

HEARING OFFICER HANSTED: So you may want to ask, and I'm not telling you what to ask, but you may want to ask if there's any understanding, besides what's written, pertaining to any guarantee of services continuing in the area.

MR. MURRAY: Other than what's in the application and what's in the affiliation agreement and the bylaws, is there any other agreement between the parties with respect to the current level of services?

MR. CUMMINGS: I'm sorry. I missed part of your question.

MR. MURRAY: Other than the application and the affiliation agreement and the proposed new bylaws for L & M, things that have already been submitted to OHCA, are there any other agreements between Yale-New Haven Health System and Lawrence & Memorial Corporation with respect to the continuation of the current level of

services?

MR. CUMMINGS: Not to my knowledge, but, for that matter, there's nothing today, irrespective of Yale-New Haven or the proposed affiliation, that guarantees the continuation of existing services.

A key reason for doing this affiliation is precisely so we can maintain and even expand services. The absence of this affiliation will put a number of services in jeopardy.

MR. MURRAY: Okay. Following up on your response just now, Mr. Cummings, what services, specifically, are in jeopardy of not being continued if the affiliation doesn't happen?

MR. CUMMINGS: I'm not going to speculate on that. We are projected to lose $22 million this year, and it's fair to say we're having conversations with our Board right now that are very difficult in nature about services throughout the organization, but they're not going to be discussed here.

MR. MURRAY: Okay. In the application, in responses to various completeness questions, one of the advantages of the acquisition, according to the Applicants, is the prevention of out migration of patients to distant, high-cost provides in Massachusetts,

Rhode Island and New York. That's what's claimed in the application.

What are the specific mechanisms that the Applicants believe will keep patients in Connecticut and not go to those distant, high-cost providers?

MS. BORGSTROM: I can take a crack at that question, because, again, I think that if you look at our track record in Bridgeport and in Greenwich, you have to start first by saying we acknowledge that Yale-New Haven Hospital in New Haven is a higher-cost provider than many other providers in the State.

There are a lot of reasons for that, but given that we all need to move to a value equation, where care is better, safer and better coordinated and affordable to people, who are paying for some of that care out of their pockets, to pull that business into New Haven, when it can be provided locally, makes absolutely no economic sense, and it doesn't make sense to the patients and their families in these communities, so what you would find, which is very similar in Greenwich and Bridgeport, is that the depth and level of services offered in those communities has been expanded tremendously, and the practitioners, who have been brought into those communities at their request to

support particularly specialty services, do the vast majority of what they do for those patients at those hospitals in their ambulatory centers, which is more convenient for the patients and more cost-effective.

That is the same approach that we would intend to work with Lawrence & Memorial and Westerly on.

MR. MURRAY: And, in answer to my question, that's the mechanism that the Applicants are going to use to prevent the outmigration to these high-cost providers out of state?

MS. BORGSTROM: It has kept more care in the local communities and we believe will continue to.

MR. MURRAY: Okay. Mr. Cummings, are there any agreements or expectations in your provider agreements with L & M employed physicians or affiliated practices that the doctors will principally or primarily refer patients to Yale-New Haven Health Systems affiliates after the acquisition?

MR. CUMMINGS: There is no such language in any of the agreements, and there is no such restriction or limitation today.

MR. MURRAY: Okay. Why did L & M end its affiliation with Dana-Farber?

MR. CUMMINGS: Well, in many respects, it

really grew out of a fundamental change, that Dana-Farber informed us and other local affiliates throughout New England.

The original Dana-Farber model provided for an extremely high level of integration and coordination with the L & M Cancer Center.

This was a signature of the Dana-Farber model, and one of the elements of that, for example, was that a facility had to be built to Dana-Farber standards. There were particular re-staffing requirements around pharmacy, for example, and lab services to meet the Dana-Farber standard.

A key feature of this model and one of the things that drew us to it is that the oncologists providing services there have access to the Dana-Farber intellectual property. Use of their clinical protocols would be employed by Dana-Farber.

That's something we wanted. That's something they insisted upon. There was a mutuality of interest.

On or about April of last year, Dana-Farber informed us and their other local affiliates that they were fundamentally changing their model, that they would no longer be employing the local oncologist, and

they were going to go to, these are my words, and I don't mean this in any kind of derogatory way, because we had a very good relationship with Farber, but they were going to go to more of a franchise model, far less involvement, far less control, pay a fee, be able to use the Dana-Farber name, have access to their clinical protocols, but they would be moving really much away to an arm's length relationship.

That was very disturbing news to our local medical oncologist, who had wanted the Dana-Farber employment and the Harvard adjunct faculty appointments, and, after consulting with them, they agreed that that was highly problematic.

Fortuitously and independent of the Dana-Farber matter, we had begun conversations with Yale-New Haven in January of that year, and, so, over the course of the summer, when it became apparent that there was going to be a definitive affiliation agreement, we informed Dana-Farber of those conversations, and they agreed that, between the change in their model, and they were going to go in a different direction, and our Board's decision to seek an affiliation with Yale-New Haven, that continuing the relationship did not make sense, and, so, it was mutually agreed that we would take

it down at the end of calendar year.

MR. MURRAY: Now in response to one of the questions posed by OHCA, the Applicants responded, and this is in answer to question 27D on page 624, that if Yale-New Haven Hospital sustained an operating loss, one of the options for fulfilling its financial commitment to L & M under the terms of this application would be an L & M debt offering. Do you recall that response?

MS. FELDMAN: Just a second.

MR. CUMMINGS: I'm not the most knowledgeable person about the intricacies of bond offerings, and, so, I think having one of the financial experts speak to that would be more appropriate.

MR. MURRAY: Okay. I guess my question, and I'm not sure we need expert testimony, my question is that it's true, correct, that one of the, in answer to OHCA's question, about whether or not Yale would be able to meet its financial commitment, one of the answers the Applicants provided was one of the options would be an L & M debt offering, is that correct?

MS. BORGSTROM: An L & M debt offering or funding from existing Yale-New Haven Health System --

MR. MURRAY: I understand. What I'm simply saying is that L & M debt offering is one of the

options that the Applicant said were open to them if there was a shortfall in the funding, correct?

MR. CUMMINGS: It does say that, yes.

MR. MURRAY: Okay, so, my question, isn't it true that, under Exhibit B of the proposed bylaws, that one of the reserve powers to the sole corporate member is the issuance and incurrence of indebtedness on behalf of the L & M Corporation?

MR. CUMMINGS: Yes, that's true.

MR. MURRAY: Okay, so, it's possible, isn't it, that, in order for Yale-New Haven Health System to meet its financial commitment under this application, it could saddle L & M with debt, for which the L & M Board would not have a power to prevent?

MS. BORGSTROM: I have to come back to it's a real hypothetical, and the Yale-New Haven Health System, if we determined, for whatever reason, that a debt issuance was going to allow us to support at a particular time a particular need at Lawrence & Memorial, we could do that through our obligated group at a rate level that would be far superior to what L & M could get independently, but, you know, debt is one of a mix of resources that we pursued to try and support investments that we are making throughout the system.

MR. MURRAY: I understand that. I appreciate it. My question to Mr. Cummings is, given the reserve power to the sole corporate member, it's possible that, if there was an issuance of debt to L & M, the current L & M Board would not be able to prevent that, since that's the reserve power to the sole corporate member?

MR. CUMMINGS: You're asking a highly-speculative question. I can't say with any certainty that one of us won't be struck by a car driving home today.

MR. MURRAY: Well it's not written in your corporate bylaws that you won't be struck by a car. I'm simply saying, under the reserve power to the sole corporate member, if the sole corporate member decided to issue L & M debt, that's a reserved power to them, correct?

MR. CUMMINGS: So you're asking me a hypothetical question. Let me ask you a hypothetical question.

MR. MURRAY: You don't get to ask questions.

HEARING OFFICER HANSTED: No, no, no. Mr. Cummings, stop.

MR. CUMMINGS: Let me ask a question. Let me respond.

HEARING OFFICER HANSTED: No.

MR. CUMMINGS: Why would --

HEARING OFFICER HANSTED: I want you to listen carefully to his question and respond to his question. I understand he's asking a hypothetical, but he needs to ask a hypothetical to get to the ultimate question that he has.

MS. FELDMAN: Yes, and he will answer. I really think he was making a rhetorical statement, rather than asking the attorney the question.

MS. BORGSTROM: Let me ask or state something. I think the reason that we're struggling with this, at least I'm struggling with this, is because it's hard for me to understand what incentive the Yale-New Haven Health System would have to add debt inappropriately to Lawrence & Memorial or any member of the system if we are trying to support a thriving, viable healthcare provider in each of our communities.

So I think, technically, the health system has the authority, the ultimate authority, to approve new debt issuances, but, you know, the inference, that that would be done in a way that would be detrimental to

Lawrence & Memorial, doesn't ring true to me.

MR. MURRAY: I think I'm still waiting for the answer to my question, which is --

HEARING OFFICER HANSTED: Let me ask you this. Assuming Yale decided to take this action, you know, we don't know if they will or they won't, okay? Let's put that aside for the moment. Would L & M have any power to prevent it?

MS. BORGSTROM: Would L & M technically have any power to prevent it? I think that, if they said, you know, we can't make this work within the context of our operating budget and plan, we would tend to agree with them, because we're responsible for the authenticity of their plan, as the sole member of this organization, but we don't take on debt lightly, and, when we've done it in the past, as with a recent ambulatory project with Bridgeport Hospital, the decision was a collaborative one and actually initiated by the Bridgeport Hospital Board and subsequently endorsed by the Yale-New Haven Health System Board.

HEARING OFFICER HANSTED: Does that satisfy you, Attorney Murray?

MR. MURRAY: Well Ms. Borgstrom talked about what might happen. I'm simply asking what the

language provides for, and I just want to clarify. Let me ask my question.

HEARING OFFICER HANSTED: Well, to be fair to Ms. Borgstrom, she was answering my question.

MR. MURRAY: Yeah, I'm sorry. She was answering your question.

HEARING OFFICER HANSTED: I didn't directly ask her about the documents.

MR. MURRAY: All I'm asking you, Mr. Cummings, is that it's true, isn't it, that, under Exhibit B, the incurrence of debt to L & M is a reserve power of the sole corporate member?

MR. CUMMINGS: Yes, as is true with any governance model.

MR. MURRAY: Okay, well, the governance model now is that the L & M Board of Trustees, if it wanted to encumber itself with debt, would make that decision, correct?

MR. CUMMINGS: Yes.

MR. MURRAY: Okay, so, my question simply is, post-acquisition, based on Exhibit B, the decision to saddle L & M Corporation with debt is a reserved power to the sole member, correct?

MR. CUMMINGS: L & M Healthcare in this

model has a seat on the Yale-New Haven Health Services Board. It's inconceivable to me that the L & M Board would be asked, or, for that matter, the Yale-New Haven Board, asked to operate or make decisions that are inimical to the investments that are guaranteed in that $85 million. Why would any organization do that?

MS. FELDMAN: I'm going to have to object to the continuing line of questions. At this point, I think we're trying to get a sound bite. I think that the attorney for the Intervenors is trying to have Mr. Cummings say, yes, it's true, but that is an answer in a vacuum. It's completely, again, irrelevant to how hospitals work, how healthcare systems work, and it's going on and on. For what purpose, I do not understand.

I mean we said earlier that the bylaws speak for themselves, and I don't see the point of badgering the witnesses.

MR. MURRAY: Asking questions is not badgering, but I'm not going to take umbrage with it. I will simply move on. I just have one last question for Mr. Cummings.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: Mr. Cummings, you currently serve as the President and CEO of the L & M Corporation,

correct?

MR. CUMMINGS: That's correct.

MR. MURRAY: Okay and as the President and CEO, you were selected to serve at the pleasure of the L & M Board of Trustees, correct?

MR. CUMMINGS: Yes, that's correct.

MR. MURRAY: Okay. Following the acquisition, based on the post-acquisition bylaws filed by the L & M Corporation, the President and CEO of L & M serves at the pleasure of the corporate member, correct?

MR. CUMMINGS: That's correct.

MR. MURRAY: I have no other questions for Mr. Cummings.

HEARING OFFICER HANSTED: Do you have any further Cross-Examination?

MR. MURRAY: Could you just give me one second?

HEARING OFFICER HANSTED: Sure. Attorney Feldman, do you have any Redirect?

MS. FELDMAN: I do. I do.

HEARING OFFICER HANSTED: Just wait one moment for Attorney Murray.

MS. FELDMAN: Okay.

MR. MURRAY: I'm sorry.

HEARING OFFICER HANSTED: Attorney Feldman?

MS. FELDMAN: Sure.

HEARING OFFICER HANSTED: You may proceed.

MS. FELDMAN: Thank you very much. Ms. Borgstrom, several individuals have provided testimony referring to the proposed application as a, quote, "takeover," or have implied that L & M would lose all control over governance if the proposal is approved.

How do you react to these descriptions? How would you describe the proposal from the standpoint of local control and governance? And I'm not talking about getting into the specifics of the bylaws, but just conceptually.

MS. BORGSTROM: So this is an affiliation. It is a sole member substitution. Our practice, our history, our approach is very collaborative. We are one of -- I serve on a couple of national organizations. We are one of the few that I know of that has preserved local governance.

We respect the members of the Lawrence & Memorial Board, as we do the Bridgeport and Greenwich Boards. We have limited participation on their Boards. They participate on the Health System Board.

What we have tried to do is work on behalf of a healthier system and healthier communities, respecting the role and the knowledge that local individual Board members have about the communities they represent.

MS. FELDMAN: Does the composition of the L & M Board remain the same, other than the addition of a representative from Yale-New Haven Health System?

MS. BORGSTROM: Yes.

MS. FELDMAN: Based upon your knowledge of corporate governance at other national healthcare systems and other systems within the State, is it your opinion that the amount of control that L & M would continue to have be unusual?

MS. BORGSTROM: Yes. It is not the typical practice, and, you know, I will tell you that it adds a little more to a number of people's workloads to have these local fiduciary Boards, but I think the benefits outweigh the additional work and time commitments.

MS. FELDMAN: And how does it differ from other systems, such as Windham, which has been repeatedly referenced throughout this proceeding, in particular, as it relates to decisions to terminate services?

MS. BORGSTROM: You know, I can't comment, specifically, on how Hartford HealthCare works, and we've spent a lot of time going through Exhibits A and B to the restated Lawrence & Memorial bylaws, but the opportunity, the decision to close or significantly change a service in either the New London or Westerly areas would have to be done in collaboration with the local Board.

It is not a unilateral authority that we have sought or that we think would serve the health system in the communities well.

MS. FELDMAN: Thank you. Now we've heard public testimony that questioned what's in it for Yale-New Haven Health. Can you please answer that question?

MS. BORGSTROM: You know, I think Mr. Cummings spoke to the fact that we've had a longstanding relationship on a number of levels, and I think you have to look at where healthcare, in general, is going.

There is no question that healthcare is too expensive right now. It is very much a sick care system, rather than focused on health and healthier communities. I don't think that there's any one reason for that.

I think that the current healthcare system we have has evolved over a long period of time, with a

number of inputs, and, frankly, the way we've paid for healthcare has not supported the concept of value, but I think that's where we all believe, as healthcare leaders and as citizens of our own communities, it needs to go, so the value to Lawrence & Memorial and I think the Yale-New Haven Health System is quite mutual, because it will allow us to scale infrastructure to support population health investments, to rationalize key services to make care better and safer.

The investment in extending the Epic system there will allow us to avoid unnecessary duplication of services.

I know that, in some of the questions, duplication was seen, as well. We don't want, you know, the same service in New Haven or Old Saybrook as is in Lawrence & Memorial. That was not the issue.

What we have found in integrating information technology is that providers can act better on more reliable patient information and avoid laboratory testing, imaging services, things that both add cost and can delay the treatment of patients.

So, you know, I think that, you know, there are tremendous benefits to both organizations.

MS. FELDMAN: With respect to value-based

contracting, which you made clear is here and is real, how will having L & M within your system benefit those types of contracting arrangements?

MS. BORGSTROM: You know, I would say value-based contracting is not here, particularly. It's an aspiration that I think the commercial insurance companies have.

I think Medicare is dabbling with it, and there's certainly been discussion of this at the State, but, you know, to say that it's become prevalent as a payment mechanism I think is premature, but I think that what we have to do is get ready for that, and no one organization can make both the corporate infrastructure investments and the kinds of financial and information system services that are going to be necessary to support value-based purchasing, and I think, you know, frankly, you know, the clinical care can be enhanced, and, you know, we don't have to rediscover the wheel in each community.

What is an evidence-based best practice in one community can more efficiently be scaled over all of the Yale-New Haven Health System associated providers.

MS. FELDMAN: So it might be more cost-effective, let's say, to have a patient receive their

care at L & M Hospital than perhaps Yale-New Haven Hospital?

MS. BORGSTROM: It clearly may be, but Yale-New Haven Hospital provides services that are not available in many other hospitals, not only in Connecticut, but in the region, and that remains a resource and a backup.

MS. FELDMAN: Can you explain to me why the costs are higher at Yale-New Haven Hospital than let's say L & M Hospital or other hospitals within the system?

MS. BORGSTROM: Well now you're into one of my favorite discussions, which I won't belabor, but I think we use cost and pricing very differently, or we use them in the same way, but they mean very different things.

If you look at what it truly costs to provide care at a place like Yale-New Haven Hospital, there are a lot of reasons for that.

Yale-New Hospital is a level one trauma service that requires that you have a number of 24-by-7, 365-day services available all the time.

If you are mowing your lawn and cut off a digit, Yale-New Haven Hospital is the only place that

you're going to find that has on-site people 24-by-7, who are going to provide that care, and I could go on and on with the clinical services.

That costs money, because they aren't used every hour of every day 365 days a year. We have 1,300 post-graduate trainees at Yale-New Haven Hospital. That is a huge program. According to the AAMC and other sources, we're one of 40 providers nationally, who are training about 50 percent of the nation's medical person power, and then, if you add technologists and PAs and nurses, a huge amount of training.

While it provides a certain amount of human person power, it also is costly, because these people are being educated, so there are a lot of things at Yale-New Haven Hospital that are going to make an organization like that more expensive, and, you know, and I think that's a reality.

The price in question, why it costs people more, I think you have to look at case mix. Yale-New Haven Hospital alone and Yale-New Haven and Bridgeport together in our health system are the largest providers of care to patients, who are medically-indigent and particularly insured by the State of Connecticut.

We are paid, on average, 30 cents on the

dollar of cost for nearly one-quarter of our patients. That doesn't even cover our variable costs, so when we are building pricing, we are in pricing negotiations with third party payers, which, by the way, is about a third of our business, two-thirds of it is governmental payers, they don't negotiate with us, it's very clear they know and we know that part of it is the cost, maybe the cost of a place like Yale-New Haven Hospital, but a big part of it is the underpayment for the significant services that we are providing.

MS. FELDMAN: So, in Mr. Hyde's rebuttal to Dr. Noether on page two, I think it was dated July 6, 2016, Mr. Hyde says that information from the Department of Social Services will shortly be made available to a task force, studying Certificate of Need in Connecticut.

This information will directly impact one question, namely, to what extent does the State of Connecticut pay Medicaid rates, which reflect monopoly pricing by Yale-New Haven Health?

I believe you just stated that -- well let me backup and ask you does Yale-New Haven Hospital, by way of example, negotiate with the Department of Social Services its Medicaid rates?

MS. BORGSTROM: No.

MS. FELDMAN: And what percentage of your payer mix is actually Medicaid?

MS. BORGSTROM: It's about 22 percent, I believe.

MS. FELDMAN: And for every dollar of expense that you incur, can you tell me what you receive approximately from the Medicaid program?

MS. BORGSTROM: I'm not sure I understand the question.

MS. FELDMAN: So if you spent a dollar in providing services to a patient, what is your reimbursement from Medicaid?

MS. BORGSTROM: Thirty cents. Thirty cents.

MS. FELDMAN: I have no more questions for Ms. Borgstrom.

HEARING OFFICER HANSTED: Okay, thank you.

MS. FELDMAN: I do have one question for Mr. Cummings.

HEARING OFFICER HANSTED: Go ahead.

MS. FELDMAN: Okay, thank you. Mr. Cummings, there has been some testimony, wherein there has been some questioning regarding how it was determined what the specific needs were of L & M and what type of

resource commitment Yale-New Haven Health was making.

Can you tell me a little bit about the process that you engaged in to determine what your actual resource commitment needs were?

MR. CUMMINGS: Yes. The senior team at L & M sat down over a period of days and were assisted by an independent outside consulting firm, Chartis. Chartis is a firm that works around the United States, has independent advisors to hospital Boards that are contemplating mergers, affiliations, or acquisitions.

Together, we mapped out, we took stock of what we projected to be our capital needs over a five-year period, and those totaled almost somewhere between $325 million and $400 million, and those, broadly speaking, those categories included the need to create the wherewithal to engage in population health.

That includes the development of a data warehouse, various predictive and analytical tools, none of which we had available. We estimated that was somewhere between $5 and $10 million to expand ambulatory services, particularly primary care services in the community that we serve that range from Old Lyme to the west to Westerly in the east, about $75 million for additional capacity to provide ambulatory care services.

We also estimated we'd need about between $30 and $40 million to replace our McKesson IT system and to migrate to Epic. We estimated between $35 and $45 million would be needed for routine replacement of lab imaging and pharmacy technology, and then somewhere between $180 million and $230 million to update our inpatient units, to upgrade our cardiac cath labs, to create additional procedural space, because more and more care is now being provided on an outpatient rather than an inpatient basis, including, specifically, to come up with more appropriate space for behavioral health services.

So when we added up all those buckets, it was somewhere between $325 and $400 million. We presented that finding to the Yale-New Haven Health System staff, and, in relatively short order, we agreed upon the $300 million commitment over five years that you've heard referenced throughout the hearing.

MS. FELDMAN: No further questions.

HEARING OFFICER HANSTED: Okay. Do you have any further Direct at all?

MS. FELDMAN: None.

HEARING OFFICER HANSTED: Okay. Attorney Murray, do you have any?

MR. MURRAY: Just a follow-up question for Ms. Borgstrom. Ms. Borgstrom, you indicated, in answer to counsel's question, about the mix of patients at Yale-New Haven Hospital, the percent that are government payers, and government payers would include both Medicaid and Medicare?

MS. BORGSTROM: Um-hum.

MR. MURRAY: Okay and --

MS. FELDMAN: I just want to clarify. I believe her answer was in response to the percentage of Medicaid patients, not all governmental payers.

MR. MURRAY: Okay, well, she agreed with me, so I don't know.

MS. FELDMAN: I thought you said governmental payers, and that includes -- governmental payers would include Medicare.

MR. MURRAY: Yeah, that's what I just said, Medicare and Medicaid.

MS. FELDMAN: Oh, I'm sorry, then.

MR. MURRAY: Yeah. I thought we understood each other.

MS. FELDMAN: Okay.

MR. MURRAY: And it's true, isn't it, when you talked about value-based contracting, it's true,

isn't it, that Yale-New Haven Hospital and Yale Medical Group have just submitted a proposal to DSS for value-based procedures for Medicaid patients in the State of Connecticut?

MS. BORGSTROM: I will embarrass myself, but I don't know that we've submitted a proposal. We have had discussions with DSS about using consulting support that we've engaged to understand how other states are looking at that, but we haven't made a proposal.

MR. MURRAY: Okay, so, as far as you know, there's no proposal?

MS. BORGSTROM: Not that I'm aware of.

MR. MURRAY: Okay. I have no other questions.

HEARING OFFICER HANSTED: Okay. Do you have any further Cross-Examination, Attorney Murray?

MR. MURRAY: No, I don't.

HEARING OFFICER HANSTED: No, okay. At this point, we will take a break. Please be back here by 5:10, so we can get started with the rest of the hearing. Thank you.

(Off the record)

HEARING OFFICER HANSTED: Okay, we're back on the record. Attorney Murray, you stated you were

completed with your Cross-Examination completely, correct?

MR. MURRAY: Yes, I am.

HEARING OFFICER HANSTED: Okay. We are going to move on to the next application involving this hearing, and that is Docket No. 15-32032-CON. Attorney Feldman, if you'd like to begin?

MS. FELDMAN: We're going to start with some testimony from Dr. Lehrach.

DR. CHRISTOPHER LEHRACH: Good evening, Attorney Hansted. Can you hear me?

HEARING OFFICER HANSTED: Yes, I can.

DR. LEHRACH: And to the rest of the OHCA staff?

HEARING OFFICER HANSTED: Can everyone hear him in the back? I think your mike is off.

DR. LEHRACH: How about that?

HEARING OFFICER HANSTED: No.

DR. LEHRACH: How about that?

HEARING OFFICER HANSTED: That's better.

DR. LEHRACH: So good evening.

HEARING OFFICER HANSTED: Good evening.

DR. LEHRACH: My name is Dr. Christopher Lehrach. I'm a clinically-active, Board-certified family

physician. I'm also a Connecticut native, with advanced degrees in business and medicine from Yale and the University of Connecticut.

Currently, I serve as the President of the Lawrence & Memorial Medical Group, and I have over 20 years of experience in medicine and medical practice management. I adopt my pre-filed testimony as my own.

My primary goal is ensuring access to quality-coordinated and cost-effective care close to home. Our goals are your goals. Everyone in this room has the same goal, quite frankly, but, right now, as we stand here in 2016, those goals are threatened, and they're threatened for three main reasons, as it relates to the Lawrence & Memorial Medical Group, and this boils down to issues of scale.

Number one, the L & M Medical Group has historically and continues to have tremendous difficulties around recruiting and retaining physicians and non-physician providers, and that extends to both specialists and primary care.

That has a lot to do with the fact that our service area is relatively small. Our lack of academic affiliation and our goal in considering a full merger with the Northeast Medical Group is to bring in

new physicians and to bring new non-physician providers to our local service area to provide care close to home.

Number two, our ability to be successful in an accountable care or risk-based environment is unlikely, without merging with a larger organization, and, again, that has to do with scale.

The number of patients that we serve, the sheer demographics of the area, what the insurance companies would call covered lives, are not here.

We also need to invest heavily and to gain expertise in data analytics and data warehousing. We need to gain expertise in care management tools and predictive analytics, and, as I said, we need to scale to manage risk.

As anyone in the insurance industry would tell you, without scale, you can't effectively manage risk.

And, lastly, given our small size, the fixed overhead associated with our small size, we cannot be cost-effective with the various back office functions that we engage in. These include revenue cycle, scheduling, purchasing, communications and others.

So how does a merger with the Northeast Medical Group help us? Well just like everyone else in

this room, I'm very concerned about access to care. You cannot underestimate the power of the Yale brand. The Yale brand will help us expand and enhance access to new physicians and non-physician providers in the L & M community, and this concept, which has primacy, is in contradistinction to what Mr. Hyde argues in his pre-filed testimony, where care will leave our community. We aim to do just the opposite.

Secondly, as it relates to access to subspecialists, we have an insufficient patient base to support a full-service line of various subspecialties. It becomes very difficult to offer such specialty care when you only have enough need for one physician or half a physician.

By merging completely with the Northeast Medical Group and affiliating with Yale-New Haven Healthcare, we can more appropriately match capacity to demand. The academic and research interests of our Applicants will also be met by the affiliation.

And very important to me and close to home is primary care. Many of our local providers have stopped accepting Medicaid, as you know, given the poor reimbursement that's been documented recently.

This is critically-important for our

community, that we can continue to offer access to Medicaid. Only through a merger with the Northeast Medical Group can we continue to execute on our mission of improving the health of this region for all individuals, regardless of their ability to pay.

Just like everyone else in this room, I'm very concerned about the value that we offer to our patients. We have been doggedly focused on cost and being efficient, so that we can reduce the total cost of care, and we will continue to make this our chief focus. We want to offer care in the lowest cost, highest quality setting.

So why NEMG? Why a merger? Well they have expertise in various functions that will help us reduce the total cost of care. This includes care coordination, so that we can reduce redundant care. They have various clinical pathways and evidence-based protocols.

They have operational efficiencies, process innovation, and experience with so-called lean technologies, which will help our operational efficiencies, and, as I've previously stated, we seek their scale to help us with our back office synergies.

Just like everyone else in this room, we

are interested in being successful around participating in Accountable Care Organizations and taking on risk in our new world of population health.

Right now, the likelihood of us being successful alone is limited. Having a single electronic health record in the form of Epic will get us partly there, but, as I previously stated, we need the expertise of the data analytics, the predictive analytics, the data warehousing, the clinical decision support tools, the patient engagement tools, the care coordination tools, the telehealth tools, the homecare tools, all the things that we can't possibly develop on our own, given our small size.

All of this is designed, so that we can intervene with our patients to keep them less sick. We want to improve lives. We want to keep patients out of the expensive emergency department. We want to keep patients from being readmitted to our hospital, and we need to be successful in population health for the benefit of our patients.

Just like everyone else in this room, I'm troubled by the costs associated with our medical group and the financial losses that they incur on our L & M healthcare system.

Now while this is largely an accounting issue, given the fact that all of the work their physicians do, the downstream revenue from that is attributed to the hospital, leading to hospital margins, while the medical group has a negative margin, we can do better if we have scale.

To some degree, this is going to become necessary, so that we can ensure continued Medicaid access.

Lastly, I want to make a point about a statement that Mr. Hyde made in his pre-filed testimony. Unfortunately, he made the odious comment, by stating that physicians under an employment arrangement have been, quote, "bought off," unquote.

As an employed physician for over 20 years, I find this very offensive. Clearly, Mr. Hyde has never directly managed physicians. Had he, he would know that they are amongst the most intelligent, independent-thinking and autonomous professionals with whom you can deal.

They are strident advocates for their patients, and that is where their value stems from. We want to encourage autonomy. We want to encourage their patient-centered focus, and we will continue to do that

under a model, where we work with NEMG.

Just like everyone else in this room, I'm concerned about a loss of local control. Our governance structure with the Lawrence & Memorial Medical Group addresses this issue.

Members of our Board will sit on the NEMG Board. We will have a local Physician Operating Committee that advises the Board, as we have now.

NEMG and Yale-New Haven Healthcare has made it crystal clear over the last 18 months that they understand that all medicine is local.

So just like everyone else in this room, I appreciate the work that OHCA does. By design, this is a very thoughtful, contemplative, yet somewhat tedious exercise, so that the needs of our patients are served.

Our challenges are related to scale. The Northeast Medical Group merger allows us to improve access to primary care and specialty care, to decrease the total cost of care, to participate and succeed in Accountable Care Organizations, where we take on risk, and to maintain local control for our patients.

And one final point that I would make is that the Governor's Executive Order does not specifically address the NEMG LMMG merger. It is outside of the

Certificate of Need presently under discussion.

For the aforementioned reasons, I would strongly urge you to approve the application, as submitted. Thank you very much.

MS. FELDMAN: Dr. Varkey will now provide some testimony.

DR. PRATHIBHA VARKEY: Good evening, Attorney Hansted and OHCA staff. My name is Prathibha Varkey. I'm a Board Certified Internal Medicine and Preventive Medicine physician and the newly-appointed Chief Executive Officer of the Northeast Medical Group. I would like to adopt my pre-filed testimony as my own.

I do appreciate the opportunity to speak about the CON application before you for the L & M Physician Association to merge into the Northeast Medical Group.

Given my short tenure at NEMG, Mr. Christopher O'Connor, who is the Chief Operating Officer of Yale-New Haven Health, was also presented a -- will also be available to answer questions.

Dr. Lehrach outlined specific reasons why LMP desires this affiliation. I would like to focus my testimony on what I consider are key community issues related to, A, access, and, B, population health and

quality of care that the overall affiliation will assist it.

I'd like to first address the topic of access. New London and its surrounding towns have a significant problem in access. In fact, the proportion of emergency room visits per community member in New London is, for example, higher than anywhere in the nation.

Because of a variety of factors, including low reimbursement for patients with government insurances and the administrative burden related to healthcare reform, more and more providers nationally are moving to be part of large medical groups.

In fact, a recent national survey from about three weeks back pointed that about 26 percent of providers in independent practices nationally moved to large medical groups for the very same reasons.

It has also become increasingly difficult for small medical groups to hire providers. In fact, recent surveys have suggested that most new graduates want to work with large health systems.

LMP's affiliation with the Yale-New Haven Health System will certainly increase the capability of the L & M physician associates to hire more providers to

the community, because of our reach to a larger pool of candidates and because of our affiliation to a larger academic health system.

Our physicians in the Northeast Medical Group live and work in the same communities that our patients live and work in, and we take great pride in providing high-quality care to our patients.

In fact, this is the very mission and reason behind the creation of the Northeast Medical Group six years back to provide high-value healthcare and access to the communities we serve.

Being community providers, we at NEMG have a strong mission also to provide care from a population health perspective, which is also very important to us, and we have been actively working on the same for several years.

In 2015, NEMG was selected as one of 89 new Medicare shared savings programs, Accountable Care Organizations nationally to provide Medicare beneficiaries with access to high quality coordinated care.

In fact, to be an ACO, one needs access to at least 5,000 covered lives and integrated electronic medical record, a significant infrastructure of care

coordinators that follow patients from hospital discharges that manage chronic diseases, data analytics and financial resources to support the same, most of which typically cannot be met by small physician organizations, such as LMP, as Dr. Lehrach alluded to.

Once the affiliation with NEMG occurs, however, LMP physicians will be able to participate in the NEMG Medicare ACO and avail of our population health capabilities.

Additionally, shared clinical and utilization data across locations allows for greater clinical integration, information sharing between physicians, and physician collaboration while minimizing wasteful duplicative utilization of scarce resources.

Our physicians at the Northeast Medical Group currently receive regular dashboards, sorry, dashboard reports regarding their adherence to a number of quality indicators, such as screenings, preventive care, medications, as well as the frequency of the emergency room visits of their patients, allowing for a discussion and analysis and improvement between and among providers, all of which are critical to work towards cost effective care.

In affiliating with the Northeast Medical

Group, LMP physicians will also gain access to much needed expert clinical pathways and protocols to provide evidence-based practice information to guide physicians in selecting the most appropriate evidence-based tests and clinical interventions for the patients.

The LMP physicians, in addition, will also have access to our lean quality improvement methodology tools, leadership development opportunities, and patient experienced training. Again, none of these currently exist at LMP.

The affiliation will also help LMP to be better positioned to respond to MACRA, which is a sweeping overhaul of the Medicare physician payment model that significantly will influence Medicare physician reimbursements to shift towards value-based metrics by 2018.

Finally, I would like to briefly address some of the points made by Dr. Hyde in his pre-filed testimony. Like Dr. Lehrach, I find it offensive and inflammatory that he suggests that our physicians have been paid off, and, so, no longer care about our patients, or about the financial challenges that our patients face.

I've run large system affiliated medical

practices in states across the country, including Texas and Minnesota, and, like the physicians in the Northeast Medical Groups, the physicians in these practices care deeply about their patients.

In fact, most physicians have joined medical foundations like Northeast Medical Group, because they care, and because they're looking for the best and most efficient way to deliver high-quality, high-value healthcare services to a diverse set of populations.

In fact, at the Northeast Medical Group I'm pleased to report that our outpatient satisfaction scores are higher than national outpatient satisfaction scores.

This is something we take very seriously, and our Chief Patient Experience Officer spends considerable time coaching and evaluating our providers on patient-centered care, which is very important to us.

In summary, to address the critical needs of access for patients to community providers and to optimize efficiency by providing the infrastructure resources necessary to take care of population health, I believe it is critical and time sensitive to approve this affiliation.

I thank you for your time and attention

and do urge you to consider and approve this CON application.

HEARING OFFICER HANSTED: Thank you, Doctor.

MS. FELDMAN: Mr. Cummings would like to provide some testimony.

MR. CUMMINGS: Thank you, Joan, and good evening, Attorney Hansted and OHCA staff. My name is Bruce Cummings. I'm the President and CEO of L & M Healthcare, which includes Lawrence & Memorial Hospital, the Westerly Hospital, the Visiting Nurse Association of Southeastern Connecticut, and, for purposes of the application now before you, the L & M Physician Association, doing business as the L & M Medical Group.

I hereby adopt my pre-filed testimony in connection with the proposed merger of the medical groups as my own.

I thought I would just step back briefly to describe the genesis of the L & M Physician Association, a non-profit affiliate of L & M Hospital.

This entity was established roughly six years ago, because of the problem of access in our community and the difficulty of recruiting physicians into a private practice model.

And, as you've heard from Dr. Lehrach, increasingly in our community by the practitioners of all stripes have stopped seeing Medicaid patients, and, increasingly, they're no longer accepting new Medicare patients, as well.

So against this backdrop, the L & M Physician Association was created to recruit new physicians and non-physician providers to the community. At no point have we ever purchased a physician practice.

Some physicians previously in private practice, for reasons that you've heard from my colleagues here, decided they could no longer afford to stay in business as a private practitioner and asked to be employed. Their practice was not purchased.

We also recruited additional new physicians to the community, but, as you've heard from Dr. Lehrach, even with the advent of the medical group, we've reached a turning point, where simply it's good, but it's not good enough to meet the requirements of the new environment in which we are operating.

And, particularly, I think, in the Southeastern Connecticut, an additional challenge, in addition to a high percentage of Medicaid patients, we also see a lot of TRICARE patients, because of the

submarine base and active military personnel located in this area and military retirees, so between the hospital and the medical group, this is the two entities really collaborate to provide access into the community.

So you've heard our case, as to why L & M Healthcare should affiliate with Yale-New Haven, and it's an affiliation, not a merger. By contrast, the medical groups is a true merger, in order to provide the scale required to recruit the next generation of physicians to our community and to promote access here.

And just a reminder, that one of the reasons why it is a merger and not an affiliation, it's a State law that specifically stipulates that there can only be one medical foundation within a given healthcare system.

We understand people in the community are worried about the fate of their local hospital and their local medical group and what will happen to prices for the future of healthcare in the future.

We share those concerns, as the future of healthcare is very uncertain and change can be frightening, but one thing is certain. Without bold changes, without finding a partner, one for the medical group and one for the balance of L & M Healthcare, our

local healthcare system will continue to deteriorate, and both access and efficiency will suffer.

Just a reminder, we received approval from the Federal Trade Commission, which is due to expire by September 8th. Thus, if this affiliation of L & M Healthcare and Yale-New Haven is not completed by September 8th, then we will need to engage in a costly and lengthy regulatory review process with the FTC again, which only further delays the needs. I will stop there. Thank you.

HEARING OFFICER HANSTED: Thank you.

MS. FELDMAN: That's all the testimony we have.

HEARING OFFICER HANSTED: Attorney Murray, do you have any presentation on this application?

MR. MURRAY: Yes, we do. We have two individuals. We'll first call on Dr. Fred Hyde, and then he'll be followed by Dr. Ellen Andrews.

DR. HYDE: Mr. Hansted, members of the staff, ladies and gentlemen, I'm going to adopt my pre-filed testimony, to the extent it's pertinent to this application, and spend as few minutes as possible, given the hour, on my testimony, but would like to preface my testimony with a description of what I've seen, so that

you will perhaps understand whatever merits or demerits my testimony might have.

I mentioned in the first hearing that I had been the first Director of the Faculty Practice Plan at Yale. I was chosen for that job by the Department Chairman at Yale, and, while having nothing but respect for their professional activities, it was the beginning of my education in the financial relationships between doctors and hospitals and doctors and doctors.

Subsequently, I spent time working with a network of hospitals in Connecticut, who were attempting to get their doctors signed up for a preferred provider organization with Blue Cross, and we were successful in creating the only such enterprise then or since, signing up 1,200 new physicians, the largest number since the merger of Blue Cross and Blue Shield in 1959 in Connecticut, all about who gets paid what for doing what.

When the Connecticut State Medical Society organized a physician-owned HMO, called MD Health Plan, I was their person to arrange the strategy for compensation, how to figure out how the doctors were going to pay themselves, because we had men and women in the Northeastern part of the state, who were not too many years from taking produce, and we had the Gold Coast,

where they had a very elevated sense of the worth of their professional services, all about the business aspect. Nothing about professional. All about the business.

Since that time, I've run a surgery center owned by physicians, 50 credentialed surgeons, and have testified in more than 50 cases as an expert on hospital/physician financial relationships. Who pays who what and with what consequence?

So it's not economics. It's real life. It's not disrespectful of doctors. It's respectful of your job, which is to figure out how the public is going to get its money's worth out of any transaction involving large physician groups.

Let me begin by stating that I can see the problem. If you look at the financial statements for September 30, 2015 from the Lawrence & Memorial Corporation and look at the supplementary material, which has the revenues and expenses associated with different divisions, you can quickly see the problem, also.

The 73 physicians have net revenue of less than $30 million, and they have a deficit of $21 million, so we're not going to have these physicians survive very long losing as much money as they bring in, nor is the

Lawrence & Memorial Corporation going to be happy about that. I think it's not anybody's fault. It's what's happened. What has happened?

Beginning in 1989, physicians found their compensation regulated. The new resource-based relative value scale became the basis for the CPT-based reimbursement, which led physicians into the first wave of, if you will, associating themselves financially with hospitals.

We had physician hospital organizations, we had physician practice management plans, actually begun by a Connecticut resident, Mr. Abe Gosman. We had a lot of scurrying in the early 1990s to try to find safe harbors, because it was perfectly clear that standardization of physician compensation was going to lead to limitation. It already severely compromised primary care physicians right out of the bat, right out of the shoot.

The solution became a little more apparent once hospitals under the outpatient perspective reimbursement system that began in 1997, which limited, just like DRGs did for the inpatient, limited outpatient reimbursement. How were both physicians and hospitals going to survive?

Beginning in the year 2000, we had, through Medicare, something called a site of service differential. This is familiar to people, who are going to a doctor, and, suddenly, the doctor is part of a hospital-based system, and they get two bills; one bill for the professional services, one bill to help keep the hospital open.

It's taken us 15 years to get rid of this site of service differential. It is going away with rules being set now for execution January 1, 2017, which may help explain some of the haste behind this application. Some things have to be done, in order to be reimbursable under the historical site of service differential rules, and, if they are not done, based on commitments entered into prior to that time or implemented at that time, they may not be reimbursable at the higher, that is dual reimbursement rate, which the general accounting office in one of the publications we've provided to you estimates for office visits at about $50 an office visit.

We know that there are some studies that have been done, and I'm going to just draw your attention to two or three of them. I realize we've given you a big bibliography. There won't be any quiz at the end, but

two or three of these articles may help.

The GAO study, which we gave you December 2015, about hospital/physician consolidation, both the vertical, if you will, and the horizontal, highlighting the need for payment reform, we gave you an article, which was Pritchett(phonetic), from 2010 from Health Affairs about unchecked provider clout in California, leading to higher than necessary payments, and we now have, six years later, an article by Melnick in the Journal of Health Care Organization Provision and Financing in April of this year, which we also gave you, that basically says because they had before and after numbers. You don't have them, and we don't have them. Nobody apparently has them.

They studied California Hospital and physician utilization and found about $4,000 per discharge for the hospitals that had gotten bigger. They found increased utilization and higher prices for the doctors, who had been brought along for the ride.

There are other articles, again, quite recent. We have the Baker Physician Practice prices paid by private insurers for office visits. We have the Association of Financial Integration between physicians and hospitals with commercial healthcare prices higher

than necessary. We even have total expenditures for patient in hospital-owned versus physician-owned organizations, and, as Dr. Smith testified, even the new Accountable Care Organizations have shown that the independent physician directed Accountable Care Organizations were the only ones to show any efficiencies.

Now why is that? I can tell you why it is. If I walked into a surgeon's lounge and confronted the orthopods with the idea they shouldn't be paying $7,000 for an elbow titanium, because Medicare was paying me $5,000, they'd laugh me out of the room and, by the way, did.

I can tell you, having been Chief Executive of some physician practices, as well as the surgery center, when the doctors confront one other about why we're paying $6,000 for a titanium elbow, it's a different conversation.

Dr. Smith testified that, for better or worse, productivity somehow gets compromised when these large organizations become even larger. Mr. Gosman from Connecticut was famously quoted, front page of Business Week at the time, why he was getting out of this field. He said I found, when I hired doctors, I got low

handicappers.

What he meant was that the doctors focus on actually getting paid for what you do, which is very tricky, somewhat disappeared.

The expenses somewhat increased. If it's the trash being picked up three times a week instead of twice, what do you care, because you're not paying for it?

The entire nature of the organization changed once there was the bureaucratization, the levels of opacity, the loss of accountability to the patient. The patient may have an unpaid bill. Not my fault. I don't have any influence over the accounts receivable management, even though that I know has a reputation for abusive billing.

So, in summary, this application, unlike the other, should not at a minimum be deferred. We know the fault of the other application, which is you don't have, nobody has, apparently, numbers on which they can agree that show the progress before and after of the acquisition of community hospitals.

We do know that a big part of the prosperity of the price leader in this field is the capacity to charge academic medical center rates for

community hospital services. Neither here, nor there.

This application is a very different, a horse of a very different color. It is such a bad idea, based on such literature as we have and common sense. I'm testifying in front of you, hopefully, as an expert on the financial relationships between doctors and hospitals, but you don't need that expertise. You know what will happen when we have these large organizations of doctors, who are able to command prices that are consistent with their financial aspirations, whether or not that fits community needs.

I'm sorry if candid talk about money is offensive, especially the younger practitioners. Nothing I can do about that, but I think we all owe each other a straight look in the eye about what the financial consequences are of allowing this merger to take place.

Once it's done, you will have insurance companies that must have these doctors, and it will be very, very difficult to undo. Thank you.

MR. MURRAY: Dr. Andrews?

DR. ELLEN ANDREWS: Thank you. I'd like to adopt my pre-filed testimony, as it relates to this application.

I'd like to, just in a few minutes, talk

about the Medicaid, what's been suggested about Medicaid underpayments and why that's such a driver here. The last study -- I know I'm sworn under oath, and I didn't memorize the study. It's been a little while since I saw it, but the last study that I know of around Medicaid rates found that Connecticut's were 99 percent average, 99 percent of Medicare, which may not sound great. It's one percent below Medicare, but that's better than either all or all, but one, other state.

Connecticut is very generous in its Medicaid rates, and I know they don't like that. And we heard that Yale-New Haven in Connecticut is a high-priced, high-cost provider, so, while it may be a stretch and it may not be as generous as, you know, people would like, it's still very generous, given the, especially given the State's finances right now.

The only cuts that have happened since then have been in dental rates, I believe it's two or three percent, and, also, home health medication administration, which are serious cuts. They're not unimportant, but I think, as a consumer advocate, I'm deeply troubled by the eligibility cuts for Husky parents, 10,000 losing coverage at the end of this month. Those are really serious and severe cuts, and I think

that needs to be put in perspective.

Also, I believe it was four years ago, we made some major changes to our Medicaid program. Connecticut took it from an insurer capitated system to one that is focused on patient-centered medical homes.

We have saved money per member per month. It was down 5.9 percent last year. Not off of trend, but down from zero. I mean it was actually down, which is remarkable, and I can't say that enough.

We have improved quality, fewer people going to the emergency room with non-urgent visits, but we also increased the number of providers by 32 percent, and it wasn't just about rates. We learned that. But it was also about operational changes that needed to be made, making life easier, paying on time, things like that that made a huge difference in our Medicaid program, so I think that that needs to be recognized, that our Medicaid program has come a long way and should not be used as a reason for requiring this merger.

Also, DSS right now is in the midst of solicitation for value-based purchasing, a shared savings program, MQISSP, which I can't remember what it stands for, for our Medicaid program, and DSS reported to me in an e-mail that I'm happy to share that Northeast Medical

Group and the Yale Medical Group have both sent in letters of intent.

The proposal is not due until August 2nd by 2:00 in the afternoon, is my understanding, so there is no proposal yet, but they have signed a letter of intent. It's non-binding.

That and the fact that they are participating in Medicare shared savings shows that there is a sophistication there. There's a lot of sophistication and risk profiling and analytics that are required for those programs, and those are, the addition of this section of the State, will add a great deal, given that attribution will be through primary care providers, will add a huge amount to their market share, in terms of the power of them and how many lives are attributed to them and how many are -- they will be under their shared savings.

They will benefit from savings that are achieved, based on those patients, so this is a huge increase, and Yale-New Haven's market power, Northeast Medical Group's medical power in the market, and, so I would urge you strongly not to approve this until the hospital decision is made and a larger decision can be made. Thank you.

HEARING OFFICER HANSTED: Thank you, doctor.

MR. MURRAY: We have no further witnesses.

HEARING OFFICER HANSTED: Okay, thank you. Attorney Feldman, do you have any Cross?

MS. FELDMAN: I do not.

HEARING OFFICER HANSTED: Attorney Murray, do you have any Cross.

MR. MURRAY: I do not.

HEARING OFFICER HANSTED: Okay.

MS. FELDMAN: I have one Redirect.

HEARING OFFICER HANSTED: Sure.

MS. FELDMAN: For Dr. Lehrach. I believe that Dr. Hyde commented that there is a site of service differential that LMPA presumably takes advantage of with respect to providing services to those in the community, and I'm not sure he used the right terminology, but perhaps he is thinking about a provider-based facility fee that some hospitals have medical groups provide.

Does LMPA provide -- is it a provider-based practice?

DR. LEHRACH: No.

MS. FELDMAN: So there's no associated facility fee with LMPA services?

DR. LEHRACH: That is correct.

MS. FELDMAN: Thank you.

HEARING OFFICER HANSTED: Anything further?

MS. FELDMAN: No.

HEARING OFFICER HANSTED: Okay.

MR. MURRAY: I just have a Redirect of Dr. Hyde.

HEARING OFFICER HANSTED: Sure.

MR. MURRAY: Dr. Hyde, when you were making that comment, were you referring to L & M?

DR. HYDE: No. As a matter of fact, I was indicating the problem. The problem is that, on net patient service revenue for $29 million, they're losing $21 million.

The site of service differential, which became part of the Medicare rules in 2000, is going away, and one question worth asking is are there plans to, in fact, incorporate a site of service differential through the rearrangement of physician/hospital relations, or is that so far from the Applicant's intent that, in fact, they would agree not to do so?

MR. MURRAY: Thank you.

MS. FELDMAN: I have another Redirect in

response to Dr. Hyde's comment. Dr. Lehrach, are you aware of the fact, in November of 2015, that Congress passed a new law, eliminating provider-based locations and site of service, as Dr. Hyde refers to it, so it no longer can be an option for anyone, any hospital?

DR. LEHRACH: My understanding is that, for applications already in process by the date of the law, November of '15, those would go through, but no new applications after November of '15 would be legal.

MS. FELDMAN: And do you have an application in process?

DR. LEHRACH: We do not.

MS. FELDMAN: Thank you.

HEARING OFFICER HANSTED: Attorney Murray, anything further?

MR. MURRAY: Doctor, I'm just going to ask you, based on the last witness's response, do you have any further information to add?

DR. HYDE: We know that the rules are still in formation. We know that hospitals are unhappy. It's a very simple question. If Yale-New Haven and Lawrence & Memorial have no intention, whatsoever, of essentially inflicting site of service differential payments on the patients in this area, a mere statement

to that effect would suffice, as opposed to arguing about where the regulations are now, what the meaning of the statement in place by June 30th, the implementation by January 1st, the legislation sign November 15th might be, very simply addressed. That's my only point. Thank you.

HEARING OFFICER HANSTED: Okay, thank you.

MS. FELDMAN: We're done.

HEARING OFFICER HANSTED: Thank you.

MR. MURRAY: No other questions.

HEARING OFFICER HANSTED: Thank you, both. And it's my understanding, before we get to OHCA's questions, it's my understanding we have a couple of elected officials here, who would like to give a statement. I'm going to take them at this time.

MS. KAILA RIGGOTT: Ernest Hewett.

MR. ERNEST HEWETT: Good afternoon.

HEARING OFFICER HANSTED: Good afternoon.

MR. HEWETT: Can you hear me? It's almost like I've been sitting in a judiciary meeting, waiting for the last three hours.

Good afternoon, Attorney Hansted. My name is Representative Ernie Hewett, and I'm a State Rep for the 39th District representing the City of New London.

As you can imagine, I've been keenly

interested and concerned about the impact this acquisition has on the individuals and families that live and work in this city.

Several months ago, I expressed my support for the Yale/Lawrence & Memorial affiliation, based upon the facts and information that I had at the time. Most importantly, I was concerned about the negative impact this merger might have had on working families, those employed at Lawrence & Memorial Hospital.

I've agreed to support the proposed deal when I receive assurances from the Union and the hospitals that job protections would be in place and secure.

Since that time, I have received new information that raises significant concerns about the benefits of this acquisition to the community, specifically related to local control, cost and price, and sustained healthcare services to our community.

Local control. The initial statements by Yale-New Haven and Lawrence & Memorial management were assured that a local Board of Directors will control L & M. I have recently learned that, in fact, according to the proposed bylaws for Lawrence & Memorial Health Corporation, Yale-New Haven is designated as the sole

corporate member of Lawrence & Memorial Health. In other words, Yale-New Haven will have total control over membership and will ultimately have control over decisions made about our community hospital.

It is essential we have an honest, upfront conversation about what this acquisition means to our community. This newly-revealed information about the power and authority held by Yale over the community hospitals undermines our trust in the key players within this proposed deal and calls into question Yale-New Haven and Lawrence & Memorial's commitment to transparency and authentic bylaws with this community.

Cost and pricing. According to a report at the beginning of this year, if this acquisition is approved, Yale will control 60 percent market share from New York to Rhode Island and more than 80 percent in Lawrence & Memorial primary service area.

Consolidation in such markets can lead to price increases of 20 percent or more. This would be a significant blow to our community and would further accelerate challenges in accessing affordable healthcare services.

I understand that OHCA has asked Yale-New Haven Hospital to provide data on how previous Yale-New

Haven mergers affected prices in the case of Bridgeport, Greenwich and St. Raphael's acquisition, helping us to potentially dispel some of these concerns.

To date, Yale has not provided this data. It does not make sense for OHCA to move forward with this acquisition without this crucial data.

Access to local services. My colleagues, who represent constituents in the Windham area, recently briefed me on changes made to critical healthcare service at Windham Hospital.

Several years ago, Hartford Hospital promised improvements and no cost to services within their community. These promises were not kept, and Windham Hospital closed its critical care unit, necessitating patients to drive and fly on helicopters to get normal healthcare.

What assurances do we have that this will not be the fate, as well? Lawrence & Memorial Hospital is a vital and crucial institution within this community, and its continued service to the individual families residing throughout the New London area must remain secure.

In order for me to have confidence and support in this proposal, these issues must be addressed.

I strongly urge OHCA to require Yale-New Haven Hospital and Lawrence & Memorial Hospital to enter into a signed, legally-enforceable community benefits agreement, negotiating with broader cross-section of the community before we move forward with this, allowing any kind of change to the community hospital.

I just want to end by saying this merger almost sounds like a Bill coming down from the Senate at the end of session.

The Bill comes down from the Senate, and it's a good Bill, it comes to the House, and we're forced to not change anything in that Bill to make it a better Bill, because if it goes back to the House, the time is going to run out, and we lose the Bill.

My opinion, I think we should just take a couple of those mays out of this law or this merger and put some shalls in there and put some teeth in it to make this a better Bill. Thank you.

HEARING OFFICER HANSTED: Thank you. Are there any other elected officials that want to give public comment on this matter?

A FEMALE VOICE: (Indiscernible - too far from microphone).

HEARING OFFICER HANSTED: Would you like

to make --

A FEMALE VOICE: I signed up.

HEARING OFFICER HANSTED: Okay, thank you. I'll take public comment from the community after OHCA has completed its question and answer session, which we're going to get to right now at this point, okay?

So, as I just stated, OHCA has some questions on both applications, primarily the 15-32033, which is the Lawrence & Memorial Hospital and Yale-New Haven Health Services, Health System, sorry.

So we're going to start. The first question, and I believe it's the only question we have pertaining to the physician group, we're going to ask first, and then the rest will be to the affiliation.

MR. BRIAN CARNEY: Okay, good evening. My name is Brian Carney. I'm an analyst with the Office of Health Care Access.

I have a question relating to the merger of physicians' group practices. How will the merger of L & M Physician Group and Northeast Medical Group impact the diversity of providers and patient choice in the region?

DR. LEHRACH: So, in a nutshell, it will expand access to both primary care and specialty care. I

don't know if that qualifies as diversity, but it will expand access.

If your question specifically was asking if there would be new services offered, then the answer is also yes. Presently, given the size of the market, we couldn't possibly recruit certain specialists and subspecialists, because there just isn't enough demand in the community to support that, however, as part of a larger system, as I said in my comments, we can better match capacity to demand by having specialists and subspecialists present in our community seeing patients in our community on a part-time basis.

MR. CARNEY: And do you have a list of those services that you could provide us?

DR. LEHRACH: It's something we can submit.

MS. FELDMAN: We could do it as a late file.

MR. CARNEY: Okay. That would be great.

HEARING OFFICER HANSTED: That will be Late File No. 1.

I just want to follow-up on that question. When we talk about, when the statute talks about diversity of providers in an area, what it's really

talking about is -- let me give you an example.

For whatever reason, there's a community member that doesn't want to see a Yale physician. I don't know why. If this proposal is approved, will there be doctors in this area outside of Yale doctors, Yale physicians, that that community member could see?

DR. LEHRACH: If I'm to understand you correctly, Attorney, you're asking if there will be physicians in our community, who are not under the employ of NEMG?

HEARING OFFICER HANSTED: Correct.

DR. LEHRACH: Currently, I don't know the actual breakdown, but there are many, many privately-employed physicians. There are physicians in front of you, who are employed by federally-qualified health centers.

There are physicians, who are employed by other large medical groups, including ProHealth. There are physicians owned by the Hartford HealthCare system, under Backus. I wouldn't expect any of that to change.

HEARING OFFICER HANSTED: Okay.

MR. CUMMINGS: If I could just add to that? We have a number of private practice specialty groups that have agreements with L & M, so the

anesthesiologists are a private practice group, not affiliated with Yale. The hospitalists are a private practice group. The emergency physicians are a private practice group, and the radiologists are a private practice group, so if you were to add up (papers on microphone) largest groups in our community are the emergency physicians and the hospitalists.

HEARING OFFICER HANSTED: Okay.

MR. CUMMINGS: Both in private practice.

HEARING OFFICER HANSTED: Thank you, both.

MS. FELDMAN: Attorney Hansted, I just -- perhaps, Dr. Lehrach, you can explain that we're not, regarding our plans to recruit existing physicians in the community versus recruiting physicians from out of the community to join the practice.

DR. LEHRACH: So the intention is to bring novel physicians and physician services to our community. If they're primary care, they would be recruited de novo. If they're specialty care, they may or may not be sourced through the NEMG YMG network, or they might be recruited independently from the outside.

Our goal is not to necessarily take on any additional practices that are presently here. We love the private practice model. I wish more doctors would

stay in private practice, but, unfortunately, the economics are conspiring against many private practitioners and they're knocking on our door.

HEARING OFFICER HANSTED: All right, thank you.

MS. RIGGOTT: I actually have a question for Dr. Hyde first. You talked about asking the simple question about inquiring whether there would be instituting a site of service differential.

DR. HYDE: Yes.

MS. RIGGOTT: If that's going away in January, I guess I'm not, we're not entirely clear on why we would want to inquire about that.

DR. HYDE: Right. We're in a transition period. As you know, Congress finally responded to a recommendation from MedPAC that the site of service differential, that is the additional charge levied for the so-called facility fee on top of the professional fee, no longer be allowed, but there were exceptions for commitments that were entered into by June 30th of this year, which commitments would be implemented by January 1 of next year.

What were those exceptions? As you know, there's a rule-making process underway, so we don't have

final resolution. My point was twofold. One is that all of us need to be wary about hospitals subsidizing doctors. Where does the money come from? We know where it's coming from. From the year 2000 forward, by capitalizing, if you will, a site of service differential.

If, in fact, this particular practice has no intention of entering into an arrangement, which would allow such a levy, they have a simple solution to my point, which is to say so. Very simple.

So I'm pointing to a problem, which is that when hospitals acquire physician practices, productivity plummets and expenses go up.

I'm pointing to a solution found in the hospital physician industry, if you will, a business solution, which is to charge more for the same services, and I'm suggesting a resolution in this case, which is commitment by the Applicants not to, in fact, levy facility fees associated with professional services, would make my point moot.

MS. RIGGOTT: Thank you. I guess my next question is for the Applicant, then. Is there an intent of instituting a site of service or facility fee?

MS. FELDMAN: I think the transcript will

reflect that that question was posed to Dr. Lehrach. I can ask the question. He said no.

DR. LEHRACH: I'm willing to restate it. Mr. Hyde's point is moot. There is none.

MS. FELDMAN: And I could also ask the same question of Dr. Varkey, and the answer would be?

DR. VARKEY: No.

MS. FELDMAN: Thank you.

HEARING OFFICER HANSTED: That's all the questions we have pertaining to the NEMG matter, so if you want to switch chairs, just to make it easier at this point for you?

DR. LEHRACH: Dr. Varkey and I appreciate the comments about our youthful appearance, however. (Laughter)

MR. CARNEY: Okay. There's been some general concerns regarding Yale's market share post-L & M acquisition. I took a look at some data, and, based on FY-2015 inpatient discharge data, Yale and L & M combined would capture more than 80 percent of inpatient discharges in L & M's primary service area.

This is only the inpatient portion of the market. Have you done a more comprehensive analysis of the before and after market share of L & M's service area

in regard to this proposal? For example, an analysis that includes outpatient care, including emergency care and group practices.

MS. FELDMAN: Dr. Noether will respond.

MR. CARNEY: Okay, thank you.

DR. NOETHER: I guess, to answer your question, first of all, unfortunately, there are no comparable data to the inpatient discharge data that enable us to calculate shares on the inpatient side, on the outpatient side, or the physician side for that matter, so one can't do the kind of comprehensive analysis that you request.

I wouldn't have great reason to believe that it's going to be hugely different on the outpatient side, though there are more independent outpatient producers generally than inpatient hospitals. We just heard testimony about there being a lot of independent physicians, so, again, they're probably lower there, but I think the more relevant point is that the reason that the share will be substantial post-affiliation is because L & M already enjoys a substantial market share in its own service area north of 70 percent, so the incremental change resulting from this transaction is really pretty minor, and that's certainly one of the reasons I suspect

that the Federal Trade Commission chose not to challenge the transaction.

MR. CARNEY: Okay. Following up on a similar question to before, then how would the market share composition following the affiliation impact the diversity of providers and patient choice in the region, as far as hospitals?

DR. NOETHER: Again, I don't think it's going to have much effect at all. As I noted in my pre-filed testimony, there isn't a lot of direct competition between Yale-New Haven Health or Yale-New Haven Hospital and L & M Hospital or L & M Health currently.

Really, they are serving different patient populations. They are 50 miles apart. There really isn't a lot of direct competition now, so there's no competition to be reduced and, therefore, no impact on diversity of providers.

MR. CARNEY: Okay, thank you. The next set of questions is sort of financial related. I'm not sure your CFO would be the most appropriate person, but I'll start off with a question, and you can determine.

How is pricing determined for hospital services? What factors are included in the negotiation with insurance companies regarding reimbursement amounts?

MS. FELDMAN: We have multiple people that can answer that.

MR. CARNEY: Okay, great.

MR. TANDLER: Sure. So when we look at pricing, the first thing we have to understand is that the preponderance of the payer mix is governmental. We're talking about one of the highest governmental payer mixes in the State at Lawrence & Memorial.

We do not dictate prices. We don't even negotiate prices with our governmental payers. Those are not negotiated.

For those that are, for those that are negotiated, those are done at arm's length. We don't reveal any rates, and I think we've covered during this discussion our ability to share rates between the parties. At this point, we are unable to do that, but, going forward, as a result of this transaction, we have committed to honoring the terms of the existing agreements for their duration.

Following the term of those existing contracts, we will negotiate those at arm's length with the various managed care commercial payers, and those go into a variety of factors.

Those are each, for all the Yale-New Haven

Health System affiliates, are negotiated separately. In fact, we are one of the only health systems that doesn't have a single rate for all of our member hospitals.

Each hospital negotiates separate rates, based on the economic circumstances of each affiliate. Those go into matters, like the factors that fall into that could be the cost index in that geographic region. It includes the perceived quality at each hospital.

It includes the shortfall from governmental payers. That is one of the independent variables that goes into the pricing with managed care payers, but, like I said before, we are honoring the existing agreements for the duration, and, following that, we would negotiate at arm's length, based on those factors I just described.

COURT REPORTER: Can you identify yourself for the record, please?

MR. TANDLER: Keith Tandler, Executive Director.

MR. CARNEY: Is market share one of the factors included in those discussions?

MR. TANDLER: No.

MR. CARNEY: Would that be a factor?

MR. TANDLER: No. Again, the economic

factors include perceived quality, the cost structure at each organization, various cost indices in each geographic region, and governmental payer shortfalls, as well as the hospital tax factors into that.

MR. CARNEY: Okay, thank you.

HEARING OFFICER HANSTED: You mentioned that you're unable to share the negotiated rates. What is the basis for that?

MR. TANDLER: So, as part of this transaction, we are not privy to the Lawrence & Memorial rates. We're not able to estimate any price change as a result of any negotiation.

If we were not honoring those existing agreements, there would be no ability for us to even gauge what that differential is.

MS. FELDMAN: I just want to make an observation generally, that most managed care contracts, if not, all, have confidentiality provisions, which prohibit a provider from disclosing to a third party their negotiated rates.

HEARING OFFICER HANSTED: And is that the case here?

MS. FELDMAN: I assume so.

MR. TANDLER: Yes. Yes. I mean counsel

has advised us that, and we've been following that as part of any business combination or affiliation that we've ever worked with.

HEARING OFFICER HANSTED: Okay.

MR. SETH VanESSENDELFT: If I could just add a comment? The two other things that would be important to kind of add onto Keith's statement is one is the expectation of pricing neutrality, so, as we go forward with these commercial payers, there is absolutely an expectation of pricing neutrality.

The second part is, in your prior question, many times we're thinking about this in kind of a same state for the same services that we would somehow negotiate a higher price or charge more.

I think what we're missing in that is really what's been tried -- we've tried to convey throughout this, that, for all of those services that have to leave the area and seek care at a higher level of care in the tertiary setting, when it could be provided in the community setting, and that's really what we're advocating here, there is a pretty significant price improvement in those cases.

So, for example, if we have lost a thoracic surgeon and we can't replace that surgeon, we

can't recruit for them, and all of that care then gets sent to Hartford, or to Yale, or to Providence, all of those cases will be at a much higher level than if we were able to continue to retain that in the existing service area, and that's absolutely what we've been advocating.

And probably the third point that's critical to this thinking is that, as we negotiate services going forward, there is an expectation that greater and greater portions of that will be risk-based, quality-adjusted, and, so, those are another thing that we try to advocate.

COURT REPORTER: State your name for the record.

MR. VanESSENDELFT: Seth VanEssendelft. I'm the CFO at L & M.

MS. FELDMAN: Attorney Hansted, I would also think it might be helpful if Dr. Noether explained the reasons why, from a legal standpoint, anti-trust laws would prohibit the sharing of that data.

HEARING OFFICER HANSTED: Okay.

DR. NOETHER: Let me first start by caveating that I'm not an attorney, but I've spent a lot of time with anti-trust attorneys and involved in

mergers, and it's certainly my understanding that it is inappropriate and, in fact, illegal for parties prior to having their merger ultimately approved or affiliation approved and consummated to share competitive information, which includes, certainly, pricing.

HEARING OFFICER HANSTED: I'd like to see that law, where it prevents the disclosure. I'm not familiar with it. I'm not saying it doesn't exist. I would just like to see the cite for it, if you could provide that as a late file.

MS. FELDMAN: I could tell you that you could find that in Section 1 of the Sherman Act. If you told us tonight that OHCA was going to approve the proposed application, we'd be happy to share information, but since we are not integrated, Section 1 of the Sherman Act would prohibit that type of information not among hospitals.

In addition, to the extent that they are commercial contracts, we have contractual provisions that would limit our disclosure to another hospital. As you can imagine, the payers would not want that information to be made public.

HEARING OFFICER HANSTED: Okay, thank you.

DR. NOETHER: Let me just add that there

have been a number of anti-trust cases brought precisely as violations of the Sherman Act that involve essentially allegations of price fixing among competitors.

HEARING OFFICER HANSTED: Okay, thank you.

MR. CARNEY: I just have another follow-up for Dr. Noether about the whole risk adjust pricing. I keep hammering away here.

You said, basically, that that information there's no metric that's appropriate to use. What about -- why is it not possible or appropriate to provide hospital prices utilizing diagnostic related groups using MSDRGs, which do categorize patients by treatment type and severity of illness?

DR. NOETHER: That certainly is a first step, and looking at case mix adjusted prices would be essentially adjusting prices for the DRG weight by essentially taking an unadjusted price and dividing it by a DRG weight, which I will say, parenthetically, it appeared, from when we looked at the Milliman Study, that they, in fact, implemented any kind of case weight adjustment incorrectly, because they multiplied instead of dividing.

The point I was trying to make earlier was that the DRG weight assumes that all patients within a

DRG are the same, and that's not the case.

MR. CARNEY: Don't they have --

DR. NOETHER: DRGs -- sorry.

MR. CARNEY: Don't they have several categories, like without comorbidities? They do have some separation, do they not? Three different categories, I believe?

DR. NOETHER: Yes, sir, you're correct. There are, at least for some DRGs, there's a with and without complications and comorbidities, so that starts to make some adjustments, but even within those two categories you can have a broad spectrum of patients, and, certainly, the Medicare program, for example, recognizes that teaching hospitals have higher costs for a number of different reasons and pays them more.

One of those reasons is it does recognize, as has been discussed earlier, that teaching hospitals have a higher range of services and tend to attract sicker patients, so that's just one example.

MR. CARNEY: Okay, thank you. All that being said, what evidence can you provide OHCA with that will help us evaluate whether or not healthcare costs will be adversely affected by this proposal?

DR. NOETHER: Is that a question for me?

MR. CARNEY: That can be for anyone.

DR. NOETHER: I can start, but I suspect others have some. I mean I think, you know, it gets back to what we were saying before, which is there really, at least from an economist perspective, there's no diminution of competition, because there hasn't been much competition between Yale-New Haven and L & M historically.

If anything, there will be efficiencies that will be generated through the transaction that should enable costs to be reduced and/or quality to be enhanced.

MR. TANDLER: So I can just add to that. There's various elements of our strategy over the years that has allowed us to reduce costs. Some of those areas we've covered today.

Access to capital was an area we covered regarding the ability to borrow. Scale has been part of our ability to reduce the cost per unit, specifically where we have increasing amounts of fixed costs. We're increasingly a capital-intensive organization, and those fixed costs get spread out over a greater number of patient visits.

This is one piece of our overall strategy.

We've actually been successful in that, as well, if you look back at some of our own history with the Hospital of St. Raphael. That's a recent example of where we've been successful.

Insurance is another area. We've had examples, where we're able, because of our size and because of our ability to tolerate and manage risk, we've been able to use our size and expertise around risk, whether it's malpractice, property casualty, or any other type of risk, to withstand that and reduce costs, and these are three examples of areas that are compelling that are part of our strategy.

MR. CARNEY: Okay and those, combined with, say, the anticipated cost savings opportunities that have been presented following the acquisition, how will that translate to, you know, potentially lowering prices for patients?

MS. BORGSTROM: Let me maybe take a crack at that, because these are very complicated issues, as you're well aware, and, to answer that factually, there's a great deal of speculation.

One, as we said in the application, we have stipulated price neutrality for Lawrence & Memorial and Westerly, and, after their contracts expire, as Mr.

VanEssendelft said, those will be negotiated, based on Lawrence & Memorial's costs and what's happening in this particular geography.

We also said earlier that the hope is that we keep more patients in the local community here, rather than having them treated, because the subspecialists are not in this community. That will make it less expensive, because this is a lower cost setting in some of those patients, who may be being transferred to New Haven.

You know, in the past five years, the Yale-New Haven Health system has reduced on an annualized basis its operating costs by over $200 million. That has not translated into a price reduction or what people may feel when they go to the hospital or physician for a couple of reasons.

One, as we've taken the $200 million out, we are now the largest taxpayer in the State of Connecticut, paying over $185 million in taxes. That, combined with reductions in payment rates for things like laboratory services and outpatient services, has more than eclipsed what we have saved.

Second, what people are feeling out of their pockets is, to a certain extent, based on employer designed insurance offerings, and we don't have any

control over that, and, as we move further in healthcare reform and the present Health Care Act organizations looking to avoid taxes, are going to put more responsibility on employees and consumers whether or not that has anything to do with the actual prices or negotiated rates with payers.

So the issues are very complicated, but we recognize that we've got to continue to try and take costs out and manage care most effectively, so that it's the right patient getting the right care in the right setting at the right time.

MR. CARNEY: Thank you. I just have one more follow-up on the contracts, saying that Yale-New Haven will honor L & M Hospital's and Westerly Hospital's existing contracts. Do we have time frames for those individual contracts? Obviously, they're probably not the same expiration dates, or do they have to be renegotiated? That will give us a feeling for how long those prices would stay the same.

MR. VanESSENDELFT: That is correct. I would say our larger contracts extend at least for two years and some of them up to three years, but you are correct. There are different periods, different renewal dates for each of the payers.

MR. CARNEY: And could we get a possible listing of those contracts and the dates?

MR. VanESSENDELFT: You can.

MR. CARNEY: Okay, that would be great. I appreciate that.

HEARING OFFICER HANSTED: That will be Late File No. 2.

MS. FELDMAN: Attorney Hansted, these late files relate to which application now?

HEARING OFFICER HANSTED: This is 32033.

MS. FELDMAN: And the first late file, is that related to 32, which was a list of --

HEARING OFFICER HANSTED: Yes, that's 32.

MS. FELDMAN: Okay.

HEARING OFFICER HANSTED: 32032.

MR. MURRAY: Attorney Hansted, could you remind me what Late File No. 1 was? My notes seem unintelligible.

MR. CARNEY: It's a list of additional services that will be offered.

MR. MURRAY: Okay, thank you very much.

MR. CARNEY: Okay. I think this is getting close to the end of my list. We've touched upon the capital commitment, bits and pieces in Cross-Exam.

I'd sort of like to hear from the CFO in sort of layman's terms for our benefit and the benefit of the public, so let me just read my question.

Yale is committed is deploy $300 million in resources in the Eastern Connecticut and Western Rhode Island region over a period of five years for the purpose of enhancing L & M's clinical and operational capabilities and services, is basically your language.

Please walk us through the funding sources and planned allocation of the $300 million commitment.

MR. TANDLER: As far as the funding sources, there's a first tranche, which is comprised of the $85 million. That's cutup into two sections. I think there's one tranche, which is $41 million, where we have been able to get preliminary recommendations on the deployment and the use of those funds, and those are for some of the outlined areas that we've covered.

There are some areas of physician recruitment, including primary care, and infrastructure for population health and IT.

There's a second $45 million. That second $45 million would come, regardless of any outcome, regardless of any return that we discussed earlier, which would come at the onset as a follow-up investment, but

without any contingencies attached to it, and that would come from some area of the health system.

It could include the Yale-New Haven Health Services parent, and it could include Lawrence & Memorial's funds, if it's part of the health system, depending on the appeal of those, who follow on investments.

The use of those investments could be similar specialties, primary care in the surrounding L & M area. So that's the first $85 million.

We discussed, also, the 215 that follows, or the balance of the total $316 million, and that's made on a -- that will be made we described as an iterative process. It would be based on the ongoing measurement, using various metrics of success, whether they're quality, patient satisfaction.

They could include our ability to manage population health, any of the program service initiatives.

MR. CARNEY: So would that be out of L & M operations?

MR. TANDLER: Yes. That would be --

MR. CARNEY: -- 215?

MR. TANDLER: The source of that funding

would also come from our ability to stabilize operations and the operating income of Lawrence & Memorial. That would come from ways of redeploying resources within Lawrence & Memorial, bringing resources to the area, growing the medical practice, creating new positions to support those.

We do expect in our plan, and we've done this in the past, to plan and execute a changed management over the course of that period.

MR. CARNEY: And the source of the $85 million again was from?

MR. TANDLER: So the $85 million is coming from -- $41 million is coming from the initial cash outlay and infrastructure, again, not based on L & M performance.

MR. CARNEY: Cash outlay, okay.

MR. TANDLER: There's an additional $44 million, and that is the anticipated margin from further clinical expansion, so we do expect some of those investments to pay for themselves.

There is a balance to these programs, and our ability to plan and manage those programs will make up the balance of that $85 million.

MR. CARNEY: Okay. One final question I

have is, given the financial commitment is dependent on operational performance, return on investment, and/or potential synergies and efficiencies, how will this commitment be met if these results fall short of projections?

MR. TANDLER: Well --

MR. CARNEY: Tough question.

MS. FELDMAN: I think there's some confusion, in terms of the financial commitment. I think what's important here to understand from the application is that there's a commitment to reinvesting money in the Eastern Connecticut region. That's the $215 million.

The $85 million is not contingent on anything, other than this application getting approved. That is ready to go, if the application is approved, so I think that is -- they're not the same. They're different.

If L & M is able to get in a position, where it is financially-stable, as you know, their bond rating was just downgraded, if we can turn that, we expect them to be, with this $85 million infusion, we expect them to be able to generate money, and that money will be reinvested in the Eastern Connecticut region.

MR. CARNEY: So the $85 million is sort of

a hard investment that you're hoping to stabilize L & M, in order for them to do better and be able to reinvest that $215 million out of their success?

MS. FELDMAN: Correct.

MS. BORGSTROM: And I think Attorney Feldman has made a very important distinction, because there are health systems nationally, where improved performance in an organization just brings in a crude strength to the system balance sheet.

The difference here is, you know, we are a mission-driven organization. Every one of our providers has a commitment to serve the communities they do.

There's a woman, a religious woman, who ran a big health system in the Midwest, who famously coined the term "No Margin, No Mission." This is about restoring Lawrence & Memorial Healthcare to clinical, fiscal and community health, so that we can invest as a health system in this geography.

MR. CARNEY: And did you see those kind of positive results at Bridgeport and Greenwich Hospitals?

MS. BORGSTROM: We absolutely did, and, you know, I think that, in testimony from Bridgeport and I know that there's a member of their community here, who is also on their Board, they can describe that very

tangibly to you.

The hospital of St. Raphael acquisition, which was a different forum, we made a commitment on cost savings and investments, and we have exceeded all of those commitments we made to the Office of Health Care Access.

MR. CUMMINGS: If I could just build on Marna's comments, one of the -- let me just raise two observations that I think will be helpful.

One is that, one of the things that gave our Board great comfort about going forward into this relationship was the opportunity to meet with and hear directly from representatives from Bridgeport about their experience and whether the commitments made to that organization indeed were honored. Did things work out the way it had planned?

Were the operational improvements realized? Did the governance model work the way it had been described? And our Board and management was very impressed upon hearing directly, without any filter, what the Bridgeport experience had been.

The other comment I wanted to make about this $85 million is really to prime the pump. It's investments in not just physician recruitment and program

development, but in population health, information technology and so forth.

In other words, to help us get ready for the changes that are coming in the future to the healthcare landscape.

You've heard references here about the shift from volume to value, about the expected emergence of accountable care arrangements in this state. It's been slow to get here, but we believe it is coming, and that was part of our Board's thinking about seeking an affiliation, that we did not have the wherewithal to be a survivor, much less even an effective participant, and the new healthcare landscaping will be dominated by accountable care, taking on risk and so forth, that what made sense then to be effective, to continue to confer value on our community was to partner with Yale-New Haven, which has many of those capabilities already in place.

We were convinced by the experience in Greenwich and Bridgeport about being able to lower their overall cost, about being able to increase the value proposition in those communities, so, you know, I think words matter, and it's appropriate that OHCA read carefully the representations in the application, but,

above and beyond that, we wanted to field test this, in terms of talking to real people, Board members, employees at the Yale-New Haven Health affiliates, to say has this actually been your experience? And the answer was, resoundingly, unequivocally, yes.

HEARING OFFICER HANSTED: I just want to get some clarification on the $215 million again. I'm sorry to be so thick about this.

Is that the investment ceiling for a specific period of time, or is that it, in terms of the region?

MR. VanESSENDELFT: If I could just comment? The 215 was really developed, if you go back to Bruce's comment earlier, about the needs of the health system and kind of coming up with the $300-plus million, and, as we thought about it, it was the investment that Yale-New Haven was willing to make upfront that we've been talking about, $85 million, that gets the infrastructure in place and almost 20 new physicians in our market.

That, then, spawns additional stability, as Marna went over, to generate returns. Those returns coming out of the system would be we kind of looked at a baseline of what we would generate through capital.

Normally, we would look at $20 or $25 million a year boding over time, and that's kind of that 150, 163 number that we've been talking about, and then just between 63 or 68, depending on what number you're referencing, of kind of new vitality and earnings being generated by the combination and partnership of what we're able to create through this new investment.

Those are kind of the way, at least in my head, I keep it straight, is those three different buckets and sources of funding and then how we're deploying them.

HEARING OFFICER HANSTED: Right, right. No, I understand.

MR. VanESSENDELFT: It's over five years.

HEARING OFFICER HANSTED: I understand that. I guess my ultimate question is, once the $215 million is reinvested into the community, it doesn't stop there. It will, as L & M makes money, that money will continue to be invested into the community beyond the 215 million.

MS. FELDMAN: So, you know, I think it's a great question, and I think what you have to look at is the history of this health system, so Bridgeport came in, and I may be off a year, in 1996.

Bridgeport came in in 1996. Greenwich followed about 18 months later. Yale-New Haven has clearly been a founding member of this. The St. Raphael's integration occurred almost four years ago.

We are responsible, as a mission-driven health system, for the care in those communities through what we directly provide through partnership with others, and we can only be successful if we continue to invest in those communities, and, so, we view this as a marriage without possibility of divorce. We are responsible.

HEARING OFFICER HANSTED: Okay. All right, thank you.

MR. CARNEY: Finally, I just want to touch upon the clinical services, seeing that's very dear to many people's hearts that live in the area, just sort of one more time. I just wanted to double check.

Following the change of ownership, are there currently any plans to reduce or consolidate any existing programs offered at L & M?

The second part of the question is if any new programs or services will be created as a result of this proposal, and where will those services be located?

MR. CUMMINGS: To the first part of your question, there are no plans to reduce or restrict

services as a byproduct of this affiliation.

With respect to the second part of your question and in keeping -- that's why the first tranche of $41 million and the following tranche of the $44 million, i.e., the $85 million that is irretrievably committed to this, regardless of financial performance, a significant part of that is about physician recruitment, expansion of clinical services.

This is a growth-oriented strategy. Expand access, gross services, retain services in the community. We've agreed broadly, and I'll come back to why I'm using the qualifier broadly, about these categories, and I think you've heard from both Ms. Borgstrom and myself those are primary care, behavioral health, maternal and child health services, emergency and critical care services, and surgery.

We are limited, again, I'm not an attorney, but in the same way that we can't share pricing information, so, too, are there restrictions, limitations on the amount of discussions that we can have about specific services, how they'll be provided, by whom they will be provided, in what setting they'll be provided, so we've been cautioned by counsel to avoid what would be tantamount to gun-jumping by getting too far ahead of the

process.

So we've agreed on broad categories. There are a lot of things that fit under that broad rubric, but, again, it's about promoting access and growth.

MR. CARNEY: Thank you very much.

MR. STEVEN LAZARUS: Steven Lazarus. Just going back to a couple of financial things, just to wrap up that category, can we get two late files, please?

The first late file will be the financial attachments that were part of the CON application. Some of them, because of the time frame where we are in the application process, it's been a while, so we'd like to get those updated.

MS. FELDMAN: That's financial Attachment A?

MR. CARNEY: Yes. Yes.

HEARING OFFICER HANSTED: That will be Late File No. 3.

MS. JENNIFER WILLCOX: And that's for both dockets?

MR. LAZARUS: Yes, for both dockets. And we just want to clarify that we'd like those for -- at least for the 32033. It should include the L & M System,

L & M Hospital, the hospital only, as well as the consolidated, and for the Yale-New Haven Health System. You can use the same format as was used in the financial Attachment A.

And, for the next late file, we would like you to provide year-to-date financial measurement indicators through June 2016. The ones in the application I believe I think the last time we got them were on page 863, I believe. That was resubmitted as part of the completeness, so we would like those to be updated for June 2016.

HEARING OFFICER HANSTED: That will be Late File No. 4.

MR. LAZARUS: The next couple of questions I have have to do with the Community Needs Health Assessment, so, generally speaking, the current Community Needs Health Assessment that's in place for L & M it had talked about six priorities that were brought out in it.

Based on the implementation plan, can you discuss what steps have been taken by L & M to make improvements in those areas, and are there any type of measurements or statistics that were collected for the outcomes on those?

MR. CUMMINGS: Thank you for that

question. The plan that you alluded to was prepared in 2013.

MR. LAZARUS: Yes.

MR. CUMMINGS: And we're in the process of completing a new Community Health Needs Assessment in partnership with Ledge Light Health District, the public health agency for this region.

Our content expert for the Community Health Needs Assessment I think is here. Laurel Holmes. Is she still here? I'm going to ask. Laurel is the Director of Community Partnerships and Population Health, and she is responsible not only for tabulating our community benefit summary, but she personally oversees many of these initiatives that I think are behind your question.

MR. LAZARUS: Perfect.

MS. HOLMES: Good evening. I'm Laurel Holmes --

COURT REPORTER: I don't know if that microphone is on.

MR. LAZARUS: Hold on one second.

MS. HOLMES: Hi, again. I'm Laurel Holmes, Director of Community Partnerships and Population Health for Lawrence & Memorial Healthcare.

Your question referred to the Community Health Implementation Plan of 2013, on which we have implemented a number of initiatives to address the needs found through our Community Health Needs Assessment. As Mr. Cummings stated, we are in the process of completing our 2016 Community Health Needs Assessment, and, so, our attention is now turned to priorities identified there, which will be in some ways similar and in some ways somewhat different from the 2013 priorities.

The areas we will be addressing going forward have to do with behavioral health, mental health and substance abuse. In particular, opioid abuse and anxiety and depression, particularly among minority populations.

We will be working on supporting and nurturing healthy lifestyles, in particular, related to diabetes, and insuring access to care, and the issues that emerge there are having to do with maternal and child health and access to care for low income populations.

That plan is in development with many community partners presently, and, so, I can't speak to anymore specifics on that.

MR. LAZARUS: Thanks for that. Could you

talk a little bit about some of the areas that did improve in relation to those six priorities in 2013, where L & M had concentrated, and what were the outcomes, based on those?

MS. HOLMES: Yes, well, we, as you mentioned, identified six priority areas, some of which we deferred to community partners for intervention, due to resource constraints, but we were successful in implementing interventions to address a number of the others, including pediatric obesity, which we implemented a program that showed positive outcomes for all participating children in that program.

For example, 60 percent of participants in that program experienced an improvement in healthy living and also experienced some weight loss.

As it relates to access to care, we implemented a Dispensary of Hope Program, which is a program, which provides free prescription medications to individuals with limited access, and that has been we've realized a $20,000 community benefit investment through our Dispensary of Hope Program since its inception, and that program is ongoing.

As it relates to cancer, we implemented the Connecticut Early Detection and Prevention Program,

which delivers health screenings to women, mammogram and pap smears. There was a colonoscopy component to that program, which has since been discontinued, but, there again, we have delivered essential care to many community members, who would not otherwise have been able to access those services through implementing this program.

As it relates to mental and behavioral health, our focus has been on reconnecting the homeless program, which involves our partnership with the Homeless Hospitality Center here in New London.

We've been supportive of their respite bed program, and, additionally, we have a social worker dedicated to working with homeless individuals, who ensures that they have access to the supports within the community that they need to have more positive health outcomes and more permanent housing, and that's been a primary focus of that social worker's work, in addition to the Homeless Hospitality Center's work. Our community benefit investment in that program exceeds half a million dollars.

And, finally, as it relates to asthma, we have implemented a school-based program in two schools in New London, working with 28 children and their families, and additionally have a dedicated community health

worker, who is working in our Emergency Department to intervene with individuals, who are not receiving or not managing their asthma well and potentially not receiving the community-based care or hadn't been receiving the community-based care that they needed, in order to manage their asthma.

She has been successful in reducing Emergency Department utilization for individuals with asthma in her work and finding them more appropriate care in the community setting, so their asthma outcomes are positive.

MR. LAZARUS: All right, thank you. You mentioned the 2016 Community Needs Health Assessment. Are you incorporating the CDC's 618 initiatives?

MS. HOLMES: We're looking for a number of benchmarks in establishing our Community Health Implementation Plan. That still is very much in process.

We are conducting that planning process in a very collaborative manner with over 30 partner organizations participating, so it's not solely our decision, as to what the strategies will be going forward, but, certainly, we will be looking to any benchmarks, including Healthy People 2020 benchmarks that we can utilize.

MR. LAZARUS: Now is that due out this September?

MS. HOLMES: It will be approved by September 30th.

MR. LAZARUS: Has Yale participated in the 2016 Community Needs Health Assessment for the L & M area? Has it been part of this process, or is that something you're waiting?

MS. BORGSTROM: We have system-wide robust Community Health Needs Assessments. We have not done anything with Lawrence & Memorial on theirs, specifically.

MR. LAZARUS: Okay, but, moving forward, obviously, Yale would have to be partners in all the priorities that are going to be set as part of this?

MS. BORGSTROM: Yes.

MR. LAZARUS: So they would be in full support?

MS. BORGSTROM: Yes, absolutely.

MR. LAZARUS: Okay. Turning to community benefit, I was on your website for L & M, and you have a very nice way of laying out the community benefits and category-wise and stuff, so, looking at the past three to four years, you have like a total community support

number up there. I'm not sure who I should address this to. Okay.

MR. CUMMINGS: Laurel is actually responsible for both the needs assessment and for the community benefit summary, and it was she, who actually came up with that very nifty summary that you saw online.

MR. LAZARUS: Kudos to you.

MS. HOLMES: Thank you.

MR. LAZARUS: For the total community support, and then you go down to breakout the community benefit, bad debt and Medicare shortfall, in 2012, you actually had other subsidized services, and then I noticed later on that category was dropped off. What was included in that other subsidized services?

MS. HOLMES: I would have to look back at our 2012 report to specifically address subsidized services within that report.

MR. LAZARUS: Oh, okay.

MS. HOLMES: Typically, that category includes support for behavioral health services in the community, women's and children's health services, those sorts of services that, for example, like cancer screening grant program represents.

MR. LAZARUS: Oh, so, they're probably

still continuing. They're just categorized differently I'm assuming?

MS. HOLMES: Yes.

MR. LAZARUS: All right. That's good. Moving forward, do the Applicants plan to commit to providing similar levels of funding toward the community benefits, as reported on the website on those reports and, also, on the 990s, in particular, with this Schedule H for L & M community?

MS. BORGSTROM: Yes.

MR. LAZARUS: And that would include the community benefits, as well as community buildings for both?

MS. BORGSTROM: I'm not sure I understand your question.

MR. LAZARUS: Well, on Schedule H, there's, you know, there's two categories. There's community benefits, as well as community building, and, so, we just want to know the commitment would be for similar levels on both those, because those combined are generally known as community benefits, putting it simply.

MS. BORGSTROM: Yes.

MR. LAZARUS: Okay.

MS. AUGUSTA MUELLER: I didn't hear the

question. Augusta Mueller. I'm the Community Benefits Manager for Yale-New Haven Health.

MR. LAZARUS: Okay. We were talking about the community benefit and, in particular, Schedule H, where you have the community building and the community benefits, and, looking at the historical moving forward, we were trying to see if the commitment is going to be similar, at the similar levels for each of those categories.

MS. MUELLER: It should be. I don't see why it would change. As you know, or as you may be aware, the IRS has been looking at various components of the community building activities and have been shifting those to community benefits, so areas, such as housing, food access, now are community benefits, where, years ago, they were community building activities, but, you know, I don't see why they would change.

MR. LAZARUS: Okay. That helps. If this proposal is approved, how will this affiliation with Yale improve L & M's community benefit?

MS. BORGSTROM: That's very speculative, because I think, what I know of L & M, they've been very engaged. They've had a very robust Community Benefits Assessment we have throughout the Yale-New Haven Health

System, as well, and I think, again, you know, sort of strength in numbers, ideas, experiences, because we've shared best practices across the health system, and, you know, two of our hospitals, Bridgeport and Yale-New Haven, are located in two of the top 24 mid-size cities in the United States, so the needs have been great, the work has been terrific, so I would just imagine that the opportunities to collaborate will be even greater.

MR. LAZARUS: All right, thank you.

MR. CUMMINGS: If I can just add to that, certainly, I've highlighted why we are approaching this with a focus on access and growth, and to the extent that L & M is in a more financially-secure position as a result of this affiliation and the ensuing investments, it will increase our capacity to confer greater community benefit.

MR. LAZARUS: Thank you.

MS. FELDMAN: Mr. Lazarus, I would also point you to page 95 of the CON application, which sets forth the affiliation agreement and specifically addresses ongoing community benefit support in Section 2.3.

MR. LAZARUS: Is that the $11 million --

MS. FELDMAN: Yes. Yes, sir.

MR. LAZARUS: -- that was referenced in there? Was that per year, or was that for a time period?

MS. FELDMAN: I believe it's five years.

MR. LAZARUS: Five years. Is that $11 million total, or is it $11 million --

MS. FELDMAN: It's a minimum amount.

MR. LAZARUS: Minimum.

MS. FELDMAN: Which is the current level.

MR. LAZARUS: The current level.

MS. FELDMAN: Yeah.

MR. LAZARUS: Okay.

MS. MUELLER: Can I add a comment? I think that, in addition to what Marna mentioned and, also, Mr. Cummings, that our corporate structure is very supportive of community benefit activities, so, I mean, Laurel and I have served together on the Community Benefits Committee at the Connecticut Hospital Association for years, so there's an opportunity for us to continue that learning, but our corporate structure we have corporate tax, corporate legal, you know, community benefits that really are I just feel so supportive, you know, organizationally, and no other hospital, you know, to my knowledge has that in the state.

Even corporate finance, you know, the

things that we have in place are very different.

MR. LAZARUS: All right, thank you. Moving on, regarding quality, if L & M can, probably addressed to you, Mr. Cummings, what was the result of the most recent DPH survey performed at L & M?

MR. CUMMINGS: Can you be more specific?

MR. LAZARUS: Yeah. This has to do with the Licensing Division. They come and do the surveys, so we want to know what was the most recent.

MR. CUMMINGS: Are you talking about our licensure survey?

MR. LAZARUS: Yes.

MR. CUMMINGS: I think we'd have to get you that information as a late filing.

MR. LAZARUS: A late file? Okay. In that case, can you --

MS. FELDMAN: I can tell you they're still licensed. (Laughter)

MR. LAZARUS: That's good. We'd like a copy of the survey, as well as all communications between the hospital and DPH.

HEARING OFFICER HANSTED: That will be Late File No. 5.

MR. MURRAY: Mr. Lazarus, can I just

clarify? When you say all communications between DPH and L & M, with respect to the licensure and the survey?

MR. LAZARUS: Yes.

MR. MURRAY: Okay.

MS. FELDMAN: Do you have a particular survey date in mind?

MR. LAZARUS: If we give you a written list, I can try to give you a date.

MR. CUMMINGS: We certainly want to make sure you have the information.

MR. LAZARUS: Sure. We can be more specific in our request, yes. We'll get you the date.

MS. FELDMAN: Thank you.

MR. LAZARUS: All right. Considering all the testimony that we've heard, especially specifically in the first day of the hearing, there were a lot of public concern and comments that were raised regarding L & M Hospital's community access to information related to the hospital's future, transparency regarding the process, if any of the changes were going to be made regarding any of the services at L & M, the impact of this proposal on the quality of care of L & M.

Can the Applicants address some of the concerns that were brought up by the various individuals

and the organizations, and we can list them here, but if you can just go down one-by-one?

First, we've talked a little about earlier the costs and pricing to the consumer and the healthcare system, L & M's community access to services and physicians locally, quality of care at L & M, community input and access to information related to L & M Hospital after the closing.

MS. FELDMAN: Can you repeat the last one, please?

MR. LAZARUS: Community input/access to information related to L & M Hospital after the closing.

MS. FELDMAN: Before we answer the question, I just want to clarify a statement made by Mr. Cummings before with respect to plans to terminate any services by virtue of the proposal, and I want to just be clear that his answer was directed at that specific question.

There may, in fact, be plans for L & M right now, based on insufficient demand, to request termination of a particular service that has nothing to do with this proposal, so I just wanted to be clear about that and not to mislead, in terms of our response.

MR. LAZARUS: Okay, thank you.

MS. FELDMAN: I think there has been a lot of testimony regarding the issue of pricing. If you would like us to respond to that again, we can.

In terms of access, I think, you know, in terms of deployment of the $85 million and what the purpose is behind that and the testimony from Dr. Lehrach, I thought he was addressing the access issue, but we're happy to restate it, if it would be helpful to OHCA.

HEARING OFFICER HANSTED: Let's do this. It's been a while since our last break, and, just to give you some time to think about your answers, let's take a 10-minute break, and then we'll reconvene.

MS. FELDMAN: Okay, thank you.

(Off the record)

HEARING OFFICER HANSTED: Folks, we're going to get started here again. The Applicants want to address our last question at this point. We'd appreciate it.

MR. LAZARUS: And before we actually go back to that, Kaila has a follow-up.

MS. RIGGOTT: I have a follow-up kind of in relation to that. As you know, OHCA is required to evaluate whether or not an Applicant has met our

statutory criteria, and with respect to pricing data for consumers we know that the Comptroller has some data on State employee costs and prices, and I believe there may be some Medicaid data from DSS that may be made available to the task force.

We understand the limitations of the Sherman Act, but I just want to ask the Applicants is there any data, even if from multiple sources, that you can provide to OHCA that will assist us in evaluating our statutory criteria related to whether or not healthcare costs to consumers will be adversely affected by this proposal?

MS. FELDMAN: In all due respect, Kaila, I think we tried to answer that, and it might be helpful to restate some of what you heard.

A couple of things. One is there is no plan to raise prices. I think the testimony included the fact that there would be price neutrality for the remainder of the contract terms, hence the late file.

There was also testimony, saying that, in the future, negotiations with payers, to the extent that there are negotiations with payers, because, as we've provided in our application, over 70 percent of our payer mix is governmental payers, we also have TRICARE, so we

not only have Medicare and Medicaid, but we have TRICARE, so there's really very little room for negotiation, but, again, it will be based on L & M's cost structure, not Yale-New Haven Hospital's cost structure, and I think that is the very reason that the Comptroller said in his e-mail that, when that Milliman Study was done, it was done thinking that the prices of Yale-New Haven Hospital would become the prices of L & M Hospital, and we're here to say that is not what will happen.

So we don't have access to the data that you're requesting. I don't know whether the Milliman data is, you know, where it came from, whether it represents the entire universe of claims, so I'm not sure how we can respond to the request, without giving the appearance, as it's been stated by the Intervenors, that we're trying to hide the ball.

That's simply not the truth. We've given every representation we can to reassure OHCA that, by virtue of the affiliation, should it be approved, that this will not trigger price increases for L & M.

MS. RIGGOTT: Thank you.

MR. CUMMINGS: Returning to your question, Mr. Lazarus, I think Attorney Feldman has already touched upon the pricing and cost, but I'll come back to that,

just to add to my own comments a little bit later, but, as I understand it, you wanted to hear about that, about access, about quality and community input, is that correct?

MR. LAZARUS: Yes.

MR. CUMMINGS: So let me start with the access area. I hope we've demonstrated we pursued this relationship, and I want to bring you back to the initial hearing.

It was L & M, who initiated this relationship, as we took stock of the changes that were occurring in the landscape, and our concern, about whether we would be able to continue to serve the community with the highest level of quality and access in the face of declining revenues, and we concluded we could not.

Through this affiliation, as you've heard, $85 million will be made available over five years, regardless of the financial reforms. No strings attached. That's to invest in growth and access.

The parties are committed to recruiting at least 20 physicians, who would be new to the community. These are not, quote, "purchased practices." These are new physicians, providing new capabilities in our

community.

You've also heard that we've agreed in broad strokes to focus on behavioral health and expanding access there, primary care, maternal and child health services, emergency and critical care, and surgical capabilities.

We want to make sure, and I think you've heard this from Ms. Borgstrom, that patients do not have to travel out of the area for routine care.

The model that we are talking about is to maximize the potential for people in this area to receive care locally for routine services, for what's called primary and secondary level services.

We are not a teaching or research institution today. We will not be one post-affiliation. That role is really performed by Yale-New Haven Hospital, and what we want to have happen is those services that appropriately can be done in this community at this hospital remain here and that we are actually able to add to those capabilities.

Patients overwhelmingly prefer to receive care locally when they possibly can, and the cost for receiving that care is a lot lower in a community hospital than it is in an academic medical center for all

the reasons that you heard from Ms. Borgstrom.

And, in the future, as I commented just before we took the 10-minute break, part of our shared view between Yale-New Haven Health and L & M is where healthcare is going in the future, and a premium will be placed on value or results at the lowest possible cost.

It would be inimical to the interests of both parties to have, particularly in a risk-based environment, which is where we're headed, for patients to receive care in a higher cost setting when a lower cost setting was available, so between the investments, the $85 million that you heard about, the minimum of 20 new physicians in the area, the investments in these five categories, program categories I alluded to, we are confident we will be able to markedly increase access to locally-available services in Southeastern Connecticut and Southwestern Rhode Island.

The flip side of that equation is, if this affiliation is not approved, access for patients and jobs for staff will be in jeopardy.

In the area of quality, one of the things that drew us to Yale-New Haven is not only their excellent reputation, but the wherewithal that they have around fostering evidence-based practices.

Yale-New Haven Hospital, in particular, because it has three missions, clinical medicine, teaching and research, makes available to its affiliates the capabilities that would otherwise not be available, in terms of best practices, and we're excited about the fact that these evidence-based practices will be not only immediately available to us upon affiliation, but will continue to be updated, as the latest literature suggests would be appropriate.

I don't recall whether it was specifically mentioned at the original hearing, but Yale-New Haven Health System has a quality council, in which there are representatives from all of the affiliates, and we look forward to being part of that, so that the Chief Medical Officers and the Chief Nursing Officers and the Chief Quality Officers are able to learn from one another and further potentiate best practices.

On the area of community input, as you heard from Laurel Holmes, my colleague, a few minutes ago, we are committed to and the continuation of both the Community Needs Assessment and the resulting community benefits, that doesn't change under this affiliation, that commitment.

L & M has a, as many hospitals do, a

Patient and Family Advisory Council we established about a year and a half ago that allows us to get direct input from former patients and family members about their experience, what went well, what didn't go well, how can we approve upon it, are there additional needs that we should be meeting in the community and in the lives of our patients? We found that very resonant in our thinking.

We routinely survey our patients, and from that, again, get extraordinary insight into what we're doing well and how we can improve.

We are, first and foremost, a community-governed and community-oriented organization. Post-affiliation, will still be local staff, local clinicians, local physicians caring for their community. There really will be no change in the people, who face forward to those patients.

We're here today. We'll be there tomorrow if the affiliation is approved. There may be fewer of them if it is not approved.

And I think, finally, I wanted to comment that, you know, both L & M and Yale-New Haven are non-profit, mission-driven organizations. We share the same values. We have a similar view of where healthcare is

heading. It was one of the reasons why, for our Board, it was a relatively easy decision to say Yale-New Haven Health is really the partner of choice for us.

We have not made the decision, we didn't even consider making a decision that some hospitals have made about seeking a for-profit partner, where community input and community need would be a far lesser consideration, and, indeed, that was one of the things that motivated the L & M Healthcare Board a couple of years ago to pursue the then bankrupt Westerly Hospital, because we knew that there were three venture capital-backed, for-profit actors, who were looking to acquire it.

We thought that would be injurious not only to the Westerly community, but for the approximately one-third of Westerly's patients, who originate from Connecticut.

We thought it would be bad for that community, it would be bad for our community, it would be bad for the staff, who are employed at L & M, if a venture capital-backed, for-profit had acquired Westerly.

Those commitments to community input and community governance that I think we've highlighted here, a local Board, with true fiduciary responsibilities, to

approve budgets, to set priorities, to make determinations whether a service should be added, or, the flip side, discontinued, originate at that local level that's there today and will be there post-affiliation.

MR. LAZARUS: Thank you very much. As you may be aware, that with some of the other recent CON decisions regarding changes of ownership, there have been some conditions that were placed on the approvals.

If this was approved down the line, would the Applicants have any issues or challenges for, say, allowing for a community representative, either picked by the local Mayor's office or by OHCA, on its local Board holding informational public forums, say, twice a year and possibly having an independent monitor ensuring compliance with any of the conditions OHCA or DPH as a whole would set forth?

MS. BORGSTROM: You know, there's a lot in that, and I think that, you know, we need to discuss. We feel we are community organizations right now. We do not condone and we are not supporting representative Boards.

Board members should be elected, in my opinion, based on their talent, their commitment, their service. We have multiple forums through which we currently account for what we do, and this is not to get

out of being accountable and responsible, but, you know, I think that the way you have described this could be problematic for us, and we would need to have discussion about what's intended and what we're really looking for.

MS. FELDMAN: With respect to the community forums, did you want to specifically respond to that?

MR. LAZARUS: And just to clarify, we're not looking for, I'm not looking for a commitment today. I just wanted to see if there were any issues and concerns that you have at this point.

MS. FELDMAN: I think that, if this is what's between us and approval, in all honesty, I think, from what Mr. Cummings just described, that this is an organization that's very committed to its community and getting feedback by way of its Community Needs Assessment, its Board, which is made up of folks from the community, who receive their services at L & M.

If you're talking about having forums, where input is provided by the community, I don't think that's a problem at all.

MR. LAZARUS: All right. Just to wrap up my questions, this application has been in front of us for a while now, so, just to sort of bring things a

little up-to-date, can you give us a little update, as far as, if this was approved, what are you thinking, as far as a closing date for this process?

MS. FELDMAN: As I believe it was mentioned earlier, I can't remember who provided the testimony, but according to our approval from the FTC, we must be closed by September 8th of 2016, so we would need to begin closing the week prior.

MR. LAZARUS: Are there any other State or Federal approvals that are required, besides the CON approval, for the Applicants to move forward towards the closing?

MS. FELDMAN: I think it was mentioned maybe at the last hearing, I don't recall, but we're in the process of also going through a parallel proceeding in Rhode Island, and that is moving along very positively.

MR. LAZARUS: Is there a possibility for the Applicants to request any kind of extension for that September 8th date?

MS. FELDMAN: No, there is not. Absolutely not. We've already vetted that with experts in Hart-Scott-Rodino filings, folks that do nothing, but that, and it cannot be extended.

If the application is not approved in time, we would have to start all over and incur a significant expense, in terms of going through that process again.

MR. LAZARUS: Thank you. If this proposal is approved after the closing, what are the planning or process priorities that the Applicants would have with L & M for, say, for the first six months? What would be the priority to get the process moving forward, in general?

MS. BORGSTROM: I'll take a crack at this, because I think, in other affiliations and integration we've done, you know, these are complicated processes.

Believe it or not, sometimes the approvals are the easy part. The hard part is actually making this work and getting the integration, so job one is making sure that people feel they are communicated with, they understand what's happening.

Our commitments are to our patients, seamless care, continuous care to our employees, toward integrating business services in a way that is not disruptive to operations, is basically, you know, starting the integration and just getting the basic functioning going, and then engage in, you know, broader

planning opportunities than we've been able to, because a lot of what we've done up until now I think, as Mr. Cummings and others have said, has been through third party consultants, because we haven't really been able to, you know, get into the details, so to speak, between the Yale-New Haven Health System and Lawrence & Memorial, but the goal would be to move very quickly on getting the information systems upgrade completed, determining the clinical priorities, beginning physician recruitments that can support perceived needs in New London.

I'll walk back to my previous comment, which, you know, we are community organizations. We're in the community all the time. We have to be accountable to the communities in which we operate.

A lot of what we need to do is be out there and explaining what this is, what it isn't, what people can expect from this.

Change is very difficult, but I think that, when people start to see the same faces, the same people working on their clinical care, on their accounts receivable, on whatever it is, you realize that the change is much more -- is longer horizon change than dramatic short-term change.

It really is the process of beginning to

blend the families.

MR. LAZARUS: Thank you. Thank you. I'm all set.

HEARING OFFICER HANSTED: That concludes OHCA's questioning, so, at this point, we'd like to go back to the public comment section of our hearing, and those individuals, who wish to give public comment, should have signed up on the sheet outside of this door.

If you don't wish to speak, keep in mind that you can give comments in writing, and the address to send those comments is on the information sheet, which is also on the table outside the door, so we're going to call individuals up in the order that you've signed up.

(Whereupon, the public spoke.)

HEARING OFFICER HANSTED: Just one bit of housekeeping. The late files that were ordered are due August 5th, and, at this time, I'll allow counsel to give a brief closing statement, if they choose to.

MR. MURRAY: Mr. Hansted, before that, Mr. Hansted, could we ask? There's a question we'd like to ask, just to clarify something for the record of the Applicants about the patient mix at Lawrence & Memorial Hospital.

There seems to be some confusion, at least

on our end here on the record, about what was stated. Would that be permitted?

HEARING OFFICER HANSTED: Do you have any objection to that, Attorney Feldman?

MS. FELDMAN: It's past my bedtime, so, yes, I do. No.

HEARING OFFICER HANSTED: Okay.

MR. MURRAY: I don't know, Joan, who should answer. I just wanted to clarify, because we've heard 70 percent, and I've heard two-thirds, in terms of government payers, mostly Medicaid and Medicare, and I just wanted to clarify what it is at Lawrence & Memorial Hospital.

MS. FELDMAN: We'll have our CFO answer the question.

MR. VanESSENDELFT: Is this mike on? So I think you may have heard maybe two of those comments. The medical group, which we spoke about in the second CON request, was in that kind of two-thirds area, around 60 percent or so. At L & M Hospital, it's closer to that 75 percent or around that area, including TRICARE.

So when we were talking about that, we were looking at Medicare, Medicaid and TRICARE.

MR. MURRAY: Okay. The reason I ask is

that, taking a look at, and maybe this is something you could clarify for the Commission, looking at note two on the consolidated fiscal year '14 and '15 statements for L & M, it indicates that the combined patients for Medicare and Medicaid in fiscal year '15 was 48 percent, and, in fiscal year '14, it was 46 percent. That's why there was some confusion we wanted to clarify.

MR. VanESSENDELFT: Can you show me what you're looking at?

MR. MURRAY: It's in a document submitted by -- oh, here it is. On page 746 of the submission for the acquisition at L & M, it says revenues from services to patients and charity care, and it goes over and says, during 2015 and 2014, approximately 36 percent and 35 percent, respectively, have met patient service. Revenue was received under the Medicare program, and 12 percent and 11 percent, respectively, under the State Medicaid Program. We needed some clarification, because --

HEARING OFFICER HANSTED: Absolutely.

MS. VanESSENDELFT: And thanks for clarifying. That was helpful. What you're really struggling with is what we're all struggling with, is the payer mix I gave you was gross revenue. That's essentially the portion of services provided. The 35 or

45 percent, the numbers you just referenced, was net patient revenue. That's what we're actually being paid, so there is a significant difference in the amount of services being provided, which is based on charges, or amount of services provided, versus the net revenue, which is what we're getting paid to provide those services, and that really highlights much of the challenge that we're having.

MR. MURRAY: So does the, in terms of fiscal year '15, does that mean that 42 percent of net revenue is paid from other sources, other than government payers?

MR. VanESSENDELFT: I'm sorry. Cite that again?

MR. MURRAY: So if the net revenue is 48 percent in fiscal year '15 from government payers, Medicare and Medicaid, does that mean that, in fiscal year '15, the net revenues from commercial payers was 52 percent?

MR. VanESSENDELFT: It would mean that the non-government payers, which would include commercial and other means, would be the remainder of that.

MR. MURRAY: Okay, thanks very much. Thank you. I wanted to clarify that. Thank you.

HEARING OFFICER HANSTED: Okay. Attorney Feldman, if you want to give a brief closing statement?

MS. FELDMAN: Yes. I'm going to keep this very short.

HEARING OFFICER HANSTED: Thank you.

MS. FELDMAN: As a favor to OHCA. This has very clearly been a very unusual proceeding, based on my own experience, and despite everything we submitted in four volumes of documents, reiterated several times and made painfully clear, we said these things to reassure those in the community that they would not be affected adversely.

Unfortunately, the proposal has become the currency by which various parties have bid their own agendas, so I respectfully request that OHCA please disregard some of the hyperbole, some of the self-serving statements, some of the flawed testimony and mistruths.

By way of example, the continued reference to this affiliation as leading to a monopoly situation, and there are many other examples that I'm not going to go through, but I do ask OHCA to please rely on the statutory criteria and the documents before you, as you know better than me.

There's 12 criteria. Even if three of

those criteria are not found in favor of this application, we believe there's convincing evidence in the record with respect to the hospital affiliation 32033 that it should be approved.

Regardless of your decision on that application, the merger between LMPA and NEMG should be viewed independently.

While I understand that the affiliation agreement ties those two transactions integrally together, I think it's up to the parties to decide how they would handle any decision by OHCA.

That is all I have to say. I want to thank you.

HEARING OFFICER HANSTED: Thank you. Attorney Murray?

MR. MURRAY: Thank you, Attorney Hansted. I wish I could say my remarks would be very brief, but I think it's the statutory and I think the public policy framework we're doing, within which you are considering this, I think need to be considered.

Since 2003, the Connecticut General Assembly has progressively strengthened the state's laws governing healthcare providers.

In 2014, the legislature instituted the

first requirement for Certificate of Need, review of physician practice acquisitions, expanded OHCA, and the State Attorney General's power to review and modify the conversion of non-profit hospitals to for-profit hospitals, and dramatically raised the bar for approval of hospital acquisitions by requiring OHCA to make findings that an Applicant for such an acquisition has affirmatively proven that a consolidation will not adversely impact cost, access, or diversity of providers.

In 2015, the General Assembly passed Public Act 15-146, a sweeping Consumer Protection law that makes Connecticut a leader among states attempting to cope with the dramatic changes in our healthcare system.

Among the policy changes made by the law, our first ever ban on some facility fees, restrictions on other facility fees, caps on surprise bills for patients, who unwittingly receive care from out-of-network providers, and a ban on the use of electronic medical records, like Epic, as a tool for market leverage.

Perhaps, most importantly, as of January 1, 2017, Connecticut's Healthcare Insurance Exchange will publish the actual allowed amounts, paid by fully-insured health plans, to each provider for the most common

diagnoses and procedures.

Public Act 15-146 demonstrated a Connecticut bipartisan commitment to creating the most transparent healthcare system in the nation.

While it's not a panacea, transparency on price, quality and access is essential if the proposed, the various proposed changes in reimbursement and acquisitions are to benefit patients, rather than to simply reshuffle money between the pockets of insurers and providers.

The transparency provisions of Public Act 15-146 are relevant here, precisely because of the dispute that's in these proceedings about whether or not the Applicants or their insurance carriers have the data that OHCA requested, and the Applicants claim that the data do not exist that the insurance companies have, and, even if it did exist, they couldn't produce it, because it's arguably either protected by proprietary contracts with the insurers, or because it's a proprietary trade secret.

Whether or not the health industry, as a whole, possess a perfect risk assessment tool to interpret the data, the raw unadjusted prices will become public in less than six months.

The Applicant should produce the information requested by OHCA as raw price data, and then OHCA could have an expert analyze it, if necessary. In addition, given the impending release of these data on January 1, 2017, it's hard to understand the Applicant's insistence that the release of the information implicates any proprietary information or contracts that they may have with the insurers.

The actual language of Public Act 146 reads, in relevant part, "On or after January 1, 2016, no contract entered into or renewed between a healthcare provider and a health carrier shall contain a provision prohibiting disclosure of, one, billed or allowed amounts, reimbursement rates, or out-of-pocket costs, and, two, any data to the all-payer claims database, program established under Section 38a-1091 of the General Statutes, for purpose of assisting consumers and institutional purchasers in making informed decisions regarding their healthcare and informed choices among healthcare providers."

Thus, any contracts renewed or entered since the beginning of the year, OHCA could demand that data, irrespective of any claims about trade secrets or protections from contracts with the insurers.

Continued withholding of this data from OSHA(sic), that OSHA(sic) requested, for the purposes of evaluating these applications we think is simply unwarranted, given the public policy environment under which they're being considered.

Moreover, PA 15-146 requires that the Health Insurance Exchange publish, as I mentioned, the allowable amounts that fully-insured plans pay to each provider for 50 of the most common inpatient diagnoses and procedures in the state, the 50 most common outpatient procedures, and the 25 most common surgical and imaging procedures.

Thus, the claim, that the data is protected from disclosure to the public, we think is a bogus claim and should be disregarded by the agency.

There really is nothing that we see that prohibits OSHA, excuse me, OHCA from requesting that data in any respect. We think that, since this data is going to be available, this pricing data is going to be available to OHCA in less than six months, then OHCA ought to simply keep the record open on this particular issue until it has that pricing data within which to evaluate whether or not this particular acquisition does have a negative impact on the pricing and the costs in

the New London area.

Throughout these proceedings, the Intervenors have raised the important issue of continuing access to health care in New London following the acquisition, and we've asked OHCA to draw lessons from the Hartford HealthCare takeover of Windham Hospital.

Not surprisingly, the Applicants argue that Windham Hospital, the events at Windham Hospital are irrelevant. This isn't true, if you take a look at OHCA's final order on the Windham case, which said, "The Applicants also stated that, currently, they will not be terminating any services, however, OHCA realizes that, in the future, the reduction of duplicate services may be necessary to further strengthen the financial viability of the system."

The vague promises made by Hartford HealthCare about the reduction in services at Windham demonstrate that such representations are, at best, untrustworthy.

The applications before you contain long passages, promising unspecified expansion of clinical programs and the devotion to the financial stability of L & M.

These mirror in many respects the promises

made by Hartford HealthCare at a time it was proposed acquiring Windham Hospital.

Given the subsequent cuts in critical services at Windham Hospital, the public in Eastern Connecticut may be given a healthy skepticism of such promises.

The application should not be approved in the absence of clear, binding, legally-enforceable commitments to the Greater New London community regarding the maintenance of services.

One of the most puzzling aspects of the application is the Applicant's insistence that L & M will remain locally-controlled.

As the testimony and documents submitted to OHCA make clear, this simply isn't true. The plain language of the proposed L & M bylaws demonstrate the crucial decision-making authority will not reside in New London.

As a sole corporate member, Yale will elect all the trustees to the L & M Board and can remove them. The President and CEO of L & M is appointed not by the L & M Board, but by Yale-New Haven Health Services.

And, importantly, as I think we pointed out in Cross-Examination, all the major financial and

strategic decisions reside with the sole corporate member.

With respect to the alleged $300 million investment, we believe OHCA should be troubled by the Applicant's unwillingness to specify the exact details and nature of the investment and whether it truly is an investment.

Surrendering control of its community hospital should yield tangible benefits to Greater New London, yet it has taken OHCA several sets of questions to get specifics on the first $41 million of that investment, which consists of software installation, training, branding, and other intangibles.

It took multiple rounds of questioning for the Applicants to state that the second $44 million would be actual new money from Yale-New Haven Healthcare assets, however, the details of these investments still remain vague.

Their most recent responses indicated that it will be split between clinical recruitment and support staff, and, despite the assurances made by Ms. Borgstrom here today, unless there's an actual assurance to OHCA that the money geared towards physician recruitment is going to go to actual recruitment of new physicians in

the New London area, rather than the acquisition of physician practices, it is going to be very hard for OHCA to evaluate the impact on the Greater New London area.

If one accepts the fact that the initial $85 million that Yale has committed to invest in OHCA is I think one of the expressions used by one of the Applicant's witnesses was hard money, the same can't be said for the remaining $215 million.

The Applicant's response is to this, of where that $215 million is going to come from, is vague, at best. In fact, the language used tonight was that it is a reinvestment of L & M's operating revenues into the viability of the system.

Finally, we want to suggest to OHCA that there's some precedent that it ought to look to in situations like this, where control of a community hospital is transferred to an out-of-market entity.

In the case of the transfer of non-profit hospitals to for-profit status in both Eastern Connecticut Health Network and the Waterbury Hospital case, the Attorney General required a substantial amount of money, $105 million in the case of Eastern Connecticut and $55 million in the case of Waterbury, to be placed in community trust for the exclusive use by the local

communities in furtherance of community health needs.

We're fully aware that those decisions occurred under a different statutory context, and it involved the change from non-profit to for-profit status, which doesn't apply here, however, in both cases, as it does here, one of the chief concerns expressed was the loss of control of an essential community asset to an out-of-market player.

We think the precedent set by the Attorney General should also inform OHCA's decision regarding the applications in this case.

Although the Intervenors' views vary on whether or not there's a viable acquisition is ultimately possible, we believe that the applications, as currently submitted to OHCA, do not fulfill the community's needs and respectfully request that OHCA deny them. Thank you.

HEARING OFFICER HANSTED: Thank you, Attorney Murray. And, with that, I thank everyone for attending this evening, and this hearing is adjourned.

(Whereupon, the hearing adjourned at 9:17 p.m.)

HEARING RE: YALE-NEW HAVEN & NORTHEAST MEDICAL GROUP
JULY 26, 2016

AGENDA

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinbefore set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness whereof I have hereunto set my hand and do so attest to the above, this 3rd day of August, 2016.

Paul Landman
President

Post Reporting Service
1-800-262-4102

Olejarz, Barbara

From: Hansted, Kevin
Sent: Friday, August 12, 2016 1:55 PM
To: Olejarz, Barbara
Subject: FW: Docket No. 15-32032 and 32033
Attachments: Applicants Objection to Admission.pdf

Kevin T. Hansted
Staff Attorney
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7044
kevin.hansted@ct.gov

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Friday, July 29, 2016 2:42 PM
To: Hansted, Kevin <Kevin.Hansted@ct.gov>
Cc: hfmurray@lapm.org; jennifer.willcox@ynhh.org; Carannante, Vincenzo <VCarannante@goodwin.com>; Lazarus, Steven <Steven.Lazarus@ct.gov>; Riggott, Kaila <Kaila.Riggott@ct.gov>; Carney, Brian <Brian.Carney@ct.gov>
Subject: Docket No. 15-32032 and 32033

Kevin:
Attached you will find the Applicants Objection regarding the submission of the Milliman document to the above-referenced proceeding.
Many thanks.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

AFFILIATION OF LAWRENCE + MEMORIAL CORPORATION WITH YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	**DOCKET NO. 15--32033-CON**
	:	**JULY 29, 2016**

APPLICANTS' OBJECTION TO ADMISSION OF MILLIMAN ANALYSIS OF STATE OF CONNECTICUT, STATE EMPLOYEES RELATIVE COST PER HOSPITAL DATED SEPTEMBER 15, 2015

Pursuant to the direction of the Hearing Officer at the Office of Healthcare Access ("OHCA") hearing held in the above-referenced matter on July 26, 2016, the Applicants, Lawrence + Memorial Corporation ("L+M") and Yale-New Haven Health Services Corporation ("YNHHSC") (collectively the "Applicants") hereby object (the "Objection")[1] to admission into the hearing record of the document referred to as the "Milliman Document Of State of Connecticut, State Employees Relative Cost Per Hospital" dated September 15, 2015 (the "Milliman Document"; by Administrative Notice with accompanying e-mail referenced as Exhibit LL). As grounds for the Objection, the Applicants submit that: 1.) the request to admit the Milliman Document was untimely, violative of OHCA's procedural requirements and its admission under the circumstances would be prejudicial to the rights of the Applicants; 2.) the Milliman Document is irrelevant and immaterial to the issues raised by the Application; and 3.) the Milliman Document is irrelevant because, by its terms, it is based on data and information which was not independently verified by Milliman and which is subject to variables so numerous and significant as to render the Milliman Document inherently unreliable. The Applicants more fully set forth the grounds of their Objection below.

[1] At the hearing held on July 26, 2016, the Applicants orally objected to admission of the Milliman Document. The Hearing Officer requested that the Applicants submit their objections in writing. The Applicants submit this Objection in compliance with that request.

A. The Request To Admit The Milliman Document Was Untimely, Violative Of OHCA's Procedural Requirements And Prejudicial.

The request to admit the Milliman Document as part of the hearing record was untimely and violative of OHCA's requirements regarding the pre-filing of written testimony and accompanying documents, especially as relates to the submission of technical and expert documents. Under the circumstances, admission of the Milliman Document into the hearing record would unfairly prejudice the Applicants' rights to fair notice and the opportunity to analyze, investigate and rebut the evidence sought to be admitted. As such, the Milliman Document should be excluded from the hearing record.

In this proceeding, OHCA ordered that all pre-filed testimony be filed by July 1, 2016, well before the commencement of the public hearing on July 11, 2016. Nonetheless, the Intervenors, despite the fact that this document has existed for some time by virtue of its date, did not submit or even mention the Milliman Document in their pre-filed testimony or accompanying exhibits. Thus, the Applicants had no notice of its existence or opportunity to reasonably analyze its contents and prepare rebuttal testimony.

For the first time at the OHCA hearing on July 11, 2016, the Intervenors sought to introduce an incomplete copy of the Milliman Document, consisting solely of the chart contained as page three of the document and completely omitting the descriptions of purpose, methodology, findings and limitations contained in the balance of the report. At that hearing, the Applicants vehemently objected to admission of the partial document for multiple reasons and, given the lack of information regarding the proposed submission, the Hearing Officer deferred his ruling pending further clarification as to the circumstances and methodology of its creation to be discussed at the July 26, 2016 continuation of the hearing.

Thereafter, apparently at the initiation of the Intervenors, the Comptroller of the State of Connecticut, Kevin Lembo, submitted a complete copy of the three page Milliman Document along with an explanatory e-mail explaining the circumstances of its preparation. While OHCA provided administrative notice of the filing to the parties[2], at no time was any written expert testimony submitted from Milliman or from any other witness purporting to explain or elaborate on the Milliman Document or the methodology and assumptions employed.

The failure to provide any pre-filed testimony regarding the highly technical Milliman Document is certainly violative of the spirit, if not the letter, of the Rules of Practice governing OHCA contested cases. Pursuant to Connecticut Department of Health Rule of Practice Section 19a-9-29(e) "[u]pon request of any party . . . or on his own motion, the presiding officer may require any party or other participant who proposes to offer technical or expert written testimony to provide such testimony to any or all other parties or intervenors, and to prefile such testimony with the presiding officer, prior to or during the course of the hearing." Thereafter, the written testimony may be received in evidence "provided that each witness shall be present at the hearing at which the prefiled testimony is offered, shall adopt the written testimony under oath and shall be available for cross-examination." Id. (emphasis added). Obviously, these provisions are intended to prevent administrative trial by ambush and to ensure fair notice and the opportunity to prepare rebuttal testimony and examination. In the instant case, the Intervenors' attempt to admit the Milliman Document without any reasonable opportunity to investigate, analyze or rebut its factual bases and findings or to cross-examine its creator is both unfair and highly prejudicial.

[2] Pursuant to the rules of evidence applicable to OCHA hearings, ordinarily notice may only be taken "of judicially cognizable facts and of the generally recognized technical or scientific facts within the agency's specialized knowledge." Conn. Gen. Stat. § 4-178(6). Obviously, nothing about the Milliman Document suggests that it falls within the purview of this rule and is properly the subject of administrative notice in these proceedings.

In sum, the Milliman Document should be excluded from the hearing record. Submission of the report was untimely, proffered in contravention of OHCA's established pre-filing procedures especially as relates to expert witness reports, and its admission would unfairly prejudice the Applicants' rights to investigate, analyze and rebut such evidence.

B. The Milliman Document Should Be Excluded Because It Is Irrelevant And Immaterial To The Issues Raised by The Application.

The Milliman Document is patently irrelevant and immaterial to the issues raised by the Application and it should not be admitted to the hearing record.[3] The admission of the Milliman Document would not serve to illuminate but rather to distort and confuse the issues to the prejudice of the Applicants.

The Milliman Document is a hypothetical analysis prepared in September of 2015 by the State's former healthcare plan consultant, Milliman, exclusively for use by the State of Connecticut Comptroller's Staff. Counsel for the Intervenor informed counsel for the Applicants that he believed that the document was prepared at the request of an AFT representative. Using unverified data, the hypothetical analysis purported to compare the average paid cost for outpatient and inpatient services incurred from 5/1/ 2014 - 4/30/2015 for a relatively small subset of active state employees utilizing hospital services at L+M and Yale New Haven Hospital. Based on the erroneous assumption that the entities would merge and that the Yale New Haven Hospital fee schedule would therefore be utilized at L+M, Milliman projected a significant increase in expense to state employees utilizing L+M's services.

However, as is now clear, the Milliman Document proceeded from hypothetical factual assumptions fundamentally different from the actual facts which underlie the Application and the

[3] The rules of evidence applicable to OCHA hearings as set forth in the Uniform Administrative Procedures Act provide in relevant part that in contested cases that: "Any oral or documentary evidence may be received, but the agency, shall, as a matter of policy, provide for the exclusion of irrelevant, immaterial or unduly repetitious evidence." Conn. Gen. Stat. § 4-178(1); Cf. Department of Public Health, Rules of Practice Section 19a-9-24.

proposed affiliation. As set forth in the Application and as made abundantly clear in the testimony at the OHCA hearing, the proposed relationship between L+M and YNHHSC is an affiliation and not a merger. Similarly, the fees to be charged by L+M after the affiliation will be separately negotiated with health insurers as is done now by each hospital member of the YNHHSC system.[4] In no event, will the fee schedule of Yale New Haven Hospital be applied at L+M as erroneously presumed by the Milliman Document. Moreover, the Applicants never denied that Yale New Haven Hospital, as an ACGME accredited teaching hospital, has more costs associated with its services and thus, is generally more expensive than a community hospital such as, Lawrence + Memorial Hospital which is not a teaching hospital. Therefore, there is no supportable relevance for the Milliman Document.

The irrelevant nature of the Milliman Document is underscored and effectively conceded in the e-mail from State Comptroller Kevin Lembo dated July 21, 2016 (the "Lembo E-mail") which accompanied his submission of the Milliman Document to the Department of Public Health. In the Lembo E-mail, Mr. Lembo explains the genesis of the Milliman Document and suggests the core reasons why it is irrelevant to the pending Application as follows:

> The analysis was produced in response to the announcement of the Yale New Haven and L&M affiliation. Please note that the analysis is a hypothetical produced at a time when it was unclear whether the relationship between Yale New Haven and L&M would be a merger (similar to the Yale New Haven St. Raphael's merger) or an affiliation agreement, similar to the relationship Yale New Haven has with Bridgeport hospital and Greenwich hospital. Yale New Haven has since stated in their CON application that they are seeking an affiliation agreement with L&M hospital and therefore contracts and fees will be negotiated with health insurers separately for L&M from Yale New Haven hospital and other affiliated hospitals in the Yale New Haven health system.

See Lembo E-mail, Exhibit LL.

[4] It should be noted that vast majority of the L+M patient population are covered by governmental plans and not by private health insurers and are, therefore, not the subject of negotiation.

Against the foregoing and given the clarifying viewpoint expressed by the Comptroller, it is difficult to fathom how admission of the Milliman Document would be probative of any relevant issue.[5] On the contrary, it would only serve to distort and confuse the record and mislead the public as to the expected results of the affiliation. As the Milliman Document is irrelevant and immaterial to the issues raised by the Application, it should be excluded from the hearing record.

C. The Milliman Document Is So Speculative And Unreliable As To Be Irrelevant To Consideration Of The Application.

In addition to being based on erroneous factual assumptions which render its analysis and conclusions irrelevant, the Milliman Document should also be excluded from the hearing record on the grounds of irrelevance because, by its terms, it is based on unverified facts and is subject to unconsidered variables so numerous and material as to render the analysis and findings too speculative and unreliable to be useful as relates to the Application.

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[5] At the July 26, 2016 OCHA hearing, the Intervenors asked various questions regarding the purported "refusal" of the Applicants to disclose competitive price information in connection with the Application. By implication, the Intervenors advocate for admission of the Milliman Document in response to this purported "refusal". As pointed out by the Applicants at the hearing and as reinforced here, the Applicants have not refused to disclose price information in connection with the Application but are prohibited from doing so by concerns that such disclosure of price information prior to the affiliation would be construed as a violation of Section 1 of the Sherman Act which prohibits a "contract, combination . . . or conspiracy" that unreasonably restrains trade. 15 U.S.C. § 1. The motivating concern is that the disclosure of pricing information among potential competitors might facilitate anticompetitive harm by advancing the ability to collude and may lead to illegal price coordination. Thus, the suggestion that the Applicants have simply "refused" to supply price information is spurious in the context of the proposed affiliation. Furthermore, the Intervenors' requested that OHCA delay the decision until January 1, 2017 when allegedly price data would be available pursuant to Connecticut General Statutes Section 38a-1034a. Specifically, the Intervenors stated that the Applicants would be required to report such price information to the Connecticut Health Insurance Exchange. This is incorrect in that only carriers are required to report price information related to a limited number of DRGs, without acuity adjustment or any other risk adjustment. Moreover, the Intervenors failed to mention the impact that *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936 (2016) may have with respect to ERISA preempting this very requirement under Connecticut law.

The Milliman Document expressly acknowledges that in preparing the analysis, Milliman relied on data and information provided by others[6] but which it did not independently audit or verify. Thus, with respect to the Milliman Document, Milliman specifically cautioned that: "If the underlying data or information is inaccurate or incomplete the results of [its] analysis may likewise be inaccurate or incomplete." Milliman Document at p.2. Similarly, Milliman expressly disavowed the utilization of the Milliman Document for any purpose beyond its specific and limited purpose. Id. Indeed, the Milliman Document states that: "Any third party recipient of Milliman's work product who desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to its specific needs." Id. Thus, Milliman itself acknowledges the limited utility of the Milliman Document and the strong potentiality for inaccuracy and misinterpretation in its use for unintended purposes such as the issues in this proceeding.

The reasons to exclude the Milliman Document from the hearing record and the grounds for its irrelevance to the Application are further underscored by the numerosity and materiality of the unconsidered variables which Milliman itself identifies and cautions could materially alter the conclusions reached. In this respect, the Milliman Document states:

> The results [of the Milliman Document] should be used with caution. Additional sources of variance that may need to be considered include, but are not limited to: Comorbid conditions of the patients treated, the number of hospital admissions for each hospital, the efficiency of the hospital's management of patient admissions, cost of living differences in geographic areas, catastrophic claims, differences in hospital errors and quality of care. Note that highly efficient hospital stays tend to have higher costs per day. We also note that different DRG Grouping methodologies may change the acuity adjustment shown in this summary.

[6] The Milliman Document indicates that data and information were provided by the State of Connecticut, Anthem and Oxford. Milliman Document at p. 2.

See Milliman Document at p. 1. As impressive as it is, even this lengthy enumeration probably does not adequately reflect all relevant risk adjusted factors which might account for variance in utilization.

Obviously, the many significant variables which were not considered in the Milliman Document serves to undermine its reliability for any purpose. When combined with flaws in methodology, the unverified nature of the underlying data and information and the faulty factual assumptions utilized as it relates to the Application, it becomes clear that the Milliman Document is so speculative and unreliable as to be entirely irrelevant. Consequently, for this reason as well, the Applicants object to admission of the Milliman Document and request that it be excluded from the hearing record.

D. Conclusion.

For the reasons set forth at length herein, the Applicants submit that the Milliman Document must be excluded from the hearing record in this proceeding. In the alternative, the Milliman Document should be given no greater weight than any other letter or public testimony provided after July 1, 2016, the date upon which all prefiled testimony should have been submitted to OHCA.

Respectfully submitted,

Lawrence + Memorial Corporation
Yale New Haven Health Services Corporation

By _____

Joan V. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103
Tel: (860) 251-5104
Email: jfeldman@goodwin.com
Their Attorneys

CERTIFICATE OF SERVICE

I hereby certify that the foregoing was served by e-mail on July 29, 2016 to the following counsel of record:

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.
557 Prospect Avenue
Hartford, CT 06105-2922
(e-mail: HFMurray@lapm.org)

Joan V. Feldman

Olejarz, Barbara

From: Hansted, Kevin
Sent: Friday, August 12, 2016 1:55 PM
To: Olejarz, Barbara
Subject: FW: Intervenors Response to Applicants' Objection
Attachments: I&m intervenors' response_20160805091519211.pdf

Kevin T. Hansted
Staff Attorney
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone: 860-418-7044
kevin.hansted@ct.gov

From: Henry F. Murray [mailto:hfmurray@lapm.org]
Sent: Friday, August 05, 2016 11:38 AM
To: Hansted, Kevin <Kevin.Hansted@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>; Lazarus, Steven <Steven.Lazarus@ct.gov>
Cc: jfeldman@goodwin.com
Subject: Intervenors Response to Applicants' Objection

Attach please find the Intervenors' Response to the Applicants' Objection to Exhibit LL.

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

ACQUISITION OF LAWRENCE & MEMORIAL CORPORATION BY YALE-NEW HAVEN HEALTH SERVICES CORPORATION	:	DOCKET NO. 15-32033 CON
	:	AUGUST 5, 2016

INTERVENORS' RESPONSE TO THE APPLICANTS' OBJECTIONS TO THE MILLIMAN REPORT

I. Introduction

During the CON hearing on July 11, 2016, Intervenors offered into evidence a one-page table that it represented had been part of a report commissioned by the Office of the State Comptroller ("OSC") and had been provided to an official of AFT Connecticut by that office. The Applicants objected to its introduction and the Hearing Officer directed the Intervenors to produce any witnesses at the next scheduled hearing on July 26, 2016, to provide testimony on the authenticity of the document prior to a ruling on its admissibility. (Tr. p. 89).[1] On July 15, 2016, the Intervenors provided counsel for the Applicants with the full three page report from which the one-page table had been excerpted. The document was a September 15, 2015, report prepared for the Comptroller by Milliman, a former consultant to the State Employee Health Plan. The report ("Milliman Report") analyzed the costs paid by the State Employee Health Plan for the same inpatient and outpatient services at both Lawrence & Memorial Hospital and Yale-New Haven Hospital over the one year period of April 1, 2014 to March 31, 2015. On July 21, 2016, Comptroller Kevin Lembo sent a copy of the Milliman Report to Department of Public Health Commissioner Raul Pino in an explanatory email. That document and email was subsequently forwarded to the Office of Health Care Access. On Friday July 22, 2016, Hearing

[1] Transcript of CON Hearing, July 11, 2016.

Officer Kevin Hansted issued an Order taking administrative notice of the Milliman Report and email from Comptroller Lembo and admitting them into the record for Docket 15-323033- CON as Exhibit LL. Subsequent to their admission in the record, the Applicants filled their objections on the grounds that (i) the request to admit was untimely and prejudiced the Applicants; (ii) the Milliman Report is both irrelevant and immaterial to the issues raised by the Application; and, (iii) the Milliman Report itself is unreliable because the data on which it was based was not independently verified. For the reasons set forth below, the Intervenors respectfully request that the Applicants' objections be overruled and denied and that Exhibit LL remain in the record.

II. Argument

A. OHCA's Administrative Notice of the Milliman Report Inflicts No Prejudice on the Applicants.

The Applicants argue that the Milliman Report must be excluded from the record because it unfairly prejudices their right to "fair notice and an opportunity to analyze, investigate and rebut the evidence." (Applicants' Objections, p. 2). It is absolutely essential in evaluating this complaint to understand precisely what the Milliman Report shows, why it was offered by the Intervenors prior to its disclosure by the Comptroller, and whether the data presented in the Report was available to the Applicants should they have been inclined to further analyze and rebut the conclusion reached in the Report.

At the outset, however, it is important to correct the record with respect to the provenance of the Milliman Report. Despite the statement of the Applicants, the Milliman Report was not "prepared at the request of AFT representatives." (Applicants' Objections, p. 4). The email from Comptroller Lembo, which is part of Exhibit LL, is quite clear that the report was prepared at the request of his office in response to the initial filing of the certificate of need with OHCA. It is clear that the impetus behind the commissioning of the report was the concern of both the

Comptroller and the Connecticut Health Cost Containment Committee that there could be increased costs for the state employee health plan as a result of the Application. The Intervenors obtained the Report from the Office of the State Comptroller. At the July 11, 2016, hearing the Intervenors offered as evidence an excerpted table from that Report. As soon as counsel for the Intervenors received the full three-page Milliman Report later that week it was promptly provided to the Applicants on July 15, 2016. The Report was therefore provided to the Applicants ten or eleven days prior to the next scheduled hearing on July 26, 2016.[2]

Applicants clearly had sufficient time following the receipt of the report to analyze their own records related to payments for services received from the state employee health plan during the one year period reviewed in the Milliman Report to determine whether they believed it accurately reflected those transactions set out in the Report or provide an alternative explanation or rebut the Report's conclusion that services billed over that one year period by Lawrence & Memorial Hospital would have cost over one million dollars more if they were based on YNHH's costs for the same services.

B. The Milliman Report Is Clearly Relevant to the Statutory Required Evaluation of Cost and Access Resulting from the Acquisition of Lawrence & Memorial Corporation

The statute requires that for any decision on Application, OHCA must make a clear finding as to whether the Applicants have "successfully demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility of care." Throughout these proceedings it has been nearly impossible for OHCA to get any pricing and cost information from the Applicants with respect to their own payments from insurance companies or historic pricing and cost data from the previous acquisitions of Bridgeport and

[2] Attached hereto as Exhibit A is an email chain between counsel for the Intervenors and counsel for the Applicants regarding the Milliman Report and representations made about that report and its origins with conversations between counsel following the July 11, 2016 hearing.

Greenwich Hospitals and the merger with the Hospital of St Raphael. Such information, OHCA correctly concluded, is clearly necessary to evaluate whether or not the acquisition by YNHHS will have an adverse impact on health care costs in the L & M service areas. Without the requested data, OHCA must either assume that it will receive no price data whatsoever or evaluate the application with the limited available information.

The Intervenors have produced what information they could find in the form of the DRG comparisons submitted as part of Dr. Hyde's testimony and pre-file documents. In addition, the Milliman Report, for which the agency has taken proper administrative notice, is the only other source of price and cost data related to the actual provision of medical services by the Applicants in a one year period of time approximating the time frame within which the Application was filed. To that extent it is relevant in suggesting the price and cost comparison between the two hospitals, permitting an inference that if this price differential exists for one payer (the state employee health plan) such a differential must also exist with respect to the contracts the Applicants maintain with other third party payers. The Milliman Report is, as admitted by the Intervenors at the July 11, 2016 hearing, an incomplete snapshot, since it only applies to active state employees who received services at the two hospitals between April 1, 2014 and March 31, 2015. But it is the only data that OHCA has on price and cost and so it should take proper administrative notice of the findings. If OHCA believes it needs more extensive price and cost data which the Applicants will not provide, for whatever reasons, the agency can clearly suspend consideration of the Application until after January 1, 2017, when such information for the 50 most common outpatient procedures, the 50 most common inpatient procedures and the 25 most common surgical and imaging procedures, paid by fully insured plans to each provider

(including the Applicants) will become public on the website of the state's Health Insurance Exchange.[3]

Intervenors have supplied OHCA with abundant evidence of the impact of consolidation on provider prices, including two studies that point directly to the sort of acquisition present in this case. *Dafny et al.* recently found strong evidence of post-acquisition price increases in hospitals acquired within the same state, even when those systems operate in distinct markets. As noted by the Intervenors in our pre-file testimony, *Dafny* correlates such increases with the existence of common insurers, common customers, adjacent markets and proximity of less than 90 miles apart. These are all present in the current Application. *Gowriskandaran et al.* found that separate negotiations do not mitigate post-acquisition price increases.

Consequently, price data are essential to understanding the potential impact of the application on cost and accessibility of care.

C. The Data On Which the Milliman Report Was Based Is Within the Custody and Control of the Applicants Who Could Have Verified Its Accuracy and Reliability

Applicants object to administrative notice by OHCA of the Milliman Report because it is based on "unverified facts" which render its analysis "speculative and unreliable." However, the universe of data on which the Report is based consists completely of payments made to each of the Applicants through July 31, 2015, for services rendered by the Applicants at their hospitals to active state employees participating in the State Employee Health Plan from April 1, 2014 to

[3] In its Objections the Applicants chide the Intervenors for not discussing the impact of the Supreme Court's March 2016 decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S. Ct. 936 (2016), which involved a collision between federal court ERISA preemption analysis and the legislative trend in many state toward transparency in healthcare costs and pricing. Although the Intervenors are unaware of question involving the applicability of *Gobeille* being raised at any time during this application process we are more than willing to weigh in. Unlike the Connecticut law, which clearly requires disclosure only from fully insured carriers subject to state insurance regulation, the Vermont statute also applied to self-insured employee health plans, thereby running afoul of the ERISA preemption applied to employee welfare plans. The Intervenors believe that *Gobeille* will have no impact on the pricing transparency required by PA15-146 and available to OHCA and the general public on January 1, 2017.

March 32, 2015. Surely the Applicants have records of payments made to them for the services they provided, billed for and which were paid to them by the State Employee Health Plan for the period of time covered by the Report. It would be difficult to imagine that they would not have such records. The Applicants clearly had access to data from which they could have analyzed, investigated and refuted, if required, the conclusions reached in the Report with respect to the difference in cost between L & M and YNHH for the provision of listed inpatient and outpatient procedures during the relevant period of time. They chose not to do so.

The disclaimers contained in the Milliman Report, on which the Applicants so heavily rely to demonstrate its speculative nature, are not unusual when a consultant is being asked to provide an analysis with data that it received from the client and did not independently verify or audit. But since the data are paid claims to the Applicants' hospitals, information they must certainly have in their custody and control, the Applicants could have tested the data to determine whether it was reliable or there were other variables that needed to be considered. If the Milliman Report is skewed, inaccurate or otherwise problematic, the Applicants could have produced data they believe is more accurate. Again, they chose not to do so.

D. Because the Milliman Report Is Probative of Relative Pricing and Costs At the Applicants' Hospitals and Was Produced At the Direction of The State Comptroller It Should be Accorded Appropriate Evidentiary Weight

In the absence of the pricing information requested of the Applicants by OHCA, the agency must of necessity rely on less comprehensive but available sources of information to carry out its statutory review and approval functions. The Milliman study was conducted at the specific request of the state Comptroller to determine the impact of the acquisition on the state employee health plan. The state Comptroller has verified its authenticity and the purpose for requesting the study. Milliman is a major industry consulting firm whose clients include large

private sector corporations, universities, health care providers, and government entities. Intervenors do not claim and have never claimed that the Milliman Report conclusively proves a large price differential between the Applicants' two hospitals. However, even with all of the limitations and disclaimers enumerated by Milliman in the Report, these are the data available to the agency and they are probative of the relative pricing and costs at the Applicants' two hospitals and suggestive of a similar differential in costs at the two hospitals in their contracts with commercial insurers. It is the Applicants themselves who are the primary obstacles to obtaining the necessary data required to analyze the potential price impact of the transaction. Therefore the agency should rely, through administrative notice, on whatever record evidence exists in considering and deciding on the Application before it. This includes the data provided by the Milliman Report.

III. Conclusion

For all of the reasons set forth above, the Intervenors respectfully request that the Applicants' objection to the inclusion of the Milliman Report in the record be denied.

Respectfully submitted,

AFT Connecticut
Connecticut Citizen Action Group
Connecticut Health Policy Project
National Physicians Alliance – Connecticut
New England Health Care Employees, 1199
United Action Connecticut
UNITE HERE Local 217,
INTERVENORS

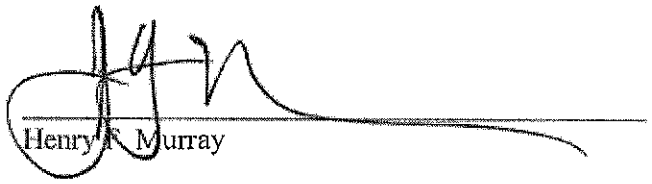
By: _____
Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105

Tel: 860.570.4635
Email: hfmurray@lapm.org

CERTIFICATION OF SERVICE

I hereby certify that the foregoing was served by email on Friday, August 5, 2016, on all counsel of record as follows:

Jane W. Feldman, Esq.
SHIPMAN & GOODWIN LLP
One Constitution Plaza
Hartford, CT 06103



Henry F. Murray

EXHIBIT A

Henry F. Murray

From: Henry F. Murray <hfmurray@lapm.org>
Sent: Friday, July 29, 2016 5:11 PM
To: 'Feldman, Joan'
Subject: RE: Objection to the Milliman Report

I said an AFT person had requested it from Lembo not that they requested the Comptroller engage a consultant to produce the Report.

Hank

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Friday, July 29, 2016 4:49 PM
To: 'Henry F. Murray'
Subject: RE: Objection to the Milliman Report

Hank:
Thanks for your message. I distinctly remember that before the conference call with Attorney Hansted, you told me in response to my query about who requested the report that you believed it was requested by an AFT representative so I am going to keep that in the objection.
Have a good weekend.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

Privileged and confidential. If received in error, please notify me by e-mail and delete the message.

please consider the environment before printing this message

From: Henry F. Murray [mailto:hfmurray@lapm.org]
Sent: Friday, July 29, 2016 4:07 PM
To: Feldman, Joan
Subject: Objection to the Milliman Report

Joan,

Thank you for the copy of the Objection you filed today on behalf of the Applicants. I haven't had an opportunity to fully review it but we will file some response next week. However I wanted to bring to your attention a factual error in your narrative that I will correct in our response or you may wish to do so before hand. On page 4 you make the statement "Counsel for the Intervenor informed counsel for the Applicants that he believed that the document was prepared at the request of an AFT representative." This statement is inaccurate. When we spoke following the conference call with Kevin Hansted I told you that the one page table was apparently the third page of a report I did not yet have but would get to you when my client got the report to me. I subsequently did a few days later. I also told you that it was a report done for the Comptroller by a consultant and that the AFT's lobbyist had been given a copy of the report by someone in the Comptroller's office. I never said that the Comptroller had the consultant prepare the report *at the request of the AFT*. I think Kevin Lembo's email is pretty clear that the Office of the State Comptroller had Milliman prepare the report because of concerns (either his own or the Health Care Cost containment group) on the potential pricing impact of the transaction on the state employee health plan. You quote the entirety of the email text with that explanation on the next page. If you want to talk about this give me a call. Should be here rest of the day or again on Monday. Have a nice weekend.

Hank Murray

Henry F. Murray, Esq.
Livingston, Adler,Pulda, Meiklejohn & Kelly PC
557 Prospect Avenue
Hartford, Connecticut 06105
860.233.9821
860.570.4635 (direct)
860.232.7818 (fax)
hfmurray@lapm.org
www.lapm.org (website)

Greer, Leslie

Subject: FW: Docket Numbers 15-32032 and 15-32033
Attachments: Letter to Kevin Hansted.pdf

From: Feldman, Joan [mailto:JFeldman@goodwin.com]
Sent: Friday, August 12, 2016 10:51 AM
To: Hansted, Kevin; Riggott, Kaila; Carney, Brian; Lazarus, Steven
Cc: hfmurray@lapm.org; jennifer.willcox@ynhh.org
Subject: Docket Numbers 15-32032 and 15-32033

Dear Attorney Hansted:
Attached you will find a letter requesting the addition of new information to the above-referenced records. We believe it is relevant in that Intervenors provided testimony (Mr. Hyde) relating to hospitals having positive operating margins.
Thank you.
Joan

Shipman & Goodwin LLP
COUNSELORS AT LAW

Joan W. Feldman
Partner
One Constitution Plaza
Hartford, CT 06103-1919

Tel (860) 251-5104
Fax (860) 251-5211
jfeldman@goodwin.com
www.shipmangoodwin.com

SHIPMAN & GOODWIN LLP®
COUNSELORS AT LAW

Joan W. Feldman
Phone: (860) 251-5104
Fax: (860) 251-5211
jfeldman@goodwin.com

August 12, 2016

Kevin T. Hansted
Staff Attorney/Hearing Officer
Department of Public Health
Office of Health Care Access
410 Capitol Ave., MS #13HCA
P.O. Box 340308
Hartford, CT 06134
Phone: 860-418-7044
Kevin.Hansted@ct.gov

Re: Docket Numbers 15-32032 and 15-32033

Dear Kevin:

Please add the attached Fitch Ratings report issued on August 10, 2016 regarding Lawrence & Memorial Hospital's financial rating to the above-mentioned records.

If you have any questions, please feel free to contact me.

Respectfully submitted,

Lawrence + Memorial Corporation
Yale New Haven Health Services Corporation

By _____
Joan W. Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103
Tel: (860) 251-5104
Email: jfeldman@goodwin.com
Their Attorneys

JWF:mg
Enclosure
7193v11

CERTIFICATE OF SERVICE

I hereby certify that the foregoing was served by e-mail on August 12, 2016 to the following counsel of record:

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.
557 Prospect Avenue
Hartford, CT 06105-2922
(e-mail: HFMurray@lapm.org)

Joan W. Feldman

FitchRatings

Fitch Downgrades Lawrence & Memorial Hospital (CT) Revs to 'A-'; Outlook Revised to Negative

Fitch Ratings-New York-10 August 2016: Fitch Ratings has downgraded to 'A-' from 'A' the rating on $47.9 million State of Connecticut Health and Educational Facilities Authority revenue bonds, series F (2011) issued on behalf of Lawrence & Memorial Hospital (LMH).

The Rating Outlook is revised to Negative from Stable.

LMH also has outstanding approximately $58 million in other long-term debt and leases, which are not rated by Fitch.

SECURITY
The bonds are secured by a pledge of gross revenues and a mortgage.

Fitch reports on the results of the consolidated Lawrence+Memorial Corporation (LMC), as defined in the Credit Profile section of the press release.

KEY RATING DRIVERS
CONTINUED OPERATING LOSSES: The downgrade to 'A-' is driven by continued trend of weakening profitability stemming from softer volumes, shift to outpatient utilization, less favorable reimbursement and the escalating Connecticut provider tax burden. The revision of the Outlook to Negative is based on Fitch's expectation that despite management's significant efforts at reversing the losses, a return to positive margin will only be achieved once the benefits from the anticipated joining of the Yale New Haven Health System (YNHHS; 'AA-', Stable Outlook) will be realized, which could take some time. Operating margin was a negative 4.1% in fiscal 2014 and 2.2% in fiscal 2015 (fiscal year-end [FYE] Sept. 30) and losses continued through the nine months ended June 30, 2016 with negative operating margin of 4.2%.

ANTICIPATED BENEFITS FROM JOINING YNHHS: LMC and YNHHS entered into an affiliation in July 2015 and the transaction has received FTC approval, but the Certificate of Need (CON) for the corporate member substitution has met regulatory delays at the state level. LMC and YNHHS already cooperate clinically in several areas, but the full integration with YNHHS would bring significant positive financial benefits to LMC, estimated at $9 million-$15 million annually, returning LMC to positive operating territory. Additionally, YNHHS has committed to directly contribute approximately $85 million to LMC.

ADEQUATE LIQUIDITY: Despite the operational challenges, liquidity metrics have remained largely sound and the balance sheet provides the organization with a sufficient cushion to weather the delay in implementation of the full integration with YNHHS. Cash to debt of 167.6% and cushion ratio of 19.8x at June 30, 2016 are consistent with Fitch's respective 'A' medians of 144% and 18.5x, but days cash on hand (DCOH) of 147.4 lags the median of 205.3 days.

MANAGEABLE DEBT BURDEN: LMC's debt burden remains light for the rating category, as evidenced by maximum annual debt service (MADS) at 1.9% of revenue in 2015, which compares favorably against the median of 3.6%. However, weak cash flows resulted in MADS coverage by EBITDA declining to 1.8x through the interim period from 3.8x in fiscal 2015.

SOLID MARKET POSITION: LMC has a dominant market share of approximately 67% in the combined primary service area (PSA) of the two LMC hospitals. The ability to use YNHHS in physician recruitment and the planned investment in clinical programs, once the full affiliation is realized, should further secure market share.

RATING SENSITIVITIES

RETURN TO IMPROVED PROFITABILITY: The 'A-' rating is contingent upon Lawrence+Memorial Corporation executing the full YNHHS affiliation which is expected to generate improved financial performance through efficiencies and benefits of scale. The return to Stable Outlook would require Lawrence+Memorial Corporation to demonstrate the traction of the Yale New Haven Health System relationship, leading to material improvement in operating performance.

CREDIT PROFILE

Lawrence+Memorial Corporation operates Lawrence & Memorial Hospital, consisting of Lawrence & Memorial Hospital (LMH) in New London, Connecticut with 198 staffed beds, and Westerly Hospital in Washington County (Westerly), Rhode Island with 40 staffed beds, as well as a number of other subsidiaries, including the L&M Physician Association (LMPA). The obligated group includes LMH and the LMC Parent only. For fiscal year ended Sept. 30, 2015, LMC had total revenues of $460 million.

BENEFITS OF JOINING YNHHS

LMC and YNHHS signed an affiliation agreement in July 2015 and the full merger would take the form of a member substitution, whereby YNHHS would become the sole corporate member of the LMC, but LMC would not be a member of the YNHHS obligated group, similar to the status of Greenwich Hospital ('AA-', Stable Outlook) in YNHHS. The merger with YNHHS is expected to bring significant benefits to LMC, estimated at $300 million over the next five years. Of this amount, approximately $85 million represents a direct commitment from YNHHS with half contributed fairly quickly once the formal corporate reorganization is completed for various initiatives, including population health management, rebranding, IT investment and physician recruitment focused on several specialty areas, in addition to primary care. The balance of the $300 million benefit will be realized from further clinical investments and from LMC operations and efficiencies and synergies and gained scale from being part of the large, fully integrated YNHHS, with revenues of $3.5 billion.

CONTINUED WEAK PROFITABILITY

LMC continues to be affected negatively by soft volumes, shift to observation patients and to outpatient utilization, and lower state and federal reimbursement rates. A significant contributor to the lower profitability is the escalating provider tax in Connecticut; the net impact of the provider tax offset by supplemental payments increased from a negative $3.9 million in 2014 to negative $9.1 million in 2015 and is expected to be as high as $13 million in this fiscal year, even after the recent reinstating of some of the supplemental payments.

Operating losses were $18.7 million in fiscal 2014 and $10.3 million in 2015, equal to negative operating margins of 4.1% and 2.2%, and operating loss through the nine months ended June 30, 2016 was reported at $14 million, a 4.2% negative operating margin. Management expects to end the 2016 fiscal year with an operating loss of $22.3 million, with the most significant variances from the $8.7 million budgeted loss stemming from the LMPA medical group and Westerly hospital. A number of initiatives from an earlier consulting engagement have already been operationalized, with over $36 million of expenses taken out. Based on initiatives continuing to be implemented currently and additional expense management likely to be realized, the 2017 budget would be close to $10 million-$13 million loss. Management has been successful in negotiating a new union contract in the spring of 2016, ahead of the expiration of the prior contract. Any relief in the state provider tax would further help improve profitability.

ADEQUATE LIQUDITY AND LOW DEBT BURDEN

LMC's liquidity in relation to its debt remains solid for the rating category, with cash of $175.4 million at June 30, 2016 equal 167.6% of debt and cushion ratio of 19.8x at June 30, 2016, both above Fitch's category medians. Overall, Fitch considers LMC's liquidity position as a partial mitigant against its compressed profitability, providing a temporary cushion until such time as LMC can see the benefits of the integration into YNHHS.

LMC's debt burden is light with MADS equal to 2% of revenues through the nine-month interim period. MADS coverage by EBITDA of 1.8x and by operating EBITDA of 1.5x were both weak against Fitch's 'A' medians at 4.2x and 3.5x, respectively, somewhat offset by a relatively conservative debt structure with 80% of debt in fixed rate mode.

DISCLOSURE

LMH covenants to provide quarterly and annual financial disclosure to the Municipal Securities Rulemaking Board's EMMA system.

Contact:

Primary Analyst
Eva Thein
Senior Director
+1-212-908-0674
Fitch Ratings, Inc.
33 Whitehall St.
New York, NY 10004

Secondary Analyst
Dmitry Feofilaktov
Associate Director
+1-212-908-0345

Committee Chairperson
James LeBuhn
Senior Director
+1-312-368-2059

Media Relations: Elizabeth Fogerty, New York, Tel: +1 (212) 908 0526, Email: elizabeth.fogerty@fitchratings.com.

Additional information is available at 'www.fitchratings.com'.

Applicable Criteria
Revenue-Supported Rating Criteria (pub. 16 Jun 2014)
(https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=750012)
U.S. Nonprofit Hospitals and Health Systems Rating Criteria (pub. 09 Jun 2015)
(https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=866807)

Additional Disclosures
Dodd-Frank Rating Information Disclosure Form
(https://www.fitchratings.com/creditdesk/press_releases/content/ridf_frame.cfm?pr_id=1010219)
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Greer, Leslie

From: Greer, Leslie
Sent: Wednesday, September 07, 2016 9:58 AM
To: jfeldman@goodwin.com; 'hfmurray@lapm.org'
Cc: Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Ciesones, Ron
Subject: Closure of Public Heaings DN's 15-32032-CON & 15-32033-CON
Attachments: 32032 Clousre of Hearing.pdf; 32033 Closure of Hearing.pdf

Tracking:

Recipient	Delivery
jfeldman@goodwin.com	
'hfmurray@lapm.org'	
Lazarus, Steven	Delivered: 9/7/2016 9:58 AM
Carney, Brian	Delivered: 9/7/2016 9:58 AM
Riggott, Kaila	Delivered: 9/7/2016 9:58 AM
Hansted, Kevin	Delivered: 9/7/2016 9:58 AM
Martone, Kim	Delivered: 9/7/2016 9:58 AM
Ciesones, Ron	Delivered: 9/7/2016 9:58 AM

Please see attached closure of public hearing for DN’s 15-32032-CON & 15-32033-CON.

Thank you,

Leslie

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Office of Health Care Access

September 7, 2016

VIA EMAIL ONLY

Joan Feldman, Esq.
Shipman & Goodwin LLP
One Constitution Plaza
Hartford, CT 06103-1919

Henry F. Murray, Esq.
Livingston, Adler, Pulda, Meiklejohn & Kelly, P.C.
557 Prospect Avenue
Hartford, CT 06105-2922

RE: Certificate of Need Application; Docket Number: 15-32033-CON
Transfer of ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation
Closure of Public Hearing

Dear Ms. Feldman and Mr. Murray:

Please be advised, by way of this letter, the public hearing held on July 11 and July 26, 2016 in the above referenced matter is hereby closed as of September 7, 2016. OHCA will receive no additional public comments or filings.

If you have any questions regarding this matter, please feel free to contact Steven Lazarus at (860) 416-7012 or Brian Carney at (860) 418-7014.

Sincerely,

Kevin T. Hansted
Hearing Officer

Connecticut Department of Public Health

Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Greer, Leslie

From: Greer, Leslie
Sent: Thursday, September 08, 2016 4:03 PM
To: jfeldman@goodwin.com; 'hfmurray@lapm.org'
Cc: Lazarus, Steven; Carney, Brian; Riggott, Kaila; Hansted, Kevin; Martone, Kim; Ciesones, Ron; Olejarz, Barbara
Subject: RE: Docket Number 15-32033-CON Agreed Settlement
Attachments: 32033 Agreed Settlement.pdf

Tracking:

Recipient	Delivery
jfeldman@goodwin.com	
'hfmurray@lapm.org'	
Lazarus, Steven	Delivered: 9/8/2016 4:04 PM
Carney, Brian	Delivered: 9/8/2016 4:04 PM
Riggott, Kaila	Delivered: 9/8/2016 4:04 PM
Hansted, Kevin	Delivered: 9/8/2016 4:04 PM
Martone, Kim	Delivered: 9/8/2016 4:04 PM
Ciesones, Ron	Delivered: 9/8/2016 4:04 PM
Olejarz, Barbara	Delivered: 9/8/2016 4:04 PM

Attorney Feldman and Attorney Murray,
Attached is the Agreed Settlement for Lawrence +Memorial Corporation and Yale New Haven Health Services Corporation's Certificate of Need Application.

Thank you,

Leslie M. Greer
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, Hartford, CT 06134
Phone: (860) 418-7013 Fax: (860) 418-7053
Website: www.ct.gov/ohca

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Agreed Settlement

Applicants: **Lawrence + Memorial Corporation**
365 Montauk Avenue
New London, CT 06320

Yale New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06519

Docket Number: **15-32033-CON**

Project Title: **Transfer of ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation**

Project Description: Lawrence + Memorial Corporation ("L+M") and Yale New Haven Health Services Corporation ("YNHHSC"), herein collectively referred to as the ("Applicants") seek authorization to transfer ownership of L+M and its subsidiaries to YNHHSC, with no associated capital expenditure.

Procedural History: The Applicants published notice of their intent to file a Certificate of Need ("CON") application in the New Haven Register and The Day (New London) on July 27, 28 and 29, 2015. On October 7, 2015, the Office of Health Care Access ("OHCA") received the CON application from the Applicants for the above-referenced project. On December 16, 2015, Commissioner Jewel Mullen designated Attorney Kevin T. Hansted as the hearing officer in this matter. The application was deemed complete on May 10, 2016. On June 17, 2016, OHCA received a petition from a coalition of organizations led by New England Health Care Employees Union, District 1199 SEIU ("District 1199") requesting intervenor status with full rights of cross-examination. The Hearing Officer granted the petition of District 1199 ("Intervenor") on June 24, 2016. On June 22, 2016, the Applicants were notified of the date, time, and place of the public hearing. On June 24, 2016, a notice to the public announcing the hearing was published in The Day. Thereafter, pursuant to Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a (f)(2), a public hearing regarding the CON application was initially held on July 11, 2016 and

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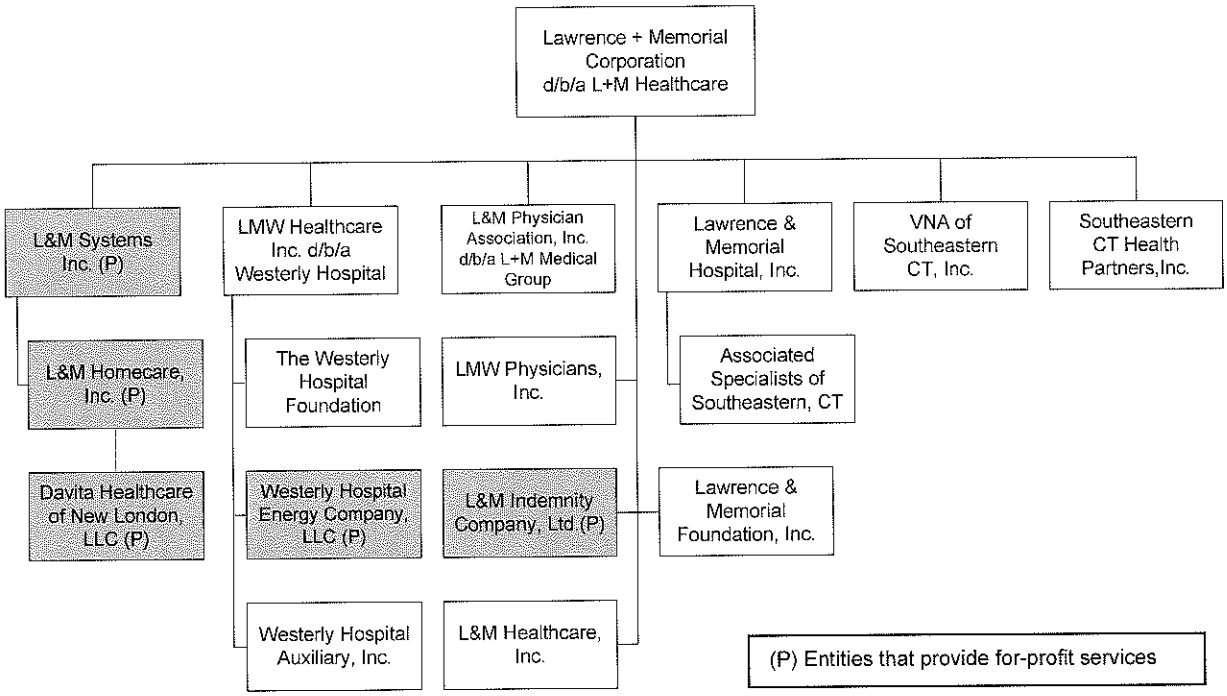
Phone: (860) 418-7001 • Fax: (860) 418-7053
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308
www.ct.gov/dph

continued on July 26, 2016. The hearing was conducted in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Conn. Gen. Stat.) and Conn. Gen. Stat. § 19a-639a (f)(2) and the Hearing Officer heard testimony from witnesses for the Applicant and the Intervenors. The public hearing record was closed on September 7, 2016. In rendering the decision, Deputy Commissioner Addo considered the entire record in this matter.

Findings of Fact and Conclusions of Law

1. L+M is a non-stock, tax-exempt corporation that is the sole member of subsidiaries operating acute care hospitals and community-based services located throughout southeastern Connecticut and southwestern Rhode Island. Ex. A, p. 23

2. L+M is the parent company of Lawrence + Memorial Hospital ("L+MH"), its principal asset in Connecticut, and various other subsidiaries and affiliated entities (see legal chart of corporate structure, below).

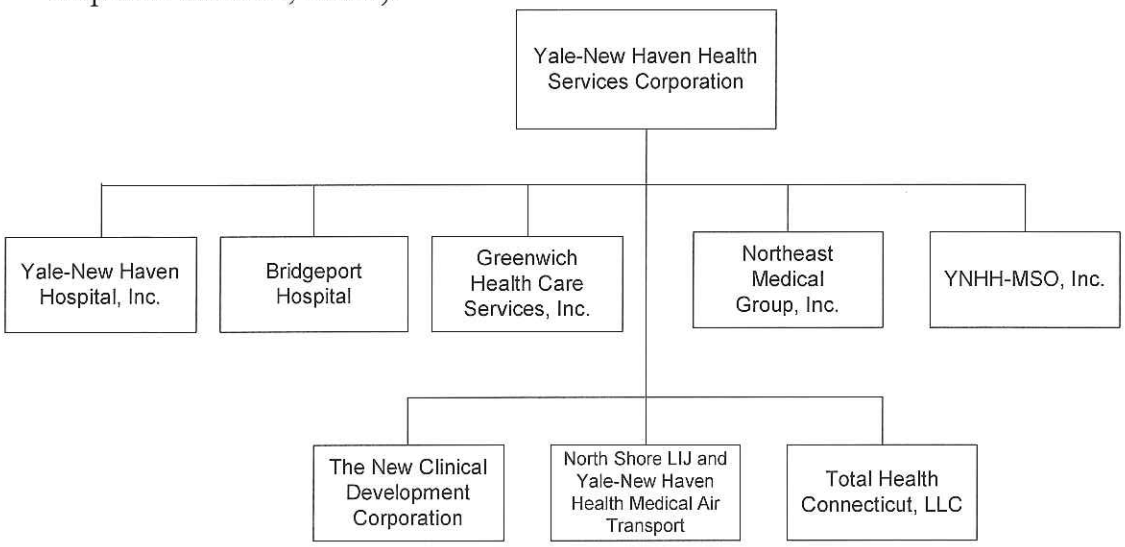


Ex. A, p. 732

3. L+MH is an acute care community hospital located in New London, Connecticut. It is licensed for 280 general hospital beds (plus 28 bassinets) and provides a full range of inpatient, outpatient and ancillary services to residents of southeastern Connecticut. Ex. A, p. 23

4. YNHHSC is a Connecticut non-stock, tax-exempt corporation that was organized in 1983 to provide support services to Yale New Haven Health System ("YNHHS"), a network of affiliated health care providers, the foremost being Yale-New Haven Hospital ("YNHH"). Ex. A, p. 22

5. In addition to YNHH, YNHHSC is the parent company of Greenwich and Bridgeport Hospitals, along with various other subsidiaries and affiliated entities (see legal chart of corporate structure, below).



Ex. A, p. 591

6. The L+M and YNHHSC boards approved execution of the Affiliation Agreement and agreed to seek regulatory approval on July 9, 2015 and July 10, 2015, respectively. Ex. A, p. 29

7. The Applicants request authorization to transfer ownership of L+M and its subsidiaries to YNHHSC, such that YNHHSC shall become the sole corporate member of L+M. Ex. A, pp. 21, 92

8. A Hart-Scott-Rodino filing[1] was submitted to the Federal Trade Commission ("FTC") on August 7, 2015 and on September 8, 2015, the FTC informed YNHHSC and L+M that it would allow the waiting period to expire without further investigation. Ex. A, p. 29

9. Following the transfer of ownership, L+MH will continue to operate as an independently licensed hospital, with its own separate medical staff, bylaws, rules, regulations and elected officers. Ex. A, p. 21

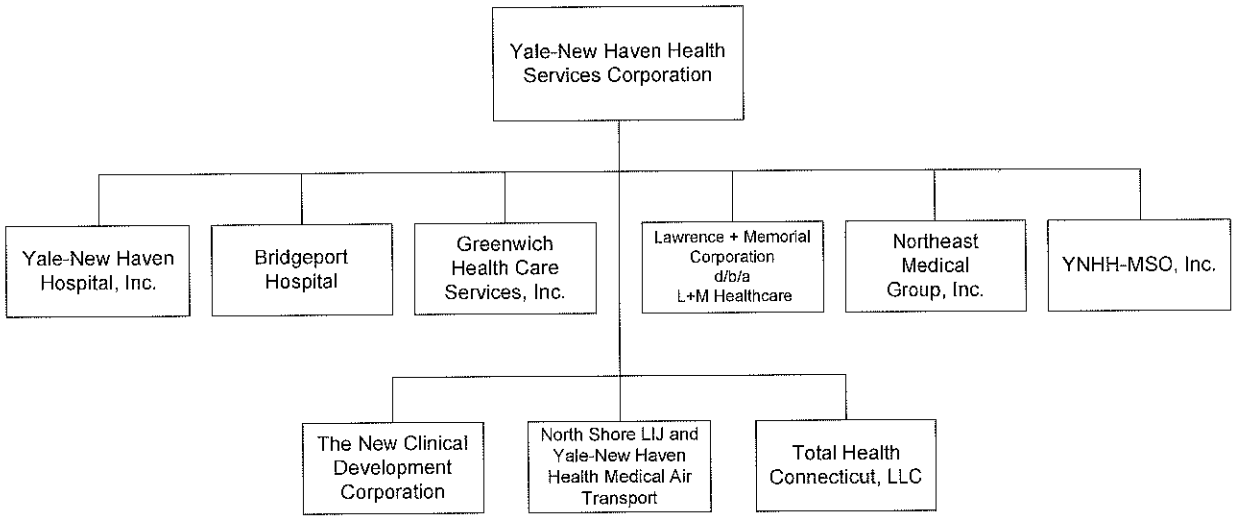
10. L+M will continue to remain a separate entity with its own board responsible for overseeing and managing L+MH and Westerly Hospital, subject to certain reserved rights of YNHHSC with respect to fundamental strategic, financial and governance matters. Ex. A, p. 26

11. The L+MH Board will continue as a fiduciary board and be responsible for the oversight and management of patient care, safety, licensure, accreditation, medical staff credentialing, election and removal of officers and approval of actions not otherwise reserved to L+M and/or YNHHSC. A YNHHSC appointee will serve on the L+MH Board as a result of the

[1] The Hart-Scott Rodino ("HSR") Act requires that information about large mergers and acquisitions be submitted to the Federal Trade Commission and the Department of Justice prior to their occurrence. The parties may not close their deal prior to the waiting period outlined in the HSR Act without government approval. Source: https://www.ftc.gov/enforcement/premerger-notification-program

proposal, however the L+MH Board's scope of responsibility and authority will be largely unchanged. Ex. A, p. 26

12. The following chart depicts the organizational structure following the proposed transaction:



Ex. A, p. 594

13. The proposal is expected to provide L+M and the community it serves the following benefits:

- enhanced access to health care services through clinical integration and collaboration with YNHHSC-affiliated physicians;
- strengthened ability to retain, develop, and recruit physicians;
- access to capital needed to re-invest in L+M and the communities it serves, including advanced diagnostic capabilities and state-of-the-art facilities and technologies;
- access to population health infrastructure and expertise; and
- greater financial stability resulting from being part of a large health system.

Ex. A, p. 25

14. YNHH offers specialized tertiary and quaternary services not available at smaller community hospitals. As a result, L+MH transfers approximately 1,000 patients each year to YNHH, via the Y Access Line transfer service. These patients have historically been referred back to the L+M community to receive follow-up care following discharge. Ex. A, p. 26

15. L+MH's primary service area consists of five towns in southeastern Connecticut; nearly half of discharged inpatients reside in Groton or New London (see table below):

TABLE 1
L+MH PRIMARY SERVICE AREA*

	FY 2015	
Town	**Discharges**	**%**
Groton	3,797	27.0%
New London	2,929	20.8%
Waterford	1,715	12.2%
East Lyme	1,293	9.2%
Ledyard	828	5.9%
PSA Total	**10,562**	**75.1%**
All other	**3,498**	**24.9%**
Total	**14,060**	**100.0%**

*Primary service area based on top 75% of patient discharges by town

Source: CT DPH Office of Health Care Access, Acute Care Hospital Discharge Database

16. As determined in its most recent Community Health Needs Assessment ("CHNA"), L+MH's service area has a higher proportion of middle aged and older adults than Connecticut and the nation overall. The Applicants estimate that service area residents in the 65+ age cohort will increase 12.5% from 2015 to 2020. Ex. A, pp. 27, 32

17. L+MH's 2012 CHNA highlights the likelihood of a higher incidence of heart disease, cancer and certain lung diseases due to the service area demographics. Other key health issues identified are as follows:

- higher cancer incidence than state and national levels for all cancers, in particular, breast, colorectal and lung;
- higher cancer mortality than state and national levels for all cancers, particularly in breast, and lung cancer;
- high Chlamydia rates,
- obesity levels higher than the state average;
- increasing diabetes incidence; and
- high alcohol consumption as compared to national benchmarks.

Ex. A, pp. 32-33

18. L+MH is currently conducting the 2016 CHNA planning process in collaboration with over 30 partner organizations to help determine appropriate strategies and benchmarks, including the use of Healthy People 2020 benchmarks. Testimony of Laurel Holmes, Director of Community Partnerships and Population Health, L+M, Exhibit PP, p. 166

19. The Applicants plan to provide similar levels of funding for community benefits and community building following approval of the proposed transaction. Testimony of Ms. Borgstrom, President and Chief Executive Officer of YNHHSC, Ex. PP, p. 169

20. The proposal is expected to provide L+M and the community it serves the following benefits:

- enhanced access to health care services through clinical integration and collaboration with YNHHSC-affiliated physicians;
- strengthened ability to retain, develop and recruit physicians;
- decreased clinical variation for L+M through standardized protocols as a result of adopting Epic, Lawson and other IT platforms used by YNHHSC;
- access to population health expertise and infrastructure;
- development of additional clinical programs identified as needed in the L+MH service area;
- access to capital on more favorable terms once L+M becomes a member of the YNHHSC Obligated Group[2]; needed to re-invest in L+M and the communities it serves, including advanced diagnostic capabilities and state-of-the-art facilities and technologies;
- supply chain-related cost savings as a result of volume discounts and efficiencies - economies of scale relating to IT, finance, insurance, equipment, supplies and other administrative services;
- more efficient clinical and business practices resulting from the proposed merger of L&M Physician Association, Inc. into Northeast Medical Group, Inc.;
- management expertise and efficiencies; and
- greater financial stability resulting from being part of a large health system.

Ex. A, pp. 25, 37

21. Overall patient volume (discharges and patient days) has declined slightly at L+MH over the past several years (see table below):

TABLE 2
L+MH HISTORICAL AND CURRENT DISCHARGES

Service	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013**	FY 2014**	FY 2015*
Medical/Surgical	10,319	10,139	9,525	9,609
Maternity (OB/GYN)	1,786	1,704	1,811	1,827
Psychiatric	866	822	812	819
Rehabilitation	331	334	310	309
Pediatric	89	98	41	40
Newborn/Neonates	1,546	1,562	1,652	1,666
Total	**14,937**	**14,659**	**14,151**	**14,270**

*FY 2015 annualized using 6 months of actual volume
**Inpatient demand declined due to the following factors: more stringent requirements for inpatient status (e.g., CMS two-midnight rule), advances in technology and non-surgical options shifting care to the outpatient setting and likely delays in seeking care due to high deductible health plans or lack of coverage. FY 2015

[2] An obligated group allows organizations to combine multiple business lines or assets to create a single entity that becomes jointly and severally liable for the organization's debt. An obligated group may be stronger financially than the sum of its individual members and generally leads to improved credit ratings, lower borrowing costs and enhanced capacity for future borrowing. Source: *http://www.lancasterpollard.com/NewsDetail/tci-fe-when-breaking-up-is-right-for-your-nonprofit*

volume is projected to increase slightly and may be the result of Westerly's maternity service closure and/or program development initiatives in cardiac, oncology and surgical services at L+MH.

TABLE 3
L+MH HISTORICAL AND CURRENT PATIENT DAYS

Service	Actual Volume (Last 3 Completed FYs)			
	FY 2012	FY 2013	FY 2014	FY 2015*
Medical/Surgical	48,738	46,352	44,415	43,675
Maternity (OB/GYN)	4,890	4,264	4,804	5,108
Psychiatric	6,433	6,367	6,679	7,101
Rehabilitation	4,721	4,536	4,494	4,730
Pediatric	238	213	129	134
Newborn/Neonates	5,537	5,581	5,811	6,183
Total	**70,556**	**67,314**	**66,332**	**66,931**

*FY 2015 is annualized using 10 months of actual volume
**Inpatient demand declined due to the following factors: more stringent requirements for inpatient status (e.g., CMS two-midnight rule), advances in technology and non-surgical options shifting care to the outpatient setting and likely delays in seeking care due to high deductible health plans or lack of coverage. FY 2015 volume is projected to increase slightly and may be the result of Westerly's maternity service closure and/or program development initiatives in cardiac, oncology and surgical services at L+MH.

Ex. A, pp. 52-53

22. Inpatient discharges are projected to increase slightly as a result of new clinical program development[3] and the addition of more specialty care to eastern Connecticut and westerly Rhode Island.

TABLE 4
L+MH PROJECTED DISCHARGES BY SERVICE

Service	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Medical/Surgical	9,649	9,633	9,607	9,608
Maternity (OB/GYN)	1,836	1,833	1,829	1,827
Psychiatric	839	847	852	856
Rehabilitation	310	310	310	310
Pediatric	61	77	93	108
Newborn/Neonates	1,696	1,712	1,727	1,741
Total	**14,391**	**14,412**	**14,418**	**14,450**

[3] Potential new programs include: musculoskeletal, neurosurgery/spine, cardiovascular, general surgery, maternity and children's services.

TABLE 5
L+MH PROJECTED PATIENT DAYS BY SERVICE

Service	Projected Volume			
	FY 2016	FY 2017	FY 2018	FY 2019
Medical/Surgical	42,852	42,150	41,489	41,512
Maternity (OB/GYN)	5,059	4,975	4,900	4,895
Psychiatric	7,146	7,104	7,059	7,094
Rehabilitation	4,653	4,583	4,524	4,526
Pediatric	200	247	293	343
Newborn/Neonates	6,142	6,081	6,037	6,078
Total	**66,052**	**65,140**	**64,302**	**64,448**

Ex. A, pp. 41, 53-54

23. Following adoption of the proposal, L+MH's target patient population will remain the same. There are no planned closures or reductions to any clinical services currently offered. Further, the Applicants are planning service enhancements and expansions to minimize the need for area residents to travel outside the service area for specialty care. Ex. A, pp. 32, 34

24. Clinical needs in the service area will be prioritized through a comprehensive strategic planning process undertaken by L+M and YNHHSC. Priority projects to be considered during the first three years following approval of the proposal include:

- behavioral health;
- emergency/urgent care;
- heart and vascular services;
- medicine services;
- oncology;
- pediatrics;
- primary care;
- surgery/ambulatory surgery; and
- women's health.

Exhibit E, p. 627; Late File 1, submitted August 2, 2016

25. Medicaid-covered patients account for 21.3% of L+MH's discharges. The Applicants do not anticipate any significant changes in payer mix as a result of the proposal.

TABLE 6
L + MH CURRENT & PROJECTED PAYER MIX

Payer	Current		Projected							
	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019[1]	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Medicare*	5,603	39.3%	5,650	39.3%	5,658	39.3%	5,661	39.3%	5,673	39.3%
Medicaid*	3,037	21.3%	3,062	21.3%	3,067	21.3%	3,068	21.3%	3,075	21.3%
CHAMPUS & TriCare	1,771	12.4%	1,785	12.4%	1,788	12.4%	1,789	12.4%	1,793	12.4%
Total Government	**10,411**	**73.0%**	**10,498**	**73.0%**	**10,514**	**73.0%**	**10,518**	**73%**	**10,542**	**73%**
Commercial Insurers*	3,698	25.9%	3,729	25.9%	3,734	25.9%	3,736	25.9%	3,744	25.9%
Uninsured	87	0.6%	88	0.6%	88	0.6%	88	0.6%	88	0.6%
Workers Compensation	75	0.5%	76	0.5%	76	0.5%	76	0.5%	76	0.5%
Total Non-Government	**3,860**	**27.0%**	**3,892**	**27.0%**	**3,898**	**27.0%**	**3,900**	**27.0%**	**3,908**	**27.0%**
Total Payer Mix	**14,271**	**100%**	**14,391**	**100%**	**14,412**	**100%**	**14,418**	**100%**	**14,450**	**100%**

*Includes managed care activity
[1] FY 2019 projections are imputed from FY 2015 percentages

Ex. A, pp. 47, 856

26. Following approval of the proposal, L+MH will adopt YNHHSC financial assistance (charity and free care) policies. Ex. A, p. 34; Ex. E, p. 617

27. There are no planned changes to L+MH's charge-master or to its existing payer contracts as a result of the proposal. YNHHSC plans to honor the terms of all existing L+M agreements for their duration. Ex. A, pp. 57-58; Testimony of Mr. Tandler, Executive Director Finance, YNHHS, Ex. PP, p. 136.

28. YNHHSC has assured price neutrality for L+MH for the remainder of the contract terms. The financial terms and reimbursement rates for each provider are unique and based on individual provider's cost structure. Once the contracts expire, they will be renegotiated and the new terms will be based on L+MH's own individual cost structure and service area. Ex. E, p. 867; Testimony of Ms. Borgstrom, President and Chief Executive Officer of YNHHSC, Ex. PP, pp. 145-146

29. The existing debt and pension obligations of L+M will remain unchanged as a result of this proposal. Ex. A, p. 57

30. L+M will become a member of the YNHHSC Obligated Group (current members include: YNHHSC, Yale New-Haven Hospital, Bridgeport Hospital, Bridgeport Hospital Foundation, Northeast Medical Group, and Yale New-Haven Care Continuum), which enables

participants to gain access to more favorable borrowing rates than otherwise would be available on their own. Ex. B. p. 640

31. L+M has experienced a loss from operations in each of the past four fiscal years (see table below):

TABLE 7
L+M INCOME/(LOSS) FROM OPERATIONS

	FY 2013	FY 2014	FY 2015	FY 2016 YTD
Operating Loss	($7,417,664)	($18,685,472)	($10,296,604)	($14,035,190)

Source: Audited Financial Statements submitted to OHCA; Late file #3

32. As of May 2016, the L+MH bond rating for its CHEFA Series F bonds was downgraded by Standard and Poor's ("S&P") to BBB+, from an A+ rating given three years earlier. S&P indicated, however, that there is upward rating potential if L+M's integration with YNHHSC provides immediate improvement to financial performance and balance sheet stability. Prefiled testimony of Bruce D. Cummings, President & CEO of L+M, p. 888

33. As of August 2016, Fitch Ratings downgraded $47.9M State of Connecticut Health and Educational Facilities Authority revenue bonds, Series F (2011), issued on behalf of L+MH from A (stable) to A- (negative) due to the "continued trend of weakening profitability stemming from softer volumes, shift to outpatient utilization, less favorable reimbursement and escalating Connecticut provider tax burden." Exhibit SS, Fitch Ratings Report

34. YNHHSC has agreed to commit as much as $300 million ("M") in resources in eastern Connecticut and western Rhode Island over the next five years to enhance L+M's clinical and operational capabilities and services. Ex. A, p. 39

35. The funding sources of YNHHSC's $300M capital commitment will be:
    - operating cash flows from L+M;
    - operating cash flows from YNHHSC; and
    - cash reserves from YNHHS.

    Ex. E, p. 624

36. The table below provides a preliminary capital investment plan. At least $163M of the $300M total will be allocated for the following capital infrastructure projects at L+M:

TABLE 8
PRELIMINARY CAPITAL INVESTMENT PLAN FOR L+M (IN THOUSANDS)

Description	Five Year Total
Capital infrastructure to maintain and improve the equipment and facilities at L+M	$163,000
Full implementation of EPIC and other clinical systems upgrades	34,000
Rebranding initiatives at L+M	2,000
Clinical program development and related capital expenditures	15,000
Avoidance of population health infrastructure costs at L+M	10,000
Unspecified; to be allocated after a more detailed assessment	76,000
Total estimated capital expenditures	**$300,000**

Ex. E, p. 625-626

37. The most recent credit ratings for YNHHSC are as follows:
    - Moody's: Aa3/Stable Outlook
    - S&P: A+/Positive Outlook
    - Fitch: AA-/Stable Outlook

Ex. E, p. 641

38. The Applicants have stated that multiple options are available to fund the $300M capital commitment in the event of a YNHHSC operating loss, including the use of YNHHSC cash on hand or an L+M debt offering. Ex. E, pp. 624-625

39. The $300 million is a commitment over the next five years to enhance services, infrastructure and operations at L+MH. A portion of the money will come from operational improvements at L+MH, however $85M will be a hard investment made by YNHHSC. A significant amount of this investment will be used for new information technology and population health infrastructure, as well as physician recruitment. In addition, the proposal will help expand the clinical areas determined to be under-supported in the L+MH and Westerly communities, including primary care, surgery, behavioral health, women/children's services and emergency critical care services. Testimony of Ms. Borgstrom, President and Chief Executive Officer of YNHHSC, Ex. PP, pp. 45-46

40. YNHHSC's commitment to L+M is dependent upon the performance of YNHHSC, L+M, community need, YNHHSC's strategic plan and mutually agreed upon business plans that achieve a positive return on investment. YNHHSC will provide $41M based on the strategic plan and an additional $44M for specific clinical and operational initiatives (years two through five of the affiliation). Ex. E, p.624

41. The $85M commitment ($41M + $44M) will be used for the following capital expenditures at L+M:
    - EPIC installation and other IT investments;
    - rebranding and communication;
    - population health infrastructure;
    - clinical programs and services for eastern Connecticut and western Rhode Island;
    - funding for new physicians; and
    - other miscellaneous expenditures including staff augmentation and clinical support.

    Ex. E, p. 626-628

42. YNHHSC plans to use the remaining $215M capital commitment balance in southeastern Connecticut for the following services:

    - expansion of primary care network including ambulatory surgery;
    - access to pediatric specialty services;
    - development of a musculoskeletal center;
    - expansion of maternal fetal medicine and obstetric capabilities;
    - enhancement of Smilow Cancer Hospital oncology services;
    - expansion of bariatric and/or laparoscopic surgical programs;
    - expansion of neuromuscular and stroke programs;
    - development of a multidisciplinary vascular program and enhancement of cardiac services;
    - enhancement of endocrinology/thyroid services;
    - development of population health and risk contracting capabilities;
    - continued access to SkyHealth;
    - expanded emergency services; and
    - physical plant and infrastructure renovations.

    Ex. A, Affiliation Agreement p. 99 & 100

43. With the exception of an initial FY 2016 loss, the Applicants project incremental gains at L+M from FY 2017 through FY 2019. These projected gains are largely due to anticipated operating expense reductions resulting from YNHHSC ownership.

TABLE 9
L+M PROJECTED INCREMENTAL REVENUES AND EXPENSES (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Revenue from Operations	($13,647)	($24,943)	($19,073)	($14,036)
Total Operating Expenses	($13,575)	($32,219)	($31,337)	($29,548)
Gain/(Loss) from Operations	**($72)**	**$7,276**	**$12,265**	**$15,512**

Ex. E, p. 857

44. Similarly, an overall loss is projected at L+M in FY 2016. However, operating gains of $14.6M, $19.1M and $16.9M are projected in FY 2017, FY 2018 and FY 2019, respectively, if the proposal is approved.

TABLE 10
L+M PROJECTED REVENUES AND EXPENSES WITH CON (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Total Operating Revenue	$455,074	$446,783	$455,808	$461,104
Total Operating Expenses	$463,843	$432,214	$436,748	$444,229
Gain/(Loss) from Operations	**($8,769)**	**$14,569**	**$19,060**	**$16,875**

Ex. E, p. 857

45. L+M's projected incremental cost savings are summarized in the table below:

TABLE 11
L+M'S PROJECTED INCREMENTAL OPERATING EXPENSE REDUCTIONS (in thousands)

	FY 2016	FY 2017	FY 2018	FY 2019
Total Reductions*	$13,575	$32,219	$31,337	$29,458

*Operating expense reductions are attributable to the following: salaries and wages, fringe benefits, physician fees, supplies and drugs, malpractice insurance, lease expense and miscellaneous operating expenses.

Ex. E, p. 857

46. YNHHSC acquisitions of Bridgeport and Greenwich Hospitals have resulted in improved financial performance and cost savings for both hospitals. Additional system savings were realized with the integration of the former Hospital of St. Raphael into Yale New Haven Hospital.

- The affiliation of Bridgeport and Greenwich Hospitals, along with the merger of the Hospital of St. Raphael into YNHHSC, has resulted in supply chain cost savings and capital avoidance of $32.8M since FY 2010. These savings were the result of the standardization of supply and pharmaceutical purchases, the integration of service contracts, volume discounts and rebates and efficient utilization of information technology and medical equipment within the system.

- In 2011, the consolidation of property insurance policies under a single contract with YNHHSC generated annual reoccurring savings of $147,000; $84,000 is attributable to cost reductions at Bridgeport and Greenwich Hospitals.

- The integration of the Hospital of St. Raphael into YNHHSC has yielded cost savings of $213M as of November 30, 2015 in the areas of supply chain management, insurance, back office functions and the standardization of clinical practices.

Ex. E. pp. 869-870

47. The financial performance of both Bridgeport and Greenwich Hospitals has improved since affiliating with YNHHSC. In FY 2015, Bridgeport and Greenwich Hospitals reported operational gains of $54.7M and $32.5M, respectively. Ex. E. p. 874 and Audited Financial Statements submitted to OHCA.

48. A Department of Public Health ("DPH") survey conducted on July 13, 2016 found that L+M was not in substantial compliance with certain Conditions of Participation required by the Centers for Medicare & Medicaid Services ("CMS"). As a result, L+M's deemed status[4] was removed by CMS. Subsequently, L+M submitted a Corrective Action Plan to DPH on July 29, 2016. Late file #5

49. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1))

50. This CON application is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2))

51. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3))

52. The Applicants have demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4))

53. The Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5))

54. The Applicants have shown that there would be no change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6))

55. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7))

56. The Applicants' historical provision of treatment in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8))

57. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9))

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[4] Sections 1865 of the Social Security Act and CMS regulations state that a provider or supplier accredited by a CMS-approved Medicare accreditation program will be "deemed" to meet all of the Medicare Conditions of Participation for hospitals. In accordance with Section 1864 of that Act, State Survey Agencies may conduct, at CMS's direction, surveys of deemed status providers in response to a substantial allegation of noncompliance or when CMS determines a full survey is required after a substantial allegation survey identifies substantial noncompliance.

58. The Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10))

59. The Applicants have demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11))

60. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or access to care. (Conn. Gen. Stat. § 19a-639(a)(12))

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

L+M is a non-stock, tax-exempt corporation that is the sole member of subsidiaries operating acute care hospitals and community-based services throughout southeastern Connecticut and southwestern Rhode Island. L+M is the parent company of L+MH, an acute care community hospital located in New London, Connecticut. L+MH is licensed for 280 general hospital beds (plus 28 bassinets) and provides a full range of inpatient, outpatient and ancillary services to residents of southeastern Connecticut. *FF1-FF3* YNHHSC is a Connecticut non-stock, tax-exempt corporation established in 1983 to provide support services to the Yale New Haven Health System ("YNHHS"), a network of affiliated health care providers, the foremost being Yale-New Haven Hospital ("YNHH"). YNHHSC is also the parent company of Greenwich and Bridgeport Hospitals. *FF4-FF5*

Community hospitals like L+MH are increasingly seeking to integrate with larger health systems to gain resources and the expertise necessary to meet the demands of health care reform. As a result of some recent financial challenges and the long standing collaborative relationship between L+M and YNHHSC, the respective boards agreed to execute an Affiliation Agreement and seek regulatory approval to unite the two health systems. *FF6* Accordingly, the Applicants submitted a Hart-Scott-Rodino filing to the FTC on August 7, 2015 and were informed on September 8, 2015 that the waiting period would be allowed to expire without further investigation. *FF8* Following this notification, the Applicants submitted their proposal to OHCA, requesting authorization to transfer ownership of L+M and its subsidiaries to YNHHSC, such that YNHHSC shall become the sole corporate member of L+M. *FF7*

Following the transfer of ownership, L+MH will continue to operate as an independently licensed hospital, with its own separate medical staff, bylaws, rules, regulations and elected officers. *FF9* The L+MH Board will include a YNHHSC appointee, however, the scope of responsibility and authority will largely be unchanged. The L+MH Board will continue to be responsible for the oversight and management of patient care, safety, licensure, accreditation, medical staff credentialing, election and removal of officers and approval of actions not otherwise reserved to L+M and/or YNHHSC. *FF11*

There are no planned closures or reductions to any clinical services currently offered at L+MH as a result of the proposal. The Applicants are currently planning service enhancements and expansions to help minimize the need for residents to travel outside the service area for specialty care. *FF23* Further, the proposal will expand under-supported clinical areas in the L+MH and Westerly communities, including primary care, surgery, behavioral health, women/children's services and emergency critical care services. *FF39*. The Applicants expect that clinical variation will decrease through the use of standardized protocols resulting from the adoption of Epic,

Lawson and other IT platforms used by YNHHSC, thus improving the experience and quality of patient care. *FF20*

The Hospital will continue to serve Medicaid patients and the indigent. Medicaid is the primary payer for approximately one out of five patients served by L+MH. The Applicants do not anticipate any significant changes in payer mix over the next three years. *FF25* Following approval of the proposal, L+MH will adopt YNHHSC's charity and free care financial assistance policies. *FF26*

There are no planned changes to L+MH's charge-master or to its existing payer contracts as a result of the proposal. YNHHSC plans to honor the terms of all existing L+MH agreements for their duration. Once existing contracts expire, they will be renegotiated with new terms based on L+MH's own individual cost structure and service area demographics. *FF27-FF28*

As a core component of the proposal, YNHHSC has agreed to a commit up to $300M in resources over a five-year period to enhance L+M's clinical and operational capabilities in eastern Connecticut and western Rhode Island. *FF34* A significant amount of this investment will be used for new information technology and population health infrastructure, as well as physician recruitment and the development of new clinical programs. *FF39*

Through the infusion of capital, L+M will be better positioned to develop state-of-the-art facilities, technologies and diagnostic capabilities. In addition, L+M will benefit from efficiencies resulting from economies of scale relating to IT, finance, insurance, equipment, supplies and other administrative services and will be able to reduce costs through supply chain-related savings as a result of volume discounts. *FF20*

L+M is currently experiencing some financial challenges, posting operational losses in each of the past four fiscal years (FYs 2013-2016). *FF31* In addition, L+MH recently had its Series F bond rating downgraded by both Standard and Poor's and Fitch Ratings to BBB (investment lower medium grade) and A- (negative), respectively. Fitch stated the downgrading was due to the "continued trend of weakening profitability stemming from softer volumes, shift to outpatient utilization, less favorable reimbursement and the escalating Connecticut provider tax burden." *FF32-FF33* Approval of the proposal should help mitigate future operational losses at L+M and help stabilize its future credit ratings.

With the exception of an initial FY 2016 loss, the Applicants project incremental operating gains at L+M from FY 2017 through FY 2019. *FF44* These projected gains are largely due to the anticipated ability of L+M to reduce operating expenses as a result of YNHHSC ownership. Operating expenses are projected to decrease in FYs 2016-2019 by $13.6M, $32.2M, $31.3M and $29.5M, respectively. These cost savings are attributable to salaries and wages, fringe benefits, physician fees, supplies and drugs, malpractice insurance, lease expense and miscellaneous operating expense reductions. *FF44* As a result of the potential for improved operational and financial performance, cost savings and capital improvements, the Applicants have demonstrated the proposal to be financially feasible and that the overall financial strength of the state's health care system will be improved.

L+M's future financial viability and its patient population's access to community health services can best be achieved by maintaining and building upon its existing relationship with YNHHSC. Integration with YNHHSC will afford L+M the opportunity to expand services, including its primary care network and ambulatory surgery offerings and to develop new local access points for vascular and musculoskeletal treatment. *FF42* The proposal will help provide needed capital and resources to improve L+M's financial strength and preserve L+M as an important source for health care in the local community. Thus, the Applicants have demonstrated a clear public need for the proposal.

The ownership change resulting from the proposal will improve the community's health by delivering high quality, cost effective, coordinated care across a broad continuum. Therefore, the Applicants have demonstrated that the proposal is consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request for the transfer of ownership of L+M Corporation to Yale New Haven Health Services Corporation, is hereby **Approved** under Conn. Gen. Stat. § 19a-639(a) subject to the enumerated conditions (the "Conditions") set forth below.

Unless expressly provided otherwise, all Conditions of this Order shall, to the extent applicable, be binding on the Applicants, their affiliates, successors and assigns, regardless of whether L+M Corporation remains the parent company and sole shareholder of L+MH. OHCA and any successor agency shall have the right to enforce the Conditions by all means and remedies available to it under law and equity, including but not limited to, the right to impose and collect a civil penalty under Conn. Gen. Stat. § 19a-653 against any person or health care facility or institution that fails to file required data or information within the prescribed time periods set forth in this Order. All references to days in these Conditions shall mean calendar days.

1. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, YNHHSC shall submit schedules to OHCA setting forth L+MH's inpatient bed allocation and the location and hours of operation for all outpatient services, by department, as of the Decision Date and publish this same information on the applicable website of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Gen. Stat. §§19a-613(b), 19a-639(a)(8) & (11); FF 21-22.*

2. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, YNHHSC shall notify OHCA of the Closing, in writing, and shall supply final execution copies of all agreements related to same, including but not limited to:
    a. the Affiliation Agreement, including any and all schedules and exhibits; and
    b. Bylaws or similar governance documents for L+M as well as for L+MH.

    YNHHSC may redact from the Affiliation Agreement any information that is exempt from disclosure under Conn. Gen. Stat. § 1-210. If YNHHSC redacts materials in accordance with the previous sentence, it shall provide a list to OHCA, which identifies in general terms the nature of the redacted material and why it is claimed to be exempt for public record purposes. OHCA is imposing this Condition to verify that the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region. *Legal and Factual Basis: Conn. Gen. Stat. §§19a-613(b), 19a-639(5); FF 6, 9*

3. Following the completion of L+MH's 2016 Community Health Needs Assessment (CHNA), YNHHSC shall participate with L+MH, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion. YNHHSC and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the new CHNA (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-

ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community health improvement plan issued by any local health department in the Service Area.[5] The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the CHNA correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community. In the event that L+MH has already substantially completed its 2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum within six (6) months of the Closing Date. The CHNA and the Implementation Strategy shall be published on the website of L+MH. Until such time as the CHNA and Implementation Strategy are submitted to OHCA, YNHHSC shall continue to support and implement L+MH's current CHNA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3) & (7); FF 3,16. 18*

4. Within one hundred and eighty (180) days following the Closing Date, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHSC. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Conn. Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 23*

5. Until such time as the Services Plan is submitted, YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) (7),(8),(9),(11) & (12); FF 23*

6. Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015-August 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs. *Legal and Factual Basis: Stat. §§ 19a-613(b), (a)(5) (12); FF 27-28*

[5] Other tools and resources which the Applicants are encouraged to consider include County Health Rankings and CDC Community Health Improvement Navigator in order to assist with the Study process in terms of an understanding of social, behavioral, and environmental conditions that affect health, identifying priorities, and the use of evidence-based interventions.

7. Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon:

    a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and

    b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and

    c. The funding source of the capital investment indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source.

    For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(3),(4) & (5); FF78, 35 ,36, 38-42*

8. For three (3) years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report:

Financial Measurement/Indicators

A. Operating Performance
1. Operating Margin
2. Non-Operating Margin
3. Total Margin
B. Liquidity
1. Current Ratio
2. Days Cash on Hand
3. Days in Net Accounts Receivables
4. Average Payment Period
C. Leverage and Capital Structure
1. Long-term Debt to Equity
2. Long-term Debt to Capitalization
3. Unrestricted Cash to Debt
4. Times Interest Earned Ratio
5. Debt Service Coverage Ratio
6. Equity Financing Ratio
D. Additional Statistics
1. Income from Operations
2. Revenue Over/(Under) Expense
3. Cash from Operations
4. Cash and Cash Equivalents
5. Net Working Capital
6. Free Cash Flow (and the elements used in the calculation)
7. Unrestricted Net Assets/Retained Earnings

8. Bad Debt as % of Gross Revenue
9. Credit Ratings (S&P, FITCH or Moody's)

OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(4) & (5); FF 31-45*

9. Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 26*

10. For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 26*

11. The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent.

    In determining L+MH's participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy.

    a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(5),(6) & (11); FF 19-20.*

12. The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population. *Legal and Factual Basis; Stat. §§ , 19a-613(b), 19a-639(a)(5),(6) & (11); FF 13-16*

13. The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population. *Legal and Factual Basis: Stat. §§ 19a-490, 19a-493, 19a-639(a)(1),(2),(5) & (6); FF 48*

14. For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH's Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 10-11*

15. Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient

population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat, 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 48*

16. The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein. *Legal and Factual Basis: Conn. Gen. §§ Stat. 19a-613(b), 19a-639(a)(1),(2),(4),(5),(6),(7),(11) & (12); FF 48*

17. For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. 19a-613(b), 19a-639(a)(2),(3),(5),(7),(8),(11) & (12); FF 10-11*

Additional Conditions Agreed to by L+M and YNHHSC

Given the importance of this affiliation to Eastern Connecticut, both L+M and YNHHSC have voluntarily agreed to the following additional conditions for the purpose of representing its ongoing commitment to the provision of high quality affordable health care services in Eastern Connecticut. To the extent that any of these conditions are duplicative or vary from other conditions imposed herein, L+M and YNHHSC agree to consult with OHCA as needed for the purpose of ensuring that L+M and YNHHSC fulfill the spirit and intent of the entire order. The following are ways in which L+M and YNHHSC shall demonstrate these commitments for a period of not less than five years (except as otherwise noted) following the Closing of the affiliation of L+M with YNHHSC:

18. L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need.

19. L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients

requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components:

a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals.

b. YNHHSC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement.

20. L+M and YNHHSC shall maintain the current L+MH and Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017 shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.

    Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.

    For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L +MH and LMMG.

21. With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG):

a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.

b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.

22. Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:

a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.

b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary

and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.

c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.

d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.

e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.

23. For purposes of determining the price per unit of service:

a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient

principal procedures, and the twenty-five most frequent inpatient surgical procedures.

b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.

c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).

d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.

e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.

24. L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.

25. L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.

26. As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of Directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.

27. L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.

28. Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at

L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).

29. L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.

30. L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.

31. L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.

32. Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail:

    a. Affirmation of the continuation of all L+MH services as described herein.

    b. A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.

    c. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.

    d. Affirmation that no L+M physician office has been converted to hospital-based status.

e. Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.

f. A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report.

   i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities;

   ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories;

   iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and

   iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

g. Affirmation of the labor and employment commitments described herein, including but not limited to L+M's service sites continued honoring of collective bargaining agreements in place as of the date hereof.

h. A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.

33. In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing:

a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.

b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.

c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.

d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.

e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide

additional community benefits as necessary to mitigate the impact of such non-compliance.

L+M Corporation and Yale New Haven Health Services Corporation
Docket Number: 15-32033-CON

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

9/8/16
Date

Yvonne Addo
Yvonne T. Addo, MBA
Deputy Commissioner

Date

Duly Authorized Agent for
Lawrence + Memorial Corporation

Signed by _____,
(Print name)

(Title)

9/7/16
Date

Marna P. Borgstrom
Duly Authorized Agent for
Yale New Haven Health Services Corporation

Signed by Marna P. Borgstrom,
(Print name)

President & CEO
(Title)

L+M Corporation and Yale New Haven Health Services Corporation
Docket Number: 15-32033-CON

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

_____
Date

_____
Yvonne T. Addo, MBA
Deputy Commissioner

_____
Date

_____
Duly Authorized Agent for
Lawrence + Memorial Corporation

Signed by Bruce D. Lawrence,
(Print name)

President and CEO
(Title)

_____
Date

_____
Duly Authorized Agent for
Yale New Haven Health Services Corporation

Signed by _____,
(Print name)

_____
(Title)

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, September 28, 2016 2:42 PM
To: Roberts, Karen; Cotto, Carmen
Cc: Greer, Leslie
Subject: FW: Submission of Conditions 1 and 2 of Docket 15-32033-CON
Attachments: Martone_EMAIL_9.28.16.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Rosenthal, Nancy [mailto:Nancy.Rosenthal@greenwichhospital.org]
Sent: Wednesday, September 28, 2016 2:36 PM
To: Martone, Kim
Cc: Capozzalo, Gayle; Willcox, Jennifer; Anderson, Maureen (LMHOSP); 'Patel, Shraddha'
Subject: Submission of Conditions 1 and 2 of Docket 15-32033-CON

Kim,

Please see attached document containing a cover letter and reporting of Conditions 1 and 2.

Nancy

Nancy Rosenthal
V.P., Strategy and Regulatory Planning

Yale New Haven Health System
2 Howe Street, Room 307
New Haven, CT 06511

203-688-5721

Nancy.Rosenthal@ynhh.org
www.ynhhs.org

Yale
NewHaven
Health

September 28, 2016

Ms. Kimberly Martone
State of Connecticut
Office of Healthcare Access
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308

Dear Ms. Martone,

Pursuant to the Order contained within the Agreed Settlement of Docket Number 15-32033-CON, "Transfer of ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation", Condition 1 and Condition 2 are required to be submitted within twenty (20) days following the Closing Date of this transaction. The Closing Date was September 8th.

Attached please find documents responsive to Conditions as 1 and 2. Condition 1 is being posted on L+MH's website immediately.

A copy of these documents will be sent via U.S. postal service.

Regards,

Nancy Levitt Rosenthal
Vice President, Strategy and Regulatory Planning

Strategy and Regulatory Planning
YNHHS, 20 York Street
(2 Howe St, 307)
New Haven, CT 06519
Phone: 203-688-5721
Fax: 203-688-5013
Nancy.Rosenthal@greenwichhospital.org
www.ynhhs.org

September 8, 2016

Lawrence + Memorial Corporation
365 Montauk Avenue
New London, CT 06320

Re: **Limited Disclosures Pursuant to Affiliation Agreement by and between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement, dated as of July 17, 2015 (the "Effective Date"), by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"), as amended to the date hereof (the "Affiliation Agreement"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

YNHHSC and L+M agree and confirm that YNHHSC has made certain limited disclosures for purposes of Article 4 of the Affiliation Agreement. More specifically, although Section 4.1.1 of the Affiliation Agreement indicates that YNHHSC has provided or made available to L+M the governing documents of all YNHHSC Affiliates, governing documents have been provided only for certain key YNHHSC Affiliates. In addition, Section 4.9.1 of the Affiliation Agreement indicates that to the Knowledge of YNHHSC, the YNHHSC Affiliates have not had any breach of information security that would constitute (i) a "security incident" (as defined in 45 CFR § 164.304) that resulted in material and actual unauthorized access, use, disclosure, modification or destruction of Protected Health Information or (ii) a "breach" under Section 13402 of the American Recovery and Reinvestment Act of 2009 and any regulations promulgated thereunder or state information security laws or regulations that require notification to or of government officials, or to individuals whose information may have been breached, the YNHHSC Affiliates have only disclosed (i) such breaches that are not routine and (ii) such breaches in connection with which no YNHHSC Affiliate could reasonably expect to have material liability. Finally, although Section 4.10.7 of the Affiliation Agreement indicates that YNHHSC has provided or made available to L+M copies of the letters and/or rulings from the IRS which recognize that the YNHHSC Obligated Group Members are Tax-Exempt Organizations exempt from United States federal income taxes under Section 501(a) of the Code as organizations described in Section 501(c)(3) of the Code and not as "private foundations" as such term is defined in Section 509 of the Code, such determinations have not been provided.

YNHHSC and L+M agree that the disclosures made under Sections 4.1.1, 4.9.1 and 4.10.7 of the Affiliation Agreement are sufficient and L+M waives any closing condition or other requirement for YNHHSC to make any additional disclosure under such sections. To the best Knowledge of YNHHSC, the effect of the information not disclosed, provided or made available to L+M as described above, would not, individually or in the aggregate, be reasonably expected to have a YNHHSC Material Adverse Effect.

[Signature page follows]

Sincerely,

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Agreed and Confirmed:

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Sincerely,

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Agreed and Confirmed:

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

September 8, 2016

Lawrence + Memorial Corporation
365 Montauk Avenue
New London, CT 06320

Re: **Schedule Supplement Pursuant to Affiliation Agreement by and between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement, dated as of July 17, 2015 (the "Effective Date"), by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"), as amended to the date hereof (the "Affiliation Agreement"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

Pursuant to Section 5.3 of the Affiliation Agreement, YNHHSC hereby delivers to L+M this update to the YNHHHSC Disclosure Schedule delivered as of the Effective Date. This Schedule Supplement includes (x) information that has first arisen or of which YNHHSC has first obtained Knowledge after the Effective Date and that if it existed on the Effective Date would have been required to be reflected on the Disclosure Schedules and (y) information that is necessary to correct any disclosure schedule or representation or warranty and that has first arisen or of which YNHHSC has first obtained Knowledge after the Effective Date. This Schedule Supplement shall be deemed to be incorporated into and to supplement and amend the YNHHSC Disclosure Schedule as of the Closing.

Section and sub-section numbers and letters used in the schedules to this letter correspond to the section and sub-section numbers and letters in the Affiliation Agreement, unless otherwise noted. The captions of each section in the schedules to this letter are included for convenience only and are not intended to limit the scope of the information required to be specifically disclosed.

No disclosure made herein or in the schedules to this letter constitutes an admission of any liability or obligation of any YNHHSC Affiliate, an admission against any interest of any YNHHSC Affiliate or a concession as to any defense available to any YNHHSC Affiliate. Unless the Affiliation Agreement specifically provides otherwise, the disclosure of specific item herein, shall not be deemed to constitute an admission that such item is not in the ordinary course of business. To the extent that any representation or warranty contained in the Affiliation Agreement is limited or qualified by the materiality of the matters to which the representation or warranty is given, the inclusion of any matter in any Schedule does not constitute an admission that such matters are material or will have a YNHHSC Material Adverse Effect. Certain information set forth herein is included solely for informational purposes and may not be required to be disclosed pursuant to the Affiliation Agreement.

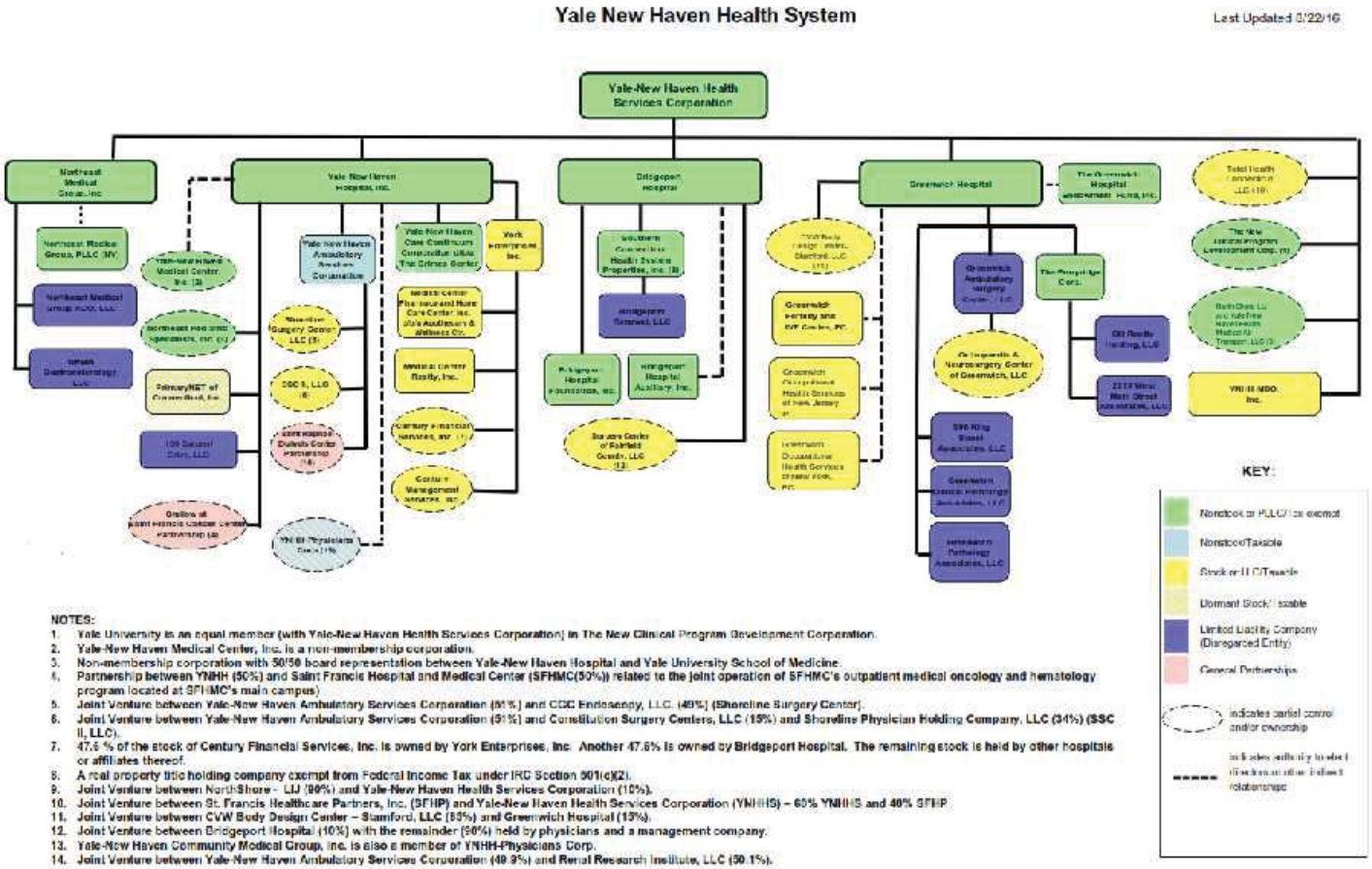
If there is any inconsistency between any provision or statement in the Affiliation Agreement and any provision or statement in the schedules (other than an exception in any section or subsection to a specific representation or warranty), then the provision or statement in the Affiliation Agreement shall control.

Sincerely,

Yale-New Haven Health Services Corporation

By: 
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Updated Schedule 4.1.1 – YNHHSC Subsidiaries



NOTES:

1. Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
2. Yale-New Haven Medical Center, Inc. is a non-membership corporation.
3. Non-membership corporation with 50/50 board representation between Yale-New Haven Hospital and Yale University School of Medicine.
4. Partnership between YNHH (50%) and Saint Francis Hospital and Medical Center (SFHMC(50%)) related to the joint operation of SFHMC's outpatient medical oncology and hematology program located at SFHMC's main campus)
5. Joint Venture between Yale-New Haven Ambulatory Services Corporation (51%) and CDC Endoscopy, LLC. (49%) (Shoreline Surgery Center).
6. Joint Venture between Yale-New Haven Ambulatory Services Corporation (51%) and Constitution Surgery Centers, LLC (15%) and Shoreline Physician Holding Company, LLC (34%) (SSC II, LLC).
7. 47.6 % of the stock of Century Financial Services, Inc. is owned by York Enterprises, Inc. Another 47.6% is owned by Bridgeport Hospital. The remaining stock is held by other hospitals or affiliates thereof.
8. A real property title holding company exempt from Federal Income Tax under IRC Section 501(c)(2).
9. Joint Venture between NorthShore - LIJ (90%) and Yale-New Haven Health Services Corporation (10%).
10. Joint Venture between St. Francis Healthcare Partners, Inc. (SFHP) and Yale-New Haven Health Services Corporation (YNHHS) – 60% YNHHS and 40% SFHP.
11. Joint Venture between CVW Body Design Center – Stamford, LLC (83%) and Greenwich Hospital (13%).
12. Joint Venture between Bridgeport Hospital (10%) with the remainder (90%) held by physicians and a management company.
13. Yale-New Haven Community Medical Group, Inc. is also a member of YNHH-Physicians Corp.
14. Joint Venture between Yale-New Haven Ambulatory Services Corporation (49.9%) and Renal Research Institute, LLC (50.1%).

Update to Schedule 4.8

Subsequent Events

The following language is added to the end of Paragraph 1 of Schedule 4.8:

The budgets for fiscal years 2016 and 2017 have been finalized, and under the final budgets we estimate that YNHHSC will incur a net tax of $149.2M, or 38.1% of the total tax liability for the State, in 2016, and a net tax of $158.7M, or 36.2% of the total tax liability for the State, in 2017.

Updates to Schedule 4.27

Consents and Approvals

The following paragraph is added as Paragraph 10 to Schedule 4.27:

The Parties were required to and did submit a Notice of Hospital Affiliation to the Connecticut Attorney General pursuant to Conn. Gen. Stat. § 19a-486i(e).

The following paragraph is added as Paragraph 11 to Schedule 4.27:

As part of the Hospital Conversion Act approval in Rhode Island, YNHHSC and L+M must pursue a separate *cy pres* action relating to the charitable assets of the Westerly Hospital Foundation, but *cy pres* relief need not be obtained prior to Closing.

September 8, 2016

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06510

Re: **Limited Disclosures and Certain Waivers Pursuant to Affiliation Agreement By and Between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement, dated as of July 17, 2015 (the "Effective Date"), by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"), as amended to the date hereof (the "Affiliation Agreement"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

Article 3

L+M and YNHHSC agree and confirm that L+M has made certain limited representations and disclosures for purposes of Article 3 of the Affiliation Agreement. More specifically, although:

1. Section 3.5.1 of the Affiliation Agreement indicates that L+M has provided to YNHHSC a copy of current title reports relating to the Principal Properties, such title reports have been provided only as of the Effective Date,

2. Section 3.9.1 of the Affiliation Agreement indicates that to the Knowledge of L+M, the L+M Affiliates have not had any breach of information security that would constitute (i) a "security incident" (as defined in 45 CFR § 164.304) that resulted in material and actual unauthorized access, use, disclosure, modification or destruction of Protected Health Information or (ii) a "breach" under Section 13402 of the American Recovery and Reinvestment Act of 2009 and any regulations promulgated thereunder or state information security laws or regulations that require notification to or of government officials, or to individuals whose information may have been breached, the L+M Affiliates have only disclosed (i) such breaches that are not routine and (2) such breaches in connection with which no L+M Affiliate could reasonably expect to have material liability,

3. Section 3.9.1 of the Affiliation indicates that L+M has provided to YNHHSC copies of any voluntary self-disclosure filing made with CMS or any other Governmental Authority and a description of the status of each such self-disclosure filing, L+M has only provided a description of the status of each such self-disclosure filing and offered to YNHHSC a copy of each such self-disclosure filing,

4. Section 3.9.6 of the Affiliation Agreement indicates that L+M has provided to YNHHSC copies of certain Contracts as of the Closing Date, copies of such Contracts have been provided only as of the Effective Date,

5. Section 3.19 of the Affiliation Agreement indicates that L+M has provided or made available to YNHHSC a correct and complete copy of (a) the minute books of the L+M Affiliates and (b) the minutes maintained by the L+M Affiliates quality assurance committees since October 1, 2011,

each subject to the qualifications set forth in Section 3.19 of the Affiliation Agreement, L+M has only provided such minutes through the Effective Date, and

6. Schedule 3.27 L+M previously disclosed to YNHHSC on Schedule 3.27 to the Affiliation Agreement that the appointment of YNHHSC as the ultimate parent of LMI may require approval of the Cayman Island Monetary Authority under Section 12 of the Cayman Island Insurance Law. The approval process with the Cayman Island Monetary Authority is currently underway, but such approval may not be received prior to the Closing. YNHHSC hereby acknowledges and confirms that it is aware that the approval of the Cayman Island Monetary has not yet been received. If approval is not received prior to the Closing, L+M will use commercially reasonable efforts to obtain the required approval as soon as practicable after the Closing.

7. Section 3.34 of the Affiliation Agreement indicates that, except as specifically disclosed to YNHHSC, none of the L+M Affiliates has material Liabilities or material obligations of any nature, as more specifically set forth in Section 3.34 of the Affiliation Agreement, arising out of, or relating to, the business operations of L+M Affiliates and which are required to be reflected on a balance sheet prepared in accordance with GAAP, except: (a) liabilities or obligations as and to the extent reflected on or accrued or reserved against as set forth in the L+M 2014 Audited Financial Statements; and (ii) liabilities incurred since the date of the L+M 2014 Audited Financial Statements in the ordinary course of business, L+M is making this representation based upon its 2015 audited financial statements, which have previously been provided by L+M to YNHHSC, rather than the L+M 2014 Audited Financial Statements.

L+M and YNHHSC agree that the disclosures and representations and warranties made under Sections 3.5.1, 3.9.1, 3.9.6, 3.19 and 3.34 of the Affiliation Agreement are sufficient and YNHHSC waives any closing condition or other requirement for L+M to make any additional representations or disclosures under such sections.

Article 5

Pursuant to Section 5.1.9(a) of the Affiliation Agreement, L+M is required to engage a qualified environmental consultant and to conduct an operational compliance self-audit of the operations of LMH, LMW, LMMG and VNA of Southeastern Connecticut with respect to Environmental, Health and Safety Requirements (an "Environmental Self-Audit") and to complete a written report of such self-audit prior to the Closing Date. As of the Closing Date, L+M has completed an Environmental Self-Audit of and delivered the corresponding written report to YNHHSC with respect to the Owned Real Property, but has not completed an Environmental Self-Audit of any leased real properties of LMH, LMW, LMMG or VNA of Southeastern Connecticut that are leased by LMH, LMW, LMMG or VNA of Southeastern Connecticut as of the Effective Date (collectively, the "Leased Properties"). L+M hereby agrees to complete an Environmental Self-Audit of the Leased Properties and to deliver the corresponding written report to YNHHSC with respect thereto within a reasonable time period following the Closing Date.

YNHHSC hereby agrees to waive the requirement that L+M complete an Environmental Self-Audit under Section 5.1.9(a) of the Affiliation Agreement with respect to the Leased Properties prior to the Closing Date; provided, that, L+M complete such Environmental Self-Audit of each Leased Property and deliver the corresponding written report to YNHHSC with respect thereto within a reasonable time period following the Closing Date.

To the best Knowledge of L+M, the effect of the information not disclosed, provided or made available to YNHHSC as described above, would not, individually or in the aggregate, be reasonably expected to have an L+M Material Adverse Effect.

Sincerely,

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Agreed and Confirmed:

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Sincerely,

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Agreed and Confirmed:

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

September 8, 2016

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06510

Re: **Schedule Supplement Pursuant to Affiliation Agreement By and Between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement (the "Affiliation Agreement"), dated as July 17, 2015, by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

Pursuant to Section 5.3 of the Affiliation Agreement, L+M hereby delivers to YNHHSC this update to the L+M Schedules to the Affiliation Agreement (the "L+M Disclosure Schedule") delivered as of the Effective Date. This letter (the "Schedule Supplement") includes (x) information that has first arisen or of which L+M has first obtained Knowledge after the Effective Date and that if it existed on the Effective Date would have been required to be reflected on the Disclosure Schedules and (y) information that is necessary to correct any disclosure schedule or representation or warranty and that has first arisen or of which L+M has first obtained Knowledge after the Effective Date. This Schedule Supplement shall be deemed to be incorporated into and to supplement and amend the L+M Disclosure Schedule as of the Closing.

Section and sub-section numbers and letters used in the attached Schedule Supplement correspond to the section and sub-section numbers and letters in the Affiliation Agreement, unless otherwise noted, and any information disclosed in in the attached Schedule Supplement shall be deemed to be disclosed to YNHHSC for all purposes of the Affiliation Agreement so long as such disclosure's relevance to the applicable section(s) of the Affiliation Agreement is reasonably apparent on its face. The captions of each section in the Schedule Supplement are included for convenience only and are not intended to limit the scope of such part, paragraph or section of the Schedule Supplement as set forth in the Affiliation Agreement.

No disclosure made herein or in the Schedule Supplement constitutes an admission of any liability or obligation of any L+M Affiliate, an admission against any interest of any L+M

Affiliate or a concession as to any defense available to any L+M Affiliate. Unless the Affiliation Agreement specifically provides otherwise, the disclosure of specific item herein, shall not be deemed to constitute an admission that such item is not in the ordinary course of business. To the extent that any representation or warranty contained in the Affiliation Agreement is limited or qualified by the materiality of the matters to which the representation or warranty is given, the inclusion of any matter in the Schedule Supplement does not constitute an admission that such matters are material or will have a L+M Material Adverse Effect. Certain information set forth herein is included solely for informational purposes and may not be required to be disclosed pursuant to the Affiliation Agreement.

If there is any inconsistency between any provision or statement in the Affiliation Agreement and any provision or statement in the Schedule Supplement (other than an exception in any section or subsection to a specific representation or warranty), then the provision or statement in the Affiliation Agreement shall control.

[Signature page follows.]

Sincerely,

Lawrence + Memorial Corporation

By: _____

Name: Bruce Cummings

Title: President and Chief Executive Officer

Update to Schedule 3.1.1

L+M Subsidiaries

Schedule 3.1.1 is hereby amended and restated in its entirety as follows:

Direct Subsidiaries of Lawrence + Memorial Corporation:

- Lawrence + Memorial Hospital, Inc.*
- LMW Healthcare, Inc.*
- L&M Physician Association, Inc.*
- L & M Systems, Inc.
- Visiting Nurse Association of Southeastern Connecticut Inc.*
- [L & M Health Care, Inc.]*
- L+M Indemnity Company Ltd.
- [Lawrence and Memorial Foundation, Inc.]*

Direct Subsidiaries of Lawrence + Memorial Hospital, Inc.:

- Associated Specialists of Southeastern Connecticut, Inc.*

Direct Subsidiaries of LMW Healthcare, Inc.:

- The Westerly Hospital Foundation, Inc.*
- Westerly Hospital Energy Company, LLC
- The Westerly Hospital Auxiliary, Inc.*

Direct Subsidiaries of L & M Systems, Inc.:

- L&M Home Care Services, Inc.
- [L & M Home Medical Equipment, LLC]

Other Entities in which any L+M Affiliate has an interest:

- DVA Healthcare of New London, LLC
- Connecticut Hospital Laboratory Network, LLC
- Value Care Alliance, LLC
- Northeast Purchasing Coalition, LLC

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* Tax-Exempt Organization

[ ] Inactive Entity

___ L+M Determination Letter has been received

Update to Schedule 3.5.1

Owned Real Property

The list of Owned Real Property is hereby amended and restated as follows:

Owner	Street	City/Town	State
LMH	365 Montauk Ave	New London	CT
LMH	7 Ray Street & 449 Ocean Avenue	New London	CT
LMH	48R Miner Lane	Waterford	CT
LMH	900 Bank Street	New London	CT
LMH	230 Waterford Parkway South	Waterford	CT
LMH	194 Howard Street	New London	CT
LMH	197 Howard Street	New London	CT
LMH	203 Howard Street	New London	CT
LMH (the "Pequot Property")*	52 Hazelnut Hill Road	Groton	CT
LMH	412 Ocean Ave	New London	CT
LMH 7/8 interest; Bank of America 1/8 interest (in trust on behalf of Elizabeth Stamm Estate) (the "Beach Property")^	Pequot Ave	New London	CT
LMW	1 Rhody Drive	Westerly	RI
LMW	65 Wells Street	Westerly	RI
LMW	11 Wells Street Unit 6	Westerly	RI
LMW	45 East Avenue	Westerly	RI
LMW	3 Rhody Drive	Westerly	RI
LMW	26 Wells Street	Westerly	RI
LMW	45 Wells Street, Unit 101	Westerly	RI
LMW	45 Wells Street, Unit 201	Westerly	RI
LMW	25 Wells Street	Westerly	RI
LMW	81 Beach Street	Westerly	RI
VNA of Southeastern Connecticut Inc.	403 N Frontage Rd	Waterford	CT
LMH	One Huntley Road	Old Lyme	CT
L+M	230 Waterford Parkway South (land)	Waterford	CT
LMH	230 Waterford Parkway South (building)	Waterford	CT

*The fee interest in the land on which the Pequot Property is situated is not owned by an L+M Affiliate, but is leased by LMH from the City of Groton, CT, pursuant to a Ground Lease, dated May 1, 1991.

^LMH owns a 7/8 interest in the Beach Property (a beach located in New London, CT for the use of L+M employees and their families). The remaining 1/8 interest in the Beach Property is held by Bank of America, in trust, on behalf of the Elizabeth Stamm Estate.

The following properties are currently on the market: 11 Wells Street Unit 6, Westerly, RI and One Huntley Road, Old Lyme, CT (offer to purchase has been received).

Update to Schedule 3.8

Subsequent Events

Schedule 3.8 is hereby amended as follows:

(b)

The description of the Integrated Leave Program is hereby amended and restated in its entirety as follows:

"*Integrated Leave Program* - Effective April 1, 2015, LMH adopted a new integrated leave program for Directors and Managers and Vice Presidents that are paid biweekly (impacting 120 employees), which includes LMH paid short term disability (self-insured) and long term disability (fully insured) insurance through Unum (Policy No. 468882 001). The plan also moves affected employees to an "All Time" bank for days off rather than Separate Paid Time Off ("PTO") and Sick banks and provides for a 2015 PTO cash out of up to 5 days (with 15 days permitted to be kept in the PTO bank) and eliminates Sick day cash out for new employees (current employees may maintain up to 100 days in frozen Sick bank until used for short term disability paid at 75% and L+M has promised to pay each applicable employee for any hours in excess of 800 in their respective Sick banks at such employee's current base rate (up to $10,000). No PTO cash out will be permitted in 2016 and employees will be permitted to roll over 10 PTO days per year on a going forward basis."

The following is hereby added to subsection (b):

The L+M Affiliates have agreed to pay retention bonuses to certain select individuals in connection with the consummation of the transactions contemplated by the Affiliation Agreement and/or the go-live of Epic Connect.

(d)

The following items are hereby added to subsection (d):

(1) LMH has purchased an HVAC for the 600 Building for a purchase price of $1,135,743.

(2) LMW has purchased an HVAC for its operating room for a purchase price of $1,840,000.

(l)

The following item is hereby added to subsection (l):

(1) In 2015 the primary layer of insurance maintained by or for LMI was exhausted, but no excess layers of such insurance were exhausted.

Update to Schedule 3.10.6

Real Property Certiorari Proceedings

Schedule 3.10.6 is hereby amended and restated in its entirety as follows:

Along with Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, the Connecticut Hospital Association and a number of other Connecticut hospitals, L+M have challenged the constitutionality of the Hospitals Tax with the State of Connecticut Department of Social Services and Department of Revenue Services.

Update to Schedule 3.13

Transactions with Affiliates

Schedule 3.13 is hereby amended as follows:

(1) Number (5) is hereby deleted in its entirety and replaced with the following:

(5) Medical Office Lease, effective August 1, 2015, by and between The New London Medical Arts Group, LLC and L+M. The New London Medical Arts Group, LLC is partially owned by Ross J. Sanfilippo, D.M.D., a member of the L+M Board of Directors.

(2) Number (9) is hereby deleted in its entirety.

(3) Number (13) is hereby deleted in its entirety and replaced with the following:

(13) Letter Agreement, dated January 1, 2016, between David F. Reisfeld, MD and LMH (for Dr. Reisfeld's services of LMH Medical Staff Immediate Past President).

(4) The following items are hereby added to Schedule 3.13:

(1) Intensivist Medical Director Agreement, dated as of January 1, 2009, by and between LMH, Southeastern Pulmonary Associates, P.C., Gold Coast Pulmonary and Sleep and Shoreline Pulmonary Associates (owned all, or in part, by Niall J. Duhig, MD, a member of the LMH Board of Directors), as amended by First Amendment to the Intensivist Medical Director Agreement, dated as of January 1, 2014, by and between LMH, Southeastern Pulmonary Associates, P.C., Gold Coast Pulmonary and Sleep, Shoreline Pulmonary Associates and IPC Hospitalists of New England, P.C. d/b/a IPC of Connecticut.

(2) Exclusive Services Agreement, dated as of May 2, 2008, by and between LMH and Anesthesia Associates of New London, P.C. (owned in part by Dr. Joseph Cecere, a member of the LMH Board of Directors), as amended by Amendment to Exclusive Services Agreement, dated as of December 28, 2009, Amendment to Exclusive Services Agreement, dated as of February 1, 2014, and Amendment to Exclusive Services Agreement, dated as of August 1, 2016, and as supplemented by the Letter of Understanding, dated as of December 10, 2010.

Update to Schedule 3.16.1

Collective Bargaining Matters

Schedule 3.16.1 is hereby amended and restated in its entirety as follows:

(1) Agreement by and between LMH and AFT-CT, AFT Healthcare, AFL-CIO Local 5049 ("Local 5049"), entered into as of March 9, 2016, including that certain Memorandum of Understanding between LMH and Local 5049, dated as of July 15, 2015, and including that certain Memorandum of Agreement by and among LMH, Local 5051, Local 5049 and Local 5123, dated as of June 20, 2016.

(2) Agreement by and between LMH and AFT-CT, AFT Healthcare, AFL-CIO Local 5051 ("Local 5051"), entered into as of March 9, 2016, including certain Memorandum of Understanding by and between LMH and Local 5051, dated as of September 15, 2015, and that certain Memorandum of Agreement between LMH and Local 5051, dated as of April 6, 2016, and also including that certain Memorandum of Agreement by and among LMH, Local 5051, Local 5049 and Local 5123, dated as of June 20, 2016.

(3) Agreement by and between LMH and Lawrence & Memorial Healthcare Workers Union, Local 5123 ("Local 5123"), AFT-CT, AFT, AFL-CIO, entered into as of March 9, 2016, including certain Memorandum of Agreement by and between LMH and Local 5123, dated as of November 19, 2015, March 24, 2016 and July 22, 2016, and also including that certain Memorandum of Agreement by and among LMH, Local 5051, Local 5049 and Local 5123, dated as of June 20, 2016.

(4) Agreement by and between LMH and International Union, Security, Police and Fire Professionals of America, dated as of February 4, 2015, including that certain Memorandum of Understanding between LMH and International Union, Security, Police and Fire Professionals of America, dated as of April 1, 2016.

(5) Agreement by and between LMW and The Westerly United Nurses and Allied Professionals, Local 5104 ("Local 5104"), dated as of July 1, 2014, including that certain Memorandum of Agreement by and between LMW and Local 5104, dated as of June 28, 2016, and also including certain Memorandum of Agreement by and between LMH and Local 5075 and 5104, undated and dated as of June 28, 2016, June 28, 2016, July 27, 2016, August 27, 2016.

(6) Agreement by and between LMW and the Westerly United Nurses and Allied Professionals, Local 5075 ("Local 5075"), dated as of July 1, 2014, including certain Memoranda of Understanding by and between LMW and Local 5075, undated and dated as of January 15, 1991, May 8, 1992, April 27, 1994, February 15, 2001, October 1, 2015, November 17, 2015, February 12, 2016, February 15, 2016, May 12, 2016, June 3, 2016 and August 1, 2016, and also including certain Memorandum of Agreement by and between LMW and Locals 5075 and 5104, undated and dated as of June 28, 2016, June 28, 2016, July 27, 2016, August 27, 2016.

(7) Collective Bargaining Agreement by and between Visiting Nurse Association of Southeastern Connecticut, Inc. and the Visiting Nurses Association of Southeastern Connecticut Federation of Registered Nurses and Home Health Aides, Local 5119 ("Local 5119"), AFT-CT, AFT, ACL-CIO, dated as of October 1, 2014, including that certain Memorandum of Understanding by and between Local 5119 and Visiting Nurse Association of Southeastern Connecticut, Inc., dated as of August 2, 2016 (RNs).

(8) Collective Bargaining Agreement by and between Visiting Nurse Association of Southeastern Connecticut, Inc. and the Visiting Nurse Association of Southeastern Connecticut Federation of

Registered Nurses and Home Health Aides, Local 5119, AFT-CT, AFT, AFL-CIO, dated as of October 1, 2014, including that certain Memorandum of Understanding by and between Local 5119 and Visiting Nurse Association of Southeastern Connecticut, Inc., dated as of August 2, 2016 (Home Health Aides).

(9) The National Labor Relations Board scheduled a union election at the Medical Office Building location of LMMG on November 25, 2014. The union, AFT-Connecticut, was seeking to represent LPNs, medical assistants, patient coordinators, patient care navigators and surgical schedulers. The election resulted in a no vote for AFT-Connecticut representation.

Update to Schedule 3.17.1

L+M Plans

Schedule 3.17.1 is hereby amended and restated as follows:

Number (2) is hereby amended and restated in its entirety as follows:

(2) LMH §457(b) Plan for Select Management Employees, effective as of October 28, 2002, as amended by that certain First Amendment to LMH §457(b) Plan, effective as of October 1, 2010 and Second Amendment to LMH §457(b) Plan, effective as of October 1, 2013. In connection with the LMH §457(b) Plan, LMH established an Irrevocable Rabbi Trust, pursuant to an Agreement by and between LMH and Lincoln Financial Group Trust Company, dated as of February 1, 2016.

Number (3) is hereby amended and restated in its entirety as follows:

(3) LMH 401(k) Plan, amended and restated effective as of February 3, 2016.

Number (15) is hereby amended and restated in its entirety as follows:

(15) LMH Medical insurance provided by Anthem Blue Cross Blue Shield and Century Preferred PPO. Prescription Coverage is through CaremarkPCS Health, L.L.C.

Number (34) is hereby amended and restated in its entirety as follows:

(34) LMH maintains a life insurance policy with Canada Life Assurance Company (Policy No. 2380459) on behalf of John F. Mirabito, the former Chief Executive Officer of L+M. The Annual Premium for the policy is $4,115.00.

Number (37) is hereby amended and restated in its entirety as follows:

(37) The Sound Medical Associates, P.C. Profit Sharing Plan, as amended, was terminated effective December 1, 2015.

Update to Schedule 3.17.4

Benefits Triggered by Agreements

Schedule 3.17.4 is hereby amended and restated in its entirety as follows:

The L+M Affiliates have agreed to pay retention bonuses to certain select individuals in connection with the consummation of the transactions contemplated by the Affiliation Agreement and/or the go-live of Epic Connect.

Schedule 3.27

Consents and Approvals

Schedule 3.27 is hereby amended to include the following items:

(1) The Parties were required to and did submit a Notice of Hospital Affiliation to the Connecticut Attorney General pursuant to Conn. Gen. Stat. § 19a-486i(e).

(2) As part of the Hospital Conversion Act approval in Rhode Island, YNHHSC and L+M must pursue a separate cy pres action relating to the charitable assets of the Westerly Hospital Foundation, but cy pres relief need not be obtained prior to Closing.

(3) Services and Support Agreement by and between Sound Medical Associates, P.C. and Island Health Project, Inc., dated as of September 21, 2001 and amended as of November 21, 2014.

(4) Consent under the following agreements with third party payors is required in connection with the closing of the LMMG-NEMG Merger:

(a) Physician Group Agreement, dated as of February 1, 2010, by and between Aetna Better Health Inc. and LMMG.

(b) Physician Group Agreement, dated as of January 1, 2010, by and between Aetna Health Inc. and LMMG.

(c) Participating Provider Group Agreement, effective as of January 1, 2010, by and between Anthem Health Plans, Inc. and LMMG.

(d) Group Agreement, effective as of January 1, 2010, by and between ConnectiCare, Inc. and LMMG.

(e) Services Agreement, effective February 24, 2012, by and between Community Cash Management Corporation (dba Marcam Associates) and LMMG.

Update to Schedule 3.28.2

Cost Report Periods

Schedule 3.28.2 is hereby amended and restated in its entirety as follows:

LMH

Government Payer Program	Last Three Complete Report Periods	Date Cost Reports Filed	NPR
Medicare	10/1/2012 - 9/30/2013	2/26/2014	No
	10/1/2013 - 9/30/2014	3/25/2015	No
	10/1/2014 - 9/30/2015	2/26/2015	No
Medicaid	10/1/2012 - 9/30/2013	7/1/2014	N/A
	10/1/2013 - 9/30/2014	7/1/2015	N/A
	10/1/2014 - 9/30/2015	7/1/2016	N/A

LMW

Government Payer Program	Last Three Complete Report Periods	Date Cost Reports Filed	NPR
Medicare	10/1/2012 - 9/30/2013	2/14/2014	4/16/16
	10/1/2013 - 9/30/2014	3/2/2015	No
	10/1/2014 - 9/30/2015	2/25/2015	No

Execution Version

FIRST AMENDMENT TO THE AFFILIATION AGREEMENT BY AND BETWEEN YALE-NEW HAVEN HEALTH SERVICES CORPORATION AND LAWRENCE + MEMORIAL CORPORATION

This First Amendment to the Affiliation Agreement by and between Yale-New Haven Health Services Corporation and Lawrence & Memorial Corporation (this "First Amendment") is made and entered into as of September 8, 2016, by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M").

RECITALS

WHEREAS, YNHHSC and L+M entered into an Affiliation Agreement dated as of July 17, 2015 (the "Affiliation Agreement");

WHEREAS, initially capitalized terms that are used in this First Amendment without other definition have the respective meanings ascribed thereto in the Affiliation Agreement;

WHEREAS, at the time the Parties entered into the Affiliation Agreement, the Parties set forth certain intentions with respect to the merger (the "Merger") of L+M Physician Association, Inc., a Connecticut non-stock medical foundation doing business as L+M Medical Group ("LMMG") and Northeast Medical Group Inc., a Connecticut non-stock medical foundation ("NEMG"), which Merger was contemplated to take place as of the Closing Date and as a condition of Closing pursuant to the Affiliation Agreement;

WHEREAS, the Parties wish to proceed to the Closing without effecting the Merger, but instead to effect the Merger at a date subsequent to the Closing to be agreed upon by YNHHSC and L+M (the "Post Closing Merger Effective Date"); and

WHEREAS, to facilitate the Closing, the Parties wish to amend the Affiliation Agreement;

NOW, THEREFORE, in consideration of the foregoing, of mutual promises of the Parties hereto and of other good and valuable consideration, the receipt and sufficiency of which hereby are acknowledged, the Parties hereby agree, and the Affiliation Agreement is hereby amended as follows.

ARTICLE 1

AMENDMENTS TO AFFILIATION AGREEMENT

1.1 Section 2.1.4 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"2.1.4 Medical Foundation Matters. **As of the Closing Date, L+M shall remain the sole member of LMMG and YNHHSC shall remain the sole member of NEMG. Following the Closing, YNHHSC and NEMG shall cooperate to maximize the efficiency of operations of LMMG and NEMG.** As of the Closing Date, (i) ~~LMMG shall be merged with and into NEMG with NEMG surviving pursuant to an Agreement and Plan of Merger (the "LMMG-NEMG Agreement and Plan of Merger") in the form attached as Exhibit 2.1.4(A); (ii)~~ two physician employees of ~~NEMG~~ **LMMG** who are members of the medical staff of LMH and/or LMW, nominated in accordance with the bylaws of NEMG, shall be elected to the board of trustees of NEMG; ~~(iii)~~ **(ii)** the president of L+M or his or her designee shall be elected to the board of trustees of NEMG; **(iii)** ~~(iv)~~ the bylaws of NEMG shall be amended and restated in the form of the Amended and Restated Bylaws of NEMG (the "Amended and Restated Bylaws of NEMG") attached hereto as Exhibit 2.1.4(B); **(iv)** the certificate of incorporation of NEMG shall be amended and restated in the form of the Amended and Restated Certificate of Incorporation of NEMG (the "Amended and Restated Certificate of Incorporation of NEMG") attached hereto as Exhibit 2.1.4(C); **(v) the bylaws of LMMG shall be amended and restated in the form of the Amended and Restated Bylaws of LMMG (the "Amended and Restated Bylaws of LMMG") attached hereto as Exhibit 2.1.4(D); and (vi) the certificate of incorporation of LMMG shall be amended and restated in the form of the Amended and Restated Certificate of Incorporation of LMMG (the "Amended and Restated Certificate of Incorporation of LMMG") attached hereto as Exhibit 2.1.4.(E). In addition, as soon as reasonably practicable following the Closing Date,** ~~and (vi)~~ the contracts held by Sound Medical Associates, P.C. will be assigned to NEMG PLLC. **In addition, as of the Post Closing Merger Effective Date, LMMG shall be merged with and into NEMG with NEMG surviving pursuant to an Agreement and Plan of Merger (the "LMMG-NEMG Agreement and Plan of Merger") in the form attached as Exhibit 2.1.4(A).**"

1.2 The final paragraph of Section 2.1.5 of the Affiliation Agreement is hereby amended as follows (deletions show in ~~strikethrough~~; additions shown in **bold**):

"The LMH Amended Certificate of Incorporation, the LMW Amended Certificate of Incorporation**, the Amended and Restated Certificate of Incorporation of LMMG** and the VNA of Southeastern Connecticut Amended Certificate of Incorporation shall be referred to herein as the "*L+M Subsidiaries Amended Certificates of Incorporation*;" the LMH Amended Bylaws, the LMW Amended Bylaws**,** ~~and~~ the VNA of Southeastern Connecticut Amended Bylaws**, and the Amended and Restated Bylaws of LMMG** shall be referred to herein as the "*L+M Subsidiaries Amended Bylaws*." From and after the Closing Date, any other L+M Subsidiaries shall be operated in conformity with the principles reflected in the L+M Subsidiaries Amended Certificates of Incorporation and the L+M Subsidiaries Amended Bylaws."

1.3 Section 2.2 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"2.2 Maintenance of Separate Corporate Existence. After giving effect to the Closing, the corporate existence, names, rights, privileges, immunities, powers,

franchises, facilities and other licenses, duties and liabilities of L+M and each L+M Subsidiary, ~~other than LMMG~~, shall be governed by the Board of Trustees of L+M or such L+M Subsidiary, as applicable, subject to the L+M Amended Certificate of Incorporation and the L+M Amended Bylaws or the L+M Subsidiaries Amended Certificates of Incorporation and L+M Subsidiaries Amended Bylaws, as applicable, **except as otherwise provided in the LMMG-NEMG Agreement and Plan of Merger as of the Post Closing Merger Effective Date**. Except as otherwise contemplated by this Agreement, the Affiliation shall not result in a transfer or conveyance as of the Closing Date of any asset or the assumption of any liability of either Party or any Affiliate of either Party."

1.4 Section 2.10 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"2.10 Obligated Group. On the earliest date following the Closing Date that is reasonably determined by YNHHSC and in accordance with the requirements of the L+M Master Trust Indenture, YNHHSC shall have the authority to cause L+M and LMH, **LMMG,** LMW and/or such other L+M Subsidiaries as YNHHSC shall determine to become YNHHSC Obligated Group Members, and effective upon becoming a YNHHSC Obligated Group Member the applicable L+M Affiliate shall execute a joinder to become a party to the YNHHSC Obligated Group Agreement and shall take such other steps as YNHHSC may require in connection with such status."

1.5 Section 3.2 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"3.2 Authorization of Transaction. L+M has full corporate power and authority to execute and deliver this Affiliation Agreement and to perform its obligations hereunder. This Agreement has been duly authorized by all requisite corporate action of L+M. This Agreement has been duly executed and delivered by L+M and, assuming due authorization, execution and delivery by YNHHSC, and receipt of the consents and approvals listed in Schedule 3.27, constitutes a valid and binding obligation of L+M, enforceable against L+M in accordance with its terms (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization, preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)). The amendment of the certificate of incorporation of L+M in the form of the L+M Amended Certificate of Incorporation and the amendment of the bylaws of L+M in the form of the L+M Amended Bylaws, in each case effective as of and subject to the Closing, has been duly authorized by all requisite corporate action of L+M. The LMMG-NEMG Agreement and Plan of Merger to become effective as of **the Post Closing Merger Effective Date** and subject to the Closing: (a) have been duly authorized by all requisite corporate action of L+M; and (b) in the case of LMMG, have been (or upon Closing will be) duly authorized by all requisite corporate action of LMMG. The amendment of the certificate of incorporation of each applicable L+M Subsidiary in the form of: (i) the LMH Amended Certificate of Incorporation; (ii) the LMW Amended Certificate of Incorporation; ~~and~~ (iii) the VNA of Southeastern

Connecticut Amended Certificate of Incorporation**; and (iv) the Amended and Restated Certificate of Incorporation of LMMG,** and the amendment of the bylaws of each applicable L+M Subsidiary in the form of: (x) the LMH Amended Bylaws; (y) the LMW Amended Bylaws; ~~and~~ (z) the VNA of Southeastern Connecticut Amended Bylaws~~,~~ **and (zz) the Amended and Restated Bylaws of LMMG,** in each case effective as of and subject to the Closing: (a) has been duly authorized by all requisite corporate action of L+M; and (b) in the case of each applicable L+M Subsidiary, has been (or upon Closing will be) duly authorized by all requisite corporate action of such L+M Subsidiary."

1.6 Section 4.2 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"4.2 Authorization of Transaction. YNHHSC has full corporate power and authority to execute and deliver this Affiliation Agreement and to perform its obligations hereunder. This Agreement has been duly authorized by all requisite corporate action of YNHHSC. This Agreement has been duly executed and delivered by YNHHSC and, assuming due authorization, execution and delivery by L+M, and receipt of the consents and approvals listed in Schedule 4.27, constitutes a valid and binding obligation of YNHHSC, enforceable against YNHHSC in accordance with its terms (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization, preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)). The LMMG-NEMG Agreement and Plan of Merger to become effective as of **the Post Closing Merger Effective Date** and subject to the Closing have been duly authorized by all requisite corporate action of NEMG **and YNHHSC**."

1.7 Section 9.2(b) of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"A copy of the L+M Amended Bylaws, and of the L+M Subsidiaries Amended Bylaws for each of the applicable L+M Subsidiaries ~~other than LMMG~~, certified to be in full force and effect and to be true and correct by the secretary or assistant secretary of L+M;"

1.8 Section 9.2(c) of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"An executed copy of the LMMG-NEMG Agreement and Plan of Merger in proper form for filing with the Secretary of State **as of the Post Closing Merger Effective Date**;".

1.9 Section 9.3(e) of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"An executed copy of the LMMG-NEMG Agreement and Plan of Merger in proper form for filing with the Secretary of State **as of the Post Closing Merger Effective Date**;".

1.10 Exhibit 2.1.4(B) of the Affiliation Agreement is hereby amended and restated in the form attached to this First Amendment as Exhibit 2.1.4(B) (deletions shown in ~~strikethrough~~;

additions shown in **bold**) [the Amended and Restated Bylaws of NEMG].

1.11 A new Exhibit 2.1.4(D) is hereby added to the Affiliation Agreement in the form attached to this First Amendment as Exhibit 2.1.4(D) [the Amended and Restated Bylaws of LMMG].

1.12 A new Exhibit 2.1.4(E) is hereby added to the Affiliation Agreement in the form attached to this First Amendment as Exhibit 2.1.4(E) [the Amended and Restated Certificate of Incorporation of LMMG].

1.13 Schedule 6.5 of the Affiliation Agreement is hereby amended and restated in the form attached to this First Amendment as Schedule 6.5 (deletions shown in ~~strikethrough~~; additions shown in **bold**).

1.14 Schedule 7.5 of the Affiliation Agreement is hereby amended and restated in the form attached to this First Amendment as Schedule 7.5 (deletions shown in ~~strikethrough~~; additions shown in **bold**).

ARTICLE 2

CLOSING

The Parties agree that the Closing Date and Effective Time are: 4:00 p.m. September 8, 2016.

ARTICLE 3

MISCELLANEOUS

3.1 Except as expressly modified hereby, all other terms and provisions of the Affiliation Agreement shall remain in full force and effect; except that any references to the merger of NEMG and LMMG that are inconsistent with the Parties' intent as reflected in the Recitals above shall be deemed amended by this First Amendment to be consistent with the Parties' intent as set forth in this First Amendment. All other terms and provisions of the Affiliation Agreement are incorporated herein by this reference, and shall govern the conduct of the Parties hereto; *provided, however,* to the extent of any inconsistency between the provisions of the Affiliation Agreement and the provisions of this First Amendment, the provisions of this First Amendment shall control.

3.2 This First Amendment may be executed in multiple counterparts, each of which shall be deemed an original First Amendment, but all of which, taken together, shall constitute one and the same First Amendment, binding on the Parties hereto. The delivery of an executed signature page hereof by facsimile or portable document format (.pdf) shall have the same effect as the delivery of a manually executed counterpart hereof.

3.3 This First Amendment and the Affiliation Agreement (as hereby amended) together contain and constitute the entire agreement between the Parties hereto with respect to the subject matter hereof, and this First Amendment and the Affiliation Agreement (as hereby

amended) may not be modified, amended, or otherwise changed in any manner, except as provided in the Affiliation Agreement (as hereby amended).

3.4 Every provision of this First Amendment is intended to be severable. If any term or provision hereof is declared by a court of competent jurisdiction to be illegal or invalid, such illegal or invalid terms or provisions shall not affect the other terms and provisions hereof, which terms and provisions shall remain binding and enforceable.

3.5 The headings used in this First Amendment are for reference purposes only, and are not intended to be used in construing this First Amendment. As used in this First Amendment, the masculine gender shall include the feminine and neuter, and the singular number shall include the plural, and vice versa.

3.6 The provisions of this First Amendment shall be interpreted and construed in accordance with the laws of the State of Connecticut, without regard to conflict of laws principles.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties have executed, or caused this First Amendment to be executed as of the date first set forth above.

Yale-New Haven Health Services Corporation, a Connecticut non-stock, tax-exempt corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Lawrence + Memorial Corporation, a Connecticut non-stock, tax-exempt corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

IN WITNESS WHEREOF, the Parties have executed, or caused this First Amendment to be executed as of the date first set forth above.

Yale-New Haven Health Services Corporation, a Connecticut non-stock, tax-exempt corporation

By:_____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Lawrence + Memorial Corporation, a Connecticut non-stock, tax-exempt corporation

By:_____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Exhibit 2.1.4(B)

Amended and Restated Bylaws of NEMG

NORTHEAST MEDICAL GROUP, INC.

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

NORTHEAST MEDICAL GROUP, INC.
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 **Name**. The name of the corporation is **Northeast Medical Group, Inc.** (the "Corporation").

Section 1.2 **General Purposes**. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 **Member**. The Corporation shall have a single member, Yale-New Haven Health Services Corporation (the "Member"), a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes.

Section 2.2 **Rights, Powers and Privileges**. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a medical foundation under the Chapter 594b of the Connecticut General Statutes (as it may be amended from time to time, the "Foundation Act") and of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act (as it may be amended from time to time, the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), without the prior approval of the Member. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the Member, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s)

exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the approval rights reserved to the Member set forth in Exhibit A, the Member expressly retains the rights to take the actions set forth in Exhibit B on behalf of and in the name of the Corporation, directly and without the approval of the Board of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 Liability and Reimbursement of Expenses. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 Powers and Duties. Subject to the powers retained by, conferred upon, or reserved to the Member by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances, and in a manner he or she reasonably believes to be in the best interests of the Corporation.

Section 3.2 Composition. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees**. Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees**. In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President of the Corporation; and

(ii) the President of each Affiliated Delivery Network, or his or her

designee.

For purposes hereof, "Affiliated Delivery Network" shall mean Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with the Yale New Haven System in the future, as designated by the Member.

Section 3.3 Number. The Board shall consist of no fewer than thirteen (13) nor more than twenty-four (24) Trustees, inclusive of Ex Officio Trustees. The number of Trustees within the range set forth in the preceding sentence shall be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors consistent with the following Board composition:

(a) two (2) representatives of senior management of the Member (each, a "YNHHSC Board Member");

(b) one (1) representative from each Affiliated Delivery Network other than Lawrence + Memorial Corporation (in addition to the President, or his or her designee, who shall serve Ex Officio as set forth in Section 3.2(b));

(c) two (2) physicians employed by LMMG, each of whom is a member in good standing on the medical staff of Lawrence + Memorial Hospital or Westerly Hospital;

(d) up to eight (8) individuals, each of whom is either (1) nominated by a majority vote of the Board and approved by the Member; or (2) self-nominated and appointed by the Member; provided, however, that each such individual, whether nominated by a majority vote of the Board or self-nominated, shall be a Provider (as defined in the Foundation Act) employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Delivery Network;

(e) two (2) representatives of Yale School of Medicine;

(f) such other individuals nominated Yale School of Medicine and approved by the Member; provided, however, that each such other individual shall be a Provider employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Deliver Network.

Notwithstanding anything herein to the contrary: (x) in accordance with the Foundation Act, the number of Trustees on the Board who are Providers shall equal or exceed the number of Trustees on the Board who are nonprovider employees of the Member; and (y) the number of Trustees appointed to the Board as representatives of, or on the nomination of, Yale School of

Medicine shall constitute twenty-five percent (25%) of the total number of Trustees on the Board.

Section 3.5 **Term and Term Limits**. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of Yale-New Haven Health Services Corporation at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of Yale-New Haven Health Services Corporation.

Section 3.6 **Resignation**. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective

at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

Section 3.9 Meetings.

(a) **Annual Meetings**. The annual meeting of the Board shall be held on such date and time as the Board or the President shall designate.

(b) **Regular Meetings**. Regular meetings of the Board shall be held on such dates and at such times and places as the Board or President shall designate.

(c) **Special Meetings**. Special meetings of the Board may be called at any time by the President and shall be called by the President upon the written request of the Member or any Trustee.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board and the Member in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President/Chief Executive Officer of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President/Chief Executive Officer of the Member has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 Officers. The officers of the Corporation shall consist of a Chair, a President, a Secretary, a Treasurer and such other officers, including Vice Chairs, as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be members of the Board.

Section 4.2 Election and Term of Office. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, any Vice Chairs, the Secretary and the Treasurer shall be nominated by the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 Powers. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President**. The President of the Corporation shall be appointed by the Member, following consultation with the Board. The appointed President shall serve at the pleasure of the Member.

The President shall be a person who in the judgment of the Member has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, employees and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board may designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s), if any, shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office, shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 Resignation and Removal.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President may be removed from office by the Member following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as may be provided for, from time to time, in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. All committees shall have the power to choose their own secretaries. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

Section 5.3 Committee Governance.

(a) **Quorum and Voting**. A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) **Meetings**. Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) **Executive Committee.** The Executive Committee shall consist of the Chair, who shall act as chair of the committee, the President, the Treasurer, and any other member of the Board that the Board may choose to appoint. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws or resolution of the Board.

(b) **Nominating and Governance Committee.** The Nominating and Governance Committee shall consist of Trustees elected by the Board. The Nominating and Governance Committee shall, after consultation with the President and other Trustees, nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all standing committees. The Nominating and Governance Committee shall also review Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process.

(c) **Finance Committee**. The Finance Committee shall have such duties as are established by the Member and set forth in the Finance Committee charter. These duties shall include, but not be limited to, approval of local operating and capital budgets and examination and monitoring of other operating and capital budgets involving the Corporation.

Section 5.6 Other Committees. The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

Section 5.7 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Member, Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 **Fiscal Year**. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 **Execution of Deeds and Contracts**. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 **Execution of Negotiable Instruments**. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

ARTICLE IX. AMENDMENTS

Subject to approval by the Member, these Bylaws may be amended, altered, or repealed at any meeting of the Board by a majority vote of the Trustees present and voting, a quorum being present. The general nature and purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice. No amendment, alteration or repeal shall take effect until it shall have been approved by the Member.

EXHIBIT A

Actions Requiring Approval of the Member

Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of the Corporation may take any of the following actions, or approve an Affiliate taking any of the following actions, without the prior approval of the Member:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate and the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the Member;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. The Member shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate;

K. Adoption of safety and quality assurance policies not in conformity with policies established by the Member; and

L. Adoption of any polices relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation.

Other Major Activities

A. In addition, the Member shall have the authority, except as otherwise provided by the Member and after consultation with this Corporation, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that the Member determines to be "major activities."

B. "Major activities" shall be those which the Member by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the Member, and shall refer to this Bylaw provision granting such approval rights to the Member. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation.

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member pursuant to these Bylaws and the Bylaws of the Member.

EXHIBIT B

Actions Direct Authority Retained by the Member

Notwithstanding anything in these Bylaws to the contrary, the Member retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by the Member in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to the Member or as otherwise directed by the Member;

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate; and

G. Appointment of the President consistent with Section 4.3(a).

Exhibit 2.1.4(D)

Amended and Restated Bylaws of LMMG

AMENDED AND RESTATED BYLAWS

OF

L+M PHYSICIAN ASSOCIATION, INC.

ARTICLE I

Name

Section 1.01 Name of Corporation. The name of this Corporation is **L+M Physician Association, Inc.**, and it shall be referred to throughout these Bylaws as the "Corporation."

ARTICLE II

Role and Purpose of the Corporation; Sole Member

Section 2.01 Role and Purpose of the Corporation. The Corporation is organized and shall be operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as now in effect or as may hereafter be amended (the "**Code**"), which purposes are set forth in the Corporation's Certificate of Incorporation, as the same may be amended from time to time. The Corporation's primary role and purpose is to practice medicine and provide health care services to the public as a medical foundation, pursuant to Chapter 594b of the Connecticut General Statutes, within the health care delivery system (the "**System**") administered by Yale New Haven Health Services Corporation ("**YNHHSC**" or the "**System Parent**").

Section 2.02 Sole Member; Lawrence + Memorial Corporation. The Corporation shall have but one (1) member, Lawrence + Memorial Corporation (the "**Member**"), which shall appoint the Board of Trustees of the Corporation (also referred to in these Bylaws as the "**Board**" or "**Board of Trustees**"), adopt, amend and repeal these Bylaws, and have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock federally tax-exempt corporation and not conferred by these Bylaws on the Board of Trustees of the Corporation. In addition to such other rights, powers and privileges as it may have by law, and subject to the System Parent's rights, powers and privileges set forth in these Bylaws, the Member shall have the right and power to:

(a) Approve the philosophy, mission and values of the Corporation and any change thereto;

(b) Adopt strategic plans for the Corporation;

(c) Recommend to the System Parent targets for the annual operating and cash flow budgets of the Corporation and targets for the annual capital budgets and budget allocations of the Corporation;

(d) Approve the Corporation's annual operating and cash flow budgets, capital budgets, capital allocations, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(e) Approve the formation or acquisition by the Corporation of any new direct or indirect subsidiaries, joint ventures or affiliations;

(f) Approve the Certificate of Incorporation, Bylaws and other governance documents of the Corporation, and any amendments thereto or restatements thereof;

(g) Approve all core competencies and qualifications required for selection of the Corporation's Trustees;

(h) In consultation with and upon recommendation of the Board, appoint all Trustees of the Corporation, and remove, with or without cause, all Trustees or board officers of the Corporation;

(i) In consultation with and upon recommendation of the Board, appoint and remove, determine the compensation for, and conduct the evaluation of, the Executive Director of the Corporation;

(j) Recommend to the System Parent the selection of any auditor of the annual audited financial statements for the Corporation;

(k) Recommend to the System Parent any accounting or debt management programs, establish any debt limits under such programs, approve any variances from such programs or limits for the Corporation, and incur or assume any debt on behalf of the Corporation;

(l) Recommend to the System Parent the incurrence of debt or financing by the Corporation, other than credit purchases of goods or services in the ordinary course of business, except as included in approved capital or operating budgets;

(m) Oversee the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(n) Approve any voluntary change to the federal income tax exemption granted by the IRS to the Corporation under Section 501(c)(3) of the Code;

(o) Initiate or consent to any form of insolvency proceeding undertaken by the Corporation or any direct or indirect subsidiary of the Corporation;

(p) Approve all projects, agreements or transactions undertaken by the Corporation involving the expenditure of funds or divestiture of assets in excess of $250,000 and not otherwise included in an approved budget;

(q) Approve the services offered by the Corporation, new service lines or termination of existing service lines not otherwise included in an approved budget or a strategic or financial plan;

(r) Approve any sale, lease, transfer, or substantial change in the use of all or substantially all of the assets of the Corporation or any direct or indirect subsidiary of the Corporation;

(s) Approve any merger, consolidation, restructuring, change in corporate ownership, dissolution, or liquidation of the Corporation or any direct or indirect subsidiary or the Corporation;

(t) Approve the acquisition of any real estate or any significant lease arrangement by the Corporation, except as otherwise included in a strategic or financial plan or approved budget;

(u) Approve any management contract or outsourcing arrangement for the Corporation which would substantially impact or alter its operations, or any settlement agreement or consent decree with any local, state or government authorities; and

(v) Approve any change in the primary business name or logo of the Corporation.

Section 2.03 Manner of Action by Member. Any action permitted or required of the Member by law, the Certificate of Incorporation or these Bylaws may be taken by vote of its board of trustees, or by or through any person or persons designated by either its bylaws or its board of trustees to act on its behalf. Any such action may also be taken without a meeting by written communication of a duly authorized representative of the Member acting within the limits of his/her authority. Any such action by the Member or its duly authorized representative shall be filed with the Secretary of the Corporation. Whenever approval by the Member is required by law, the Certificate of Incorporation or these Bylaws, the Member shall attempt to act on a request for approval within the timeframe set forth in any schedule that may be developed from time to time, or if no such schedule exists, in a timely manner.

ARTICLE III

System Authority

Section 3.01 System Parent. YNHHSC serves as the parent company of the Member and oversees the System and its affiliated entities, including the Corporation.

Section 3.02 Rights and Powers of the System Parent. (a) YNHHSC shall, as the parent company of the Corporation's Member, have the ultimate authority to approve any decisions made by the Member by virtue of its rights and powers under state law. Such ultimate authority granted to YNHHSC shall include the right and power to approve the following:

(i) Merger, consolidation, reorganization or dissolution of this Corporation and the creation or acquisition of an interest in any corporate entity, including joint ventures;

(ii) Amendment or restatement of the mission, Certificate of Incorporation or the Bylaws of this Corporation, or any new or revised "doing business as" name;

(iii) Adoption of operating and cash flow budgets of the Corporation, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation within parameters established by the System Parent;

(iv) Adoption of capital budgets and capital allocations of this Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the System Parent);

(v) Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the System Parent;

(vi) Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;

(vii) Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

(viii) Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation;

(ix) Approval of major new programs and clinical services of this Corporation or discontinuation or consolidation of any such program. YNHHSC shall from time to time define the term "major" in this context;

(xi) Approval of strategic plans of this Corporation;

(xii) Adoption of safety and quality assurance policies not in conformity with policies established by YNHHSC;

(xiii) Adoption of any polices relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation;

(xiv) Appointment of the President of Corporation;

(xiv) Any major activities of the Corporation. "Major activities" shall be those which YNHHSC, by a vote of not less than two-thirds (2/3) of its Board of Trustees, has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of YNHHSC, and shall refer to this Bylaw provision granting such approval rights to YNHHSC. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation. Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by YNHHSC pursuant to these Bylaws and the Bylaws of YNHHSC.

(b) The System Parent retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Member or Board of this Corporation:

(i) Adoption of targets for the annual operating and cash flow budgets of the Corporation, including consolidated or combined budgets of the Corporation and all subsidiary organizations of the Corporation;

(ii). Adoption of targets for the annual capital budgets and capital allocations of the Corporation;

(iii) Adoption of annual operating, cash flow and annual capital budgets for the Corporation within the targets established by YNHHSC in the event of any failure of the Corporation to do so;

(iv) Issuance and incurrence of indebtedness on behalf of the Corporation;

(v) Management and control of the liquid assets of the Corporation, including the authority to cause such assets to be funded to YNHHSC or as otherwise directed by YNHHSC; and

(vi) Appointment of the independent auditor for the Corporation and the management of the audit process and compliance process and procedures for the Corporation.

ARTICLE IV

Board of Trustees

Section 4.01 Composition. The Board of Trustees shall consist of not fewer than five (5) nor more than eleven (11) Trustees, including *ex officio* Trustees, such number within the variable range to be determined by the Member at its annual meeting. The Member's President and Chief Executive Officer and the Corporation's Executive Director shall serve *ex officio* on

the Board and shall each have a vote and be counted for quorum purposes. The Member's Governance Committee shall ensure that: (i) in the event that there are employees of the Member serving as Trustees on the Board at any time who are not physicians, there shall be at least an equal number of physicians serving as Trustees on the Board.

Section 4.02 Election and Terms. Except individuals serving *ex officio* on the Board or as provided otherwise in this Article III, Trustees shall serve a term of three (3) years, or until their resignation, removal or death. Trustees shall be divided into three (3) classes of approximately equal size with approximately equal representation from each Director category. One class of Trustees shall be elected by the Member at each annual meeting from a slate of nominees prepared by the Member's Governance Committee, subject to approval by the System Parent; provided however that in the event the System Parent does not approve any such nominee Director, the Member shall elect a different Director for approval by the System Parent; and provided further that in the event any such successor nominee Director is not approved by the System Parent within thirty (30) days following the System Parent's annual meeting, the System Parent may direct the Member to elect the System Parent's nominee.

Section 4.03 Resignation. A Director may resign at any time by delivering written notice to the Secretary of the Corporation. The resignation shall be effective when the notice is delivered, unless the notice specifies a later effective date.

Section 4.04 Removal. A Director may be removed by the Member at any time, with or without cause. The Member shall remove a Director at the direction of the System Parent.

Section 4.05 Vacancies. A vacancy of a Director shall be filled for the balance of the vacated term by the Member, with the approval of the System Parent.

Section 4.06 Duties and Responsibilities. Subject to the rights, powers and privileges accorded to the Member and System Parent in the Certificate of Incorporation, these Bylaws, or by law, the Board of Trustees shall manage and direct the business, property, and affairs of the Corporation. The Board shall exercise all of the powers of the Corporation in accordance with these Bylaws. Without limiting the foregoing and to the extent applicable to the Corporation's operations, the Board shall have the power to:

(a) Develop and recommend to the Member and System Parent the philosophy, mission and values of the Corporation and any changes thereto;

(b) Develop and recommend to the Member and the System Parent the Corporation's strategic plans;

(c) Develop and recommend to the Member and System Parent the Corporation's annual operating and financial targets, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(d) Annually assess the Corporation's performance against approved budgets, initiatives and strategic plans adopted by the Member and System Parent;

(e) Recommend to the Member and System Parent the sale, transfer or substantial change in use of all or substantially all of the assets, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any direct or indirect subsidiary of the Corporation;

(f) Recommend to the Member and System Parent the formation or acquisition by the Corporation of any new direct or indirect subsidiaries, joint ventures or affiliations;

(g) Recommend to the Member and System Parent the introduction or termination of any services to be offered by the Corporation not otherwise included in an approved budget or a strategic or financial plan;

(h) Approve any consent decree or settlements from state and federal authorities, following consultation with the Member;

(i) Recommend to the Member and System Parent changes to the Corporation's Certificate of Incorporation and Bylaws;

(j) Recommend to the Member and System Parent nominations for and removal of Trustees of the Corporation;

(k) Elect officers of the Board, and recommend to the Member the removal of any officer of the Board;

(l) Approve business transactions or material contracts, subject to the rights of the Member set forth in Section 2.02 and System Parent in Section 3.02, not otherwise included in an approved budget or a strategic or financial plan;

(m) Recommend to the System Parent any incurrence or assumption of debt by the Corporation in accordance with the guidelines for accounting and debt management programs established by the Member and System Parent;

(n) Periodically assess the Corporation's Quality Initiatives, including tracking and reporting on the Corporation's performance under quality measures, quality and patient safety programs and initiatives, patient satisfaction and cultural competence initiatives;

(o) Periodically assess the Corporation's policies and programs to assure corporate and regulatory compliance, including all required state and federal license and generally recommended accreditations and certifications;

(p) Periodically assess the Corporation's policies and programs relating to human relations and labor relations;

(q) Periodically assess the Corporation's Development Plans and its Planned Giving Plans;

(r) Periodically assess the Corporation's Community Relations Initiatives and Community Outreach Programs;

(s) Plan and implement policies and programs relating to the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds, annual appeal funds, and net proceeds from special fundraising events; and

(t) Evaluate the Board's performance.

Section 4.07 Compensation. The Trustees shall serve without compensation for their services as Trustees but may be reimbursed by the Corporation for their reasonable expenses and disbursements in that capacity on behalf of the Corporation.

ARTICLE V

Meetings of the Board of Trustees

Section 5.01 Annual and Regular Meetings. The annual meeting of the Board shall be held in the month of December on a date to be fixed by the Chair from year to year, unless the Chair shall designate a different date for the annual meeting. The transaction of business at the annual meeting shall be unlimited except as otherwise specified in these Bylaws. There shall be up to twelve (12) regular meetings of the Board per fiscal year, with a schedule of such meetings to be adopted by resolution of the Board.

Section 5.02 Notice of Annual and Regular Meetings. The Secretary shall give notice of the date, time and place of the annual meeting and each regular meeting of the Board by mail, electronic mail, telecommunications, telephone, facsimile or in person to each member of the Board at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule approved by the Board.

Section 5.03 Special Meetings. Special meetings may be called at any time by the Chair, and shall be called by the Chair within seven (7) days of receipt of the written request of any three (3) Trustees. Notice of the date, time, place and purpose of a special meeting shall be given to each member by mail, electronic mail, telecommunications, telephone, facsimile or in person at least twenty-four (24) hours before the scheduled date of the meeting and no business shall be transacted at such meeting other than that specifically set forth in the notice.

Section 5.04 Quorum; Vote Required for Action. A majority of all Trustees shall constitute a quorum at all meetings of the Board. The affirmative vote of a majority of the Trustees present at a meeting at which time a vote is taken shall be the act of the Board, unless the vote of a greater number is required by the Certificate of Incorporation, these Bylaws, or by law. *Ex officio* Trustees shall be counted in determining a quorum and shall be entitled to vote.

Section 5.05 Action Without Meeting. If all members of the Board consent in writing to any action taken or to be taken, the action shall be the same as if authorized at a meeting of the

Board; all written consent(s) shall be included in the corporate minutes or filed with the corporate records.

Section 5.06 Participation by Conference Telephone. Any member of the Board may participate in a meeting by means of a conference telephone or similar communications equipment enabling all members of the Board participating in the meeting to hear one another, and such participation shall constitute presence in person at such meeting.

Section 5.07 Agenda and Records of Meetings. There shall be a written agenda for each meeting of the Board, and minutes of each meeting shall be prepared and submitted to the Board for approval by the Secretary or a delegate. Minutes shall reflect attendance at the meeting, and shall be dated, signed and maintained in the corporate records following approval.

ARTICLE VI

Officers

Section 6.01 Officers. The officers shall be the Chair, an Executive Director, a Secretary, a Treasurer and such other officers as may from time to time be designated by the Board. The Chair, Secretary and Treasurer shall be chosen from the members of the Board.

Section 6.02 Election. The officers, except for the Executive Director, shall be chosen by the Board at its annual meeting, and shall hold office until the next annual meeting.

Section 6.03 Vacancies. Any vacancy occurring in any office shall be filled promptly by the Board at any Board meeting.

Section 6.04 Removal. Any officer may be removed with or without cause by the Member at any meeting of the board of trustees of the Member, provided that the notice of the meeting specifically states that the purpose or one of the purposes of the meeting is removal of the officer.

Section 6.05 Duties. The duties of the officers shall be as follows:

(a) Chair. The Chair shall preside at all meetings of the Board, shall be an *ex officio* member of all committees, and shall perform other duties incident to the office or delegated by the Board or these Bylaws. In the event of the Chair's absence or disability, a Director who is the Chair's delegate or who is appointed by the Board shall perform the duties of the Chair.

(b) Executive Director. The Executive Director shall be the chief executive officer of the Corporation. The Member shall appoint the Executive Director, who shall serve until his or her death, resignation, disability or removal in accordance with these Bylaws. Subject to the powers expressly reserved to the Board or the Member, the Executive Director shall, in general, supervise and control all the business and affairs of the Corporation, and shall see that the objectives, policies and orders of the Board are properly executed. The Executive Director shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair has been appointed or in the absence of the Chair, the Executive Director shall preside at each meeting of the Board. In general, he or she

shall perform such other duties incident to the office of Executive Director and such other duties as may from time to time be assigned to the Executive Director by these Bylaws, by the Board, or by the Member.

(c) Secretary. The Secretary shall: maintain the minutes of the meetings of the Board in the corporate records; give or cause to be given all notices required by these Bylaws or by law; serve as custodian of the Corporation's records; make such records available to the Board upon its request; and perform all other duties incident to the office or delegated by the Board or these Bylaws.

(d) Treasurer. The Treasurer shall: supervise the receipt and custody of the Corporation's funds and investments; render a full account and statement of the condition of the Corporation's finances at each annual meeting and at such other times as requested by the Board; and perform other duties incident to the office or as may be delegated by the Board or these Bylaws.

ARTICLE VII

Committees

Section 7.01 Committees. The Board may create such ad hoc committees from time to time as the Board may deem necessary to carry out special fund raising events or other initiatives of the Board. Committees may not exercise the authority of the Board, and any acts taken by them shall be solely advisory in nature. The members and chairs of each committee shall be appointed by the Board, and each such committee shall consist of at least one (1) Director and two (2) other individuals who may or may not be Trustees. Each committee established by the Board shall be chaired by a Director of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

Section 7.02 Committee Procedures; Action by Committee. Each committee may fix rules of procedure for its business. A majority of the members of a committee shall constitute a quorum for the transaction of business and the act of a majority of those present at a meeting at which a quorum is present shall be the act of the committee. Any action required or permitted to be taken at a meeting of a committee may be taken without a meeting, if a unanimous written consent which sets forth the action is signed by each member of the committee and filed with the minutes of the committee. The members of a committee may conduct any meeting thereof by conference telephone in accordance with the provisions of Section 4.06.

Section 7.03 "Medical Review Committees." Any committee or subcommittee referred to in or otherwise established in accordance with the provisions of these Bylaws, as well as the Board itself, when engaged in any peer review activity, is intended to be a "medical review committee" within the meaning of that term as set forth in Chapter 368a of the Connecticut General Statutes, as amended from time to time.

ARTICLE VIII

Conflict of Interest; Confidentiality

Section 8.01 "Conflict of Interest" Defined; Conflict of Interest and Confidentiality Policies. The Board expects its members to exercise good judgment and follow high ethical standards. Individuals serving the Corporation should never permit private interests to conflict in any way with their obligations to the Corporation and to any entities affiliated with the Corporation. In addition, all members of the Board must honor the confidential nature of Corporation information and strive to maintain its confidentiality. To this end, from time to time the Board shall adopt a Conflict of Interest Policy and a Confidentiality Policy; such policies shall be deemed by this reference to be a part of these Bylaws. These policies shall be consistent with requirements of state law and the law of tax-exempt organizations, and shall address, among other things: the definition of "confidential materials" and "related persons"; disclosure by Board members; the purchase of goods and services; compensation decisions; and procedures to implement and enforce these policies.

ARTICLE IX

Miscellaneous

Section 9.01 Principal Office. The principal office of the Corporation shall be located in New London, Connecticut.

Section 9.02 Waivers of Notice. Whenever any notice of time, place, purpose or any other matter, including any special notice or form of notice, is required or permitted to be given to any person by law or under the provisions of the Certificate of Incorporation or these Bylaws, or of a resolution of the Member or the Board of Trustees, a written waiver of notice signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be equivalent to the giving of such notice. The Secretary of the Corporation shall cause any such waiver to be filed with or entered upon the records of the Corporation or, in the case of a waiver of notice of a meeting, the records of the meeting. The attendance of any person at or participation in a meeting waives any required notice to that person of the meeting unless at the beginning of the meeting, or promptly upon the person's arrival, the person objects to the holding of the meeting or the transacting of business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

ARTICLE X

Amendments

Section 10.01 Amendments. Except as otherwise provided by the Certificate of Incorporation, or by law, the Member and the System Parent may adopt, amend or repeal these Bylaws.

Adopted by the Board of Trustees of
Lawrence + Memorial Corporation on August 29, 2016

Exhibit 2.1.4(E)

Amended and Restated Certificate of Incorporation of LMMG

AMENDED AND RESTATED
CERTIFICATE OF INCORPORATION

L&M PHYSICIAN ASSOCIATION, INC.

L&M PHYSICIAN ASSOCIATION, INC. hereby amends and restates its Certificate of Incorporation so that the same shall read in its entirety as follows:

1. Name. The name of the Corporation is L&M PHYSICIAN ASSOCIATION, INC. (the "Corporation").

2. Purposes. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and shall include the following:

(a) to operate and maintain one or more offices or facilities for the study, diagnosis and treatment of human ailments and injuries by licensed persons;

(b) to render medical and surgical treatment, consultation or advice by duly licensed employees or agents of the Corporation to patients without regard to race, color, creed, sex, age or ability to pay for such care and services;

(c) to promote, enhance, improve, and develop medical, surgical and scientific research at providers affiliated with Yale-New Haven Health Services Corporation, including, for so long as such providers are affiliated with the Yale New Haven Health System (the "System") administered by Yale-New Haven Health Services Corporation ("YNHHSC"), which System shall include Lawrence + Memorial Corporation, Lawrence + Memorial Hospital, Westerly Hospital, Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, and such other providers that may affiliate with the System in the future (the "Affiliated Delivery Networks") and throughout the communities they serve;

(d) to promote, enhance, improve and augment the quality of medical and clinical education and patient care at the Affiliated Delivery Networks and at any other sites determined by the Corporation;

(e) to promote and enhance a high quality of medical care and other human services for the benefit of all persons in the communities it serves;

(f) to augment the planning process for the promotion of the general well-being and human health needs of the communities it serves;

(g) to solicit, accept, hold, invest, reinvest, and administer any contributions, grants, donations, gifts, bequests, devises, benefits of trusts (but not to act as trustee of any trust), and property of any sort, without limitation as to amount or value, and to use, disperse or donate the income or principal thereof for exclusively charitable and educational purposes in such

manner as, in the judgment of the Board of Trustees and the Member of the Corporation, will best promote the purposes of the Corporation;

(h) to contract for, purchase, receive, own, manage, operate or lease property, real, personal and mixed, wheresoever situated, as may be necessary to promote and further the purposes and objectives of the Corporation; and

(i) to engage in any lawful act or activity for which a medical foundation may be organized under Chapter 594b of the Connecticut General Statutes or for which a nonstock corporation may be organized under Chapter 602 of the Connecticut General Statutes, the Connecticut Revised Nonstock Corporation Act (the "Act").

In furtherance of the purposes set forth herein, the Corporation shall (i) participate as an integral part of the System, which System provides, through the Corporation and its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the Corporation's charitable purposes and the charitable purposes of all System affiliates.

3. Nonprofit. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

4. Member. The Corporation shall have one member, Lawrence + Memorial Corporation (the "Member"). The Member is an affiliate of a "Health System," as defined in Section 33-182aa of the Connecticut General Statutes, overseen by the Member's parent company, Yale New Haven Health Services Corporation (sometimes referred to as the "System Parent"). The Member shall have the rights, powers and privileges provided in the Corporation's Bylaws and by Connecticut law, including certain expressly reserved powers and retained rights described in the Corporation's Bylaws (the "Bylaws"). The Bylaws may provide that certain rights, powers and privileges of the Member shall be reserved exclusively to, or may be subject to the prior approval of, the System Parent.

5. Board of Trustees. Subject to the rights, powers and privileges of the Member or the System Parent, the Corporation shall operate under the management of its Board of Trustees. The Bylaws may provide that certain persons occupying certain positions within or without the Corporation shall be ex-officio trustees, who may be counted in determining a quorum and may have the right to vote as may be provided in the Bylaws. As may be further provided in the Bylaws, the terms of elected trustees may be staggered by dividing the elected trustees into up to three groups so that approximately an equal number of such trustees have terms that expire each year. Trustees may be removed by the Member or at the direction of the System Parent as provided in the Bylaws.

6. Restrictions. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, the Corporation's trustees, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Section 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of "statements") any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

7. Dissolution. Upon the dissolution or termination of the existence of the Corporation, all of its property and assets, after payment of the lawful debts of the Corporation and the expenses of its dissolution or termination, shall be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to YNHHSC, or, if at the time of the dissolution or termination of the existence of the Corporation, YNHHSC is not in existence or does not qualify as exempt under Section 501(c)(3) of the Code, to any organization (or organizations) that qualifies as an organization exempt under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

8. Limitation of Liability of Trustees. In addition to and not in derogation of any other rights conferred by law, a trustee shall not be personally liable for monetary damages for breach of duty as a trustee in an amount greater than the amount of compensation received by the trustee for serving the Corporation during the year of the violation, provided that such breach did not (a) involve a knowing and culpable violation of law by the trustee, (b) enable the trustee or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the trustee to the Corporation under circumstances in which the trustee was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the trustee's duty to the Corporation. Any lawful repeal or modification of this Section 8 or the adoption of any provision inconsistent herewith by the Board of Trustees or the Member of the Corporation shall not, with respect to a person who is or was a trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a trustee provided for in this Section 8 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

9. Indemnification. The Corporation shall provide its trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Act. In furtherance of the foregoing, the Corporation shall indemnify its trustees against liability as defined in Section 33-1116(4) of the Act to any person for any action taken, or any failure to take any action, as a trustee, except liability that (1) involved a knowing and culpable violation of law by the trustee, (2) enabled the trustee or an associate to receive an improper personal economic gain, (3) showed a lack of good faith and a conscious disregard for the duty of the trustee to the Corporation under circumstances in which the trustee was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a trustee, or who is a trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Act.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Code.

10. Amendment of Certificate of Incorporation and Bylaws. This Certificate of Incorporation and the Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Member and the System Parent.

11. References. References in this Certificate of Incorporation to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or may hereafter be amended. References in this Certificate of Incorporation to a provision of the Connecticut General Statutes or any provision of Connecticut law set forth in such Statutes is to such provision of the General Statutes of Connecticut or the corresponding provision(s) of any subsequent Connecticut law. Reference in this Certificate of Incorporation to a provision of the Act is to such provision of the Connecticut Revised Nonstock Corporation Act, as amended, or the corresponding provisions(s) of any subsequent Connecticut law.

Schedule 6.5

YNHHSC Third Party Approvals

1. The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

2. **Certificate of Need approval from OHCA for** ~~T~~**t**he appointment of YNHHSC as the sole corporate member of L+M **pursuant to the YNHHSC-L+M Affiliation Agreement, as amended by this First Amendment**~~will require Certificate of Need approval from OHCA~~.

3. The merger of LMMG with and into NEMG will require notice to OHCA of LMMG Board approval of the merger and Certificate of Need approval from OHCA, and **at least** thirty (30) days prior to consummating the merger and closing the aforementioned transaction, notice must be filed with the Connecticut Attorney General.

4. The appointment of YNHHSC as the ultimate corporate parent of LMW must be approved by both RIDOH and the Rhode Island Attorney General through a Hospital Conversion Act application. The change in control effected by the appointment of YNHHSC as the ultimate parent of LMW must also be approved by the RIDOH Office of Health Systems Development through a Change in Effective Control application.

5. Notice of the Affiliation must be given to the Connecticut Attorney General at the same time that premerger notification under the HSR Act is given to the Federal Trade Commission.

~~6. A Transaction Test certificate is required to be delivered as a condition to the merger of LMMG with and into NEMG in satisfaction of the requirements of Section 408 of the YNHHSC Master Trust Indenture; Section 6.27 of that certain Reimbursement Agreement by and between YNHHSC and Bank of America, N.A., dated as of June 1, 2014; and each of the three International Swap Dealers Association, Inc. Master Agreements, each dated as of June 23, 2014, by and between YNHHSC and the following counterparties respectively: (i) Barclays Bank PLC; (ii) JPMorgan Chase Bank, N.A. ("JPMC"); and (iii) Goldman Sachs Bank USA.~~

~~7. The written consent of Wells Fargo Bank, National Association ("Wells Fargo") is required to be obtained as a condition of the merger of LMMG with and into NEMG, pursuant to Section 7.6(b) of that certain Amended and Restated Letter of Credit and Reimbursement Agreement by and among Wells Fargo, Yale-New Haven Hospital, Inc. and YNHHSC, dated as of June 23, 2014.~~

~~8. The written consent of JPMC is required to be obtained as a condition of the merger of LMMG with and into NEMG, pursuant to Section 15(d) of that certain Letter of Credit and Reimbursement Agreement by and between YNHHSC and JPMC, dated as of June 1, 2014.~~

~~9~~**6**. The 1999 Affiliation Agreement between Yale University and YNHHSC, as amended (the "1999 Affiliation Agreement") requires that if a health care provider becomes a member of

Yale New Haven Health System, YNHHSC must promptly notify the Yale School of Medicine ("YSM") and, if such new system member has medical education affiliation agreements with medical schools other than YSM, YNHHSC must give notice of the expiration date and material program terms of such medical education affiliation agreements.

Schedule 7.5

L+M Third Party Approvals

1. The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

2. **Certificate of Need approval from OHCA for** ~~T~~**t**he appointment of YNHHSC as the sole corporate member of L+M **pursuant to the YNHHSC-L+M Affiliation Agreement, as amended by this First Amendment**~~will require Certificate of Need approval from OHCA~~.

3. The merger of LMMG with and into NEMG will require notice to OHCA of LMMG Board approval of the merger and Certificate of Need approval from OHCA, and **at least** thirty (30) days prior to consummating the merger and closing the aforementioned transaction, notice must be filed with the Connecticut Attorney General.

4. The appointment of YNHHSC as the ultimate corporate parent of LMW must be approved by both RIDOH and the Rhode Island Attorney General through a Hospital Conversion Act application. The change in control effected by the appointment of YNHHSC as the ultimate parent of LMW must also be approved by the RIDOH Office of Health Systems Development through a Change in Effective Control application.

5. Notice of the Affiliation must be given to the Connecticut Attorney General at the same time that premerger notification under the HSR Act is given to the Federal Trade Commission.

6. ~~(7)~~ Consent of Bank of America, N.A. to the consummation of the transactions contemplated by the Affiliation Agreement under Section 7(p), and confirmation of Bank of America, N.A. that the transactions contemplated by the Affiliation Agreement will not contravene Section 7(g), of that certain Continuing Covenants Agreement, dated as of October 13, 2013, by and among L+M and LMH on the one hand and Bank of America, N.A. on the other hand.

~~6~~**7**. Consent of the Connecticut Health and Education Facilities Authority to the consummation of the transactions contemplated by the Affiliation Agreement under Section 6.11 of the Master Trust Indenture, dated as of February 1, 1990, by and among L+M and LMH on the one hand and the Master Trustee named therein on the other hand, as the same has been amended or supplemented from time to time in accordance with its terms.

~~7~~**8**. Notification to TD Bank, National Association pursuant to Section 5.30 of that certain Letter of Credit and Reimbursement Agreement, dated as of November 5, 2013, by and among L+M and LMH on the one hand and TD Bank, National Association, on the other hand.

L+M Hospital Inpatient Bed Allocation			
As of 9/8/16			
	Licensed	**Available**	
	Beds	**Beds**	
Med/Surg		142	
Critical Care (ICU/CCU)		20	
Psychiatric		18	
Rehabilitation		16	
Maternity		24	
NICU/Newborn Nursery		27	
Total	308*	247	
*note: total includes 280 general hospital beds and 28 bassinets			

L+M Hospital Outpatient Services by Service, Location and Hours of Operation

As of 9/8/16

Service	Department	Location	Hours of Operation
Ambulatory Surgery	Surgery	52 Hazelnut Hill Road, Groton, CT	T, W, F 06:00 - 18:00
Ambulatory Surgery	Surgery	365 Montauk Avenue, New London, CT	M-F 07:00 - 17:30
Audiology	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M 09:00 - 17:30 T-Th 08:00 - 18:30 F 08:00 - 18:00
Audiology	Rehabilitation	40 Boston Post Road, Waterford, CT	M-Th 07:00 - 18:00 F 09:00 - 17:30
Automated Whole Breast Screening Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 16:30 Sa 07:30 - 11:00
Blood Draw	Laboratory	365 Montauk Avenue, New London, CT	M-F 06:30 - 18:00 Sa 07:00 - 12:00
Blood Draw	Laboratory	339 Flanders Road, East Lyme, CT	M-F 06:30 - 17:00 Sat 07:00 - 12:00
Blood Draw	Laboratory	52 Hazelnut Hill Road, Groton, CT	M-F 06:30 - 19:00 Sa 07:00 - 19:00 Su 09:00 - 17:30
Blood Draw	Laboratory	194 Howard Street, New London, CT	M-F 08:30 - 17:00
Bone Density	Radiology	52 Hazelnut Hill Road, Groton, CT	M-Th 07:30 - 18:00 Every other Sa 07:30 - 15:00
Bone Density	Radiology	196 Parkway South, Suite 102, Waterford, CT	T,W,F 08:00 - 15:00
Breast Imaging	Radiology	365 Montauk Avenue, New London, CT	M-Th 07:00 - 18:00 F 07:00 - 16:30 Sa 06:30 - 15:00
Breast Imaging	Radiology	52 Hazelnut Hill Road, Groton, CT	M-Th 06:30 - 19:00 F, Sa 06:30 - 15:00
Breast Imaging	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-Th 06:30 - 15:00 F 07:30 - 16:00 Sa 06:30 - 15:00
Cardiac and Pulmonary Rehab	Rehabilitation	365 Montauk Avenue, New London, CT	M-F 07:30 - 17:30
Cardiac Diagnostic Testing	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 15:30
Cardiac Diagnostic Testing	Cardiology	52 Hazelnut Hill Road, Groton, CT	T, W, F 06:00 - 18:00
Cath Lab	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Chemo Infusion	Oncology	230 Waterford Parkway S, Waterford, CT	M-F 08:00 - 17:00

Computerized Tomography (CT)	Radiology	365 Montauk Avenue, New London, CT	7 days/week 07:00 - 19:00
Computerized Tomography (CT)	Radiology	52 Hazelnut Hill Road, Groton, CT	7 days/week 07:00 - 19:00
Computerized Tomography (CT)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M,W,Th,F 07:30 - 16:00
Cardiovasular Ultrasound (CV Ultrasound)	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 19:00
Cardiovasular Ultrasound (CV Ultrasound)	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 16:30
Cardiovasular Ultrasound (CV Ultrasound)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:00 - 16:30
Diagnostic Radiology	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 19:00 Sa 09:00 - 11:00
Diagnostic Radiology	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 20:00 Sa 09:00 - 16:30
Diagnostic Radiology	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:30 - 17:00
Emergency Services	Emergency	365 Montauk Avenue, New London, CT	7 days/week Open 24 hours
Emergency Services	Emergency	52 Hazelnut Hill Road, Groton, CT	7 days/week 07:00 - 23:00
Infusion (non-chemo)	Infusion (non-chemo)	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00 Sa, Su, Holidays - on call
Intensive Outpatient Program	Psychiatry	365 Montauk Avenue, New London, CT	M-F 09:00 - 12:00
Interventional Radiology	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 16:30 On Call 24/7
Magnetic Resonance Imaging (MRI)	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 21:00 Sa,Su 07:00 - 19:00
Magnetic Resonance Imaging (MRI)	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 07:00 - 17:00 Sa 07:00 - 17:00
Magnetic Resonance Imaging (MRI)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 07:00 - 17:00 Sa 07:00 - 15:00
Neurodiagnostics	Neurodiagnostics	365 Montauk Avenue, New London, CT	M-F 07:00 - 16:30 1 Sa a month - 07:00 - 16:30
Nuclear Medicine (Nuclear Med)	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 17:00 MIBIs Only - Sa 08:00 - 12:00
Occupational Health	Occupational health	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 16:30
Occupational Therapy	Rehabilitation	339 Flanders Road, East Lyme, CT	M, W 09:30 - 19:00 T, Th 07:00 - 14:00 M, F 07:00 - 18:00
Occupational Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	T 06:30 - 19:00 W 07:00 - 1900 Th 07:30 - 19:00 Sat 07:00 - 16:00 (hands) Sun as needed for hands

Occupational Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	M, W 07:30 - 18:00 T, F 07:30 - 15:30 Th 07:30 - 16:30
Positron Emission Tomography (PET)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M,W,F 07:00 - 15:00
Physical Therapy	Rehabilitation	339 Flanders Road, East Lyme, CT	M-Th 06:30 - 19:00 F 06:30 - 16:30
Physical Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M-Th 06:30 - 19:00 F 06:30 - 18:00
Physical Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	M-Th 06:30 - 18:30 F 06:30 - 17:30
Pre-admisson testing	Surgery	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00 Th 08:00 - 16:30
Pre-admisson testing	Surgery	52 Hazelnut Hill Road, Groton, CT	T,W,F Variable
Pulmonary Function Testing	Restorative Services	365 Montauk Avenue, New London, CT	M, Th 07:00 - 16:00
Radiation Therapy	Oncology	230 Waterford Parkway S, Waterford, CT	M-F 08:00 - 17:00
Sleep lab	Restorative Services	224 Goldstar Highway, Groton, CT	T-Sa 19:00 - 07:30
Speech Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M 08:00 - 18:30 T, F 08:00 - 16:30 W, Th 08:00 - 17:30
Speech Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	T, Th, F 07:00 - 17:00
Stress Testing	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Targeted Breast Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M,W,F 13:00 - 16:30 T,Th 08:00 - 16:30
Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 19:00 Every other Sa 07:00 - 15:30
Ultrasound	Radiology	52 Hazelnut Hill Road, Groton, CT	7 days/week 08:00 - 16:30
Ultrasound	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:00 - 16:30
Vascular Lab	Radiology	365 Montauk Avenue, New London, CT	M-F 08:30 - 17:00
Wound Care and Hyperbarics	Rehabilitation	40 Boston Post Road, Waterford, CT	M-F 08:00 - 16:30

Yale NewHaven Health

AGENDA

October 11, 2016

I. Purpose of Meeting: To review conflicting conditions and clarify one set of coordinated conditions.

- Strategic Plan
- Financial Reporting
- Cost and Market Impact Review
- Independent Monitor
- Community Benefit
- Charity Care
- Employment
- Governance
- Licensing, Physician Office Conversion and Cost Savings Attainment

II. Timing and Format of Reporting

Scheduled Meeting
Lawrence + Memorial and Yale-New Haven Health System
Certificate of Need Transfer of Ownership
Docket Numbers 15-32033-CON and 15-32032-CON

Date of Meeting: 10/11/2016

Name (Please Print)	Affiliation
Gayle Capozza w/o	YNHHS
Mary Rosenthal	YNHHS

Present from OHCA were:

Kimberly Martone	Carmen Cotto
Karen Roberts	

Meeting Start Time: 2:00 pm
Meeting End Time: 3:30 pm

Yale
NewHaven
Health

September 28, 2016

Ms. Kimberly Martone
State of Connecticut
Office of Healthcare Access
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308

Dear Ms. Martone,

Pursuant to the Order contained within the Agreed Settlement of Docket Number 15-32033-CON, "Transfer of ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation", Condition 1 and Condition 2 are required to be submitted within twenty (20) days following the Closing Date of this transaction. The Closing Date was September 8th.

Attached please find documents responsive to Conditions as 1 and 2. Condition 1 is being posted on L+MH's website immediately.

A copy of these documents will be sent via U.S. postal service.

Regards,

Nancy Levitt Rosenthal
Vice President, Strategy and Regulatory Planning

Strategy and Regulatory Planning
YNHHS, 20 York Street
(2 Howe St, 307)
New Haven, CT 06519
Phone: 203-688-5721
Fax: 203-688-5013
Nancy.Rosenthal@greenwichhospital.org
www.ynhhs.org

September 8, 2016

Lawrence + Memorial Corporation
365 Montauk Avenue
New London, CT 06320

Re: **Limited Disclosures Pursuant to Affiliation Agreement by and between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement, dated as of July 17, 2015 (the "Effective Date"), by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"), as amended to the date hereof (the "Affiliation Agreement"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

YNHHSC and L+M agree and confirm that YNHHSC has made certain limited disclosures for purposes of Article 4 of the Affiliation Agreement. More specifically, although Section 4.1.1 of the Affiliation Agreement indicates that YNHHSC has provided or made available to L+M the governing documents of all YNHHSC Affiliates, governing documents have been provided only for certain key YNHHSC Affiliates. In addition, Section 4.9.1 of the Affiliation Agreement indicates that to the Knowledge of YNHHSC, the YNHHSC Affiliates have not had any breach of information security that would constitute (i) a "security incident" (as defined in 45 CFR § 164.304) that resulted in material and actual unauthorized access, use, disclosure, modification or destruction of Protected Health Information or (ii) a "breach" under Section 13402 of the American Recovery and Reinvestment Act of 2009 and any regulations promulgated thereunder or state information security laws or regulations that require notification to or of government officials, or to individuals whose information may have been breached, the YNHHSC Affiliates have only disclosed (i) such breaches that are not routine and (ii) such breaches in connection with which no YNHHSC Affiliate could reasonably expect to have material liability. Finally, although Section 4.10.7 of the Affiliation Agreement indicates that YNHHSC has provided or made available to L+M copies of the letters and/or rulings from the IRS which recognize that the YNHHSC Obligated Group Members are Tax-Exempt Organizations exempt from United States federal income taxes under Section 501(a) of the Code as organizations described in Section 501(c)(3) of the Code and not as "private foundations" as such term is defined in Section 509 of the Code, such determinations have not been provided.

YNHHSC and L+M agree that the disclosures made under Sections 4.1.1, 4.9.1 and 4.10.7 of the Affiliation Agreement are sufficient and L+M waives any closing condition or other requirement for YNHHSC to make any additional disclosure under such sections. To the best Knowledge of YNHHSC, the effect of the information not disclosed, provided or made available to L+M as described above, would not, individually or in the aggregate, be reasonably expected to have a YNHHSC Material Adverse Effect.

[Signature page follows]

Sincerely,

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Agreed and Confirmed:

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Sincerely,

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Agreed and Confirmed:

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

September 8, 2016

Lawrence + Memorial Corporation
365 Montauk Avenue
New London, CT 06320

Re: **Schedule Supplement Pursuant to Affiliation Agreement by and between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement, dated as of July 17, 2015 (the "Effective Date"), by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"), as amended to the date hereof (the "Affiliation Agreement"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

Pursuant to Section 5.3 of the Affiliation Agreement, YNHHSC hereby delivers to L+M this update to the YNHHHSC Disclosure Schedule delivered as of the Effective Date. This Schedule Supplement includes (x) information that has first arisen or of which YNHHSC has first obtained Knowledge after the Effective Date and that if it existed on the Effective Date would have been required to be reflected on the Disclosure Schedules and (y) information that is necessary to correct any disclosure schedule or representation or warranty and that has first arisen or of which YNHHSC has first obtained Knowledge after the Effective Date. This Schedule Supplement shall be deemed to be incorporated into and to supplement and amend the YNHHSC Disclosure Schedule as of the Closing.

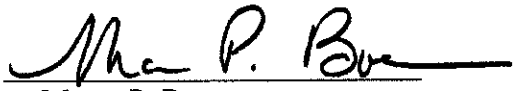
Section and sub-section numbers and letters used in the schedules to this letter correspond to the section and sub-section numbers and letters in the Affiliation Agreement, unless otherwise noted. The captions of each section in the schedules to this letter are included for convenience only and are not intended to limit the scope of the information required to be specifically disclosed.

No disclosure made herein or in the schedules to this letter constitutes an admission of any liability or obligation of any YNHHSC Affiliate, an admission against any interest of any YNHHSC Affiliate or a concession as to any defense available to any YNHHSC Affiliate. Unless the Affiliation Agreement specifically provides otherwise, the disclosure of specific item herein, shall not be deemed to constitute an admission that such item is not in the ordinary course of business. To the extent that any representation or warranty contained in the Affiliation Agreement is limited or qualified by the materiality of the matters to which the representation or warranty is given, the inclusion of any matter in any Schedule does not constitute an admission that such matters are material or will have a YNHHSC Material Adverse Effect. Certain information set forth herein is included solely for informational purposes and may not be required to be disclosed pursuant to the Affiliation Agreement.

If there is any inconsistency between any provision or statement in the Affiliation Agreement and any provision or statement in the schedules (other than an exception in any section or subsection to a specific representation or warranty), then the provision or statement in the Affiliation Agreement shall control.

Sincerely,

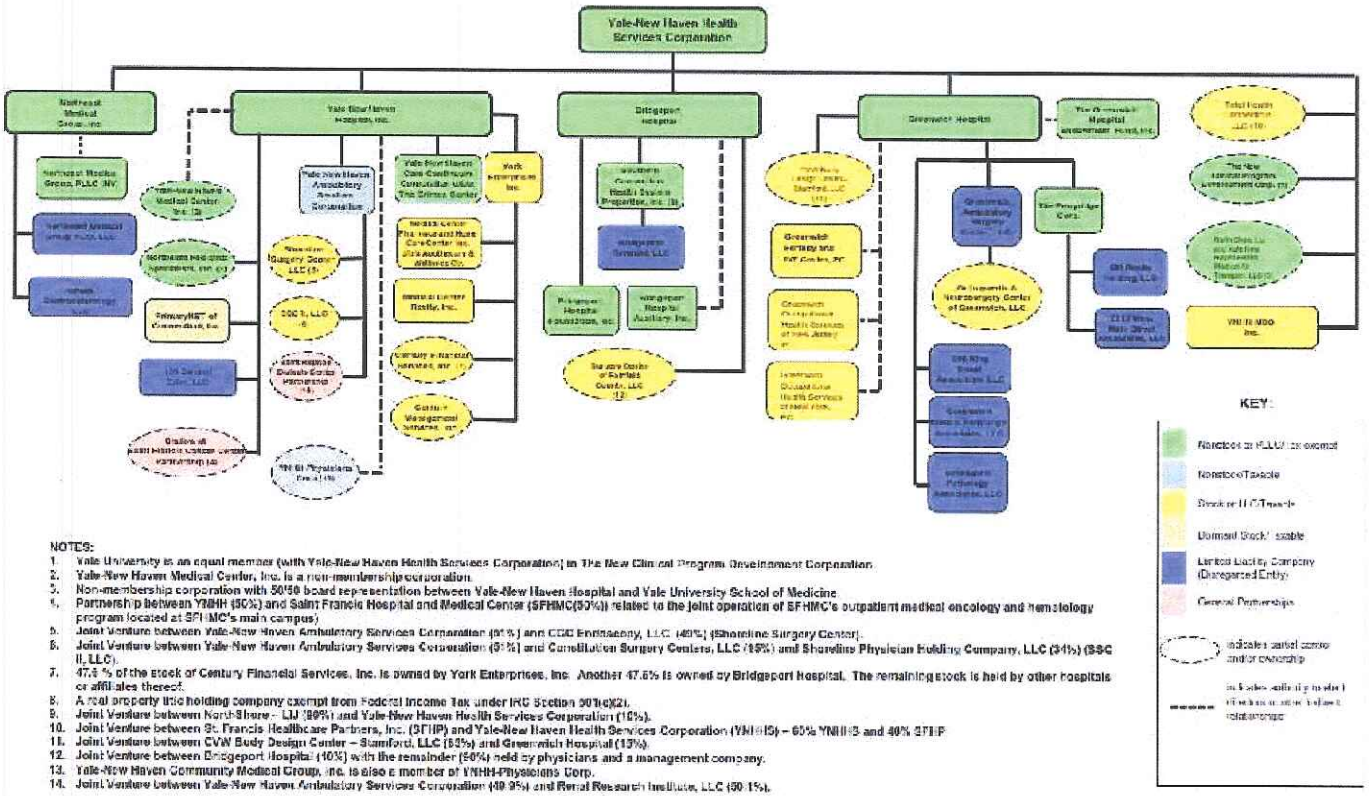
Yale-New Haven Health Services Corporation

By: 
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Updated Schedule 4.1.1 – YNHHSC Subsidiaries

Yale New Haven Health System

Last Updated 2/22/10



NOTES:

1. Yale University is an equal member (with Yale-New Haven Health Services Corporation) in The New Clinical Program Development Corporation.
2. Yale-New Haven Medical Center, Inc. is a non-membership corporation.
3. Non-membership corporation with 50/50 board representation between Yale-New Haven Hospital and Yale University School of Medicine.
4. Partnership between YNHH (50%) and Saint Francis Hospital and Medical Center (SFHMC(50%)) related to the joint operation of SFHMC's outpatient medical oncology and hematology program located at SFHMC's main campus).
5. Joint Venture between Yale-New Haven Ambulatory Services Corporation (51%) and CCC Endosurgery, LLC (49%) (Shoreline Surgery Center).
6. Joint Venture between Yale-New Haven Ambulatory Services Corporation (51%) and Constitution Surgery Centers, LLC (15%) and Shoreline Physician Holding Company, LLC (34%) (SSC II, LLC).
7. 47.4 % of the stock of Century Financial Services, Inc. is owned by York Enterprises, Inc. Another 47.6% is owned by Bridgeport Hospital. The remaining stock is held by other hospitals or affiliates thereof.
8. A real property title holding company exempt from Federal Income Tax under IRC Section 501(c)(2).
9. Joint Venture between North Shore – LIJ (80%) and Yale-New Haven Health Services Corporation (10%).
10. Joint Venture between St. Francis Healthcare Partners, Inc. (STHP) and Yale-New Haven Health Services Corporation (YNHHSC) – 60% YNHHS and 40% STHP
11. Joint Venture between CVW Buddy Design Center – Stamford, LLC (83%) and Greenwich Hospital (17%).
12. Joint Venture between Bridgeport Hospital (10%) with the remainder (90%) held by physicians and a management company.
13. Yale-New Haven Community Medical Group, Inc. is also a member of YNHH-Physicians Corp.
14. Joint Venture between Yale-New Haven Ambulatory Services Corporation (49.9%) and Renal Research Institute, LLC (50.1%).

Update to Schedule 4.8

Subsequent Events

The following language is added to the end of Paragraph 1 of Schedule 4.8:

The budgets for fiscal years 2016 and 2017 have been finalized, and under the final budgets we estimate that YNHHSC will incur a net tax of $149.2M, or 38.1% of the total tax liability for the State, in 2016, and a net tax of $158.7M, or 36.2% of the total tax liability for the State, in 2017.

Updates to Schedule 4.27

Consents and Approvals

The following paragraph is added as Paragraph 10 to Schedule 4.27:

The Parties were required to and did submit a Notice of Hospital Affiliation to the Connecticut Attorney General pursuant to Conn. Gen. Stat. § 19a-486i(e).

The following paragraph is added as Paragraph 11 to Schedule 4.27:

As part of the Hospital Conversion Act approval in Rhode Island, YNHHSC and L+M must pursue a separate *cy pres* action relating to the charitable assets of the Westerly Hospital Foundation, but *cy pres* relief need not be obtained prior to Closing.

September 8, 2016

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06510

Re: **Limited Disclosures and Certain Waivers Pursuant to Affiliation Agreement By and Between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement, dated as of July 17, 2015 (the "Effective Date"), by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"), as amended to the date hereof (the "Affiliation Agreement"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

Article 3

L+M and YNHHSC agree and confirm that L+M has made certain limited representations and disclosures for purposes of Article 3 of the Affiliation Agreement. More specifically, although:

1. Section 3.5.1 of the Affiliation Agreement indicates that L+M has provided to YNHHSC a copy of current title reports relating to the Principal Properties, such title reports have been provided only as of the Effective Date,

2. Section 3.9.1 of the Affiliation Agreement indicates that to the Knowledge of L+M, the L+M Affiliates have not had any breach of information security that would constitute (i) a "security incident" (as defined in 45 CFR § 164.304) that resulted in material and actual unauthorized access, use, disclosure, modification or destruction of Protected Health Information or (ii) a "breach" under Section 13402 of the American Recovery and Reinvestment Act of 2009 and any regulations promulgated thereunder or state information security laws or regulations that require notification to or of government officials, or to individuals whose information may have been breached, the L+M Affiliates have only disclosed (i) such breaches that are not routine and (2) such breaches in connection with which no L+M Affiliate could reasonably expect to have material liability,

3. Section 3.9.1 of the Affiliation indicates that L+M has provided to YNHHSC copies of any voluntary self-disclosure filing made with CMS or any other Governmental Authority and a description of the status of each such self-disclosure filing, L+M has only provided a description of the status of each such self-disclosure filing and offered to YNHHSC a copy of each such self-disclosure filing,

4. Section 3.9.6 of the Affiliation Agreement indicates that L+M has provided to YNHHSC copies of certain Contracts as of the Closing Date, copies of such Contracts have been provided only as of the Effective Date,

5. Section 3.19 of the Affiliation Agreement indicates that L+M has provided or made available to YNHHSC a correct and complete copy of (a) the minute books of the L+M Affiliates and (b) the minutes maintained by the L+M Affiliates quality assurance committees since October 1, 2011,

each subject to the qualifications set forth in Section 3.19 of the Affiliation Agreement, L+M has only provided such minutes through the Effective Date, and

6. Schedule 3.27 L+M previously disclosed to YNHHSC on Schedule 3.27 to the Affiliation Agreement that the appointment of YNHHSC as the ultimate parent of LMI may require approval of the Cayman Island Monetary Authority under Section 12 of the Cayman Island Insurance Law. The approval process with the Cayman Island Monetary Authority is currently underway, but such approval may not be received prior to the Closing. YNHHSC hereby acknowledges and confirms that it is aware that the approval of the Cayman Island Monetary has not yet been received. If approval is not received prior to the Closing, L+M will use commercially reasonable efforts to obtain the required approval as soon as practicable after the Closing.

7. Section 3.34 of the Affiliation Agreement indicates that, except as specifically disclosed to YNHHSC, none of the L+M Affiliates has material Liabilities or material obligations of any nature, as more specifically set forth in Section 3.34 of the Affiliation Agreement, arising out of, or relating to, the business operations of L+M Affiliates and which are required to be reflected on a balance sheet prepared in accordance with GAAP, except: (a) liabilities or obligations as and to the extent reflected on or accrued or reserved against as set forth in the L+M 2014 Audited Financial Statements; and (ii) liabilities incurred since the date of the L+M 2014 Audited Financial Statements in the ordinary course of business, L+M is making this representation based upon its 2015 audited financial statements, which have previously been provided by L+M to YNHHSC, rather than the L+M 2014 Audited Financial Statements.

L+M and YNHHSC agree that the disclosures and representations and warranties made under Sections 3.5.1, 3.9.1, 3.9.6, 3.19 and 3.34 of the Affiliation Agreement are sufficient and YNHHSC waives any closing condition or other requirement for L+M to make any additional representations or disclosures under such sections.

Article 5

Pursuant to Section 5.1.9(a) of the Affiliation Agreement, L+M is required to engage a qualified environmental consultant and to conduct an operational compliance self-audit of the operations of LMH, LMW, LMMG and VNA of Southeastern Connecticut with respect to Environmental, Health and Safety Requirements (an "Environmental Self-Audit") and to complete a written report of such self-audit prior to the Closing Date. As of the Closing Date, L+M has completed an Environmental Self-Audit of and delivered the corresponding written report to YNHHSC with respect to the Owned Real Property, but has not completed an Environmental Self-Audit of any leased real properties of LMH, LMW, LMMG or VNA of Southeastern Connecticut that are leased by LMH, LMW, LMMG or VNA of Southeastern Connecticut as of the Effective Date (collectively, the "Leased Properties"). L+M hereby agrees to complete an Environmental Self-Audit of the Leased Properties and to deliver the corresponding written report to YNHHSC with respect thereto within a reasonable time period following the Closing Date.

YNHHSC hereby agrees to waive the requirement that L+M complete an Environmental Self-Audit under Section 5.1.9(a) of the Affiliation Agreement with respect to the Leased Properties prior to the Closing Date; provided, that, L+M complete such Environmental Self-Audit of each Leased Property and deliver the corresponding written report to YNHHSC with respect thereto within a reasonable time period following the Closing Date.

To the best Knowledge of L+M, the effect of the information not disclosed, provided or made available to YNHHSC as described above, would not, individually or in the aggregate, be reasonably expected to have an L+M Material Adverse Effect.

Sincerely,

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Agreed and Confirmed:

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Sincerely,

Lawrence + Memorial Corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Agreed and Confirmed:

Yale-New Haven Health Services Corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

September 8, 2016

Yale-New Haven Health Services Corporation
789 Howard Avenue
New Haven, CT 06510

Re: **Schedule Supplement Pursuant to Affiliation Agreement By and Between Yale-New Haven Health Services Corporation and Lawrence + Memorial Corporation**

Ladies and Gentlemen:

Reference is made to the Affiliation Agreement (the "Affiliation Agreement"), dated as July 17, 2015, by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M"). All capitalized terms used, but not defined, herein shall have the meaning ascribed to such terms in the Affiliation Agreement.

Pursuant to Section 5.3 of the Affiliation Agreement, L+M hereby delivers to YNHHSC this update to the L+M Schedules to the Affiliation Agreement (the "L+M Disclosure Schedule") delivered as of the Effective Date. This letter (the "Schedule Supplement") includes (x) information that has first arisen or of which L+M has first obtained Knowledge after the Effective Date and that if it existed on the Effective Date would have been required to be reflected on the Disclosure Schedules and (y) information that is necessary to correct any disclosure schedule or representation or warranty and that has first arisen or of which L+M has first obtained Knowledge after the Effective Date. This Schedule Supplement shall be deemed to be incorporated into and to supplement and amend the L+M Disclosure Schedule as of the Closing.

Section and sub-section numbers and letters used in the attached Schedule Supplement correspond to the section and sub-section numbers and letters in the Affiliation Agreement, unless otherwise noted, and any information disclosed in in the attached Schedule Supplement shall be deemed to be disclosed to YNHHSC for all purposes of the Affiliation Agreement so long as such disclosure's relevance to the applicable section(s) of the Affiliation Agreement is reasonably apparent on its face. The captions of each section in the Schedule Supplement are included for convenience only and are not intended to limit the scope of such part, paragraph or section of the Schedule Supplement as set forth in the Affiliation Agreement.

No disclosure made herein or in the Schedule Supplement constitutes an admission of any liability or obligation of any L+M Affiliate, an admission against any interest of any L+M

Affiliate or a concession as to any defense available to any L+M Affiliate. Unless the Affiliation Agreement specifically provides otherwise, the disclosure of specific item herein, shall not be deemed to constitute an admission that such item is not in the ordinary course of business. To the extent that any representation or warranty contained in the Affiliation Agreement is limited or qualified by the materiality of the matters to which the representation or warranty is given, the inclusion of any matter in the Schedule Supplement does not constitute an admission that such matters are material or will have a L+M Material Adverse Effect. Certain information set forth herein is included solely for informational purposes and may not be required to be disclosed pursuant to the Affiliation Agreement.

If there is any inconsistency between any provision or statement in the Affiliation Agreement and any provision or statement in the Schedule Supplement (other than an exception in any section or subsection to a specific representation or warranty), then the provision or statement in the Affiliation Agreement shall control.

[Signature page follows.]

Sincerely,

Lawrence + Memorial Corporation

By: _____

Name: Bruce Cummings
Title: President and Chief Executive Officer

Update to Schedule 3.1.1

L+M Subsidiaries

Schedule 3.1.1 is hereby amended and restated in its entirety as follows:

Direct Subsidiaries of Lawrence + Memorial Corporation:

- Lawrence + Memorial Hospital, Inc.*
- LMW Healthcare, Inc.*
- L&M Physician Association, Inc.*
- L & M Systems, Inc.
- Visiting Nurse Association of Southeastern Connecticut Inc.*
- [L & M Health Care, Inc.]*
- L+M Indemnity Company Ltd.
- [Lawrence and Memorial Foundation, Inc.]*

Direct Subsidiaries of Lawrence + Memorial Hospital, Inc.:

- Associated Specialists of Southeastern Connecticut, Inc.*

Direct Subsidiaries of LMW Healthcare, Inc.:

- The Westerly Hospital Foundation, Inc.*
- Westerly Hospital Energy Company, LLC
- The Westerly Hospital Auxiliary, Inc.*

Direct Subsidiaries of L & M Systems, Inc.:

- L&M Home Care Services, Inc.
- [L & M Home Medical Equipment, LLC]

Other Entities in which any L+M Affiliate has an interest:

- DVA Healthcare of New London, LLC
- Connecticut Hospital Laboratory Network, LLC
- Value Care Alliance, LLC
- Northeast Purchasing Coalition, LLC

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* Tax-Exempt Organization

[ ] Inactive Entity

___ L+M Determination Letter has been received

Update to Schedule 3.5.1

Owned Real Property

The list of Owned Real Property is hereby amended and restated as follows:

Owner	Street	City/Town	State
LMH	365 Montauk Ave	New London	CT
LMH	7 Ray Street & 449 Ocean Avenue	New London	CT
LMH	48R Miner Lane	Waterford	CT
LMH	900 Bank Street	New London	CT
LMH	230 Waterford Parkway South	Waterford	CT
LMH	194 Howard Street	New London	CT
LMH	197 Howard Street	New London	CT
LMH	203 Howard Street	New London	CT
LMH (the "Pequot Property")*	52 Hazelnut Hill Road	Groton	CT
LMH	412 Ocean Ave	New London	CT
LMH 7/8 interest; Bank of America 1/8 interest (in trust on behalf of Elizabeth Stamm Estate) (the "Beach Property")^	Pequot Ave	New London	CT
LMW	1 Rhody Drive	Westerly	RI
LMW	65 Wells Street	Westerly	RI
LMW	11 Wells Street Unit 6	Westerly	RI
LMW	45 East Avenue	Westerly	RI
LMW	3 Rhody Drive	Westerly	RI
LMW	26 Wells Street	Westerly	RI
LMW	45 Wells Street, Unit 101	Westerly	RI
LMW	45 Wells Street, Unit 201	Westerly	RI
LMW	25 Wells Street	Westerly	RI
LMW	81 Beach Street	Westerly	RI
VNA of Southeastern Connecticut Inc.	403 N Frontage Rd	Waterford	CT
LMH	One Huntley Road	Old Lyme	CT
L+M	230 Waterford Parkway South (land)	Waterford	CT
LMH	230 Waterford Parkway South (building)	Waterford	CT

*The fee interest in the land on which the Pequot Property is situated is not owned by an L+M Affiliate, but is leased by LMH from the City of Groton, CT, pursuant to a Ground Lease, dated May 1, 1991.

^LMH owns a 7/8 interest in the Beach Property (a beach located in New London, CT for the use of L+M employees and their families). The remaining 1/8 interest in the Beach Property is held by Bank of America, in trust, on behalf of the Elizabeth Stamm Estate.

The following properties are currently on the market: 11 Wells Street Unit 6, Westerly, RI and One Huntley Road, Old Lyme, CT (offer to purchase has been received).

Update to Schedule 3.8

Subsequent Events

Schedule 3.8 is hereby amended as follows:

(b)

The description of the Integrated Leave Program is hereby amended and restated in its entirety as follows:

"*Integrated Leave Program* - Effective April 1, 2015, LMH adopted a new integrated leave program for Directors and Managers and Vice Presidents that are paid biweekly (impacting 120 employees), which includes LMH paid short term disability (self-insured) and long term disability (fully insured) insurance through Unum (Policy No. 468882 001). The plan also moves affected employees to an "All Time" bank for days off rather than Separate Paid Time Off ("PTO") and Sick banks and provides for a 2015 PTO cash out of up to 5 days (with 15 days permitted to be kept in the PTO bank) and eliminates Sick day cash out for new employees (current employees may maintain up to 100 days in frozen Sick bank until used for short term disability paid at 75% and L+M has promised to pay each applicable employee for any hours in excess of 800 in their respective Sick banks at such employee's current base rate (up to $10,000). No PTO cash out will be permitted in 2016 and employees will be permitted to roll over 10 PTO days per year on a going forward basis."

The following is hereby added to subsection (b):

The L+M Affiliates have agreed to pay retention bonuses to certain select individuals in connection with the consummation of the transactions contemplated by the Affiliation Agreement and/or the go-live of Epic Connect.

(d)

The following items are hereby added to subsection (d):

(1) LMH has purchased an HVAC for the 600 Building for a purchase price of $1,135,743.

(2) LMW has purchased an HVAC for its operating room for a purchase price of $1,840,000.

(l)

The following item is hereby added to subsection (l):

(1) In 2015 the primary layer of insurance maintained by or for LMI was exhausted, but no excess layers of such insurance were exhausted.

Update to Schedule 3.10.6

Real Property Certiorari Proceedings

Schedule 3.10.6 is hereby amended and restated in its entirety as follows:

Along with Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, the Connecticut Hospital Association and a number of other Connecticut hospitals, L+M have challenged the constitutionality of the Hospitals Tax with the State of Connecticut Department of Social Services and Department of Revenue Services.

Update to Schedule 3.13

Transactions with Affiliates

Schedule 3.13 is hereby amended as follows:

(1) Number (5) is hereby deleted in its entirety and replaced with the following:

(5) Medical Office Lease, effective August 1, 2015, by and between The New London Medical Arts Group, LLC and L+M. The New London Medical Arts Group, LLC is partially owned by Ross J. Sanfilippo, D.M.D., a member of the L+M Board of Directors.

(2) Number (9) is hereby deleted in its entirety.

(3) Number (13) is hereby deleted in its entirety and replaced with the following:

(13) Letter Agreement, dated January 1, 2016, between David F. Reisfeld, MD and LMH (for Dr. Reisfeld's services of LMH Medical Staff Immediate Past President).

(4) The following items are hereby added to Schedule 3.13:

(1) Intensivist Medical Director Agreement, dated as of January 1, 2009, by and between LMH, Southeastern Pulmonary Associates, P.C., Gold Coast Pulmonary and Sleep and Shoreline Pulmonary Associates (owned all, or in part, by Niall J. Duhig, MD, a member of the LMH Board of Directors), as amended by First Amendment to the Intensivist Medical Director Agreement, dated as of January 1, 2014, by and between LMH, Southeastern Pulmonary Associates, P.C., Gold Coast Pulmonary and Sleep, Shoreline Pulmonary Associates and IPC Hospitalists of New England, P.C. d/b/a IPC of Connecticut.

(2) Exclusive Services Agreement, dated as of May 2, 2008, by and between LMH and Anesthesia Associates of New London, P.C. (owned in part by Dr. Joseph Cecere, a member of the LMH Board of Directors), as amended by Amendment to Exclusive Services Agreement, dated as of December 28, 2009, Amendment to Exclusive Services Agreement, dated as of February 1, 2014, and Amendment to Exclusive Services Agreement, dated as of August 1, 2016, and as supplemented by the Letter of Understanding, dated as of December 10, 2010.

Update to Schedule 3.16.1

Collective Bargaining Matters

Schedule 3.16.1 is hereby amended and restated in its entirety as follows:

(1) Agreement by and between LMH and AFT-CT, AFT Healthcare, AFL-CIO Local 5049 ("Local 5049"), entered into as of March 9, 2016, including that certain Memorandum of Understanding between LMH and Local 5049, dated as of July 15, 2015, and including that certain Memorandum of Agreement by and among LMH, Local 5051, Local 5049 and Local 5123, dated as of June 20, 2016.

(2) Agreement by and between LMH and AFT-CT, AFT Healthcare, AFL-CIO Local 5051 ("Local 5051"), entered into as of March 9, 2016, including certain Memorandum of Understanding by and between LMH and Local 5051, dated as of September 15, 2015, and that certain Memorandum of Agreement between LMH and Local 5051, dated as of April 6, 2016, and also including that certain Memorandum of Agreement by and among LMH, Local 5051, Local 5049 and Local 5123, dated as of June 20, 2016.

(3) Agreement by and between LMH and Lawrence & Memorial Healthcare Workers Union, Local 5123 ("Local 5123"), AFT-CT, AFT, AFL-CIO, entered into as of March 9, 2016, including certain Memorandum of Agreement by and between LMH and Local 5123, dated as of November 19, 2015, March 24, 2016 and July 22, 2016, and also including that certain Memorandum of Agreement by and among LMH, Local 5051, Local 5049 and Local 5123, dated as of June 20, 2016.

(4) Agreement by and between LMH and International Union, Security, Police and Fire Professionals of America, dated as of February 4, 2015, including that certain Memorandum of Understanding between LMH and International Union, Security, Police and Fire Professionals of America, dated as of April 1, 2016.

(5) Agreement by and between LMW and The Westerly United Nurses and Allied Professionals, Local 5104 ("Local 5104"), dated as of July 1, 2014, including that certain Memorandum of Agreement by and between LMW and Local 5104, dated as of June 28, 2016, and also including certain Memorandum of Agreement by and between LMH and Local 5075 and 5104, undated and dated as of June 28, 2016, June 28, 2016, July 27, 2016, August 27, 2016.

(6) Agreement by and between LMW and the Westerly United Nurses and Allied Professionals, Local 5075 ("Local 5075"), dated as of July 1, 2014, including certain Memoranda of Understanding by and between LMW and Local 5075, undated and dated as of January 15, 1991, May 8, 1992, April 27, 1994, February 15, 2001, October 1, 2015, November 17, 2015, February 12, 2016, February 15, 2016, May 12, 2016, June 3, 2016 and August 1, 2016, and also including certain Memorandum of Agreement by and between LMW and Locals 5075 and 5104, undated and dated as of June 28, 2016, June 28, 2016, July 27, 2016, August 27, 2016.

(7) Collective Bargaining Agreement by and between Visiting Nurse Association of Southeastern Connecticut, Inc. and the Visiting Nurses Association of Southeastern Connecticut Federation of Registered Nurses and Home Health Aides, Local 5119 ("Local 5119"), AFT-CT, AFT, ACL-CIO, dated as of October 1, 2014, including that certain Memorandum of Understanding by and between Local 5119 and Visiting Nurse Association of Southeastern Connecticut, Inc., dated as of August 2, 2016 (RNs).

(8) Collective Bargaining Agreement by and between Visiting Nurse Association of Southeastern Connecticut, Inc. and the Visiting Nurse Association of Southeastern Connecticut Federation of

Registered Nurses and Home Health Aides, Local 5119, AFT-CT, AFT, AFL-CIO, dated as of October 1, 2014, including that certain Memorandum of Understanding by and between Local 5119 and Visiting Nurse Association of Southeastern Connecticut, Inc., dated as of August 2, 2016 (Home Health Aides).

(9) The National Labor Relations Board scheduled a union election at the Medical Office Building location of LMMG on November 25, 2014. The union, AFT-Connecticut, was seeking to represent LPNs, medical assistants, patient coordinators, patient care navigators and surgical schedulers. The election resulted in a no vote for AFT-Connecticut representation.

Update to Schedule 3.17.1

L+M Plans

Schedule 3.17.1 is hereby amended and restated as follows:

Number (2) is hereby amended and restated in its entirety as follows:

(2) LMH §457(b) Plan for Select Management Employees, effective as of October 28, 2002, as amended by that certain First Amendment to LMH §457(b) Plan, effective as of October 1, 2010 and Second Amendment to LMH §457(b) Plan, effective as of October 1, 2013. In connection with the LMH §457(b) Plan, LMH established an Irrevocable Rabbi Trust, pursuant to an Agreement by and between LMH and Lincoln Financial Group Trust Company, dated as of February 1, 2016.

Number (3) is hereby amended and restated in its entirety as follows:

(3) LMH 401(k) Plan, amended and restated effective as of February 3, 2016.

Number (15) is hereby amended and restated in its entirety as follows:

(15) LMH Medical insurance provided by Anthem Blue Cross Blue Shield and Century Preferred PPO. Prescription Coverage is through CaremarkPCS Health, L.L.C.

Number (34) is hereby amended and restated in its entirety as follows:

(34) LMH maintains a life insurance policy with Canada Life Assurance Company (Policy No. 2380459) on behalf of John F. Mirabito, the former Chief Executive Officer of L+M. The Annual Premium for the policy is $4,115.00.

Number (37) is hereby amended and restated in its entirety as follows:

(37) The Sound Medical Associates, P.C. Profit Sharing Plan, as amended, was terminated effective December 1, 2015.

Update to Schedule 3.17.4

Benefits Triggered by Agreements

Schedule 3.17.4 is hereby amended and restated in its entirety as follows:

The L+M Affiliates have agreed to pay retention bonuses to certain select individuals in connection with the consummation of the transactions contemplated by the Affiliation Agreement and/or the go-live of Epic Connect.

Schedule 3.27

Consents and Approvals

Schedule 3.27 is hereby amended to include the following items:

(1) The Parties were required to and did submit a Notice of Hospital Affiliation to the Connecticut Attorney General pursuant to Conn. Gen. Stat. § 19a-486i(e).

(2) As part of the Hospital Conversion Act approval in Rhode Island, YNHHSC and L+M must pursue a separate cy pres action relating to the charitable assets of the Westerly Hospital Foundation, but cy pres relief need not be obtained prior to Closing.

(3) Services and Support Agreement by and between Sound Medical Associates, P.C. and Island Health Project, Inc., dated as of September 21, 2001 and amended as of November 21, 2014.

(4) Consent under the following agreements with third party payors is required in connection with the closing of the LMMG-NEMG Merger:

(a) Physician Group Agreement, dated as of February 1, 2010, by and between Aetna Better Health Inc. and LMMG.

(b) Physician Group Agreement, dated as of January 1, 2010, by and between Aetna Health Inc. and LMMG.

(c) Participating Provider Group Agreement, effective as of January 1, 2010, by and between Anthem Health Plans, Inc. and LMMG.

(d) Group Agreement, effective as of January 1, 2010, by and between ConnectiCare, Inc. and LMMG.

(e) Services Agreement, effective February 24, 2012, by and between Community Cash Management Corporation (dba Marcam Associates) and LMMG.

Update to Schedule 3.28.2

Cost Report Periods

Schedule 3.28.2 is hereby amended and restated in its entirety as follows:

LMH

Government Payer Program	Last Three Complete Report Periods	Date Cost Reports Filed	NPR
Medicare	10/1/2012 - 9/30/2013	2/26/2014	No
	10/1/2013 - 9/30/2014	3/25/2015	No
	10/1/2014 - 9/30/2015	2/26/2015	No
Medicaid	10/1/2012 - 9/30/2013	7/1/2014	N/A
	10/1/2013 - 9/30/2014	7/1/2015	N/A
	10/1/2014 - 9/30/2015	7/1/2016	N/A

LMW

Government Payer Program	Last Three Complete Report Periods	Date Cost Reports Filed	NPR
Medicare	10/1/2012 - 9/30/2013	2/14/2014	4/16/16
	10/1/2013 - 9/30/2014	3/2/2015	No
	10/1/2014 - 9/30/2015	2/25/2015	No

Execution Version

FIRST AMENDMENT TO THE AFFILIATION AGREEMENT BY AND BETWEEN YALE-NEW HAVEN HEALTH SERVICES CORPORATION AND LAWRENCE + MEMORIAL CORPORATION

This First Amendment to the Affiliation Agreement by and between Yale-New Haven Health Services Corporation and Lawrence & Memorial Corporation (this "First Amendment") is made and entered into as of September 8, 2016, by and between Yale-New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M").

RECITALS

WHEREAS, YNHHSC and L+M entered into an Affiliation Agreement dated as of July 17, 2015 (the "Affiliation Agreement");

WHEREAS, initially capitalized terms that are used in this First Amendment without other definition have the respective meanings ascribed thereto in the Affiliation Agreement;

WHEREAS, at the time the Parties entered into the Affiliation Agreement, the Parties set forth certain intentions with respect to the merger (the "Merger") of L+M Physician Association, Inc., a Connecticut non-stock medical foundation doing business as L+M Medical Group ("LMMG") and Northeast Medical Group Inc., a Connecticut non-stock medical foundation ("NEMG"), which Merger was contemplated to take place as of the Closing Date and as a condition of Closing pursuant to the Affiliation Agreement;

WHEREAS, the Parties wish to proceed to the Closing without effecting the Merger, but instead to effect the Merger at a date subsequent to the Closing to be agreed upon by YNHHSC and L+M (the "Post Closing Merger Effective Date"); and

WHEREAS, to facilitate the Closing, the Parties wish to amend the Affiliation Agreement;

NOW, THEREFORE, in consideration of the foregoing, of mutual promises of the Parties hereto and of other good and valuable consideration, the receipt and sufficiency of which hereby are acknowledged, the Parties hereby agree, and the Affiliation Agreement is hereby amended as follows.

ARTICLE 1

AMENDMENTS TO AFFILIATION AGREEMENT

1.1 Section 2.1.4 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"2.1.4 Medical Foundation Matters. **As of the Closing Date, L+M shall remain the sole member of LMMG and YNHHSC shall remain the sole member of NEMG. Following the Closing, YNHHSC and NEMG shall cooperate to maximize the efficiency of operations of LMMG and NEMG.** As of the Closing Date, (i) ~~LMMG shall be merged with and into NEMG with NEMG surviving pursuant to an Agreement and Plan of Merger (the "LMMG-NEMG Agreement and Plan of Merger") in the form attached as Exhibit 2.1.4(A); (ii)~~ two physician employees of ~~NEMG~~ **LMMG** who are members of the medical staff of LMH and/or LMW, nominated in accordance with the bylaws of NEMG, shall be elected to the board of trustees of NEMG; ~~(iii)~~ **(ii)** the president of L+M or his or her designee shall be elected to the board of trustees of NEMG; **(iii)** ~~(iv)~~ the bylaws of NEMG shall be amended and restated in the form of the Amended and Restated Bylaws of NEMG (the "Amended and Restated Bylaws of NEMG") attached hereto as Exhibit 2.1.4(B); **(iv)** the certificate of incorporation of NEMG shall be amended and restated in the form of the Amended and Restated Certificate of Incorporation of NEMG (the "Amended and Restated Certificate of Incorporation of NEMG") attached hereto as Exhibit 2.1.4(C); **(v) the bylaws of LMMG shall be amended and restated in the form of the Amended and Restated Bylaws of LMMG (the "Amended and Restated Bylaws of LMMG") attached hereto as Exhibit 2.1.4(D); and (vi) the certificate of incorporation of LMMG shall be amended and restated in the form of the Amended and Restated Certificate of Incorporation of LMMG (the "Amended and Restated Certificate of Incorporation of LMMG") attached hereto as Exhibit 2.1.4.(E). In addition, as soon as reasonably practicable following the Closing Date,** ~~and (vi)~~ the contracts held by Sound Medical Associates, P.C. will be assigned to NEMG PLLC. **In addition, as of the Post Closing Merger Effective Date, LMMG shall be merged with and into NEMG with NEMG surviving pursuant to an Agreement and Plan of Merger (the "LMMG-NEMG Agreement and Plan of Merger") in the form attached as Exhibit 2.1.4(A).**"

1.2 The final paragraph of Section 2.1.5 of the Affiliation Agreement is hereby amended as follows (deletions show in ~~strikethrough~~; additions shown in **bold**):

"The LMH Amended Certificate of Incorporation, the LMW Amended Certificate of Incorporation**, the Amended and Restated Certificate of Incorporation of LMMG** and the VNA of Southeastern Connecticut Amended Certificate of Incorporation shall be referred to herein as the "*L+M Subsidiaries Amended Certificates of Incorporation*;" the LMH Amended Bylaws, the LMW Amended Bylaws, ~~and~~ the VNA of Southeastern Connecticut Amended Bylaws**, and the Amended and Restated Bylaws of LMMG** shall be referred to herein as the "*L+M Subsidiaries Amended Bylaws.*" From and after the Closing Date, any other L+M Subsidiaries shall be operated in conformity with the principles reflected in the L+M Subsidiaries Amended Certificates of Incorporation and the L+M Subsidiaries Amended Bylaws."

1.3 Section 2.2 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"2.2 Maintenance of Separate Corporate Existence. After giving effect to the Closing, the corporate existence, names, rights, privileges, immunities, powers,

franchises, facilities and other licenses, duties and liabilities of L+M and each L+M Subsidiary, ~~other than LMMG~~, shall be governed by the Board of Trustees of L+M or such L+M Subsidiary, as applicable, subject to the L+M Amended Certificate of Incorporation and the L+M Amended Bylaws or the L+M Subsidiaries Amended Certificates of Incorporation and L+M Subsidiaries Amended Bylaws, as applicable, **except as otherwise provided in the LMMG-NEMG Agreement and Plan of Merger as of the Post Closing Merger Effective Date**. Except as otherwise contemplated by this Agreement, the Affiliation shall not result in a transfer or conveyance as of the Closing Date of any asset or the assumption of any liability of either Party or any Affiliate of either Party."

1.4 Section 2.10 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"2.10 Obligated Group. On the earliest date following the Closing Date that is reasonably determined by YNHHSC and in accordance with the requirements of the L+M Master Trust Indenture, YNHHSC shall have the authority to cause L+M and LMH, **LMMG,** LMW and/or such other L+M Subsidiaries as YNHHSC shall determine to become YNHHSC Obligated Group Members, and effective upon becoming a YNHHSC Obligated Group Member the applicable L+M Affiliate shall execute a joinder to become a party to the YNHHSC Obligated Group Agreement and shall take such other steps as YNHHSC may require in connection with such status."

1.5 Section 3.2 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"3.2 Authorization of Transaction. L+M has full corporate power and authority to execute and deliver this Affiliation Agreement and to perform its obligations hereunder. This Agreement has been duly authorized by all requisite corporate action of L+M. This Agreement has been duly executed and delivered by L+M and, assuming due authorization, execution and delivery by YNHHSC, and receipt of the consents and approvals listed in Schedule 3.27, constitutes a valid and binding obligation of L+M, enforceable against L+M in accordance with its terms (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization, preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)). The amendment of the certificate of incorporation of L+M in the form of the L+M Amended Certificate of Incorporation and the amendment of the bylaws of L+M in the form of the L+M Amended Bylaws, in each case effective as of and subject to the Closing, has been duly authorized by all requisite corporate action of L+M. The LMMG-NEMG Agreement and Plan of Merger to become effective as of **the Post Closing Merger Effective Date** and subject to the Closing: (a) have been duly authorized by all requisite corporate action of L+M; and (b) in the case of LMMG, have been (or upon Closing will be) duly authorized by all requisite corporate action of LMMG. The amendment of the certificate of incorporation of each applicable L+M Subsidiary in the form of: (i) the LMH Amended Certificate of Incorporation; (ii) the LMW Amended Certificate of Incorporation; ~~and~~ (iii) the VNA of Southeastern

Connecticut Amended Certificate of Incorporation**; and (iv) the Amended and Restated Certificate of Incorporation of LMMG,** and the amendment of the bylaws of each applicable L+M Subsidiary in the form of: (x) the LMH Amended Bylaws; (y) the LMW Amended Bylaws; ~~and~~ (z) the VNA of Southeastern Connecticut Amended Bylaws~~;~~ **and (zz) the Amended and Restated Bylaws of LMMG,** in each case effective as of and subject to the Closing: (a) has been duly authorized by all requisite corporate action of L+M; and (b) in the case of each applicable L+M Subsidiary, has been (or upon Closing will be) duly authorized by all requisite corporate action of such L+M Subsidiary."

1.6 Section 4.2 of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"4.2 Authorization of Transaction. YNHHSC has full corporate power and authority to execute and deliver this Affiliation Agreement and to perform its obligations hereunder. This Agreement has been duly authorized by all requisite corporate action of YNHHSC. This Agreement has been duly executed and delivered by YNHHSC and, assuming due authorization, execution and delivery by L+M, and receipt of the consents and approvals listed in Schedule 4.27, constitutes a valid and binding obligation of YNHHSC, enforceable against YNHHSC in accordance with its terms (except as may be limited by bankruptcy, insolvency, fraudulent transfer, moratorium, reorganization, preference or similar Applicable Laws of general applicability relating to or affecting the rights of creditors generally and subject to general principles of equity (regardless of whether enforcement is sought in equity or at law)). The LMMG-NEMG Agreement and Plan of Merger to become effective as of **the Post Closing Merger Effective Date** and subject to the Closing have been duly authorized by all requisite corporate action of NEMG **and YNHHSC**."

1.7 Section 9.2(b) of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"A copy of the L+M Amended Bylaws, and of the L+M Subsidiaries Amended Bylaws for each of the applicable L+M Subsidiaries ~~other than LMMG~~, certified to be in full force and effect and to be true and correct by the secretary or assistant secretary of L+M;"

1.8 Section 9.2(c) of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"An executed copy of the LMMG-NEMG Agreement and Plan of Merger in proper form for filing with the Secretary of State **as of the Post Closing Merger Effective Date**;".

1.9 Section 9.3(e) of the Affiliation Agreement is hereby amended as follows (deletions shown in ~~strikethrough~~; additions shown in **bold**):

"An executed copy of the LMMG-NEMG Agreement and Plan of Merger in proper form for filing with the Secretary of State **as of the Post Closing Merger Effective Date**;".

1.10 Exhibit 2.1.4(B) of the Affiliation Agreement is hereby amended and restated in the form attached to this First Amendment as Exhibit 2.1.4(B) (deletions shown in ~~strikethrough~~;

additions shown in **bold**) [the Amended and Restated Bylaws of NEMG].

1.11 A new Exhibit 2.1.4(D) is hereby added to the Affiliation Agreement in the form attached to this First Amendment as Exhibit 2.1.4(D) [the Amended and Restated Bylaws of LMMG].

1.12 A new Exhibit 2.1.4(E) is hereby added to the Affiliation Agreement in the form attached to this First Amendment as Exhibit 2.1.4(E) [the Amended and Restated Certificate of Incorporation of LMMG].

1.13 Schedule 6.5 of the Affiliation Agreement is hereby amended and restated in the form attached to this First Amendment as Schedule 6.5 (deletions shown in ~~strikethrough~~; additions shown in **bold**).

1.14 Schedule 7.5 of the Affiliation Agreement is hereby amended and restated in the form attached to this First Amendment as Schedule 7.5 (deletions shown in ~~strikethrough~~; additions shown in **bold**).

ARTICLE 2

CLOSING

The Parties agree that the Closing Date and Effective Time are: 4:00 p.m. September 8, 2016.

ARTICLE 3

MISCELLANEOUS

3.1 Except as expressly modified hereby, all other terms and provisions of the Affiliation Agreement shall remain in full force and effect; except that any references to the merger of NEMG and LMMG that are inconsistent with the Parties' intent as reflected in the Recitals above shall be deemed amended by this First Amendment to be consistent with the Parties' intent as set forth in this First Amendment. All other terms and provisions of the Affiliation Agreement are incorporated herein by this reference, and shall govern the conduct of the Parties hereto; *provided, however,* to the extent of any inconsistency between the provisions of the Affiliation Agreement and the provisions of this First Amendment, the provisions of this First Amendment shall control.

3.2 This First Amendment may be executed in multiple counterparts, each of which shall be deemed an original First Amendment, but all of which, taken together, shall constitute one and the same First Amendment, binding on the Parties hereto. The delivery of an executed signature page hereof by facsimile or portable document format (.pdf) shall have the same effect as the delivery of a manually executed counterpart hereof.

3.3 This First Amendment and the Affiliation Agreement (as hereby amended) together contain and constitute the entire agreement between the Parties hereto with respect to the subject matter hereof, and this First Amendment and the Affiliation Agreement (as hereby

amended) may not be modified, amended, or otherwise changed in any manner, except as provided in the Affiliation Agreement (as hereby amended).

3.4 Every provision of this First Amendment is intended to be severable. If any term or provision hereof is declared by a court of competent jurisdiction to be illegal or invalid, such illegal or invalid terms or provisions shall not affect the other terms and provisions hereof, which terms and provisions shall remain binding and enforceable.

3.5 The headings used in this First Amendment are for reference purposes only, and are not intended to be used in construing this First Amendment. As used in this First Amendment, the masculine gender shall include the feminine and neuter, and the singular number shall include the plural, and vice versa.

3.6 The provisions of this First Amendment shall be interpreted and construed in accordance with the laws of the State of Connecticut, without regard to conflict of laws principles.

[REMAINDER OF PAGE LEFT INTENTIONALLY BLANK]

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties have executed, or caused this First Amendment to be executed as of the date first set forth above.

Yale-New Haven Health Services Corporation, a Connecticut non-stock, tax-exempt corporation

By: _____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Lawrence + Memorial Corporation, a Connecticut non-stock, tax-exempt corporation

By: _____
Name: Bruce Cummings
Title: President and Chief Executive Officer

IN WITNESS WHEREOF, the Parties have executed, or caused this First Amendment to be executed as of the date first set forth above.

Yale-New Haven Health Services Corporation, a Connecticut non-stock, tax-exempt corporation

By:_____
Name: Marna P. Borgstrom
Title: President and Chief Executive Officer

Lawrence + Memorial Corporation, a Connecticut non-stock, tax-exempt corporation

By:_____
Name: Bruce Cummings
Title: President and Chief Executive Officer

Exhibit 2.1.4(B)

Amended and Restated Bylaws of NEMG

NORTHEAST MEDICAL GROUP, INC.

AMENDED AND RESTATED BYLAWS

Amended and Restated as of _____, 201__

TABLE OF CONTENTS

NORTHEAST MEDICAL GROUP, INC.
AMENDED AND RESTATED BYLAWS

ARTICLE I. NAME AND GENERAL PURPOSES

Section 1.1 Name. The name of the corporation is Northeast Medical Group, Inc. (the "Corporation").

Section 1.2 General Purposes. The purposes of the Corporation shall be as set forth in the Corporation's Certificate of Incorporation as in effect from time to time. These Bylaws, the powers of the Corporation, its member, trustees and officers, and all matters concerning the conduct and regulation of the affairs of the Corporation shall be subject to the Certificate of Incorporation.

ARTICLE II. MEMBERSHIP

Section 2.1 Member. The Corporation shall have a single member, Yale-New Haven Health Services Corporation (the "Member"), a "Health System" as defined in Section 33-182aa of the Connecticut General Statutes.

Section 2.2 Rights, Powers and Privileges. The Member shall have all the rights, powers and privileges usually or by law accorded to the member of a medical foundation under the Chapter 594b of the Connecticut General Statutes (as it may be amended from time to time, the "Foundation Act") and of a Connecticut nonstock, nonprofit corporation under the Connecticut Revised Nonstock Corporation Act (as it may be amended from time to time, the "Nonstock Act") and not conferred thereby or by the Certificate of Incorporation or these Bylaws upon the Board of Trustees of the Corporation (the "Board"), including the right to elect the members of the Board in accordance with these Bylaws.

Notwithstanding anything in these Bylaws to the contrary:

(a) Neither the Board, nor any officer or employee of the Corporation, may take any of the actions set forth in Exhibit A of these Bylaws, nor may the Board or any officer or employee of the Corporation approve the taking of any such action by an Affiliate (as hereafter defined), without the prior approval of the Member. For purposes hereof, an "Affiliate" of the Corporation shall mean, unless otherwise determined by the Member, any entity which at the time Affiliate status is being determined is directly or indirectly controlling or controlled by or under the direct or indirect common control with the Corporation. "Control" shall mean the legal power to (a) elect or cause the election of a majority of the governing body of the subject entity, or (b) direct or cause the direction of the subject entity's operations or management, whether the foregoing power(s)

exist(s) through voting securities, other voting rights, reserved powers, contract rights, or other legally enforceable means.

(b) In addition to the approval rights reserved to the Member set forth in Exhibit A, the Member expressly retains the rights to take the actions set forth in Exhibit B on behalf of and in the name of the Corporation, directly and without the approval of the Board of this Corporation.

(c) The Board shall have the authority, from time to time, to delegate to the Member any rights, powers and privileges that would otherwise be exercised by the Board to the fullest extent permitted by applicable law.

Section 2.3 **Liability and Reimbursement of Expenses**. Unless the Member expressly agrees otherwise in writing, the Member shall not be liable for the debts or obligations of the Corporation. The Member may be reimbursed for expenses reasonably incurred on behalf of the Corporation.

ARTICLE III. BOARD OF TRUSTEES

Section 3.1 **Powers and Duties**. Subject to the powers retained by, conferred upon, or reserved to the Member by law or under these Bylaws, the Board shall have charge, control and management of the affairs, property and funds of the Corporation in the manner and subject to the limitations set forth in these Bylaws. Each Trustee shall discharge his or her duties in good faith with the care an ordinarily prudent person in like position would exercise under similar circumstances, and in a manner he or she reasonably believes to be in the best interests of the Corporation.

Section 3.2 **Composition**. The Board shall consist of two classes of voting Trustees, the Elected Trustees and the Ex Officio Trustees (collectively, the "Trustees").

(a) **Elected Trustees**. Elected Trustees shall be the persons elected by the Member for terms as set forth in these Bylaws, following nomination and approval pursuant to Section 3.4 of this Article III. Elected Trustees will represent a cross section of major segments of the community served by the Corporation and shall be selected, on the basis of demonstrated skill and ability, for their potential contribution to the governance of the affairs of the Corporation.

(b) **Ex Officio Trustees**. In addition to the Elected Trustees, there shall be the following Ex Officio Trustees, each of whom shall serve automatically by virtue of and while holding the designated office:

(i) the President of the Corporation; and

(ii) the President of each Affiliated Delivery Network, or his or her

designee.

For purposes hereof, "Affiliated Delivery Network" shall mean Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Corporation, Yale-New Haven Hospital and such other providers that may affiliate with the Yale New Haven System in the future, as designated by the Member.

Section 3.3 Number. The Board shall consist of no fewer than thirteen (13) nor more than twenty-four (24) Trustees, inclusive of Ex Officio Trustees. The number of Trustees within the range set forth in the preceding sentence shall be determined from time to time by the Member.

Section 3.4 Election of Trustees. At the annual meeting of the Member, the Member shall elect successors to the Elected Trustees whose terms are then expiring. The Member shall elect such successors consistent with the following Board composition:

(a) two (2) representatives of senior management of the Member (each, a "YNHHSC Board Member");

(b) one (1) representative from each Affiliated Delivery Network other than Lawrence + Memorial Corporation (in addition to the President, or his or her designee, who shall serve Ex Officio as set forth in Section 3.2(b));

(c) two (2) physicians employed by LMMG, each of whom is a member in good standing on the medical staff of Lawrence + Memorial Hospital or Westerly Hospital;

(d) up to eight (8) individuals, each of whom is either (1) nominated by a majority vote of the Board and approved by the Member; or (2) self-nominated and appointed by the Member; provided, however, that each such individual, whether nominated by a majority vote of the Board or self-nominated, shall be a Provider (as defined in the Foundation Act) employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Delivery Network;

(e) two (2) representatives of Yale School of Medicine;

(f) such other individuals nominated Yale School of Medicine and approved by the Member; provided, however, that each such other individual shall be a Provider employed or engaged by the Corporation and a member in good standing on the medical staff of one or more Affiliated Deliver Network.

Notwithstanding anything herein to the contrary: (x) in accordance with the Foundation Act, the number of Trustees on the Board who are Providers shall equal or exceed the number of Trustees on the Board who are nonprovider employees of the Member; and (y) the number of Trustees appointed to the Board as representatives of, or on the nomination of, Yale School of

Medicine shall constitute twenty-five percent (25%) of the total number of Trustees on the Board.

Section 3.5 **Term and Term Limits**. There shall be three (3) classes of Elected Trustees, with approximately one-third of the Elected Trustees in each class, and the terms of all Trustees in the same class shall expire at the adjournment of the same annual meeting of the Member at which Trustees are elected. Elected Trustees shall take office at the close of the meeting of the Member at which they were elected or at such later date as may be established by the Member and, subject to Section 3.6 of this Article III, shall hold office for a term of three (3) years and until a successor is duly elected and qualified.

Notwithstanding anything herein to the contrary:

(a) No person shall be elected a Trustee for a term beginning after the date of his or her seventy-sixth birthday, provided that an Elected Trustee who is seventy-six (76) years of age or older may be re-elected for another term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(b) An Elected Trustee who has served three (3) consecutive full terms (provided that for the purposes of this Section 3.5 a term of service of more than one-half of a full term shall be considered a full term) shall not be eligible for re-election for a period of one year, provided that a Trustee may be re-elected for an additional consecutive term if (i) the Trustee is also elected as an officer of the Corporation or appointed chair of a standing committee at the beginning of such additional term; or (ii) the Member determines that additional service is appropriate due to the Trustee's unique expertise and commitment to the Board, which such determination shall be made only in limited circumstances and shall be made prior to each proposed re-election after the Trustee's completion of three (3) consecutive full terms. In the instance of re-election as a Trustee for an additional term as provided in clause (i) of the foregoing sentence, Board membership shall be coterminous with said Trustee's service as an officer or committee chair.

(c) The provisions of paragraphs (a) and (b) of this Section shall not apply to an Elected Trustee in the event such Trustee also serves as a trustee of Yale-New Haven Health Services Corporation at the time such person is elected to serve as an Elected Trustee for a term otherwise prohibited by such paragraphs (a) and (b). In the instance of re-election as a Trustee for an additional term as provided in this paragraph (c), Board membership shall be coterminous with said Trustee's service as a trustee of Yale-New Haven Health Services Corporation.

Section 3.6 **Resignation**. Any Elected Trustee may resign at any time by giving written notice of such resignation to the Secretary of this Corporation. Such resignation shall be effective

at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective. Any Ex Officio Trustee who for any reason ceases to hold the office or position from which his or status as an Ex Officio Trustee derives shall automatically be deemed to have resigned as a Trustee of the Corporation and from any position held by virtue of such office with any Affiliate.

Section 3.7 Removal. One or more Elected Trustees may be removed from the Board with cause by action of the Member, which action may be taken upon its own initiative or upon the recommendation of the Board.

Section 3.8 Vacancies. In the event of the death, resignation or removal of an Elected Trustee, the vacancy resulting therefrom may be filled only by the Member in accordance with Section 3.4 of these Bylaws. An individual elected to fill a vacancy shall serve the remainder of the term of the Trustee replaced.

Section 3.9 Meetings.

(a) Annual Meetings. The annual meeting of the Board shall be held on such date and time as the Board or the President shall designate.

(b) Regular Meetings. Regular meetings of the Board shall be held on such dates and at such times and places as the Board or President shall designate.

(c) Special Meetings. Special meetings of the Board may be called at any time by the President and shall be called by the President upon the written request of the Member or any Trustee.

Section 3.10 Notice of Meetings. Notice of the date, time and place of any meeting of the Board shall be given to each Trustee and to the Member at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule established at the beginning of the fiscal year and provided to the Board and the Member in writing. Any notice of a meeting required under these Bylaws may be communicated to a Trustee in person, by mail or other delivery service, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic email address at which a Trustee has consented to receive notice. Notice to the Member shall be directed to the President/Chief Executive Officer of the Member and may be provided in person, by mail, or by telephone, facsimile or other electronic means, including electronic mail directed to an electronic mail address at which the President/Chief Executive Officer of the Member has consented to receive notice.

Section 3.11 Waiver of Notice. Notice of any meeting of the Board may be waived in writing by all the Trustees and, if any Trustee present at a meeting of the Board does not protest prior to or at the commencement of the meeting the lack of proper notice, he or she shall be deemed to have waived notice of such meeting.

Section 3.12 Action by Unanimous Written Consent. Any action required or permitted to be taken by the Board may be taken without a meeting if all the Trustees unanimously consent to such action in writing. Such written consent(s) shall be filed with the minutes of the Corporation and shall have the same force and effect as a vote of Trustees at a duly convened meeting. For purposes of this section, a Trustee may evidence his or her consent with any manual, facsimile, conformed or electronic signature, including an email communication from the Trustee to the Corporation from an email address provided by the Trustee to the Corporation.

Section 3.13 Participation by Conference Call. The members of the Board may participate in a meeting of the Board by means of conference telephone or similar communications equipment (including, without limitation, video conferencing equipment) affording all persons participating in the meeting the ability to hear one another, and such participation in the meeting by means of such equipment shall constitute presence in person at such meeting.

Section 3.14 Quorum and Voting. A majority of the number of Trustees in office at the time shall constitute a quorum for the transaction of business at all meetings of the Board, provided that if less than a majority of the Trustees is present at said meeting, a majority of the Trustees present may adjourn the meeting from time to time without further notice. The act of a majority of the Trustees present at a meeting at which a quorum is present at the time of the act shall be the act of the Board, unless the act of a greater number is required by these Bylaws, by the Certificate of Incorporation or by law. Notwithstanding the foregoing, in the event that any Trustee has a conflict of interest with respect to any transaction to be undertaken by the Corporation, such transaction shall require the approval of the Board or the Member consistent with Article VII.

ARTICLE IV. OFFICERS

Section 4.1 Officers. The officers of the Corporation shall consist of a Chair, a President, a Secretary, a Treasurer and such other officers, including Vice Chairs, as may be appointed from time to time consistent with Section 4.6. The Chair and any Vice Chair shall be members of the Board.

Section 4.2 Election and Term of Office. The President shall be appointed in accordance with Section 4.3(a) of this Article IV. The Chair, any Vice Chairs, the Secretary and the Treasurer shall be nominated by the Nominating and Governance Committee and elected annually by the Board for a term of one year and until their successors are duly elected and qualified. The Board may create and fill such other offices as it deems necessary consistent with Section 4.6.

Section 4.3 Powers. The officers shall have the powers and perform the duties commonly incident to their respective offices, including the powers and duties listed below.

(a) **President**. The President of the Corporation shall be appointed by the Member, following consultation with the Board. The appointed President shall serve at the pleasure of the Member.

The President shall be a person who in the judgment of the Member has the combination of education, experience, professional standards and demonstrated leadership ability to fulfill successfully the responsibilities of the position and to command the confidence and respect of the Board, employees and the community.

The President shall be delegated the responsibility for overall management of the Corporation and shall have all authority necessary to carry out this responsibility, subject only to such policies as may be adopted by the Board. The President shall act as the duly authorized representative of the Board in all matters in which the Board has not formally delegated some other person to so act. The duties, responsibilities and authority of the President shall be defined in a written statement adopted by the Member in consultation with the Board.

The President shall be a voting member of all standing committees except as otherwise specified in these Bylaws.

(b) **Chair**. The Chair of the Board shall preside at meetings of the Board. The Chair shall perform such other duties as the Board may from time to time prescribe.

(c) **Vice Chair**. The Board may designate one or more Vice Chairs, who shall exercise the powers and duties of the Chair during absence or disability. The Vice Chair(s), if any, shall perform such other duties as the Board or the Chair may from time to time prescribe.

(d) **Secretary**. The Secretary shall have the custody of the records of the Corporation pertaining to the Secretary's office, shall keep minutes of the meetings of the Board, and shall cause notice of such meetings to be given as required by law or these Bylaws. The Secretary shall perform such other duties as the Board or the Chair may from time to time prescribe.

(e) **Treasurer**. The Treasurer of the Corporation shall be responsible for the safekeeping of all funds and securities of the Corporation, shall see that proper records showing all financial transactions of the Corporation are maintained, and shall present financial reports to the Board.

Section 4.4 **Resignation and Removal**.

(a) An officer of the Corporation may resign at any time by giving written notice of such resignation to the Secretary. Such resignation shall be effective at the time specified in the notice, or if no time is specified, upon receipt by the Secretary. The acceptance of such resignation shall not be necessary to make it effective.

(b) The Board may remove from office any officer with or without cause; provided, however, that the President may be removed from office by the Member following consultation with the Board. Removal of an officer shall be without prejudice to the officer's contract rights, if any.

Section 4.5 Vacancies. In the case of the death, resignation or removal of any officer, except the President, the vacancy may be filled by the Board for the unexpired term. A vacancy in the office of President shall be filled in accordance with Section 4.3(a).

Section 4.6 Other Officers. The Corporation may have such other officer or officers, including assistant officers, as the Board may from time to time determine. Any such officer or assistant officer shall be appointed or elected in the manner and for the term determined by the Board, and the officer shall have the duties assigned by the Board.

ARTICLE V. COMMITTEES

Section 5.1 Classification. There shall be such standing committees as may be provided for, from time to time, in this Article V and such other committees as shall be established by Board resolution from time to time. Standing committees shall have the powers and duties set forth in this Article V and in a charter approved by the Board. Other committees shall have the powers and duties set forth in the resolution establishing them and in a charter approved by the Board. Each committee shall periodically review its charter and revise it as necessary; provided, however, that no amendment shall become effective until approved by the Board.

Section 5.2 Appointment of Committee Members. Except as otherwise provided in these Bylaws, members and chairs of all standing committees shall be appointed by the Board on nomination of the Nominating and Governance Committee. All such committee members and chairs shall serve at the pleasure of the Board until the next annual meeting of the Board and until their successors shall be chosen. All committees shall have the power to choose their own secretaries. Unless otherwise provided, individuals who are not Trustees may be appointed to committees and each such person so appointed shall have a vote and be included for purposes of determining a quorum; provided, however, that if a committee is authorized to act on behalf of the Board, any such action must be approved by a majority of the committee members who are Trustees.

Section 5.3 Committee Governance.

(a) Quorum and Voting. A majority of the committee members shall constitute a quorum at committee meetings except as otherwise provided in these Bylaws. The act of a majority of the committee members present at a meeting at which a quorum is present at the time of the act shall be the act of such committee, unless the act of a greater number is required by these Bylaws, by resolution of the Board or by law.

(b) Meetings. Except as otherwise provided in these Bylaws or by resolution of the Board, each committee shall establish its own rules and procedures and shall fix the time and place of its meetings. Each committee shall keep minutes of its meetings which shall be made available to the Board upon request.

Section 5.4 Standing Committees.

(a) Executive Committee. The Executive Committee shall consist of the Chair, who shall act as chair of the committee, the President, the Treasurer, and any other member of the Board that the Board may choose to appoint. The Executive Committee shall possess and may exercise in the intervals between meetings of the Board all such powers of the Board, except as may otherwise be provided by law, these Bylaws or resolution of the Board.

(b) Nominating and Governance Committee. The Nominating and Governance Committee shall consist of Trustees elected by the Board. The Nominating and Governance Committee shall, after consultation with the President and other Trustees, nominate candidates to be voted upon in electing officers and members of the Board and nominate for appointment by the Board the chairs and members of all standing committees. The Nominating and Governance Committee shall also review Board governance matters and recommend enhancements to strengthen the Board and ensure the comprehensiveness and efficiency of its governance process.

(c) Finance Committee. The Finance Committee shall have such duties as are established by the Member and set forth in the Finance Committee charter. These duties shall include, but not be limited to, approval of local operating and capital budgets and examination and monitoring of other operating and capital budgets involving the Corporation.

Section 5.6 Other Committees. The Board may establish and appoint from among the Trustees or others, such other committees with such powers and authority as the Board shall designate, except that no such committee may exercise the authority of the Board.

Section 5.7 Powers of Committees. No committee established by the Board shall have power to fill vacancies on the Board or on any of its committees, to amend the Certificate of Incorporation of the Corporation or these Bylaws, to approve a plan of merger, to approve a sale, lease, exchange or other disposition of all, or substantially all, of the property of the Corporation other than in the usual and regular course of affairs of the Corporation, to approve a proposal to dissolve, or to authorize any other action inconsistent with the Certificate of Incorporation or these Bylaws.

ARTICLE VI. INDEMNIFICATION

The Corporation shall indemnify and defend the Corporation's Member, Trustees, officers and employees as set forth in the Certificate of Incorporation.

ARTICLE VII. CONFLICTS OF INTEREST

The Trustees and officers of the Corporation shall comply with any Conflicts of Interest policy adopted by the Corporation, as any such policy may be amended from time to time, and with the provisions of the Nonstock Act related to disclosure and approval of "Director's conflicting interest transactions" (as such term is defined in the Nonstock Act). Consistent with the requirements of the Nonstock Act, any "Director's conflicting interest transaction" shall, when possible, be approved and authorized by either (i) the Member or (i) a majority of the disinterested Trustees voting on the transaction at a meeting at which a majority (but no fewer than two (2)) of all disinterested Trustees on the Board shall constitute a quorum, in each case following any required disclosure of the facts of the conflicting interest transaction.

ARTICLE VIII. MISCELLANEOUS PROVISIONS

Section 8.1 Fiscal Year. The fiscal year of the Corporation shall begin on the first day of October and end on the last day of September in each year unless the Board of Trustees shall otherwise determine.

Section 8.2 Execution of Deeds and Contracts. Except as otherwise directed by the Board, all deeds and mortgages made by the Corporation and all other written contracts, agreements and undertakings to which the Corporation shall be a party shall be executed in its name by the President or such other officers or officers as may be specified by the Board or authorized by the President.

Section 8.3 Execution of Negotiable Instruments. All checks, drafts, notes, bonds, bills of exchange and orders for the payment of money shall be signed by the President or such officer or officers of the Corporation as the Board may specify from time to time.

ARTICLE IX. AMENDMENTS

Subject to approval by the Member, these Bylaws may be amended, altered, or repealed at any meeting of the Board by a majority vote of the Trustees present and voting, a quorum being present. The general nature and purpose of such proposed amendment(s) shall be set forth in the notice of the meeting, and the actual language of the proposed amendments need not be included in the notice. No amendment, alteration or repeal shall take effect until it shall have been approved by the Member.

EXHIBIT A

Actions Requiring Approval of the Member

Notwithstanding anything in these Bylaws to the contrary, neither the Board nor any officer or employee of the Corporation may take any of the following actions, or approve an Affiliate taking any of the following actions, without the prior approval of the Member:

A. Merger, consolidation, reorganization or dissolution of this Corporation or any Affiliate and the creation or acquisition of an interest in any corporate entity, including joint ventures;

B. Amendment or restatement of the Mission, Certificate of Incorporation or the Bylaws of this Corporation or any Affiliate, or any new or revised "doing business as" name;

C. Adoption of operating and cash flow budgets of the Corporation or any Affiliate, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

D. Adoption of capital budgets and capital allocations of this Corporation or any Affiliate (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the Member);

E. Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the Member;

F. Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;

G. Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

H. Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation or any Affiliate;

I. Approval of major new programs and clinical services of this Corporation or any Affiliate or discontinuation or consolidation of any such program. The Member shall from time to time define the term "major" in this context;

J. Approval of strategic plans of this Corporation or any Affiliate;

K. Adoption of safety and quality assurance policies not in conformity with policies established by the Member; and

L. Adoption of any polices relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation.

Other Major Activities

A. In addition, the Member shall have the authority, except as otherwise provided by the Member and after consultation with this Corporation, to require the prior review and approval of those activities of this Corporation or any subsidiary or affiliate entity that the Member determines to be "major activities."

B. "Major activities" shall be those which the Member by a vote of not less than two-thirds (2/3) of its Board of Trustees has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the Member, and shall refer to this Bylaw provision granting such approval rights to the Member. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation.

Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by the Member pursuant to these Bylaws and the Bylaws of the Member.

EXHIBIT B

Actions Direct Authority Retained by the Member

Notwithstanding anything in these Bylaws to the contrary, the Member retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Board of this Corporation:

A. Adoption of targets for the annual operating and cash flow budgets of this Corporation and its Affiliates, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation;

B. Adoption of targets for the annual capital budgets and capital allocations of this Corporation and any Affiliate;

C. Adoption of annual operating, cash flow and annual capital budgets for the Corporation and any Affiliate within the targets established by the Member in the event of any failure of the Corporation to do so;

D. Issuance and incurrence of indebtedness on behalf of this Corporation;

E. Management and control of the liquid assets of this Corporation, including the authority to cause such assets to be funded to the Member or as otherwise directed by the Member;

F. Appointment of the independent auditor for this Corporation and each Affiliate and the management of the audit process and compliance process and procedures for this Corporation and each Affiliate; and

G. Appointment of the President consistent with Section 4.3(a).

Exhibit 2.1.4(D)

Amended and Restated Bylaws of LMMG

AMENDED AND RESTATED BYLAWS

OF

L+M PHYSICIAN ASSOCIATION, INC.

ARTICLE I

Name

Section 1.01 Name of Corporation. The name of this Corporation is **L+M Physician Association, Inc.**, and it shall be referred to throughout these Bylaws as the "Corporation."

ARTICLE II

Role and Purpose of the Corporation; Sole Member

Section 2.01 Role and Purpose of the Corporation. The Corporation is organized and shall be operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as now in effect or as may hereafter be amended (the "**Code**"), which purposes are set forth in the Corporation's Certificate of Incorporation, as the same may be amended from time to time. The Corporation's primary role and purpose is to practice medicine and provide health care services to the public as a medical foundation, pursuant to Chapter 594b of the Connecticut General Statutes, within the health care delivery system (the "**System**") administered by Yale New Haven Health Services Corporation ("**YNHHSC**" or the "**System Parent**").

Section 2.02 Sole Member; Lawrence + Memorial Corporation. The Corporation shall have but one (1) member, Lawrence + Memorial Corporation (the "**Member**"), which shall appoint the Board of Trustees of the Corporation (also referred to in these Bylaws as the "**Board**" or "**Board of Trustees**"), adopt, amend and repeal these Bylaws, and have all of the other rights, powers and privileges usually or by law accorded to the members of a nonstock federally tax-exempt corporation and not conferred by these Bylaws on the Board of Trustees of the Corporation. In addition to such other rights, powers and privileges as it may have by law, and subject to the System Parent's rights, powers and privileges set forth in these Bylaws, the Member shall have the right and power to:

(a) Approve the philosophy, mission and values of the Corporation and any change thereto;

(b) Adopt strategic plans for the Corporation;

(c) Recommend to the System Parent targets for the annual operating and cash flow budgets of the Corporation and targets for the annual capital budgets and budget allocations of the Corporation;

(d) Approve the Corporation's annual operating and cash flow budgets, capital budgets, capital allocations, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(e) Approve the formation or acquisition by the Corporation of any new direct or indirect subsidiaries, joint ventures or affiliations;

(f) Approve the Certificate of Incorporation, Bylaws and other governance documents of the Corporation, and any amendments thereto or restatements thereof;

(g) Approve all core competencies and qualifications required for selection of the Corporation's Trustees;

(h) In consultation with and upon recommendation of the Board, appoint all Trustees of the Corporation, and remove, with or without cause, all Trustees or board officers of the Corporation;

(i) In consultation with and upon recommendation of the Board, appoint and remove, determine the compensation for, and conduct the evaluation of, the Executive Director of the Corporation;

(j) Recommend to the System Parent the selection of any auditor of the annual audited financial statements for the Corporation;

(k) Recommend to the System Parent any accounting or debt management programs, establish any debt limits under such programs, approve any variances from such programs or limits for the Corporation, and incur or assume any debt on behalf of the Corporation;

(l) Recommend to the System Parent the incurrence of debt or financing by the Corporation, other than credit purchases of goods or services in the ordinary course of business, except as included in approved capital or operating budgets;

(m) Oversee the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds;

(n) Approve any voluntary change to the federal income tax exemption granted by the IRS to the Corporation under Section 501(c)(3) of the Code;

(o) Initiate or consent to any form of insolvency proceeding undertaken by the Corporation or any direct or indirect subsidiary of the Corporation;

(p) Approve all projects, agreements or transactions undertaken by the Corporation involving the expenditure of funds or divestiture of assets in excess of $250,000 and not otherwise included in an approved budget;

(q) Approve the services offered by the Corporation, new service lines or termination of existing service lines not otherwise included in an approved budget or a strategic or financial plan;

(r) Approve any sale, lease, transfer, or substantial change in the use of all or substantially all of the assets of the Corporation or any direct or indirect subsidiary of the Corporation;

(s) Approve any merger, consolidation, restructuring, change in corporate ownership, dissolution, or liquidation of the Corporation or any direct or indirect subsidiary or the Corporation;

(t) Approve the acquisition of any real estate or any significant lease arrangement by the Corporation, except as otherwise included in a strategic or financial plan or approved budget;

(u) Approve any management contract or outsourcing arrangement for the Corporation which would substantially impact or alter its operations, or any settlement agreement or consent decree with any local, state or government authorities; and

(v) Approve any change in the primary business name or logo of the Corporation.

Section 2.03 Manner of Action by Member. Any action permitted or required of the Member by law, the Certificate of Incorporation or these Bylaws may be taken by vote of its board of trustees, or by or through any person or persons designated by either its bylaws or its board of trustees to act on its behalf. Any such action may also be taken without a meeting by written communication of a duly authorized representative of the Member acting within the limits of his/her authority. Any such action by the Member or its duly authorized representative shall be filed with the Secretary of the Corporation. Whenever approval by the Member is required by law, the Certificate of Incorporation or these Bylaws, the Member shall attempt to act on a request for approval within the timeframe set forth in any schedule that may be developed from time to time, or if no such schedule exists, in a timely manner.

ARTICLE III

System Authority

Section 3.01 System Parent. YNHHSC serves as the parent company of the Member and oversees the System and its affiliated entities, including the Corporation.

Section 3.02 Rights and Powers of the System Parent. (a) YNHHSC shall, as the parent company of the Corporation's Member, have the ultimate authority to approve any decisions made by the Member by virtue of its rights and powers under state law. Such ultimate authority granted to YNHHSC shall include the right and power to approve the following:

(i) Merger, consolidation, reorganization or dissolution of this Corporation and the creation or acquisition of an interest in any corporate entity, including joint ventures;

(ii) Amendment or restatement of the mission, Certificate of Incorporation or the Bylaws of this Corporation, or any new or revised "doing business as" name;

(iii) Adoption of operating and cash flow budgets of the Corporation, including consolidated or combined budgets of this Corporation and all subsidiary organizations of the Corporation within parameters established by the System Parent;

(iv) Adoption of capital budgets and capital allocations of this Corporation (pursuant to the authority delegated to this Corporation by the Member to adopt such budgets within parameters established by the System Parent);

(v) Incurring aggregate operating or capital expenditures on an annual basis that exceed operating or capital budgets of the Corporation adopted by the Member by a specified dollar amount to be determined from time to time by the System Parent;

(vi) Long-term or material agreements including, but not limited to, equity financings, capitalized leases, operating leases and installment contracts; and purchase, sale, lease, disposition, hypothecation, exchange, gift, pledge or encumbrance of any asset, real or personal, with a fair market value in excess of a dollar amount to be determined from time to time by the Member, which shall not be less than 10% of the total annual capital budget of this Corporation;

(vii) Approval of any new relationships or agreements for undergraduate or graduate medical education programs or any material amendments to or terminations of existing agreements for undergraduate or graduate medical education programs;

(viii) Contracting with an unrelated third party for all or substantially all of the management of the assets or operations of this Corporation;

(ix) Approval of major new programs and clinical services of this Corporation or discontinuation or consolidation of any such program. YNHHSC shall from time to time define the term "major" in this context;

(xi) Approval of strategic plans of this Corporation;

(xii) Adoption of safety and quality assurance policies not in conformity with policies established by YNHHSC;

(xiii) Adoption of any polices relating to compensation of employed physicians or the taking of any other action to establish or adjust compensation of employed physicians. For purposes hereof, compensation shall include salary, fringe benefits and deferred compensation;

(xiv) Appointment of the President of Corporation;

(xiv) Any major activities of the Corporation. "Major activities" shall be those which YNHHSC, by a vote of not less than two-thirds (2/3) of its Board of Trustees, has declared major, by written notice to this Corporation, delivered personally or transmitted by registered or certified mail return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of YNHHSC, and shall refer to this Bylaw provision granting such approval rights to YNHHSC. Notices received pursuant to this section shall be recorded in the minutes of this Corporation and shall be filed with the minutes of this Corporation. Nothing in these Bylaws shall be construed in a manner that is inconsistent with the authorities with respect to the Corporation that are reserved or retained by YNHHSC pursuant to these Bylaws and the Bylaws of YNHHSC.

(b) The System Parent retains authority to take the following actions on behalf of and in the name of this Corporation, directly and without the approval of the Member or Board of this Corporation:

(i) Adoption of targets for the annual operating and cash flow budgets of the Corporation, including consolidated or combined budgets of the Corporation and all subsidiary organizations of the Corporation;

(ii). Adoption of targets for the annual capital budgets and capital allocations of the Corporation;

(iii) Adoption of annual operating, cash flow and annual capital budgets for the Corporation within the targets established by YNHHSC in the event of any failure of the Corporation to do so;

(iv) Issuance and incurrence of indebtedness on behalf of the Corporation;

(v) Management and control of the liquid assets of the Corporation, including the authority to cause such assets to be funded to YNHHSC or as otherwise directed by YNHHSC; and

(vi) Appointment of the independent auditor for the Corporation and the management of the audit process and compliance process and procedures for the Corporation.

ARTICLE IV

Board of Trustees

Section 4.01 Composition. The Board of Trustees shall consist of not fewer than five (5) nor more than eleven (11) Trustees, including *ex officio* Trustees, such number within the variable range to be determined by the Member at its annual meeting. The Member's President and Chief Executive Officer and the Corporation's Executive Director shall serve *ex officio* on

the Board and shall each have a vote and be counted for quorum purposes. The Member's Governance Committee shall ensure that: (i) in the event that there are employees of the Member serving as Trustees on the Board at any time who are not physicians, there shall be at least an equal number of physicians serving as Trustees on the Board.

Section 4.02 Election and Terms. Except individuals serving *ex officio* on the Board or as provided otherwise in this Article III, Trustees shall serve a term of three (3) years, or until their resignation, removal or death. Trustees shall be divided into three (3) classes of approximately equal size with approximately equal representation from each Director category. One class of Trustees shall be elected by the Member at each annual meeting from a slate of nominees prepared by the Member's Governance Committee, subject to approval by the System Parent; provided however that in the event the System Parent does not approve any such nominee Director, the Member shall elect a different Director for approval by the System Parent; and provided further that in the event any such successor nominee Director is not approved by the System Parent within thirty (30) days following the System Parent's annual meeting, the System Parent may direct the Member to elect the System Parent's nominee.

Section 4.03 Resignation. A Director may resign at any time by delivering written notice to the Secretary of the Corporation. The resignation shall be effective when the notice is delivered, unless the notice specifies a later effective date.

Section 4.04 Removal. A Director may be removed by the Member at any time, with or without cause. The Member shall remove a Director at the direction of the System Parent.

Section 4.05 Vacancies. A vacancy of a Director shall be filled for the balance of the vacated term by the Member, with the approval of the System Parent.

Section 4.06 Duties and Responsibilities. Subject to the rights, powers and privileges accorded to the Member and System Parent in the Certificate of Incorporation, these Bylaws, or by law, the Board of Trustees shall manage and direct the business, property, and affairs of the Corporation. The Board shall exercise all of the powers of the Corporation in accordance with these Bylaws. Without limiting the foregoing and to the extent applicable to the Corporation's operations, the Board shall have the power to:

(a) Develop and recommend to the Member and System Parent the philosophy, mission and values of the Corporation and any changes thereto;

(b) Develop and recommend to the Member and the System Parent the Corporation's strategic plans;

(c) Develop and recommend to the Member and System Parent the Corporation's annual operating and financial targets, major clinical and/or financial initiatives, and financial plans (including capital and operating budgets);

(d) Annually assess the Corporation's performance against approved budgets, initiatives and strategic plans adopted by the Member and System Parent;

(e) Recommend to the Member and System Parent the sale, transfer or substantial change in use of all or substantially all of the assets, the divestiture, dissolution and/or disposition of assets, closure, merger, consolidation, change in corporate membership or ownership or corporate reorganization of the Corporation or any direct or indirect subsidiary of the Corporation;

(f) Recommend to the Member and System Parent the formation or acquisition by the Corporation of any new direct or indirect subsidiaries, joint ventures or affiliations;

(g) Recommend to the Member and System Parent the introduction or termination of any services to be offered by the Corporation not otherwise included in an approved budget or a strategic or financial plan;

(h) Approve any consent decree or settlements from state and federal authorities, following consultation with the Member;

(i) Recommend to the Member and System Parent changes to the Corporation's Certificate of Incorporation and Bylaws;

(j) Recommend to the Member and System Parent nominations for and removal of Trustees of the Corporation;

(k) Elect officers of the Board, and recommend to the Member the removal of any officer of the Board;

(l) Approve business transactions or material contracts, subject to the rights of the Member set forth in Section 2.02 and System Parent in Section 3.02, not otherwise included in an approved budget or a strategic or financial plan;

(m) Recommend to the System Parent any incurrence or assumption of debt by the Corporation in accordance with the guidelines for accounting and debt management programs established by the Member and System Parent;

(n) Periodically assess the Corporation's Quality Initiatives, including tracking and reporting on the Corporation's performance under quality measures, quality and patient safety programs and initiatives, patient satisfaction and cultural competence initiatives;

(o) Periodically assess the Corporation's policies and programs to assure corporate and regulatory compliance, including all required state and federal license and generally recommended accreditations and certifications;

(p) Periodically assess the Corporation's policies and programs relating to human relations and labor relations;

(q) Periodically assess the Corporation's Development Plans and its Planned Giving Plans;

(r) Periodically assess the Corporation's Community Relations Initiatives and Community Outreach Programs;

(s) Plan and implement policies and programs relating to the Corporation's use, management and investment of its permanent and temporarily restricted endowment funds, annual appeal funds, and net proceeds from special fundraising events; and

(t) Evaluate the Board's performance.

Section 4.07 Compensation. The Trustees shall serve without compensation for their services as Trustees but may be reimbursed by the Corporation for their reasonable expenses and disbursements in that capacity on behalf of the Corporation.

ARTICLE V

Meetings of the Board of Trustees

Section 5.01 Annual and Regular Meetings. The annual meeting of the Board shall be held in the month of December on a date to be fixed by the Chair from year to year, unless the Chair shall designate a different date for the annual meeting. The transaction of business at the annual meeting shall be unlimited except as otherwise specified in these Bylaws. There shall be up to twelve (12) regular meetings of the Board per fiscal year, with a schedule of such meetings to be adopted by resolution of the Board.

Section 5.02 Notice of Annual and Regular Meetings. The Secretary shall give notice of the date, time and place of the annual meeting and each regular meeting of the Board by mail, electronic mail, telecommunications, telephone, facsimile or in person to each member of the Board at least five (5) days in advance of the meeting, except that no notice need be given of a regular meeting held in accordance with a schedule approved by the Board.

Section 5.03 Special Meetings. Special meetings may be called at any time by the Chair, and shall be called by the Chair within seven (7) days of receipt of the written request of any three (3) Trustees. Notice of the date, time, place and purpose of a special meeting shall be given to each member by mail, electronic mail, telecommunications, telephone, facsimile or in person at least twenty-four (24) hours before the scheduled date of the meeting and no business shall be transacted at such meeting other than that specifically set forth in the notice.

Section 5.04 Quorum; Vote Required for Action. A majority of all Trustees shall constitute a quorum at all meetings of the Board. The affirmative vote of a majority of the Trustees present at a meeting at which time a vote is taken shall be the act of the Board, unless the vote of a greater number is required by the Certificate of Incorporation, these Bylaws, or by law. *Ex officio* Trustees shall be counted in determining a quorum and shall be entitled to vote.

Section 5.05 Action Without Meeting. If all members of the Board consent in writing to any action taken or to be taken, the action shall be the same as if authorized at a meeting of the

Board; all written consent(s) shall be included in the corporate minutes or filed with the corporate records.

Section 5.06 Participation by Conference Telephone. Any member of the Board may participate in a meeting by means of a conference telephone or similar communications equipment enabling all members of the Board participating in the meeting to hear one another, and such participation shall constitute presence in person at such meeting.

Section 5.07 Agenda and Records of Meetings. There shall be a written agenda for each meeting of the Board, and minutes of each meeting shall be prepared and submitted to the Board for approval by the Secretary or a delegate. Minutes shall reflect attendance at the meeting, and shall be dated, signed and maintained in the corporate records following approval.

ARTICLE VI

Officers

Section 6.01 Officers. The officers shall be the Chair, an Executive Director, a Secretary, a Treasurer and such other officers as may from time to time be designated by the Board. The Chair, Secretary and Treasurer shall be chosen from the members of the Board.

Section 6.02 Election. The officers, except for the Executive Director, shall be chosen by the Board at its annual meeting, and shall hold office until the next annual meeting.

Section 6.03 Vacancies. Any vacancy occurring in any office shall be filled promptly by the Board at any Board meeting.

Section 6.04 Removal. Any officer may be removed with or without cause by the Member at any meeting of the board of trustees of the Member, provided that the notice of the meeting specifically states that the purpose or one of the purposes of the meeting is removal of the officer.

Section 6.05 Duties. The duties of the officers shall be as follows:

(a) Chair. The Chair shall preside at all meetings of the Board, shall be an *ex officio* member of all committees, and shall perform other duties incident to the office or delegated by the Board or these Bylaws. In the event of the Chair's absence or disability, a Director who is the Chair's delegate or who is appointed by the Board shall perform the duties of the Chair.

(b) Executive Director. The Executive Director shall be the chief executive officer of the Corporation. The Member shall appoint the Executive Director, who shall serve until his or her death, resignation, disability or removal in accordance with these Bylaws. Subject to the powers expressly reserved to the Board or the Member, the Executive Director shall, in general, supervise and control all the business and affairs of the Corporation, and shall see that the objectives, policies and orders of the Board are properly executed. The Executive Director shall have the power to sign, acknowledge and deliver on behalf of the Corporation all deeds, agreements and other formal instruments. If no Chair has been appointed or in the absence of the Chair, the Executive Director shall preside at each meeting of the Board. In general, he or she

shall perform such other duties incident to the office of Executive Director and such other duties as may from time to time be assigned to the Executive Director by these Bylaws, by the Board, or by the Member.

(c) Secretary. The Secretary shall: maintain the minutes of the meetings of the Board in the corporate records; give or cause to be given all notices required by these Bylaws or by law; serve as custodian of the Corporation's records; make such records available to the Board upon its request; and perform all other duties incident to the office or delegated by the Board or these Bylaws.

(d) Treasurer. The Treasurer shall: supervise the receipt and custody of the Corporation's funds and investments; render a full account and statement of the condition of the Corporation's finances at each annual meeting and at such other times as requested by the Board; and perform other duties incident to the office or as may be delegated by the Board or these Bylaws.

ARTICLE VII

Committees

Section 7.01 Committees. The Board may create such ad hoc committees from time to time as the Board may deem necessary to carry out special fund raising events or other initiatives of the Board. Committees may not exercise the authority of the Board, and any acts taken by them shall be solely advisory in nature. The members and chairs of each committee shall be appointed by the Board, and each such committee shall consist of at least one (1) Director and two (2) other individuals who may or may not be Trustees. Each committee established by the Board shall be chaired by a Director of the Board. Committee members shall serve at the pleasure of the Board and until their successors are elected.

Section 7.02 Committee Procedures; Action by Committee. Each committee may fix rules of procedure for its business. A majority of the members of a committee shall constitute a quorum for the transaction of business and the act of a majority of those present at a meeting at which a quorum is present shall be the act of the committee. Any action required or permitted to be taken at a meeting of a committee may be taken without a meeting, if a unanimous written consent which sets forth the action is signed by each member of the committee and filed with the minutes of the committee. The members of a committee may conduct any meeting thereof by conference telephone in accordance with the provisions of Section 4.06.

Section 7.03 "Medical Review Committees." Any committee or subcommittee referred to in or otherwise established in accordance with the provisions of these Bylaws, as well as the Board itself, when engaged in any peer review activity, is intended to be a "medical review committee" within the meaning of that term as set forth in Chapter 368a of the Connecticut General Statutes, as amended from time to time.

ARTICLE VIII

Conflict of Interest; Confidentiality

Section 8.01 "Conflict of Interest" Defined; Conflict of Interest and Confidentiality Policies. The Board expects its members to exercise good judgment and follow high ethical standards. Individuals serving the Corporation should never permit private interests to conflict in any way with their obligations to the Corporation and to any entities affiliated with the Corporation. In addition, all members of the Board must honor the confidential nature of Corporation information and strive to maintain its confidentiality. To this end, from time to time the Board shall adopt a Conflict of Interest Policy and a Confidentiality Policy; such policies shall be deemed by this reference to be a part of these Bylaws. These policies shall be consistent with requirements of state law and the law of tax-exempt organizations, and shall address, among other things: the definition of "confidential materials" and "related persons"; disclosure by Board members; the purchase of goods and services; compensation decisions; and procedures to implement and enforce these policies.

ARTICLE IX

Miscellaneous

Section 9.01 Principal Office. The principal office of the Corporation shall be located in New London, Connecticut.

Section 9.02 Waivers of Notice. Whenever any notice of time, place, purpose or any other matter, including any special notice or form of notice, is required or permitted to be given to any person by law or under the provisions of the Certificate of Incorporation or these Bylaws, or of a resolution of the Member or the Board of Trustees, a written waiver of notice signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be equivalent to the giving of such notice. The Secretary of the Corporation shall cause any such waiver to be filed with or entered upon the records of the Corporation or, in the case of a waiver of notice of a meeting, the records of the meeting. The attendance of any person at or participation in a meeting waives any required notice to that person of the meeting unless at the beginning of the meeting, or promptly upon the person's arrival, the person objects to the holding of the meeting or the transacting of business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

ARTICLE X

Amendments

Section 10.01 Amendments. Except as otherwise provided by the Certificate of Incorporation, or by law, the Member and the System Parent may adopt, amend or repeal these Bylaws.

Adopted by the Board of Trustees of
Lawrence + Memorial Corporation on August 29, 2016

Exhibit 2.1.4(E)

Amended and Restated Certificate of Incorporation of LMMG

AMENDED AND RESTATED
CERTIFICATE OF INCORPORATION

L&M PHYSICIAN ASSOCIATION, INC.

L&M PHYSICIAN ASSOCIATION, INC. hereby amends and restates its Certificate of Incorporation so that the same shall read in its entirety as follows:

1. Name. The name of the Corporation is L&M PHYSICIAN ASSOCIATION, INC. (the "Corporation").

2. Purposes. The nature of the activities to be conducted and the purposes to be promoted or carried out by the Corporation shall be exclusively charitable, scientific and educational within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), and shall include the following:

(a) to operate and maintain one or more offices or facilities for the study, diagnosis and treatment of human ailments and injuries by licensed persons;

(b) to render medical and surgical treatment, consultation or advice by duly licensed employees or agents of the Corporation to patients without regard to race, color, creed, sex, age or ability to pay for such care and services;

(c) to promote, enhance, improve, and develop medical, surgical and scientific research at providers affiliated with Yale-New Haven Health Services Corporation, including, for so long as such providers are affiliated with the Yale New Haven Health System (the "System") administered by Yale-New Haven Health Services Corporation ("YNHHSC"), which System shall include Lawrence + Memorial Corporation, Lawrence + Memorial Hospital, Westerly Hospital, Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, and such other providers that may affiliate with the System in the future (the "Affiliated Delivery Networks") and throughout the communities they serve;

(d) to promote, enhance, improve and augment the quality of medical and clinical education and patient care at the Affiliated Delivery Networks and at any other sites determined by the Corporation;

(e) to promote and enhance a high quality of medical care and other human services for the benefit of all persons in the communities it serves;

(f) to augment the planning process for the promotion of the general well-being and human health needs of the communities it serves;

(g) to solicit, accept, hold, invest, reinvest, and administer any contributions, grants, donations, gifts, bequests, devises, benefits of trusts (but not to act as trustee of any trust), and property of any sort, without limitation as to amount or value, and to use, disperse or donate the income or principal thereof for exclusively charitable and educational purposes in such

manner as, in the judgment of the Board of Trustees and the Member of the Corporation, will best promote the purposes of the Corporation;

(h) to contract for, purchase, receive, own, manage, operate or lease property, real, personal and mixed, wheresoever situated, as may be necessary to promote and further the purposes and objectives of the Corporation; and

(i) to engage in any lawful act or activity for which a medical foundation may be organized under Chapter 594b of the Connecticut General Statutes or for which a nonstock corporation may be organized under Chapter 602 of the Connecticut General Statutes, the Connecticut Revised Nonstock Corporation Act (the "Act").

In furtherance of the purposes set forth herein, the Corporation shall (i) participate as an integral part of the System, which System provides, through the Corporation and its affiliates, comprehensive, cost effective, advanced patient care characterized by safety and clinical and service quality; and (ii) fund and promote activities and programs of the System, including activities and programs of its affiliates, consistent with and in furtherance of the Corporation's charitable purposes and the charitable purposes of all System affiliates.

3. Nonprofit. The Corporation is nonprofit and shall not have or issue shares of stock or make distributions.

4. Member. The Corporation shall have one member, Lawrence + Memorial Corporation (the "Member"). The Member is an affiliate of a "Health System," as defined in Section 33-182aa of the Connecticut General Statutes, overseen by the Member's parent company, Yale New Haven Health Services Corporation (sometimes referred to as the "System Parent"). The Member shall have the rights, powers and privileges provided in the Corporation's Bylaws and by Connecticut law, including certain expressly reserved powers and retained rights described in the Corporation's Bylaws (the "Bylaws"). The Bylaws may provide that certain rights, powers and privileges of the Member shall be reserved exclusively to, or may be subject to the prior approval of, the System Parent.

5. Board of Trustees. Subject to the rights, powers and privileges of the Member or the System Parent, the Corporation shall operate under the management of its Board of Trustees. The Bylaws may provide that certain persons occupying certain positions within or without the Corporation shall be ex-officio trustees, who may be counted in determining a quorum and may have the right to vote as may be provided in the Bylaws. As may be further provided in the Bylaws, the terms of elected trustees may be staggered by dividing the elected trustees into up to three groups so that approximately an equal number of such trustees have terms that expire each year. Trustees may be removed by the Member or at the direction of the System Parent as provided in the Bylaws.

6. Restrictions. No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, the Corporation's trustees, officers or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Section 2 hereof. No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of "statements") any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of this Certificate of Incorporation, the Corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

7. Dissolution. Upon the dissolution or termination of the existence of the Corporation, all of its property and assets, after payment of the lawful debts of the Corporation and the expenses of its dissolution or termination, shall be delivered, conveyed and paid over (subject to any restrictions imposed by any applicable will, deed, grant, conveyance, agreement, memorandum, writing or other governing document) to YNHHSC, or, if at the time of the dissolution or termination of the existence of the Corporation, YNHHSC is not in existence or does not qualify as exempt under Section 501(c)(3) of the Code, to any organization (or organizations) that qualifies as an organization exempt under Section 501(c)(3) of the Code, in such proportions and for such exclusively charitable, scientific or educational purposes as the Board of Trustees may determine.

8. Limitation of Liability of Trustees. In addition to and not in derogation of any other rights conferred by law, a trustee shall not be personally liable for monetary damages for breach of duty as a trustee in an amount greater than the amount of compensation received by the trustee for serving the Corporation during the year of the violation, provided that such breach did not (a) involve a knowing and culpable violation of law by the trustee, (b) enable the trustee or an associate, as defined in Section 33-840 of the Connecticut General Statutes, to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the trustee to the Corporation under circumstances in which the trustee was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the trustee's duty to the Corporation. Any lawful repeal or modification of this Section 8 or the adoption of any provision inconsistent herewith by the Board of Trustees or the Member of the Corporation shall not, with respect to a person who is or was a trustee, adversely affect any limitation of liability, right or protection of such person existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a trustee provided for in this Section 8 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any person under, Connecticut law.

9. Indemnification. The Corporation shall provide its trustees with the full amount of indemnification that the Corporation is permitted to provide pursuant to the Act. In furtherance of the foregoing, the Corporation shall indemnify its trustees against liability as defined in Section 33-1116(4) of the Act to any person for any action taken, or any failure to take any action, as a trustee, except liability that (1) involved a knowing and culpable violation of law by the trustee, (2) enabled the trustee or an associate to receive an improper personal economic gain, (3) showed a lack of good faith and a conscious disregard for the duty of the trustee to the Corporation under circumstances in which the trustee was aware that his or her conduct or omission created an unjustifiable risk of serious injury to the Corporation, or (4) constituted a sustained and unexcused pattern of inattention that amounted to an abdication of the trustee's duty to the Corporation.

The Corporation may indemnify and advance expenses to each officer, employee or agent of the Corporation who is not a trustee, or who is a trustee but is made a party to a proceeding in his or her capacity solely as an officer, employee or agent, to the same extent as the Corporation is permitted to provide the same to a trustee, and may indemnify and advance expenses to such persons to the extent permitted by Section 33-1122 of the Act.

Notwithstanding any provision hereof to the contrary, the Corporation shall not indemnify any trustee, officer, employee or agent against any penalty excise taxes assessed against such person under Section 4958 of the Code.

10. Amendment of Certificate of Incorporation and Bylaws. This Certificate of Incorporation and the Bylaws of the Corporation may be amended or repealed, and new Bylaws may be adopted, only with the approval of the Member and the System Parent.

11. References. References in this Certificate of Incorporation to a Section of the Code shall be construed to refer both to such Section and to the regulations promulgated thereunder, as they now exist or may hereafter be amended. References in this Certificate of Incorporation to a provision of the Connecticut General Statutes or any provision of Connecticut law set forth in such Statutes is to such provision of the General Statutes of Connecticut or the corresponding provision(s) of any subsequent Connecticut law. Reference in this Certificate of Incorporation to a provision of the Act is to such provision of the Connecticut Revised Nonstock Corporation Act, as amended, or the corresponding provisions(s) of any subsequent Connecticut law.

Schedule 6.5

YNHHSC Third Party Approvals

1. The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

2. **Certificate of Need approval from OHCA for** ~~T~~the appointment of YNHHSC as the sole corporate member of L+M **pursuant to the YNHHSC-L+M Affiliation Agreement, as amended by this First Amendment**~~will require Certificate of Need approval from OHCA~~.

3. The merger of LMMG with and into NEMG will require notice to OHCA of LMMG Board approval of the merger and Certificate of Need approval from OHCA, and **at least** thirty (30) days prior to consummating the merger and closing the aforementioned transaction, notice must be filed with the Connecticut Attorney General.

4. The appointment of YNHHSC as the ultimate corporate parent of LMW must be approved by both RIDOH and the Rhode Island Attorney General through a Hospital Conversion Act application. The change in control effected by the appointment of YNHHSC as the ultimate parent of LMW must also be approved by the RIDOH Office of Health Systems Development through a Change in Effective Control application.

5. Notice of the Affiliation must be given to the Connecticut Attorney General at the same time that premerger notification under the HSR Act is given to the Federal Trade Commission.

~~6. A Transaction Test certificate is required to be delivered as a condition to the merger of LMMG with and into NEMG in satisfaction of the requirements of Section 408 of the YNHHSC Master Trust Indenture; Section 6.27 of that certain Reimbursement Agreement by and between YNHHSC and Bank of America, N.A., dated as of June 1, 2014; and each of the three International Swap Dealers Association, Inc. Master Agreements, each dated as of June 23, 2014, by and between YNHHSC and the following counterparties respectively: (i) Barclays Bank PLC; (ii) JPMorgan Chase Bank, N.A. ("JPMC"); and (iii) Goldman Sachs Bank USA.~~

~~7. The written consent of Wells Fargo Bank, National Association ("Wells Fargo") is required to be obtained as a condition of the merger of LMMG with and into NEMG, pursuant to Section 7.6(b) of that certain Amended and Restated Letter of Credit and Reimbursement Agreement by and among Wells Fargo, Yale New Haven Hospital, Inc. and YNHHSC, dated as of June 23, 2014.~~

~~8. The written consent of JPMC is required to be obtained as a condition of the merger of LMMG with and into NEMG, pursuant to Section 15(d) of that certain Letter of Credit and Reimbursement Agreement by and between YNHHSC and JPMC, dated as of June 1, 2014.~~

~~9~~6. The 1999 Affiliation Agreement between Yale University and YNHHSC, as amended (the "1999 Affiliation Agreement") requires that if a health care provider becomes a member of

Yale New Haven Health System, YNHHSC must promptly notify the Yale School of Medicine ("YSM") and, if such new system member has medical education affiliation agreements with medical schools other than YSM, YNHHSC must give notice of the expiration date and material program terms of such medical education affiliation agreements.

Schedule 7.5

L+M Third Party Approvals

1. The Federal Trade Commission must be given notice of the appointment of YNHHSC as the sole member of L+M through the premerger notification program under the HSR Act, and the transaction may not close until the HSR-required waiting period has passed.

2. **Certificate of Need approval from OHCA for** ~~T~~the appointment of YNHHSC as the sole corporate member of L+M **pursuant to the YNHHSC-L+M Affiliation Agreement, as amended by this First Amendment**~~will require Certificate of Need approval from OHCA~~.

3. The merger of LMMG with and into NEMG will require notice to OHCA of LMMG Board approval of the merger and Certificate of Need approval from OHCA, and **at least** thirty (30) days prior to consummating the merger and closing the aforementioned transaction, notice must be filed with the Connecticut Attorney General.

4. The appointment of YNHHSC as the ultimate corporate parent of LMW must be approved by both RIDOH and the Rhode Island Attorney General through a Hospital Conversion Act application. The change in control effected by the appointment of YNHHSC as the ultimate parent of LMW must also be approved by the RIDOH Office of Health Systems Development through a Change in Effective Control application.

5. Notice of the Affiliation must be given to the Connecticut Attorney General at the same time that premerger notification under the HSR Act is given to the Federal Trade Commission.

6. ~~(7)~~ Consent of Bank of America, N.A. to the consummation of the transactions contemplated by the Affiliation Agreement under Section 7(p), and confirmation of Bank of America, N.A. that the transactions contemplated by the Affiliation Agreement will not contravene Section 7(g), of that certain Continuing Covenants Agreement, dated as of October 13, 2013, by and among L+M and LMH on the one hand and Bank of America, N.A. on the other hand.

~~6~~**7**. Consent of the Connecticut Health and Education Facilities Authority to the consummation of the transactions contemplated by the Affiliation Agreement under Section 6.11 of the Master Trust Indenture, dated as of February 1, 1990, by and among L+M and LMH on the one hand and the Master Trustee named therein on the other hand, as the same has been amended or supplemented from time to time in accordance with its terms.

~~7~~**8**. Notification to TD Bank, National Association pursuant to Section 5.30 of that certain Letter of Credit and Reimbursement Agreement, dated as of November 5, 2013, by and among L+M and LMH on the one hand and TD Bank, National Association, on the other hand.

L+M Hospital Inpatient Bed Allocation			
As of 9/8/16			
	Licensed	**Available**	
	Beds	**Beds**	
Med/Surg		142	
Critical Care (ICU/CCU)		20	
Psychiatric		18	
Rehabilitation		16	
Maternity		24	
NICU/Newborn Nursery		27	
Total	308*	247	
*note: total includes 280 general hospital beds and 28 bassinets			

L+M Hospital Outpatient Services by Service, Location and Hours of Operation

As of 9/8/16

Service	Department	Location	Hours of Operation
Ambulatory Surgery	Surgery	52 Hazelnut Hill Road, Groton, CT	T, W, F 06:00 - 18:00
Ambulatory Surgery	Surgery	365 Montauk Avenue, New London, CT	M-F 07:00 - 17:30
Audiology	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M 09:00 - 17:30 T-Th 08:00 - 18:30 F 08:00 - 18:00
Audiology	Rehabilitation	40 Boston Post Road, Waterford, CT	M-Th 07:00 - 18:00 F 09:00 - 17:30
Automated Whole Breast Screening Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 16:30 Sa 07:30 - 11:00
Blood Draw	Laboratory	365 Montauk Avenue, New London, CT	M-F 06:30 - 18:00 Sa 07:00 - 12:00
Blood Draw	Laboratory	339 Flanders Road, East Lyme, CT	M-F 06:30 - 17:00 Sat 07:00 - 12:00
Blood Draw	Laboratory	52 Hazelnut Hill Road, Groton, CT	M-F 06:30 - 19:00 Sa 07:00 - 19:00 Su 09:00 - 17:30
Blood Draw	Laboratory	194 Howard Street, New London, CT	M-F 08:30 - 17:00
Bone Density	Radiology	52 Hazelnut Hill Road, Groton, CT	M-Th 07:30 - 18:00 Every other Sa 07:30 - 15:00
Bone Density	Radiology	196 Parkway South, Suite 102, Waterford, CT	T,W,F 08:00 - 15:00
Breast Imaging	Radiology	365 Montauk Avenue, New London, CT	M-Th 07:00 - 18:00 F 07:00 - 16:30 Sa 06:30 - 15:00
Breast Imaging	Radiology	52 Hazelnut Hill Road, Groton, CT	M-Th 06:30 - 19:00 F, Sa 06:30 - 15:00
Breast Imaging	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-Th 06:30 - 15:00 F 07:30 - 16:00 Sa 06:30 - 15:00
Cardiac and Pulmonary Rehab	Rehabilitation	365 Montauk Avenue, New London, CT	M-F 07:30 - 17:30
Cardiac Diagnostic Testing	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 15:30
Cardiac Diagnostic Testing	Cardiology	52 Hazelnut Hill Road, Groton, CT	T, W, F 06:00 - 18:00
Cath Lab	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Chemo Infusion	Oncology	230 Waterford Parkway S, Waterford, CT	M-F 08:00 - 17:00

Computerized Tomography (CT)	Radiology	365 Montauk Avenue, New London, CT	7 days/week 07:00 - 19:00
Computerized Tomography (CT)	Radiology	52 Hazelnut Hill Road, Groton, CT	7 days/week 07:00 - 19:00
Computerized Tomography (CT)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M,W,Th,F 07:30 - 16:00
Cardiovasular Ultrasound (CV Ultrasound)	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 19:00
Cardiovasular Ultrasound (CV Ultrasound)	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 16:30
Cardiovasular Ultrasound (CV Ultrasound)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:00 - 16:30
Diagnostic Radiology	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 19:00 Sa 09:00 - 11:00
Diagnostic Radiology	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 20:00 Sa 09:00 - 16:30
Diagnostic Radiology	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:30 - 17:00
Emergency Services	Emergency	365 Montauk Avenue, New London, CT	7 days/week Open 24 hours
Emergency Services	Emergency	52 Hazelnut Hill Road, Groton, CT	7 days/week 07:00 - 23:00
Infusion (non-chemo)	Infusion (non-chemo)	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00 Sa, Su, Holidays - on call
Intensive Outpatient Program	Psychiatry	365 Montauk Avenue, New London, CT	M-F 09:00 - 12:00
Interventional Radiology	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 16:30 On Call 24/7
Magnetic Resonance Imaging (MRI)	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 21:00 Sa,Su 07:00 - 19:00
Magnetic Resonance Imaging (MRI)	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 07:00 - 17:00 Sa 07:00 - 17:00
Magnetic Resonance Imaging (MRI)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 07:00 - 17:00 Sa 07:00 - 15:00
Neurodiagnostics	Neurodiagnostics	365 Montauk Avenue, New London, CT	M-F 07:00 - 16:30 1 Sa a month - 07:00 - 16:30
Nuclear Medicine (Nuclear Med)	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 17:00 MIBIs Only - Sa 08:00 - 12:00
Occupational Health	Occupational health	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 16:30
Occupational Therapy	Rehabilitation	339 Flanders Road, East Lyme, CT	M, W 09:30 - 19:00 T, Th 07:00 - 14:00 M, F 07:00 - 18:00 T 06:30 - 19:00 W 07:00 - 1900 Th 07:30 - 19:00 Sat 07:00 - 16:00 (hands)
Occupational Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	Sun as needed for hands

Occupational Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	M, W 07:30 - 18:00 T, F 07:30 - 15:30 Th 07:30 - 16:30
Positron Emission Tomography (PET)	Radiology	196 Parkway South, Suite 102, Waterford, CT	M,W,F 07:00 - 15:00
Physical Therapy	Rehabilitation	339 Flanders Road, East Lyme, CT	M-Th 06:30 - 19:00 F 06:30 - 16:30
Physical Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M-Th 06:30 - 19:00 F 06:30 - 18:00
Physical Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	M-Th 06:30 - 18:30 F 06:30 - 17:30
Pre-admisson testing	Surgery	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00 Th 08:00 - 16:30
Pre-admisson testing	Surgery	52 Hazelnut Hill Road, Groton, CT	T,W,F Variable
Pulmonary Function Testing	Restorative Services	365 Montauk Avenue, New London, CT	M, Th 07:00 - 16:00
Radiation Therapy	Oncology	230 Waterford Parkway S, Waterford, CT	M-F 08:00 - 17:00
Sleep lab	Restorative Services	224 Goldstar Highway, Groton, CT	T-Sa 19:00 - 07:30
Speech Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M 08:00 - 18:30 T, F 08:00 - 16:30 W, Th 08:00 - 17:30
Speech Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	T, Th, F 07:00 - 17:00
Stress Testing	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Targeted Breast Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M,W,F 13:00 - 16:30 T,Th 08:00 - 16:30
Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 19:00 Every other Sa 07:00 - 15:30
Ultrasound	Radiology	52 Hazelnut Hill Road, Groton, CT	7 days/week 08:00 - 16:30
Ultrasound	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:00 - 16:30
Vascular Lab	Radiology	365 Montauk Avenue, New London, CT	M-F 08:30 - 17:00
Wound Care and Hyperbarics	Rehabilitation	40 Boston Post Road, Waterford, CT	M-F 08:00 - 16:30

L+M Hospital Outpatient Services by Service, Location and Hours of Operation

As of 9/8/16

Service	Department	Location	Hours of Operation
Ambulatory Surgery	Surgery	52 Hazelnut Hill Road, Groton, CT	T, W, F 06:00 - 18:00
Ambulatory Surgery	Surgery	365 Montauk Avenue, New London, CT	M-F 07:00 - 17:30
Audiology	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M 09:00 - 17:30 T-Th 08:00 - 18:30 F 08:00 - 18:00
Audiology	Rehabilitation	40 Boston Post Road, Waterford, CT	M-Th 07:00 - 18:00 F 09:00 - 17:30
Automated Whole Breast Screening Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 16:30 Sa 07:30 - 11:00
Blood Draw	Laboratory	365 Montauk Avenue, New London, CT	M-F 06:30 - 18:00 Sa 07:00 - 12:00
Blood Draw	Laboratory	339 Flanders Road, East Lyme, CT	M-F 06:30 - 17:00 Sat 07:00 - 12:00
Blood Draw	Laboratory	52 Hazelnut Hill Road, Groton, CT	M-F 06:30 - 19:00 Sa 07:00 - 19:00 Su 09:00 - 17:30
Blood Draw	Laboratory	194 Howard Street, New London, CT	M-F 08:30 - 17:00
Bone Density	Radiology	52 Hazelnut Hill Road, Groton, CT	M-Th 07:30 - 18:00 Every other Sa 07:30 - 15:00
Bone Density	Radiology	196 Parkway South, Suite 102, Waterford, CT	T,W,F 08:00 - 15:00
Breast Imaging	Radiology	365 Montauk Avenue, New London, CT	M-Th 07:00 - 18:00 F 07:00 - 16:30 Sa 06:30 - 15:00
Breast Imaging	Radiology	52 Hazelnut Hill Road, Groton, CT	M-Th 06:30 - 19:00 F, Sa 06:30 - 15:00
Breast Imaging	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-Th 06:30 - 15:00 F 07:30 - 16:00 Sa 06:30 - 15:00
Cardiac and Pulmonary Rehab	Rehabilitation	365 Montauk Avenue, New London, CT	M-F 07:30 - 17:30
Cardiac Diagnostic Testing	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 15:30
Cardiac Diagnostic Testing	Cardiology	52 Hazelnut Hill Road, Groton, CT	T, W, F 06:00 - 18:00
Cath Lab	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Chemo Infusion	Oncology	230 Waterford Parkway S, Waterford, CT	M-F 08:00 - 17:00
CT	Radiology	365 Montauk Avenue, New London, CT	7 days/week 07:00 - 19:00
CT	Radiology	52 Hazelnut Hill Road, Groton, CT	7 days/week 07:00 - 19:00
CT	Radiology	196 Parkway South, Suite 102, Waterford, CT	M,W,Th,F 07:30 - 16:00
CV Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 19:00
CV Ultrasound	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 16:30
CV Ultrasound	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:00 - 16:30
Diagnostic Radiology	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 19:00 Sa 09:00 - 11:00

Diagnostic Radiology	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 20:00 Sa 09:00 - 16:30
Diagnostic Radiology	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:30 - 17:00
Emergency Services	Emergency	365 Montauk Avenue, New London, CT	7 days/week Open 24 hours
Emergency Services	Emergency	52 Hazelnut Hill Road, Groton, CT	7 days/week 07:00 - 23:00
Infusion (non-chemo)	Infusion (non-chemo)	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00 Sa, Su, Holidays - on call
Intensive Outpatient Program	Psychiatry	365 Montauk Avenue, New London, CT	M-F 09:00 - 12:00
Interventional Radiology	Radiology	365 Montauk Avenue, New London, CT	M-F 08:00 - 16:30 On Call 24/7
MRI	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 21:00 Sa,Su 07:00 - 19:00
MRI	Radiology	52 Hazelnut Hill Road, Groton, CT	M-F 07:00 - 17:00 Sa 07:00 - 17:00
MRI	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 07:00 - 17:00 Sa 07:00 - 15:00
Neurodiagnostics	Neurodiagnostics	365 Montauk Avenue, New London, CT	M-F 07:00 - 16:30 1 Sa a month - 07:00 - 16:30
Nuclear Med	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 17:00 MIBIs Only - Sa 08:00 - 12:00
Occupational Health	Occupational health	52 Hazelnut Hill Road, Groton, CT	M-F 08:00 - 16:30
Occupational Therapy	Rehabilitation	339 Flanders Road, East Lyme, CT	M, W 09:30 - 19:00 T, Th 07:00 - 14:00
Occupational Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M, F 07:00 - 18:00 T 06:30 - 19:00 W 07:00 - 1900 Th 07:30 - 19:00 Sat 07:00 - 16:00 (hands) Sun as needed for hands
Occupational Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	M, W 07:30 - 18:00 T, F 07:30 - 15:30 Th 07:30 - 16:30
PET	Radiology	196 Parkway South, Suite 102, Waterford, CT	M,W,F 07:00 - 15:00
Physical Therapy	Rehabilitation	339 Flanders Road, East Lyme, CT	M-Th 06:30 - 19:00 F 06:30 - 16:30
Physical Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M-Th 06:30 - 19:00 F 06:30 - 18:00
Physical Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	M-Th 06:30 - 18:30 F 06:30 - 17:30
Pre-admisson testing	Surgery	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Pre-admisson testing	Surgery	52 Hazelnut Hill Road, Groton, CT	Th 08:00 - 16:30 T,W,F Variable
Pulmonary Function Testing	Restorative Services	365 Montauk Avenue, New London, CT	M, Th 07:00 - 16:00
Radiation Therapy	Oncology	230 Waterford Parkway S, Waterford, CT	M-F 08:00 - 17:00
Sleep lab	Restorative Services	224 Goldstar Highway, Groton, CT	T-Sa 19:00 - 07:30

Speech Therapy	Rehabilitation	52 Hazelnut Hill Road, Groton, CT	M 08:00 - 18:30 T, F 08:00 - 16:30 W, Th 08:00 - 17:30
Speech Therapy	Rehabilitation	40 Boston Post Road, Waterford, CT	T, Th, F 07:00 - 17:00
Stress Testing	Cardiology	365 Montauk Avenue, New London, CT	M-F 07:30 - 16:00
Targeted Breast Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M,W,F 13:00 - 16:30 T,Th 08:00 - 16:30
Ultrasound	Radiology	365 Montauk Avenue, New London, CT	M-F 07:00 - 19:00 Every other Sa 07:00 - 15:30
Ultrasound	Radiology	52 Hazelnut Hill Road, Groton, CT	7 days/week 08:00 - 16:30
Ultrasound	Radiology	196 Parkway South, Suite 102, Waterford, CT	M-F 08:00 - 16:30
Vascular Lab	Radiology	365 Montauk Avenue, New London, CT	M-F 08:30 - 17:00
Wound Care and Hyperbarics	Rehabilitation	40 Boston Post Road, Waterford, CT	M-F 08:00 - 16:30

Yale
NewHaven
Health

October 4, 2016

Ms. Kimberly Martone
State of Connecticut
Office of Healthcare Access
410 Capitol Avenue, MS#13HCA
Hartford, Connecticut 06134-0308

Dear Ms. Martone,

Pursuant to the Order contained within the Agreed Settlement of Docket Number 15-32033-CON, "Transfer of ownership of Lawrence + Memorial Corporation (L+MH) to Yale New Haven Health Services Corporation (YNHHS)", Condition 3 and Condition 31 are required to be submitted to OHCA within thirty (30) days following the completion and Board approval of L+MH's 2016 Community Health Needs Assessment (CHNA) and its Implementation Strategy. The CHNA and Implementation Plan was approved by L+MH's Board on August 29, 2016.

Attached please find documents responsive to Conditions 3 and 31. The CHNA and Implementation Plan are being posted on L+MH's website immediately under "About Us".

A copy of these documents will be sent via U.S. postal service.

Regards,

Nancy Levitt Rosenthal
Vice President, Strategy and Regulatory Planning

Strategy and Regulatory Planning
YNHHS, 20 York Street
(2 Howe St, 307)
New Haven, CT 06519
Phone: 203-688-5721
Fax: 203-688-5013
Nancy.Rosenthal@greenwichhospital.org
www.ynhhs.org

Community Health Assessment

LAWRENCE + MEMORIAL HOSPITAL

LLHD Ledge Light Health District

Collective Action to Create a Healthier Community

Acknowledgements

Primary Contributors

Laurel Holmes, MSW, Director of Community Partnerships + Population Health, L+M Healthcare

Russell Melmed, MPH, Supervisor Health Education and Community Outreach and Epidemiologist, Ledge Light Health District

Jennifer Muggeo, MPH, Supervisor Finance and Administration and Special Projects in Population Health, Ledge Light Health District

SE CT Health Improvement Collaborative Steering Committee Members

***also a Focus Group Facilitator/Scribe*

Maritza Bond, MPH, Executive Director, Eastern Area Health Education Center

Yolanda Bowes, Director Community Outreach Services, United Community and Family Services

Megan Brown, CFRE, Senior Director of Marketing and Development, Thames Valley Council for Community Action

**Stephanye Clarke, New London NAACP, Universal Health Care Foundation Advocacy Communications Fellow, African American Health Council

Nancy Cowser, Senior Vice President of Strategy, United Community and Family Services

Jim Haslam, Staff Attorney, CT Legal Services

Leah Hendriks, BSN, RN, Supervisor School Health and Wellness and Program Administrator Nurse-Family Partnership, Visiting Nurse Association of Southeastern CT

Jerry Lokken, Recreation Services Manager, Groton Parks and Recreation

Alejandro Melendez-Cooper, President, Hispanic Alliance

Cathy McCarthy, LCSW, Social Worker, L+M Cancer Center

Patrick McCormack, MPH, Director of Health, Uncas Health District

Jennifer O'Brien, Program Director, Community Foundation of Eastern Connecticut

Michael Passero, Mayor, City of New London

Tracee Reiser, Associate Dean for Community Learning, Associate Director Holleran Center, Connecticut College

**Dianna Rodriguez, LMSW, Behavioral Health Clinician, Community Health Center Inc.

Ariella Rotramel, PhD, Assistant Professor of Gender and Women's Studies, Connecticut College

**Michele Scott, MSOL, Community Development Specialist, Mashantucket Pequot Tribal Nation

**Stephen Smith, MD, Community Health Center

Kathleen Stauffer, MPA, Chief Executive Officer, The Arc New London County

Victor Villagra, MD, UCONN Health Disparities Institute

Consultants and Support

Jessica Hill, AHEPA, Focus Group Facilitator

Shaniece Jones, Ledge Light Health District, Intern

Kenn Harris, Pastor, Born Again Evangelistic Outreach Ministries, Focus Group Facilitator

Toby Matthew, Focus Group Scribe

Sharon Mierszwa, MPH, Community Partner Forum Facilitator

Colleen Milligan, Senior Manager, Baker Tilley Virchow Krause LLP, Prioritization Event Facilitator

Jessica Seyfried, MPH/MSW, Ledge Light Health District and L+M Hospital, Intern

Aracelis Vázquez Hayes, M.Div, M.Ed, Church of the City, Focus Group Facilitator

Crystal Worsley, Focus Group Facilitator and Scribe

Funding Support

Partial funding for this project was generously provided by the Community Foundation of Eastern Connecticut and the U.S. Preventative Health and Health Services Block Grant

Executive Summary

Guided by the Southeastern CT Health Improvement Collaborative, a coalition of health care providers, local public health, federally qualified health centers, tribal representatives, higher education, and numerous non-profit organizations serving the region, L+M Hospital (L+M) and Ledge Light Health District (LLHD) considered data from primary and secondary sources to identify and elucidate the leading health indicators for the region included in this report. Accompanying this assessment is a Community Health Improvement Plan (CHIP) to address the Community Health Assessment findings.

The data sources in this assessment provided a rich array of information and moved the process toward a more holistic understanding of health status, perceptions, barriers, and strategies for improvement. Community member input revealed consistent themes around communication, connections and bias, disparities, access to care, safety concerns, mental health, and chronic disease.

Recognizing the significant contribution of social determinants to overall health and wellness, particular attention has been paid in this assessment to the interaction between socioeconomic and environmental conditions as well as to health disparities. One such social determinant, economic security—or the ability to regularly and comfortably pay for one's basic needs such as food, housing, transportation, and other goods and services, is closely associated with health outcomes. Although fewer residents of New London County experienced poverty in the past 12 months compared to the state, there still exist disparities around family construct and geography. Residents in lower income categories reported higher anxiety and depression, and lower incomes are correlated with higher suicides and self-inflicted injuries. There are also significant disparities related to employment in Greater New London; the real unemployment rate among Blacks is more than twice that of Whites.

Housing stock in the region is older in general and more likely to harbor health hazards such as defective lead paint, failing plumbing, and asbestos insulation, contributing to poorer health among lower income residents who are more likely to live in poor quality housing. Further, transportation emerged as a key issue impacting health; when asked about their vision of a healthy community, focus group and web survey participants and community partners repeatedly cited the need for more and better public transportation, bike lanes and pedestrian-friendly roads .

As it relates to chronic disease, there are repeated associations between poor health and social determinants in the assessment data. When sedentary lifestyle is examined by income, those with incomes less than $50,000 are more likely to be sedentary than the state and Greater New London overall. Smoking, diabetes and heart disease also have higher prevalence among those within lower income categories and those with lower levels of education. Lower income and education is also correlated with higher emergency department use, the delaying of healthcare, not getting necessary care, and not getting necessary medications due to cost.

Mental and emotional wellbeing is an area of concern, with disparities by race and also by income. Mental health concerns and substance use are often co-occurring—in 2015, depression was the fourth most prevalent condition among hospitalizations and alcohol/ substance use was the fifth. Although the data reflect a time period before the most recent dramatic spike in opioid overdoses and related deaths, there nonetheless is an upward trend seen in recent years.

Racial and ethnic health disparities were evident on several indicators including asthma (higher among Hispanics and African Americans), oral health (less preventive care among African Americans), hypertension (higher among African Americans) and the experience of violence (higher among Hispanics). African Americans and Hispanics are more likely to use the hospital emergency department (ED) for care, considered a proxy for access to care in the community.

Understanding the connections between wide-ranging factors and their relative contributions to overall health is one goal of the community health assessment process. Only through this understanding can the community effectively impact policies, systems and practices toward a healthier community.

Contact

L+M Healthcare, Community Partnerships + Population Health (860) 271-4698, lholmes@lmhosp.org or
Ledge Light Health District (860) 448-4882 ext. 300, jmuggeo@llhd.org

Table of Contents

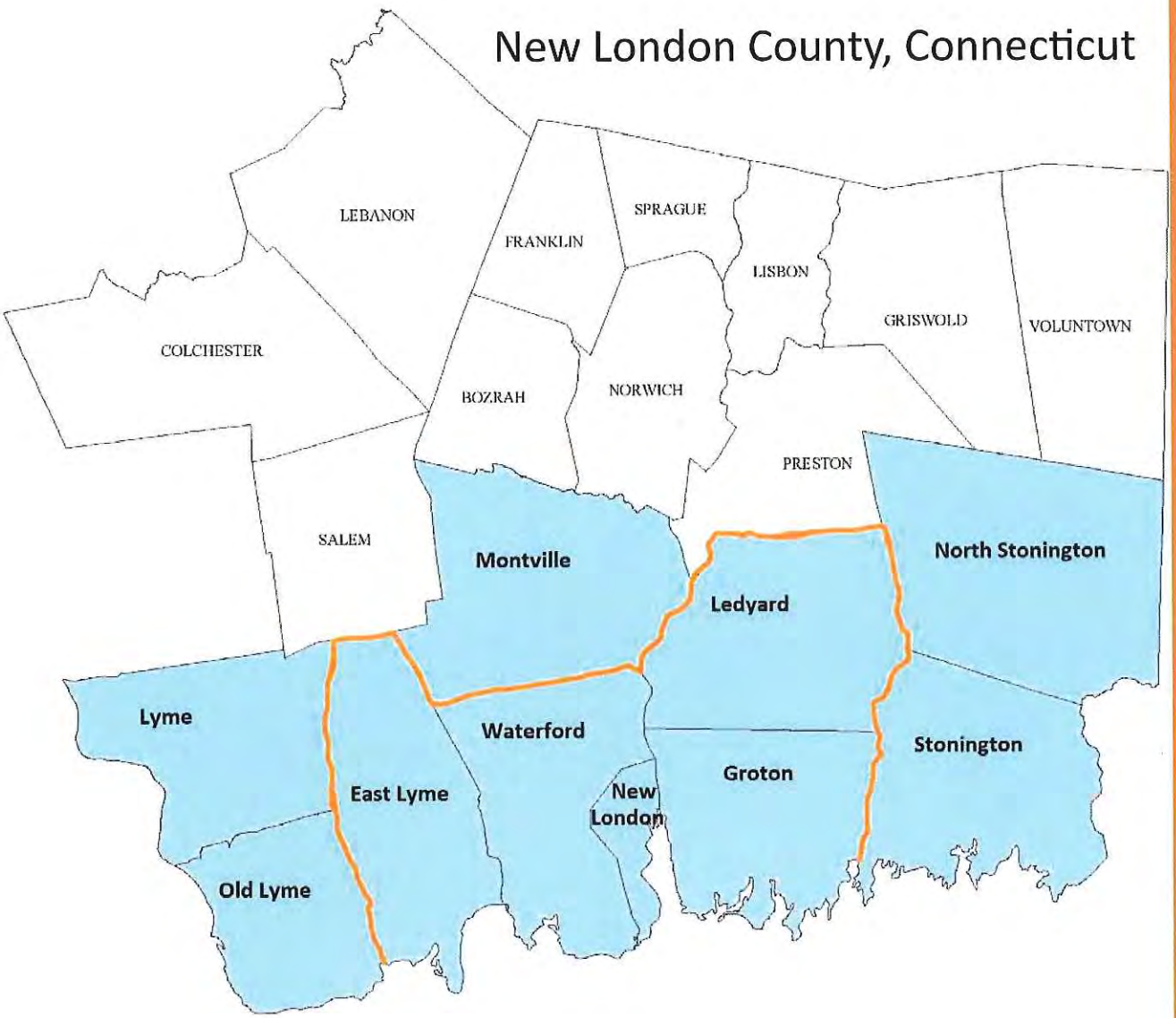
Introduction

With a shared vision for a healthy community, and continuing a long-term partnership on many community health improvement activities, Lawrence + Memorial Hospital (L+M) and Ledge Light Health District (LLHD) joined together in 2015-16 to lead a Community Health Assessment (CHA) process for Greater New London (see map page 7). Guided by the Southeastern CT Health Improvement Collaborative, a coalition of health care providers, local public health, federally qualified health centers, tribal representatives, higher education, and numerous non-profit organizations serving the region, L+M and LLHD considered data from primary and secondary sources to identify and elucidate the leading health indicators for the region included in this report. Accompanying this assessment will be a Community Health Improvement Plan (CHIP) to address the CHA findings, developed by the Southeastern CT Health Improvement Collaborative. Through the prioritization and planning process, the Collaborative will identify initiatives that include addressing social determinants in order to achieve improved health outcomes. While the CHA and CHIP are designed to meet the requirements for L+M to maintain their non-for-profit status as a community hospital and for LLHD to earn accreditation through the Public Health Accreditation Board, both organizations intend for the reports to serve as guides for planning future programs and policies for these agencies and for the community overall.

Among public health and human service advocates in Greater New London, there is a recognition that social determinants, such as poverty, educational attainment, food security, housing, and transportation, contribute to overall wellbeing and health more than clinical care, behaviors or family history. Otherwise stated, zip code is more important that genetic code as a contributor to health. Developing the best strategies to improve health requires an understanding of how social determinants influence health. It is especially important when considering health inequities; that some groups within our communities bear disproportionate rates of disease and/or experience disparate quality of care is related to many intersecting factors. Achieving a "healthy community" where everyone has the same opportunities to make healthy choices and access quality, culturally and linguistically sensitive, timely and affordable health care requires us to examine inequities in socioeconomic conditions, and the policies and practices that create them.

Geographic Scope

This Community Health Assessment Report focuses on the leading health indicators of Greater New London, which is the Lawrence and Memorial Hospital primary service area (highlighted in blue on this map) and includes the member municipalities of Ledge Light Health District (outlined in orange).



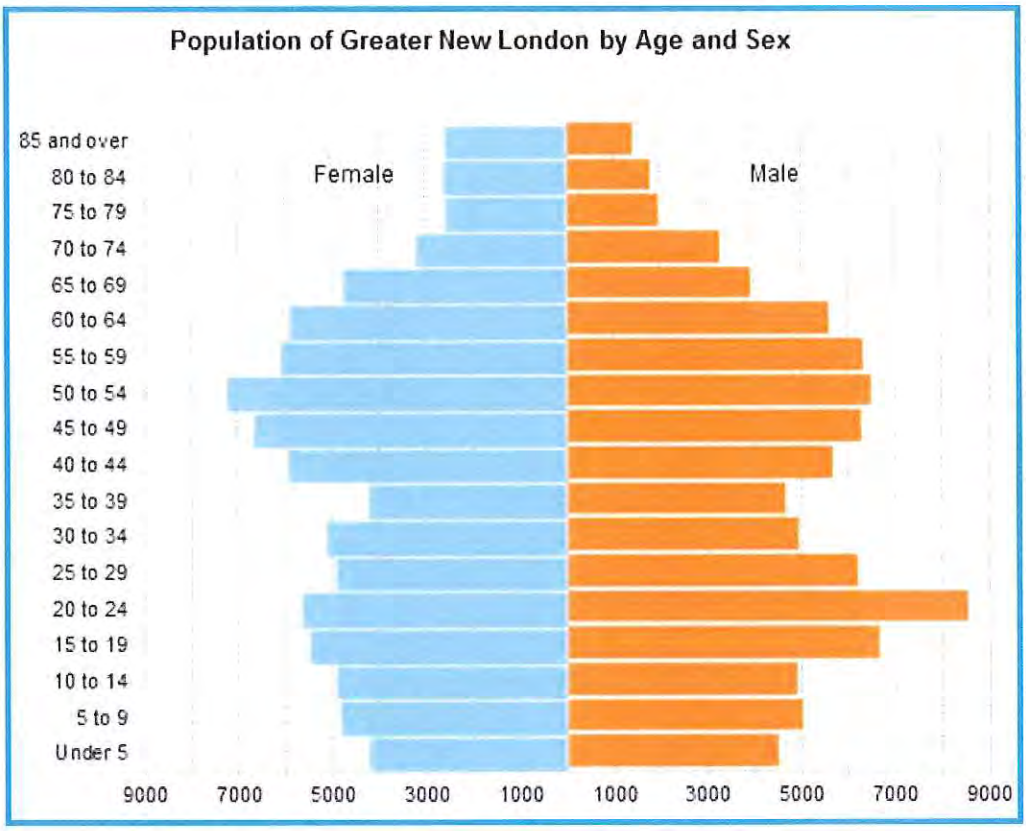
Demographics

The Lawrence + Memorial Hospital service area covers 17 U.S. Census zip code tabulation areas. The information presented in this section reflects the total population of those areas from the American Community Survey.

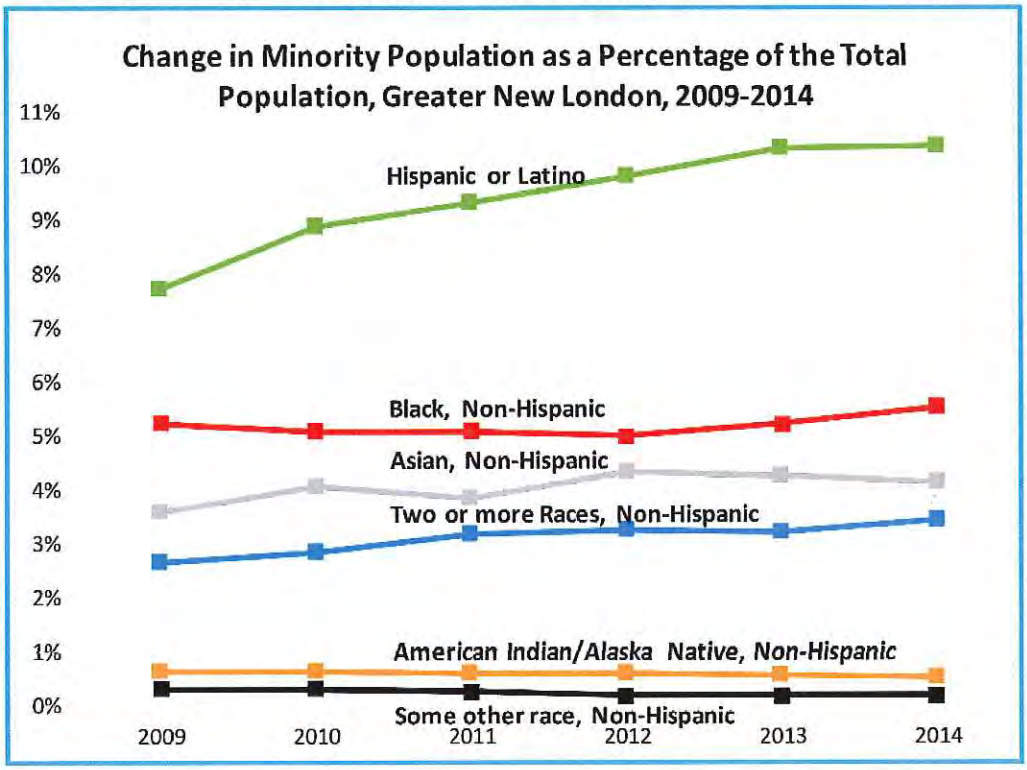
Total Population	174,814
Gender	
Male	50.5%
Female	49.5%
Race/Ethnicity	
White, Non-Hispanic	76.0%
Hispanic or Latino of Any Race	10.4%
Black, Non-Hispanic	5.5%
Asian, Non-Hispanic	4.1%
Two or more Races, Non-Hispanic	3.4%
American Indian/Alaska Native, Non-Hispanic	0.5%
Some Other Race, Non-Hispanic	0.1%
Disability	
Total Population	12.1%
Under 5 Years	1.8%
5 to 17 Years	5.4%
18 to 64 Years	10.0%
65 Years and Over	30.1%

	Languages Other than English Spoken in Greater New London		
	Rank	% of Population who Speak the Language	% Who Speak English Less than "Very Well"
Spanish or Spanish Creole:	1	6.5%	37.9%
Chinese:	2	1.3%	55.5%
Tagalog (Filipino:	3	0.6%	36.5%
French (incl. Patois, Cajun):	4	0.5%	17.4%
Italian:	5	0.4%	23.3%
Other Asian languages:	6	0.4%	19.2%
French Creole:	7	0.3%	83.6%
German:	8	0.3%	16.4%
Hindi:	9	0.3%	40.0%
Russian:	10	0.3%	38.6%

Demographics



According to the 2014 American Community Survey, the population of Greater New London is 174,814, having grown by about 2,500 people in the past 5 years. The population is nearly evenly divided by sex, with 50.5% being male, though the population 65 years and older is made up of more females (55.8%). Of particular importance is the large wave of those in and around the baby boom generation (ages 50-70). As this group continues to age, it will place increasing health, social and economic pressures on families, social service and governmental agencies. Both in absolute terms and as a percentage of the population (24%), the population of non-White minorities has grown in Greater New London over the past 5 years (up from 20% in 2009). This growth has been driven primarily by those identifying as Hispanic or Latino, whose population has grown from 7.7% of the population in 2009 to 10.4% in 2014.



Process

On May 26, 2015, L+M and LLHD organized the first meeting of what would become the Southeastern CT Health Improvement Collaborative (Collaborative). Representatives from a number of community agencies were invited to serve as a steering/advisory committee for L+M and LLHD's assessment. The Collaborative met bimonthly and provided insight and guidance in the design of data collection efforts. In November, Collaborative members joined other community agencies for a facilitated conversation considering the assets and challenges to health in the region. At subsequent Collaborative meetings, members organized focus groups and reviewed preliminary data. LLHD and L+M hosted a preliminary data release in March 2016 and a prioritization event in May 2016.

This assessment includes review and analysis of data from primary and secondary data sources:

The statewide Wellbeing Survey of adults, conducted by DataHaven in the late summer and fall of 2015. A statewide telephone survey of area residents with oversampling conducted in select communities, the survey included 1,200 residents from Greater New London. The survey was delivered in English and Spanish and included both landline and cell phones. The sampling methodology and survey tool are included as Appendix A.

A supplemental survey tool developed in English and Spanish and deployed in community settings including clinic waiting rooms and sporting events. The goal of the supplemental survey was to obtain information from individuals who may not have been represented in the initial telephone survey.

The November key informant/community partner forum with over 30 participants (see distribution list Appendix B). At the forum participants shared their insights on the most important health and wellbeing issues in our region and how to address them.

Qualitative data from 12 focus groups held in early 2016 in order to explore issues of concern revealed in the household survey. These groups included conversations among African Americans, Hispanics, Native Americans, youth, seniors, LGBTQ people, and people living in poverty (see focus group reports in Appendix C).

Secondary data from a wide range of sources, including Centers for Disease Control, the CT Department of Public Health, the U.S. Census, Healthy People 2020, and the CT Hospital Association. A complete list of data sources for this report are listed on page 15.

Community Conversations

Community engagement was a key component of the CHA. The CHA included participation of not only public health experts and health care providers but also representatives, ranging in age from 12 to 87, of medically underserved, low income, minority, and youth populations and an array of community organizations from throughout the region. Their voices were heard through a community partner forum, twelve focus groups including diverse representation, the CHA steering committee, and a web-based survey. Throughout the various engagement activities, several themes emerged.

Connections, Communication, Bias

In general, there is a feeling that there has been a loss of sense of community locally. Community members and partners said that there is a lack of communication, coordination, and understanding of differences, between people and with organizations and systems. Examples of widespread bias along many lines—racial/ethnic, mental health, gender, age, ability, sexual orientation, resulting in discrimination, disparities, and stigma and ultimately negatively impacting access to care and quality of services, were described. Within organizations, there is a need for greater cultural competence to bridge differences. The "we know best" culture, particularly in healthcare, needs to be addressed. Some feel that although there is division within the community overall, communication may be better within a single culture.

> *"A lot of people in this area are invisible."*
> *–faith community focus group participant*

Access

The complexity and fragmentation of the healthcare system impacts access; it's difficult to navigate, with many barriers including finances, health insurance status, literacy, time constraints, and "how it is organized." As a region, there is a need to start thinking collectively and to examine the infrastructure, education and training deficits. It is generally understood that the area doesn't benefit from as many state resources as do the urban centers elsewhere in the state; this calls for standing together and demanding attention and support. Some challenges include an inadequate public and safety net transportation system which has a major influence on access to services including health and social services, lack of access to safe affordable housing, place-based issues including neighborhood challenges, and economic disparities. The region's population is aging and experiencing increased isolation. Focus group participants and community partners expressed concern that technology may create new barriers to access, particularly among older residents.

> *"The high cost of health care is making individuals skimp in ways like splitting pills, deferring care, and foregoing dental care and on necessities like food."*
> *–access to care focus group participant*

Safety

Many focus group participants cited safety concerns including neighborhood issues, family violence, bullying, and sexual abuse. Factors contributing to a decreased sense of safety include drug and alcohol use, poverty, and mental health. Residents expressed concern that children are witnessing drug use and extreme violence. Older residents feel that increased law enforcement in a neighborhood leads to a safer environment, but younger residents noted an overall decrease in feeling safe. Youth expressed worries about early death or injury from violence.

> *"A gun is easier to get than an apple."*
> *–youth focus group participant*

Mental Health

As it relates to mental health, stress and anxiety are cited as having a dramatic impact on the overall health of residents and these concerns are increasing. Community members indicate that greater awareness, education, de-stigmatization, understanding, and coordination of care, to include integration of behavioral health services with medical care. There are excellent resources available in this region but it is felt that they aren't as networked or as culturally competent as they should be. Young people cited the stress of helping their parents provide for their families.

> *"There are so many people in this building who have mental health issues and need services, but they don't know where to go or how to pay for the services. I have friends who are survivors of traumatic domestic violence who need support services, but they don't know who to go to or how to get started. These are parents—with heavy baggage—raising kids in a place no one else in the community cares about. We love each other but know we're a bunch of throwaways, like those misfit toys in that Christmas special."*
> *–public housing focus group participant*

Chronic Disease

Residents have many ideas about contributing factors to chronic disease. They cited lack of access to healthy foods, too many processed foods that are easily obtained, cost of fresh foods, and limited nutritional education, including information on appropriate portion sizes. There are cultural practices that contribute to poor nutrition and which could potentially be improved with education. It is also believed that greater information about available recreational opportunities for all residents would have a positive influence on overall health.

> *"Kids are not moving as much, there isn't as much recess, and all of the technology is keeping them inside."*
> *– community member*

Smoking, air quality, built environment, and lack of trust in the healthcare system were also raised as influences on health.

Focus group and web survey participants were asked about their vision for a healthy community. Ideas cited included integrated community development, readily accessible healthy foods, recreational opportunities available for all regardless of age or ability, and a transportation system that truly meets the community's needs. Despite the challenges acknowledged, there is a sense of optimism that Greater New London has a healthy future.

Thinking ahead about the future of your community, what is your vision related to people's health? What do you think needs to happen to make this vision a reality?

"Full Service Community Center with a state of the art gym, pool, fitness guidance classes all at affordable rates."

"There needs to be innovation in how services are provided and made available to support holistic health."

"Better/more information regarding services available to the underserved."

"Improvement in the diet of the community- e.g. less processed food and more fresh, healthy options."

"Provide low cost care not only with primary doctors, but also for specialists."

"Sustainable public spaces that promote health and wellness."

"Better services for people with disabilities."

"Elder care is an increasing issue, both health services and living spaces."

"More public transportation."

"Middle class benefits - most people making a middle class income are just getting by or not and makes it impossible to qualify for services."

"More inclusion in politics."

"Bicycle paths and sidewalks to walk safely on would be wonderful!"

"More community leaders stepping up and folks buying into the notion of taking care of one another instead of looking out solely for themselves."

"A greater focus on walkability."

"Early intervention with children's needs."

"Less racism."

"Improving mental health and domestic violence prevention are very important to me."

"Better availability of paid maternity leave, preschool, neighborhood childcare."

"Safer and better maintained housing for low income families."

"More and better employment opportunities that pay a living wage."

"More public health, safety out reach groups. There needs to be more youth activities for the children."

Leading Health Indicators

The graphs and information included on the following pages reflect data from several sources:

- The 2015 DataHaven Wellbeing Survey (2015 Wellbeing Survey)
- The American Community Survey (ACS)
- Centers for Disease Control and Prevention (CDC)
- Connecticut Department of Public Health (CT DPH)
- Connecticut Health Foundation
- Connecticut Hospital Association
- Environmental Protection Agency (EPA)
- FBI Uniform Crime Reporting
- Harvard School of Public Health
- Institute for Future Studies
- Lawrence + Memorial Hospital (L+M)
- Ledge Light Health District (LLHD)
- Locally Conducted Focus Groups
- Robert Wood Johnson Foundation
- Southeastern Regional Action Council (SERAC)
- United Way of Southeastern Connecticut (ALICE Report)
- University of Massachusetts
- World Health Organization

The applicable data source is noted on each graph.

As much as possible, where valid data were available from the 2015 Wellbeing Survey, these graphs reflect the primary service area of L+M Hospital, as shown on the map on page 7 and as reflected in the demographics highlighted on pages 8 and 9 and referred to as "Greater New London." In some cases, the graphs reflect data only for the LLHD member municipalities (see map on page 7), while in other cases the graphs reflect New London County or the state of Connecticut. In these instances, the geographic scope of the graph is noted.

Leading Health Indicators

L+M and LLHD identified leading health indicators in eight domains. The indicators selected are limited to those for which there are local data. This report will be updated if additional sources of local incidence or prevalence of disease, illness or injury are identified. It should be noted that there is a significant lack of local population health data on children. Data about childhood asthma, vaccinations and substance use are included; there may be other leading childhood health indicators for which local data are not currently available.

The domains and sub-categories include:

Social Determinants of Health

>Education >Economic Security >Housing >Employment
>Transportation >Public Safety >Social Cohesion

Health Systems and Access to Care

>Public Health and Healthcare Infrastructure >Emergency Department Use
>Health Insurance >Barriers to Care
>Emergency Preparedness

Chronic Disease

>Risk Factors >Diabetes >Cardiovascular Disease
>Chronic Lower Respiratory Disease >Asthma >Cancer
>Oral Health

Infectious Disease

>HIV/AIDS and Hepatitis >Sexually Transmitted Infections
>Vaccine Preventable Diseases >Tickborne Disease >Foodborne Illness

Maternal and Infant Health

>Prenatal Care >Low Birthweight Babies >Births to Teens
>Neonatal Abstinence Syndrome >Infant Mortality

Mental Health and Substance Abuse

>Mental and Emotional Wellbeing >Suicide and Self-Inflicted Injury
>Substance Abuse and Overdose >Substance Abuse among Youth

Injury and Violence

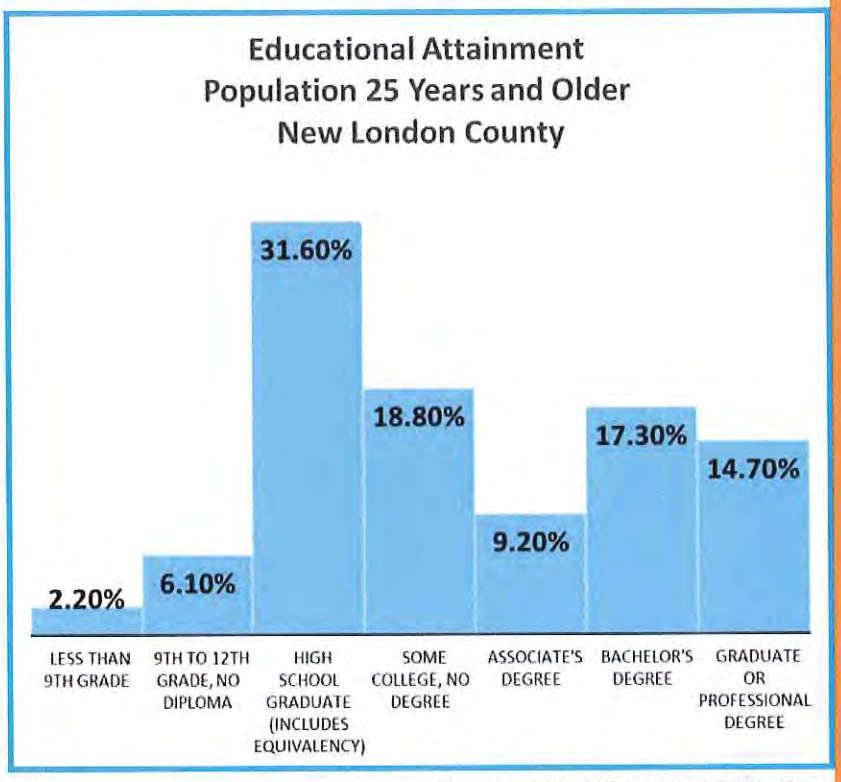
>Violence >Unintentional Injury

Environmental Risk Factors and Health

>Lead >Radon

Social Determinants of Health

Educational attainment is strongly associated with health and wellbeing. People with higher levels of education tend to live longer, healthier lives than those with lower levels of education. Existing research has documented that this association is not due to differences in health literacy or behavior alone, but also influenced by differences in income, housing, social support and childhood poverty and trauma.

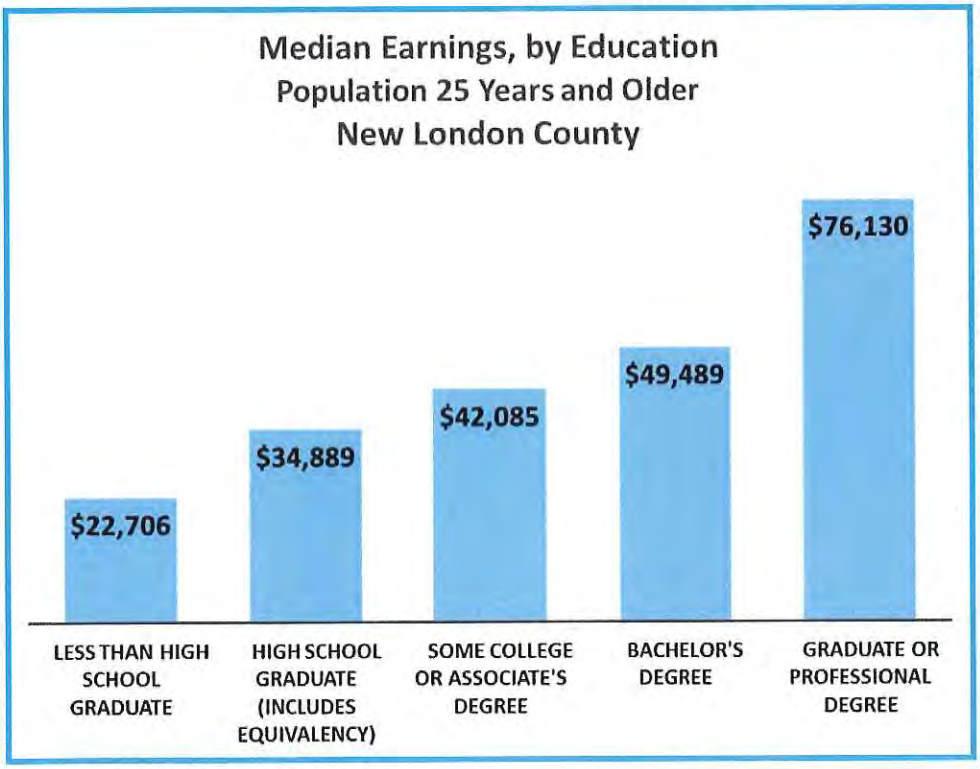


Source: ACS, 2014 5-Year Estimates

Residents of New London County enjoy high levels of educational attainment overall, though rates of adults with bachelor's or graduate degrees lag slightly behind the state (20.6% and 16.4% respectively).

Education

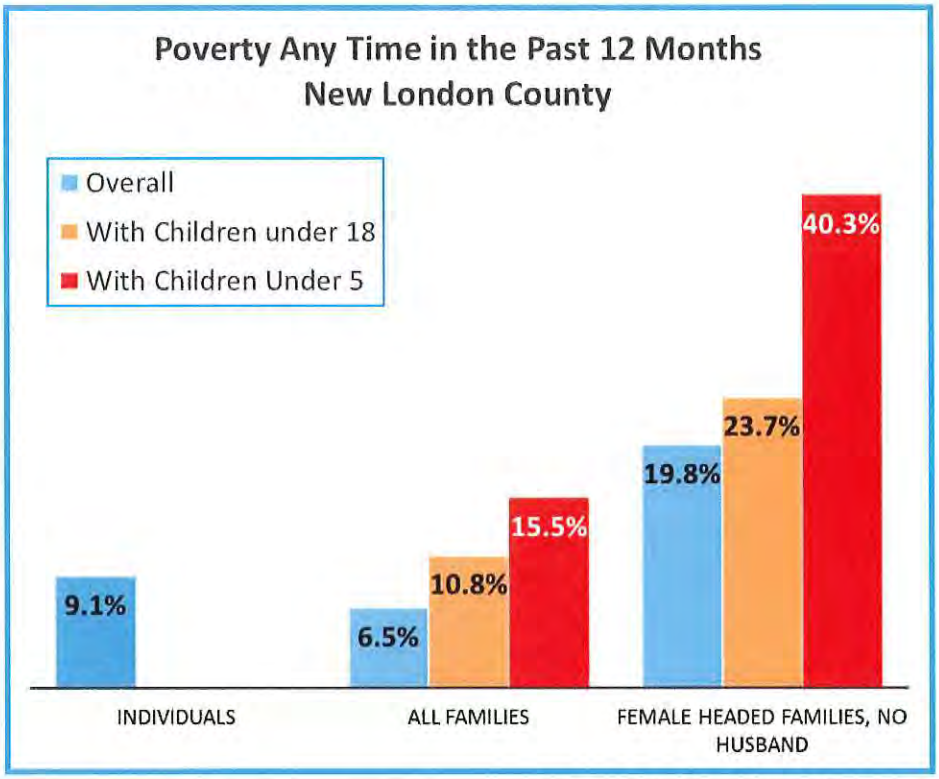
Educational attainment is closely linked with the ability to earn a living, often trapping those with less education in jobs that pay very little. 1 in 4 adults in New London County without a high school diploma live in poverty.



Source: ACS, 2014 5-Year Estimates

Those with the highest levels of education on average earn more than three times as much as those with the least education.

Economic security, or the ability to regularly and comfortably pay for one's basic needs such as food, housing, transportation, and other goods and services, is closely associated with health outcomes. Overall, residents of New London County appear to enjoy high levels of income, with median household earnings of $66,693 (ACS 2014 5-Year Estimates). In addition, fewer residents of New London County experienced poverty in the past 12 months compared to the state (10.5%). Sadly, however, disparities still exist. Families with children, and in particular single-parent families with young children, had much higher rates of poverty.



Source: ACS, 2014 5-Year Estimates

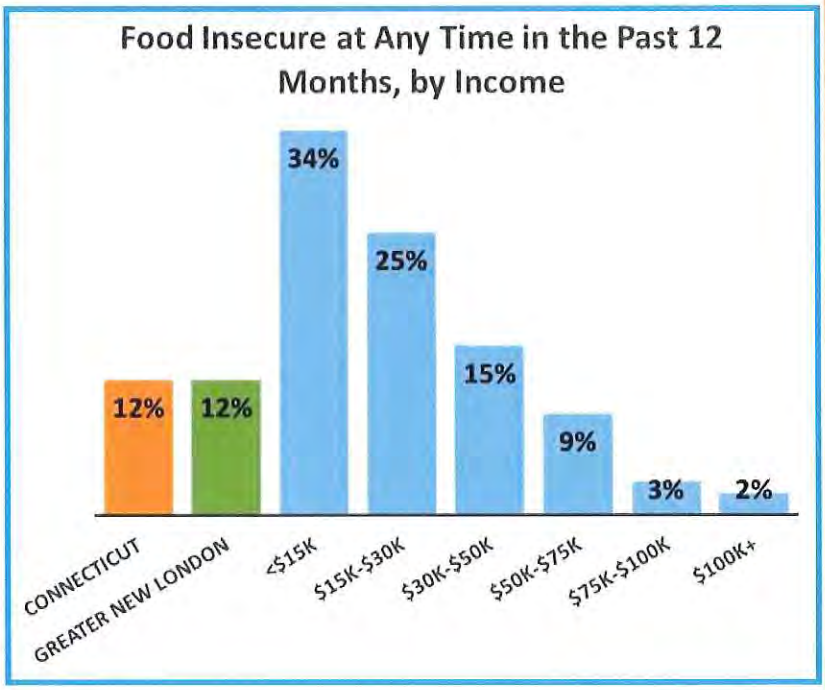
Economic Security

While the median household income for the county appears high, according to the United Way of Southeastern CT (UWSECT), the basic survival budget for a household with young children is approximately $63,000, only slightly below the county's median income level.

According to the United Way of Southeastern CT, 26% of households in New London County are considered asset limited, income constrained, employed (ALICE).

Part of being economically "secure" is achieving a comfortable degree of financial stability and predictability. Many residents of the Greater New London area (46%) reported that if they lost their source of income, they could continue to live as they currently are for at least six months. About 1 in 5 residents, however, are less than one month away from having to make major life changes if their current source of income were to end, suggesting a tenuous or non-existent degree of economic security for a large portion of the population of the region.

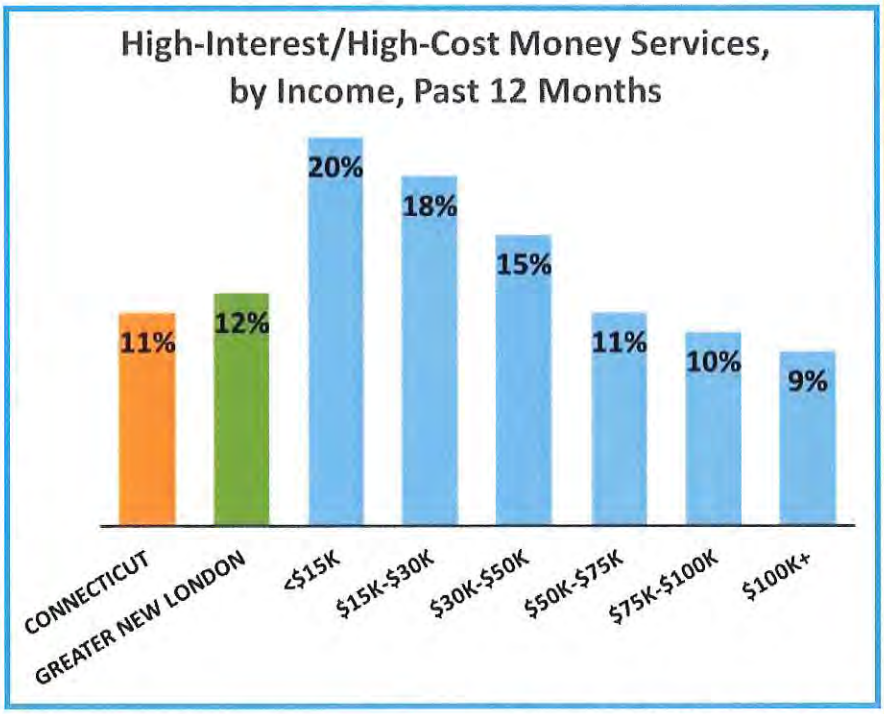
One of the direst consequences of poverty is the inability to afford to buy food. Though comparable to the state overall, food insecurity in the past 12 months still rose to levels that should be considered unacceptable, especially among those earning less than $30,000 per year. That there appear to be co-occurring epidemics of food insecurity and obesity, especially among low income populations, speaks to the nutritional density of affordable food, and suggests the very real need to address the food system in the region.



Source: 2015 Wellbeing Survey

Economic Security

Though only about 1 in 8 adults overall used them in the past 12 months, high interest, high cost money services such as check cashing, money orders, and refund anticipation loans exact an economic cost on people of low income far more frequently. Contributing to what is often referred to as the "poverty tax" because they are used by those who can least afford them, these services are needed more often by people of low income in order to pay regular bills, service debt, and purchase basic necessities like food. While 92% of adults overall in the Greater New London region held a bank account in the past 12 months, only 68% of those earning less than $15K held one, increasing the need among this group to access alternative services. Though filling a need, these high-cost money services also exacerbate the economic struggles of those living in poverty.



Source: 2015 Wellbeing Survey

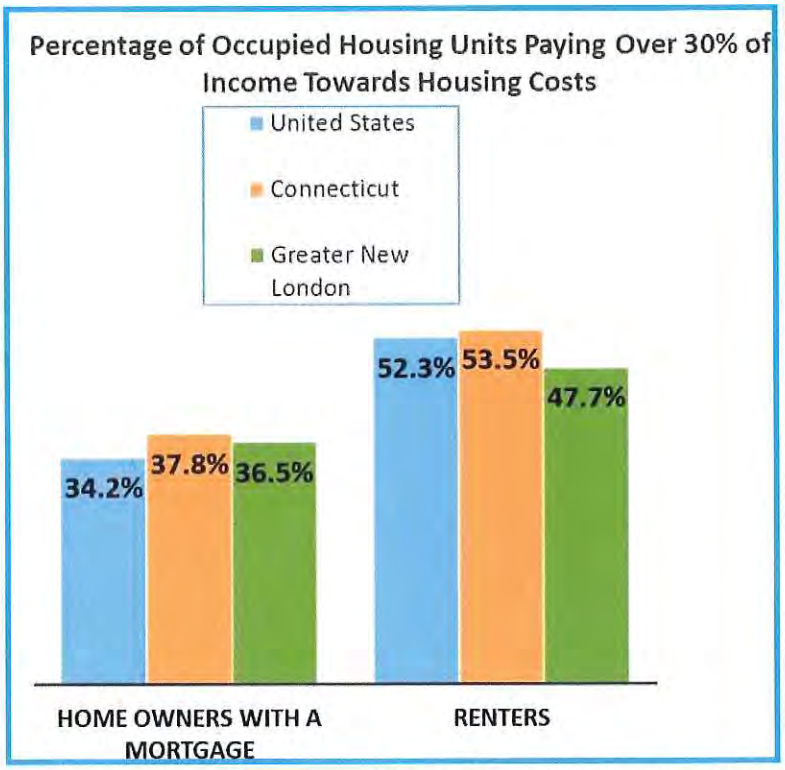
According to the Robert Wood Johnson Foundation May 2011 brief on housing and health, good health depends on having safe, clean, affordable homes. Housing stability contributes to healthy neighborhoods and a sense of community. "Poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases, injuries and poor childhood development." Substandard housing typically presents many triggers to asthma including mold, rodents, cockroaches, dust, and poor air quality in general, and is often located near major roadways with associated increased air pollution.

Source: Robert Wood Johnson Foundation

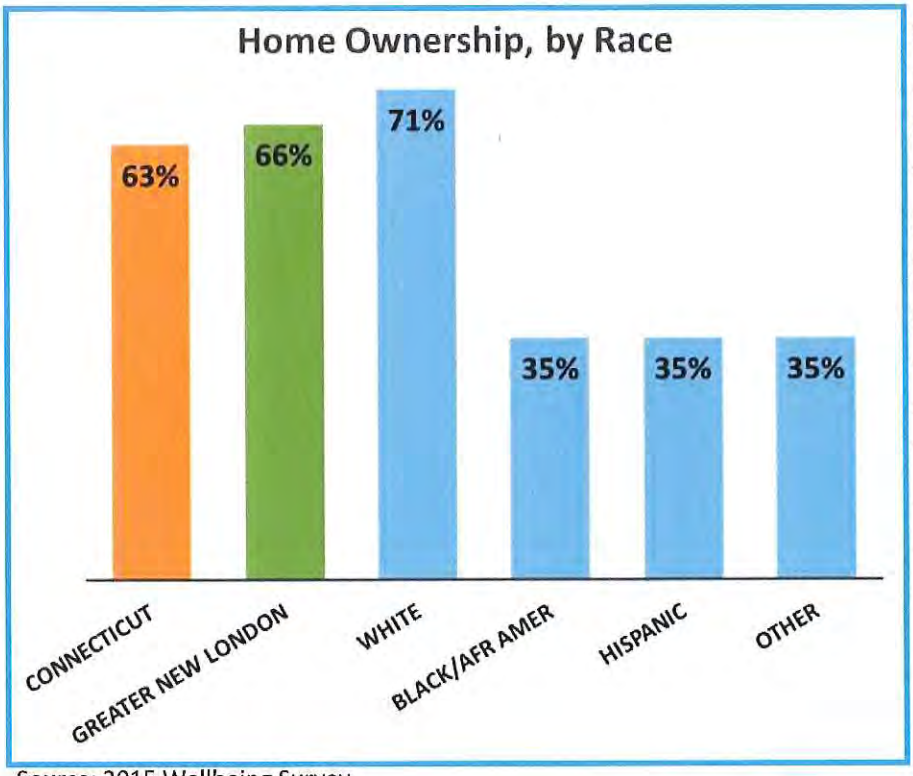
Housing

Nearly 60% of all housing units in Greater New London were built before 1960 (ACS 5-Year Estimates). Older housing stock is more likely to harbor health hazards such as defective lead paint, failing plumbing, and asbestos insulation.

Particular health problems associated with poor housing conditions include respiratory infections, asthma and other chronic diseases, lead poisoning, injuries, impaired child development, and poor mental health. Though on par with or slightly better than the country and the state, home ownership and rental costs as a percentage of income are still unacceptably high in the Greater New London area. When residents spend over 30% of their income on housing alone, some struggle to pay for other necessities such as food, transportation, healthcare, and child care. This burden is felt most acutely by low income residents.



Source: ACS, 2014 5-Year Estimates

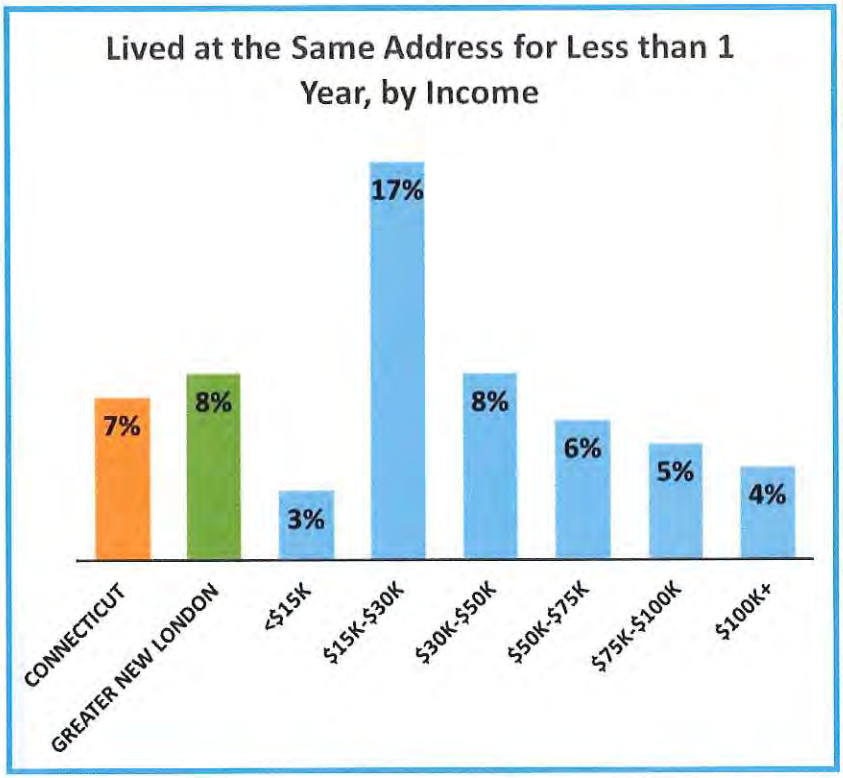


Source: 2015 Wellbeing Survey

66% of residents in Greater New London own their home, slightly better than the state overall. Significant racial disparities exist, with the frequency of home ownership twice as high among Whites in the area compared to all other races. While much of this disparity can be attributed to the concentration of wealth among Whites, it remains possible that discrimination in the real estate and financing markets exist that make it more difficult for racial minorities to purchase a home.

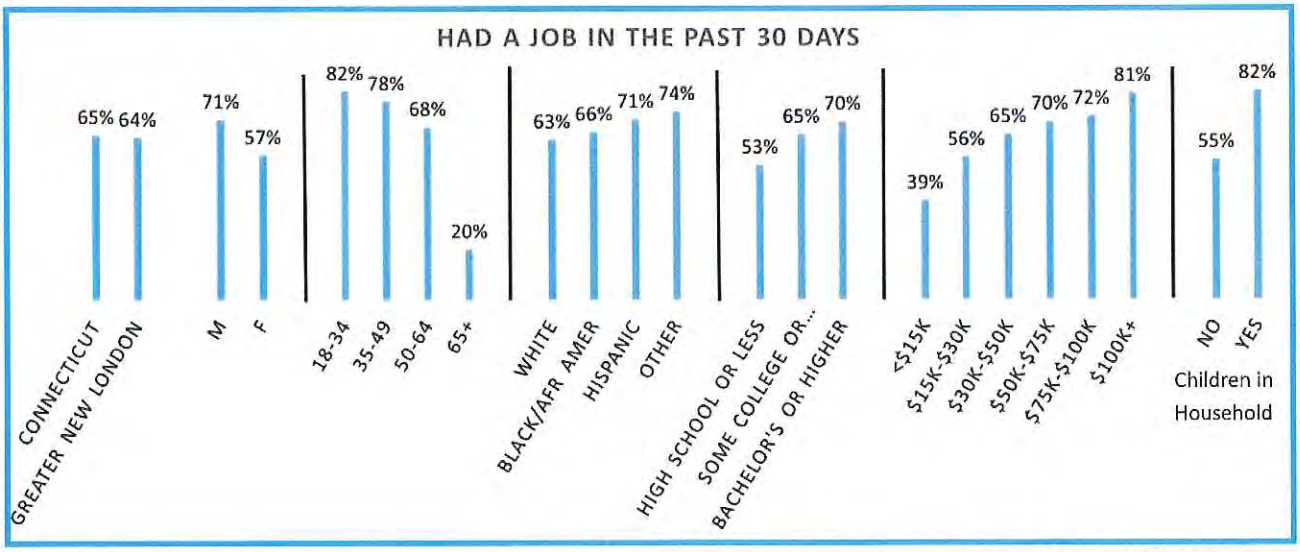
Housing

Housing stability is fairly strong in the region, with only 1 in 12 residents in the Greater New London area having lived in their home for less than one year (about the same as the state overall). With the exception of those earning less than $15,000 per year—who enjoy the highest level of housing stability (likely due to high levels of occupancy in subsidized housing), as income decreases, so does housing stability. About 1 in 6 people earning between $15,000 - $30,000 have lived in their current home less than one year—twice the overall rate.



Source: 2015 Wellbeing Survey

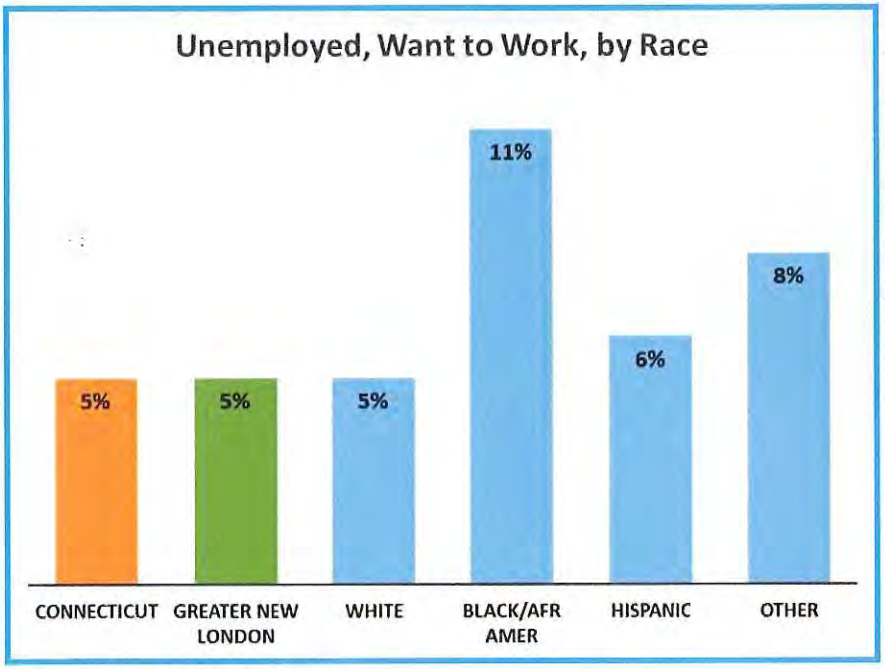
Having a steady job with good wages impacts health in a number of ways and provides more than just income. Employment often comes with benefits such as healthcare, retirement benefits, and support and paid time off to accommodate family needs. On the opposite end, losing a job or being unable to find work is associated with a number of negative health consequences including stroke, heart attack, heart disease, and arthritis (Robert Wood Johnson Foundation). While the overall employment rate for Greater New London is on par with the state's, the picture is much different for certain segments of the population.



Source: 2015 Wellbeing Survey

Employment

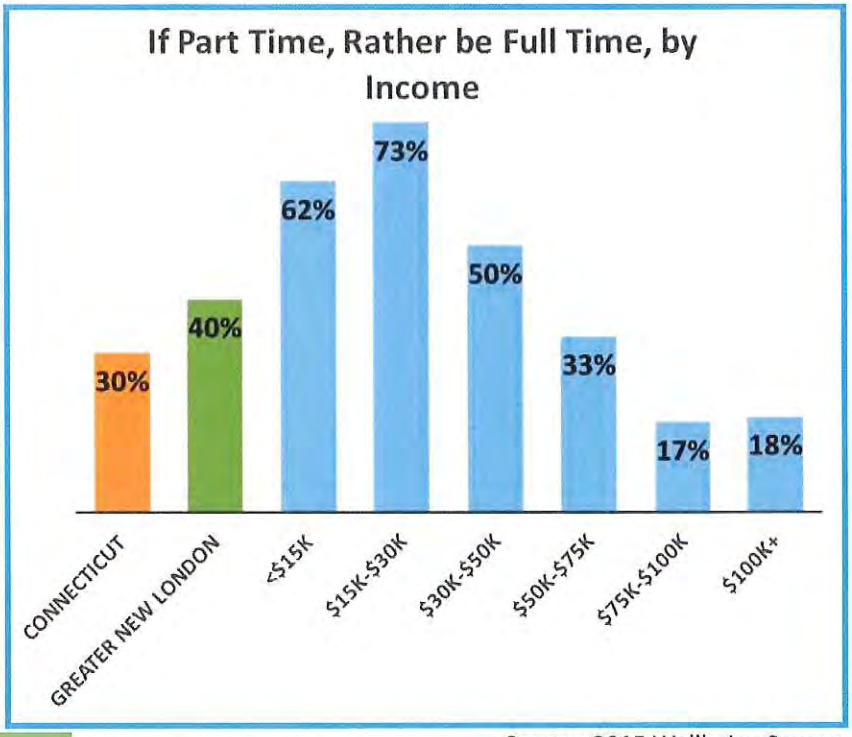
"Real unemployment" is the term used to reference the portion of the population who are unemployed but would like to be working. The real unemployment rate in Greater New London is the same as the state overall (5%) but racial disparities exist in our community.



Source: 2015 Wellbeing Survey

The real unemployment rate among Blacks is more than twice that of Whites. (Wellbeing Survey)

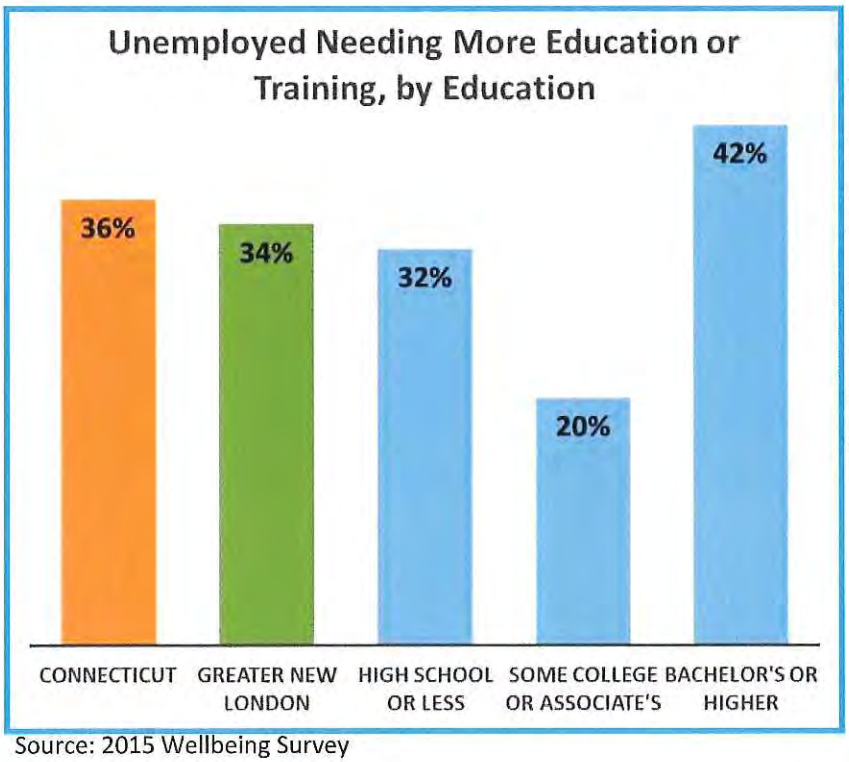
Overall, 69% of residents of the Greater New London area who are employed are full time, compared to 77% in the state. Of those who are part time, 40% would rather be full time, compared to 30% in the state. Both are troubling statistics that suggest the availability of full time jobs in the area is far from being robust enough to meet the needs of residents.



Source: 2015 Wellbeing Survey

Employment

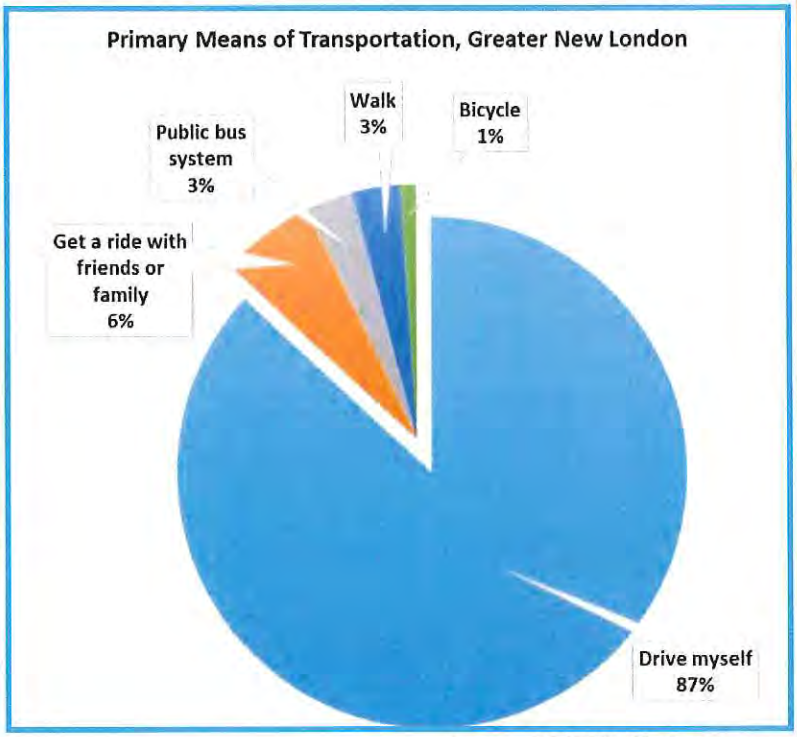
In the Greater New London area, only 1 in 3 residents rated the ability of people to get suitable employment as good or excellent, highlighting the perception among residents, even among some who are employed, that good jobs in the area are hard to come by. (Wellbeing Survey)



Source: 2015 Wellbeing Survey

For those who are unemployed, 1 in 3 say they need additional education or training, about the same as the state overall. Interestingly, the group that more frequently said they required more education or training to get a job were those who already had a bachelor's degree or higher.

Transportation impacts health both directly and indirectly. Injuries and fatalities from traffic accidents affect the health of a community, and pollution from the burning of petroleum products for fuel exacerbates chronic lung diseases. Additionally, transportation infrastructure often cuts off low income neighborhoods from the rest of their communities, isolating groups of people and making it difficult to access the goods and services necessary to live healthy lives.

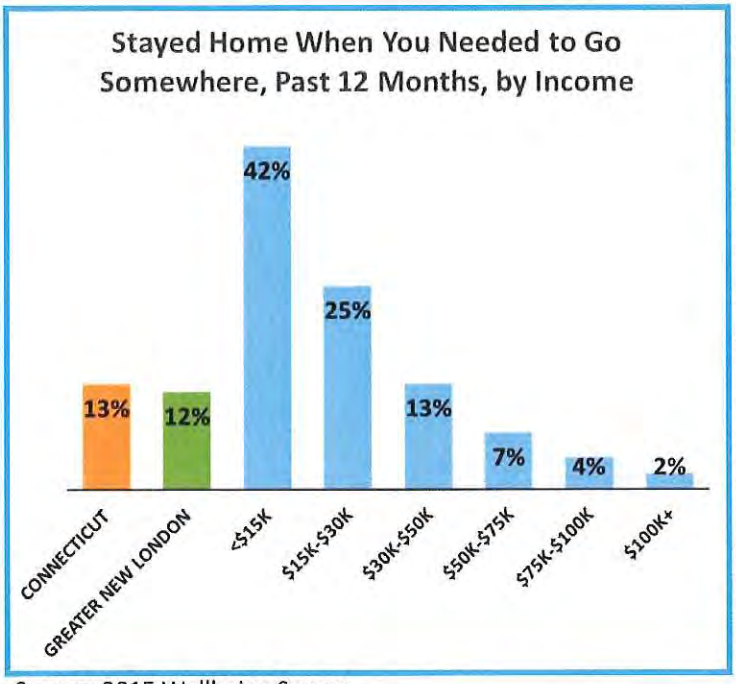


Source: 2015 Wellbeing Survey

Transportation

Focus group and web survey participants repeatedly cited the need for more and better public transportation, bike lanes and pedestrian-friendly roads when asked about their vision of a healthy community.

The vast majority of residents, almost 9 in 10, drive themselves as their primary means of transportation. But only about half of those earning the least, under $15,000 per year, drive themselves, with 1 in 5 reporting never or almost never having access to a car. 1 in 4 people of low income report using buses as their primary means of transportation. 2 in 5 residents earning less than $15,000 per year reported having to stay home when they needed to go somewhere in the past 12 months, nearly 4 times the rate of the Greater New London area and the state overall. Even those earning slightly more, between $15K-$30K per year, reported having to stay home at nearly twice the rate compared to the region and state.



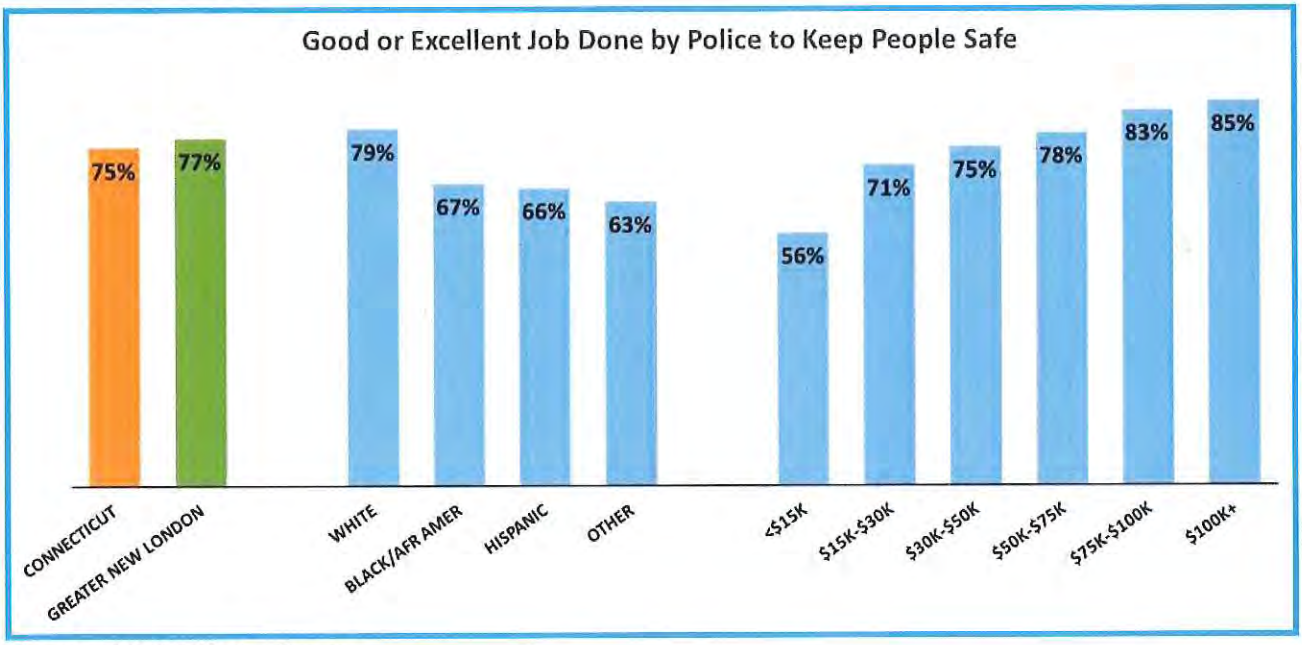
Source: 2015 Wellbeing Survey

Having safe neighborhoods encourages residents to participate in a number of healthy activities, including socializing with neighbors, engaging in outdoor physical activity, and frequenting local businesses. On the flip side, when public safety is poor, residents are less likely to be outdoors in general or participate in other healthy activities. In addition, living in an unsafe neighborhood can contribute to the development of stress-related health conditions.

The total index crime rate for New London County in 2014 was 1,833.6 per 100,000 persons, slightly lower than the state rate overall. The leading crime reported, accounting for about 68% of all offenses, was larceny, or the theft of personal property. While the index crime rate has declined over the last 5 years in the county, the rate of larcenies has remained stable. Some in local law enforcement suggest that this could be related to the actions of residents struggling with addiction to heroin and other opiates who engage in theft, often from friends or family, in order to pay for drugs to feed their addictions.

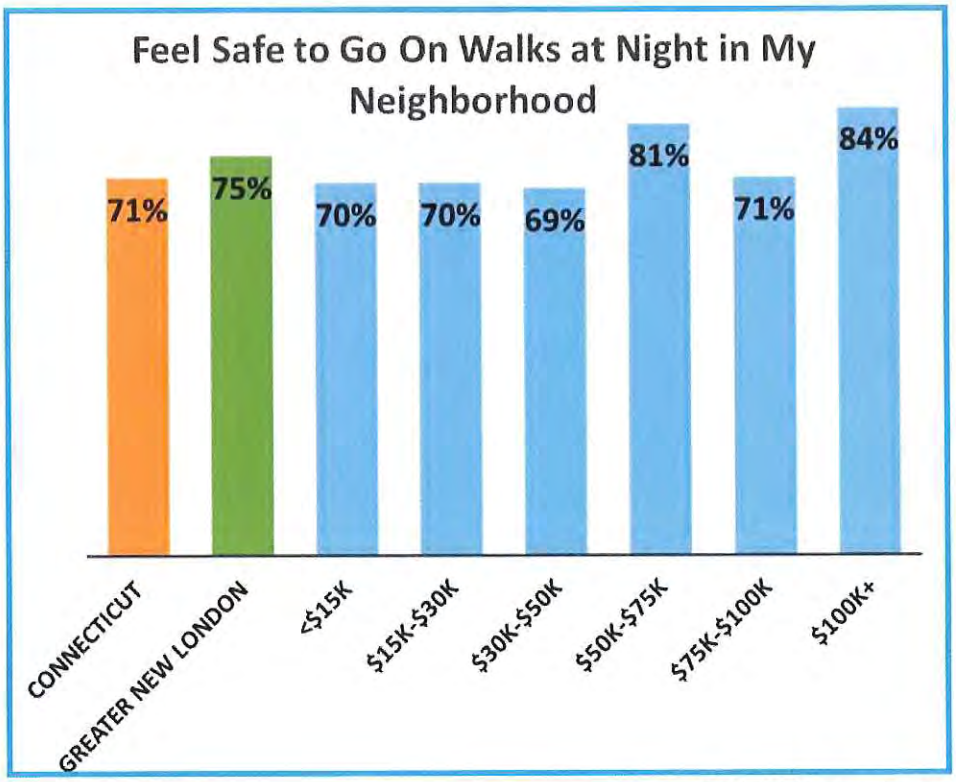
Public Safety

In general, people in the Greater New London area feel that the police are doing a good or excellent job keeping residents safe. However, that perception is less favorable among racial minorities and people with lower incomes.



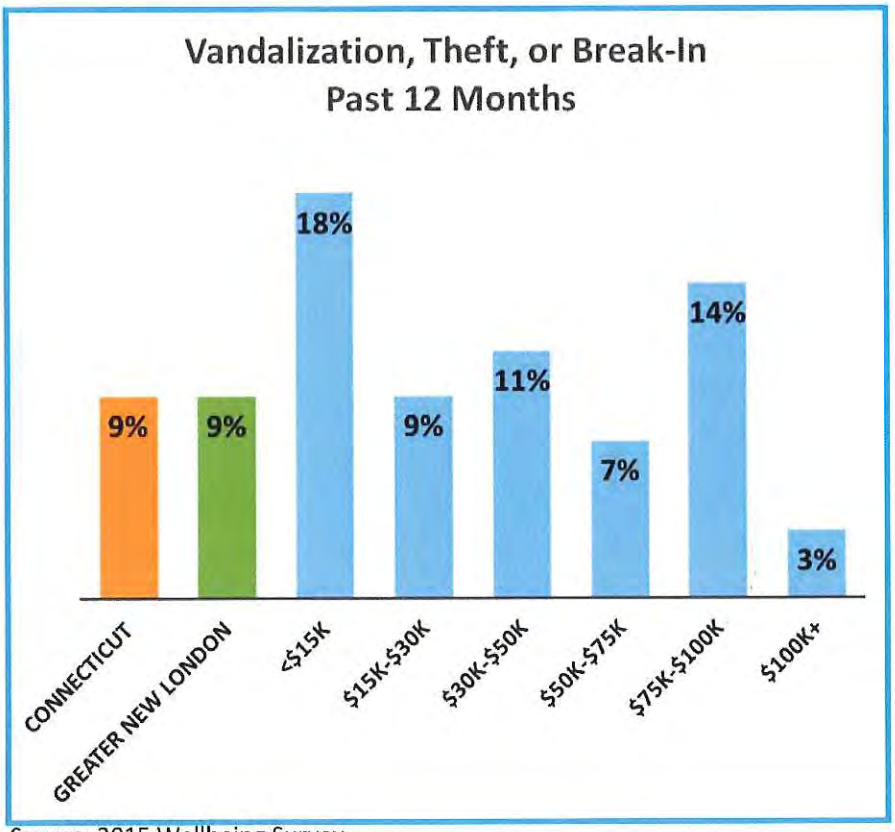
Source: 2015 Wellbeing Survey

75% of all residents in Greater New London reported feeling safe to go on walks in their neighborhood at night, slightly better than the state overall. Hispanics, however, were far less likely to report feeling safe. Disparities also exist between income groups.



Source: 2015 Wellbeing Survey

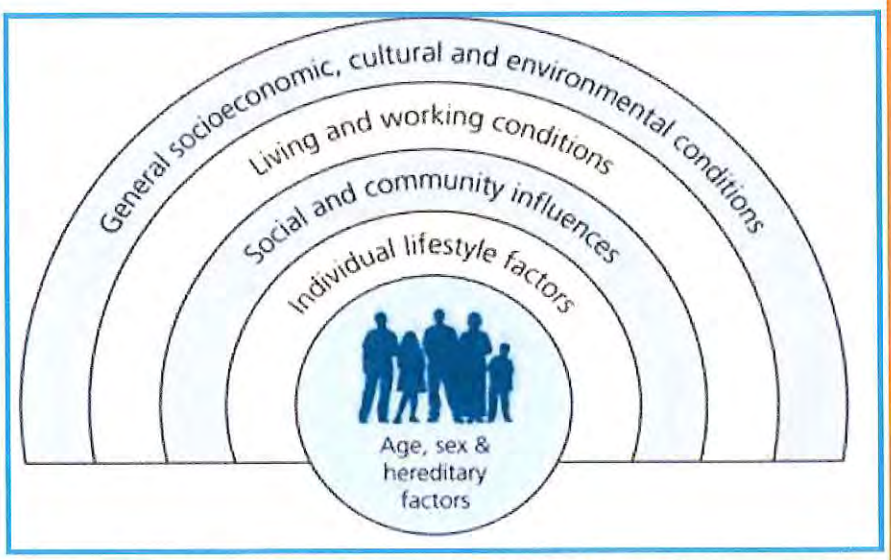
Public Safety



While the overall rate of experiencing vandalization, theft or break-in in the past 12 months for Greater New London is equal to the state, significant disparities exist between income groups.

Source: 2015 Wellbeing Survey

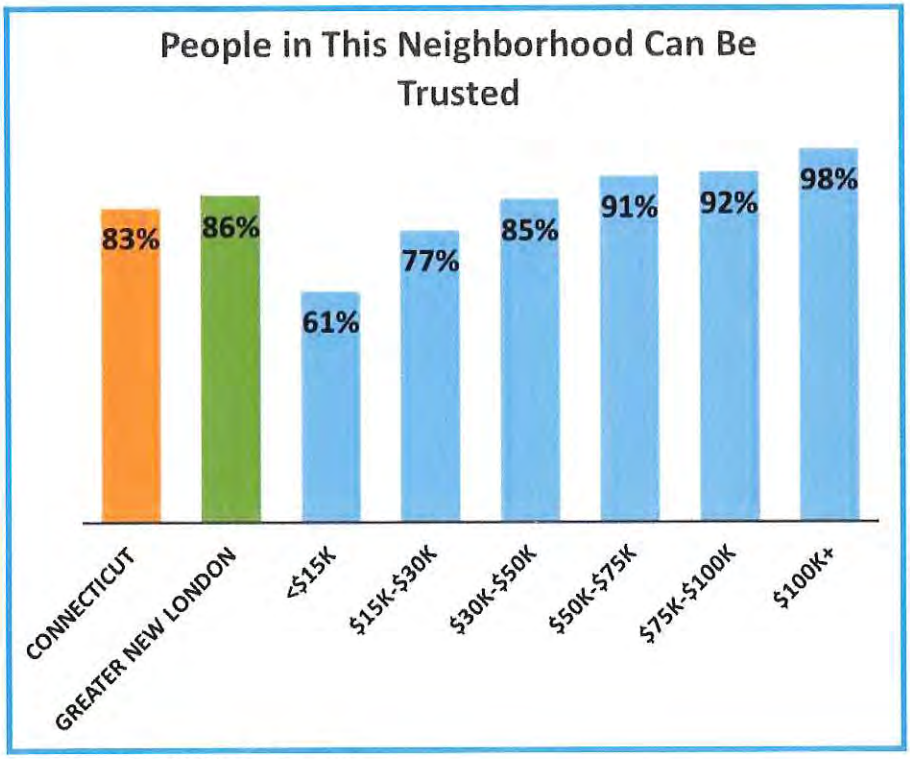
Having a strong social support system and feeling connected to a community can be a protective factor for both physical and mental health. Dahlgren and Whitehead's Social Model of Health and others hold social and community influences above individual lifestyle factors and genetics. Overall, most residents of Greater New London report they have friends or relatives they can count on for help, although the rates among Hispanics (89%) and those making less than $15k per year (77%) were lower than among other groups.



Source: Dahlgren G, Whitehead M. 1991. Institute for Futures Studies.

Among survey respondents, there was a direct relationship between income and identifying positive role models for children in town, with only 63% of those in the lowest income bracket responding that there are role models compared with 84% of those in the highest bracket. (Wellbeing Survey)

Social Cohesion



Substantially fewer people in the lowest income bracket reported that they trusted people in their neighborhood; this may be related to the higher rate of experiencing vandalization, theft or break-in in the past 12 months among this same group.

Source: 2015 Wellbeing Survey

Health Systems and Access to Care

Public Health and Healthcare Infrastructure

In CT, local public health departments differ significantly in size and structure. LLHD is a health district as defined in Connecticut General Statutes; the organization has a full time Director of Health and serves as the health department for the Town of East Lyme, the Town and City of Groton, the Town of Ledyard, the City of New London and the Town of Waterford. LLHD's counterpart to the north is Uncas Health District, which counts Montville—part of the L+M primary service area and thus this report, as one of its 9 member municipalities. The other towns included in this report—Lyme, North Stonington, Old Lyme, and Stonington, have what is referred to as "part time" health departments. These stand alone health departments are incorporated into the municipal structure and, while they may have one or more full-time employees, have a part time Director of Health. In addition, the Mashuntucket Pequot and Mohegan Tribal Nations, which border the towns in the L+M service area, have their own health departments.

L+M Hospital, founded in 1912, is a 280 bed not-for-profit community hospital located in the city of New London, CT. The hospital served a total of 464,834 people in fiscal year 2015. 66.4% had government-sponsored insurance such as Medicaid, Medicare or Tricare while another 5,578 of those patients treated reported to be self-pay/uninsured. The hospital currently offers a wide range of inpatient, outpatient, and clinical services onsite, and gives back millions of dollars worth of community benefits services each year. In addition to providing outpatient and acute care services through L+M Hospital, the L+M Healthcare system includes primary and specialty care services delivered through the L+M Medical Group, the L+M Cancer Center, the Visiting Nurse Association of Southeastern Connecticut, and Westerly Hospital in southwestern Rhode Island.

A community's public health infrastructure or system includes "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction" (CDC). As the community hospital and one of the local health departments, L+M and LLHD constitute significant parts of the public health infrastructure in Greater New London, but the list of organizations and individuals who make up the whole is endless.

The area is served by three Federally Qualified Health Center locations—United Community and Family Services and the Groton and New London sites of Community Health Center, Inc. Both organizations provide primary and specialty care, including oral and mental health care, on a sliding fee scale to those without insurance. Together, they serve as the primary source of medical care for many of the area's Medicaid beneficiaries.

Child and Family Agency of Southeastern Connecticut joins United Community and Family Services and Community Health Center, Inc. in providing both primary and mental healthcare to children at area schools through School Based Health Centers. These clinicians work hand in hand with school nurses and primary care providers to support the health and wellbeing of area school children.

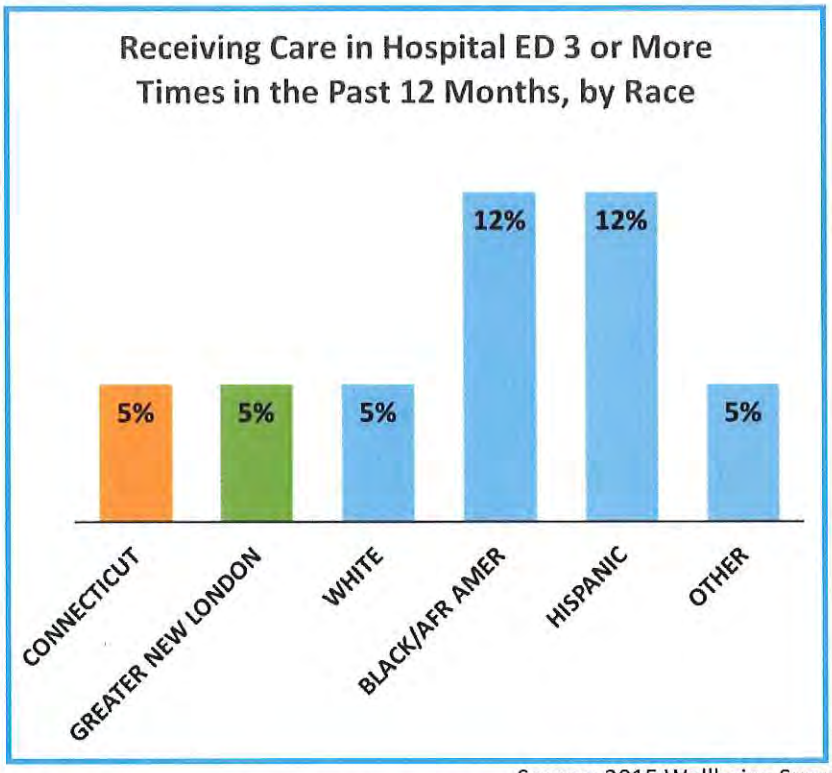
These public health and medical professionals are joined by countless social service agencies, schools, municipal departments, economic development organizations and advocacy and support groups who deliver services and support that impact health.

Public Health and Healthcare Infrastructure

Stakeholders in the Local Public Health and Healthcare Infrastructure

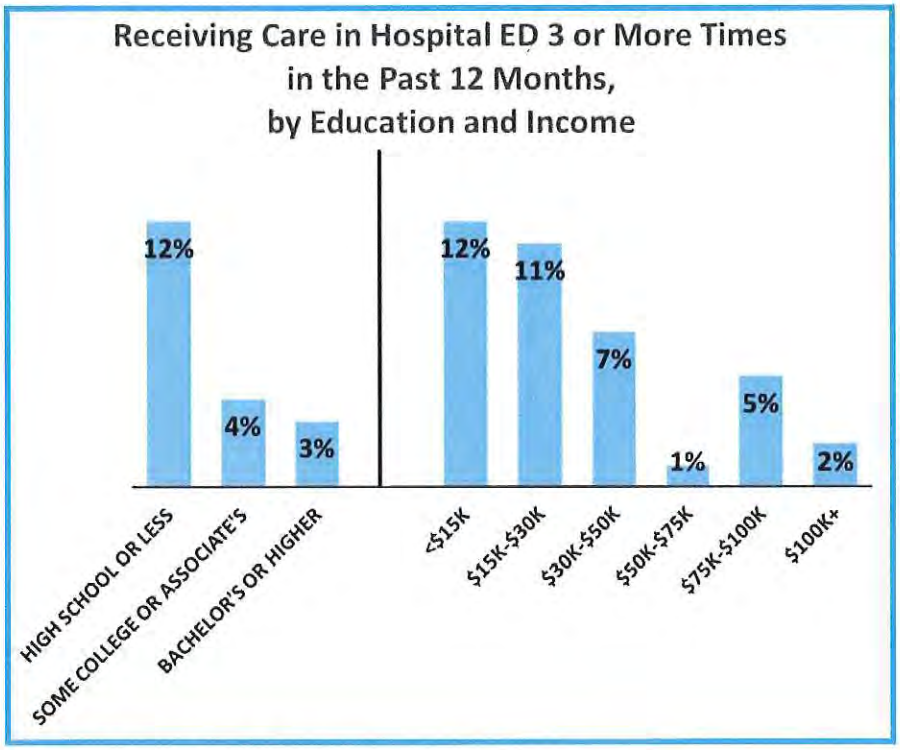
Emergency Department Use

Emergency Department (ED) utilization has increased dramatically in the last decade, resulting in longer wait times and a higher cost of care. Frequently these visits are for routine healthcare that would be better addressed within a community, primary care setting. Insurance status is associated with patterns of ED use and the most often cited reason for the ED visit is seriousness of medical issue, according to the National Health Statistics Report (Feb 2016). National studies have demonstrated that people living in poverty and non-Hispanic Black and Hispanics are more likely to visit an ED more than once during a year. That disparity is evident locally, where Black and Hispanic residents are more than twice as likely as Whites to have received care in the ED 3 or more times in the past 12 months.



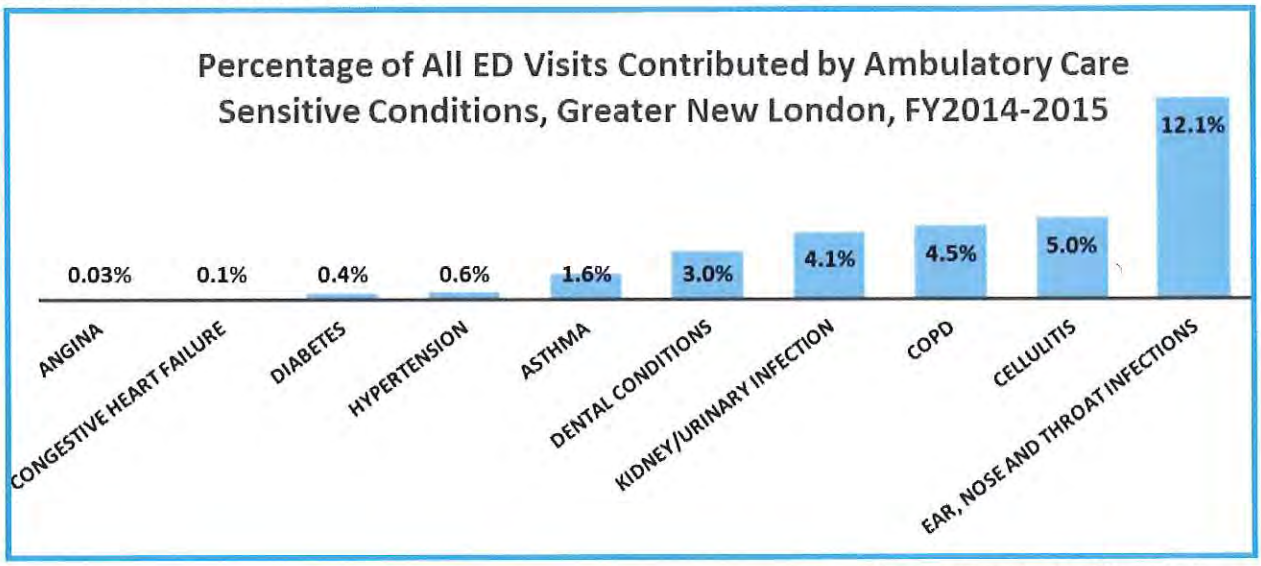
Source: 2015 Wellbeing Survey

ED utilization is also closely linked to insurance status with Medicaid beneficiaries the most likely to have multiple ED visits. In Greater New London, frequent use of the ED decreases as education and income increase.



Source: 2015 Wellbeing Survey

At times residents access care through the emergency department for conditions that would be better addressed in another setting. In 2015, 31.5% of all ED visits by residents of Greater New London were for ambulatory care sensitive conditions—health concerns that require care but are typically not emergency situations.

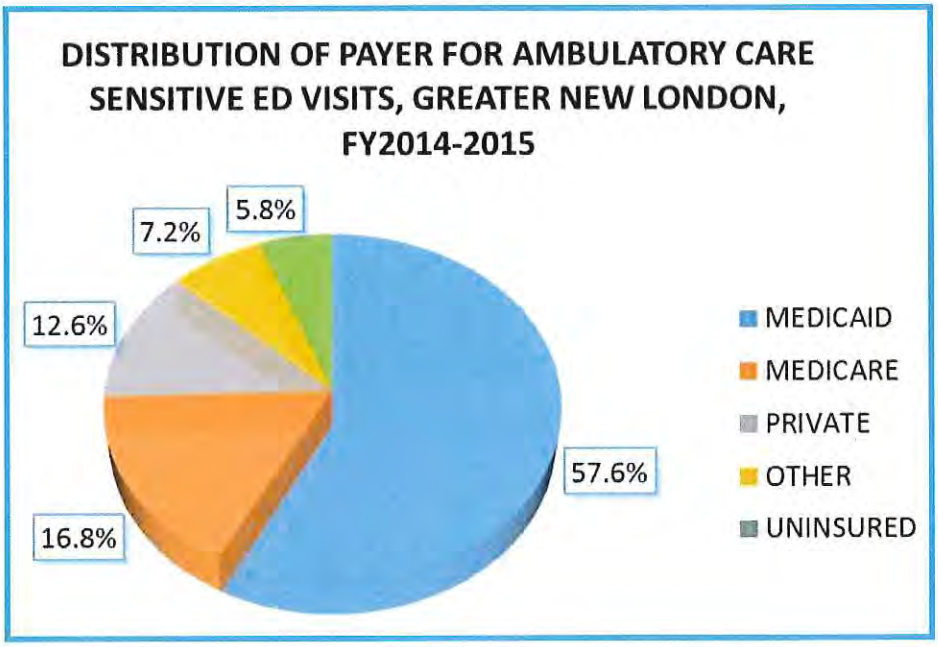


Source: Connecticut Hospital Association

Emergency Department Use

Ear, nose and throat infections ranked as the most frequent ambulatory care sensitive condition, followed by cellulitis, COPD and kidney/urinary infection.

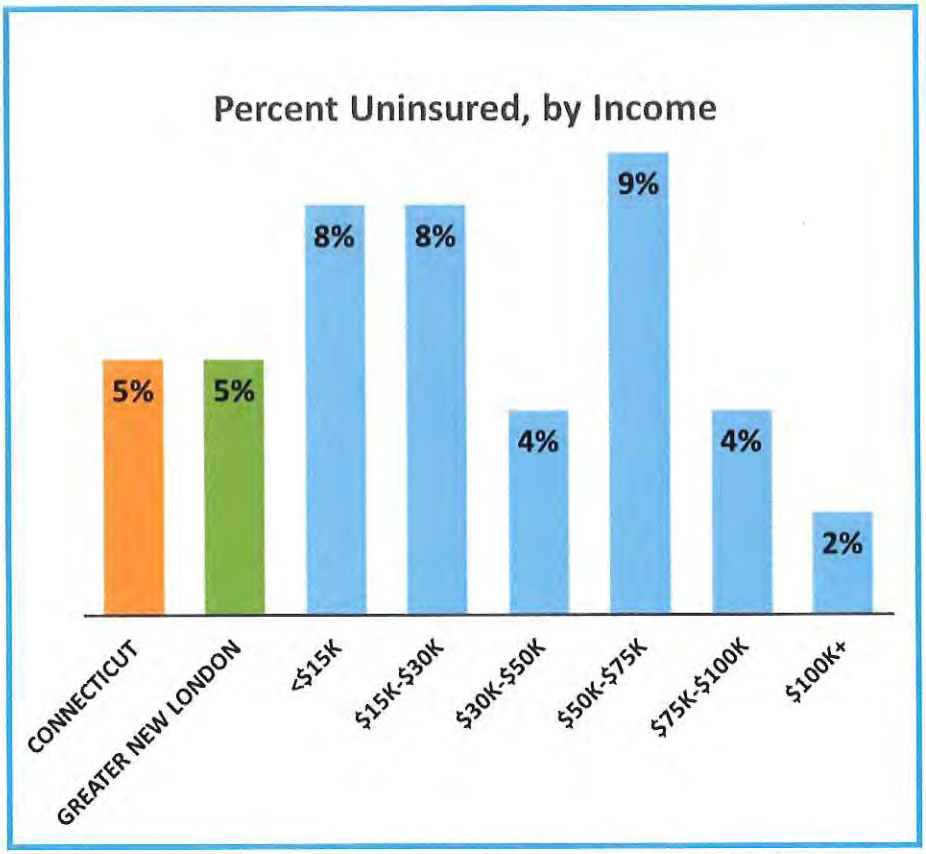
While some of these visits occurred during the overnight and early morning hours, 55.7% of them were between 8am and 5pm, when care is typically available in a provider's office. The association between insurance status and ED use is evident in the data regarding ambulatory care sensitive conditions as well; 57.6% of these visits were among Medicaid beneficiaries. The fact that so many visits occur during daytime hours and are among this group could be indicative of local Medicaid beneficiaries having difficulties accessing primary care services.



Source: Connecticut Hospital Association

Health Insurance

Having health insurance is one important part of accessing quality healthcare. In the fall of 2015, following the implementation of the Affordable Care Act but before the first tax penalties for lack of insurance were assessed, 5% of residents in Greater New London reported being uninsured.



Source: 2015 Wellbeing Survey

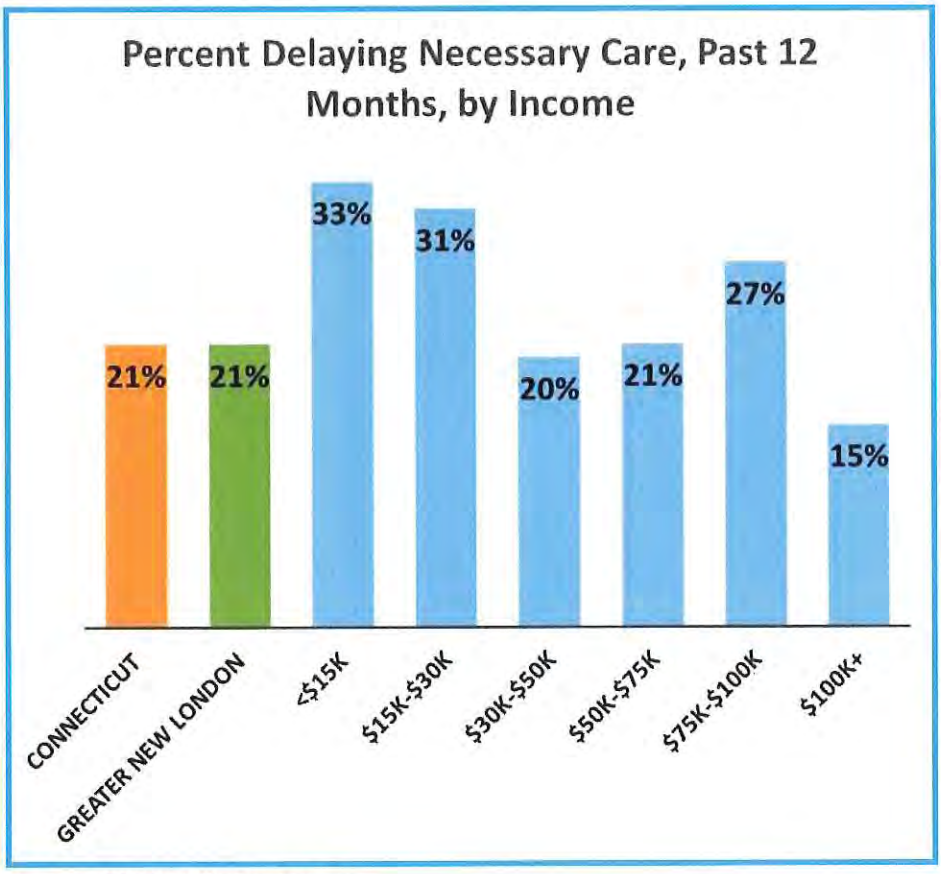
That rate was higher among those making under $30,000 per year and among those making $50,000-$75,000. Residents in lower income brackets are less likely to have access to employer-sponsored plans but may make too much to qualify for Medicaid coverage.

In 2016, approximately 8,700 parents across the state will lose Medicaid eligibility; a University of Massachusetts study estimated that out-of-pocket costs for these residents, who make 138-155% of the federal poverty level, will increase by $1,200 a year (Connecticut Health Foundation).

This disparity may, unfortunately, increase in coming years as recent changes to the income caps for Medicaid qualification in Connecticut are rolled out. In 2015, one group of parents lost Medicaid eligibility and in 2016, a second, larger group will lose Medicaid when their transitional benefits expire. The CT Department of Social Services has reported that of those who did not continue to be eligible for Medicaid, only 27% enrolled in a qualified health plan through Access Health CT; 44% of those who did enroll experienced a gap in coverage (Connecticut Health Foundation).

Possessing health insurance does not guarantee access to healthcare. There remain numerous barriers to care which result in individuals not getting the healthcare that they need, postponing necessary care, or needing to sacrifice other basic needs in order to get care. Barriers to care are more pronounced among those in the lower income categories, are associated with insurance status, cost of care, and availability of care at convenient times, and can be insurmountable. Access to medical specialists (orthopedics, gastroenterology, dermatology and others) for lower income and publicly insured individuals is particularly limited locally. Medical provider cultural competence also impacts access to care for people for whom language, literacy, sexual orientation, gender identity, and/or personal history (past trauma, domestic violence, previous negative experiences with medical providers, etc.) are factors. Impaired access often results in delayed care leading to an exacerbation of chronic conditions, increased ED use and hospitalizations, and premature mortality.

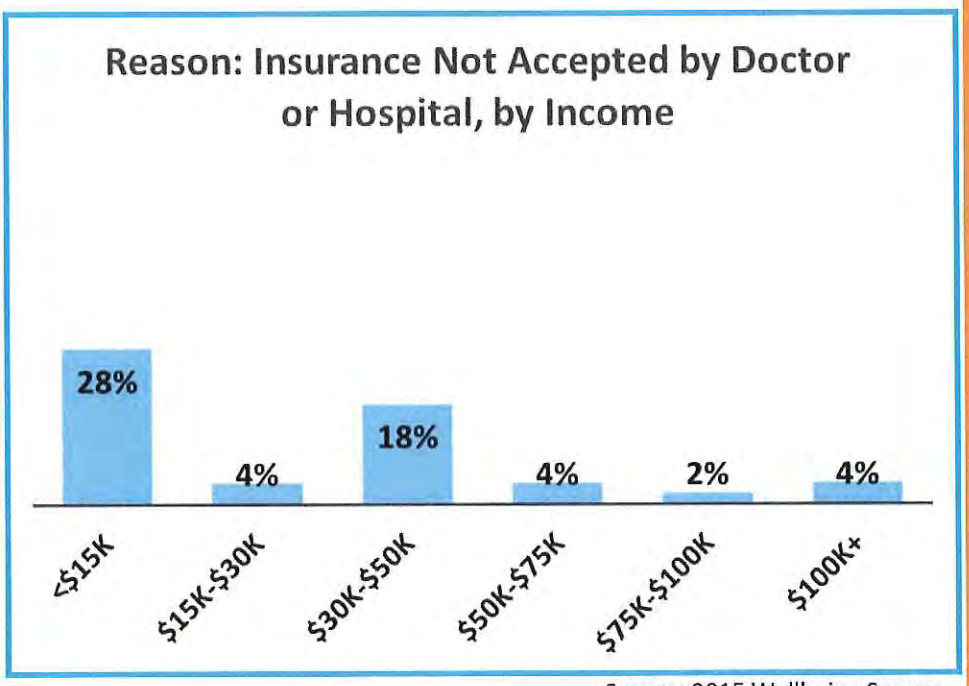
Barriers to Care



According to the 2015 Wellbeing Survey, one-third of respondents with incomes below $15,000 indicated that in the last 12 months they delayed receiving necessary care.

Source: 2015 Wellbeing Survey

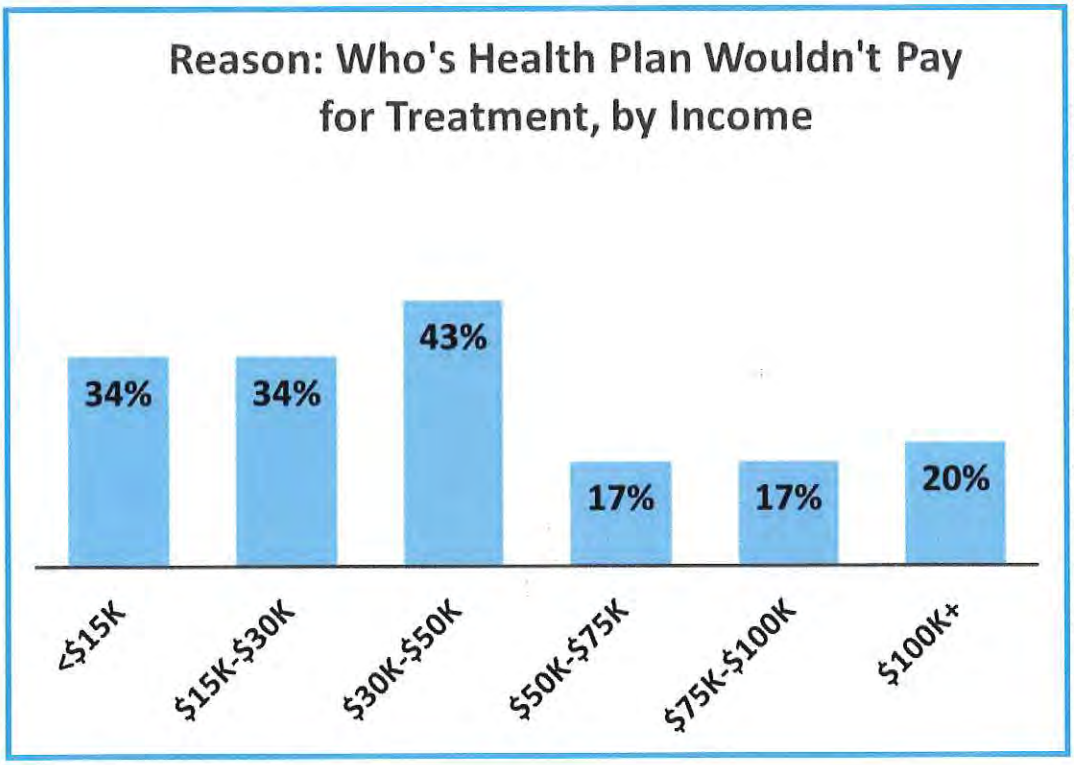
Respondents who indicated they delated care where asked if they did so because their insurance was not accepted by a doctor or hospital. More than a quarter of the <$15,000 income group responded that they had. Availability of medical providers, particularly providers of specialized care, that will accept uninsured or publicly insured patients is limited in the region. Individuals with public insurance report long wait times for appointments with the providers that do accept their coverage.



Source: 2015 Wellbeing Survey

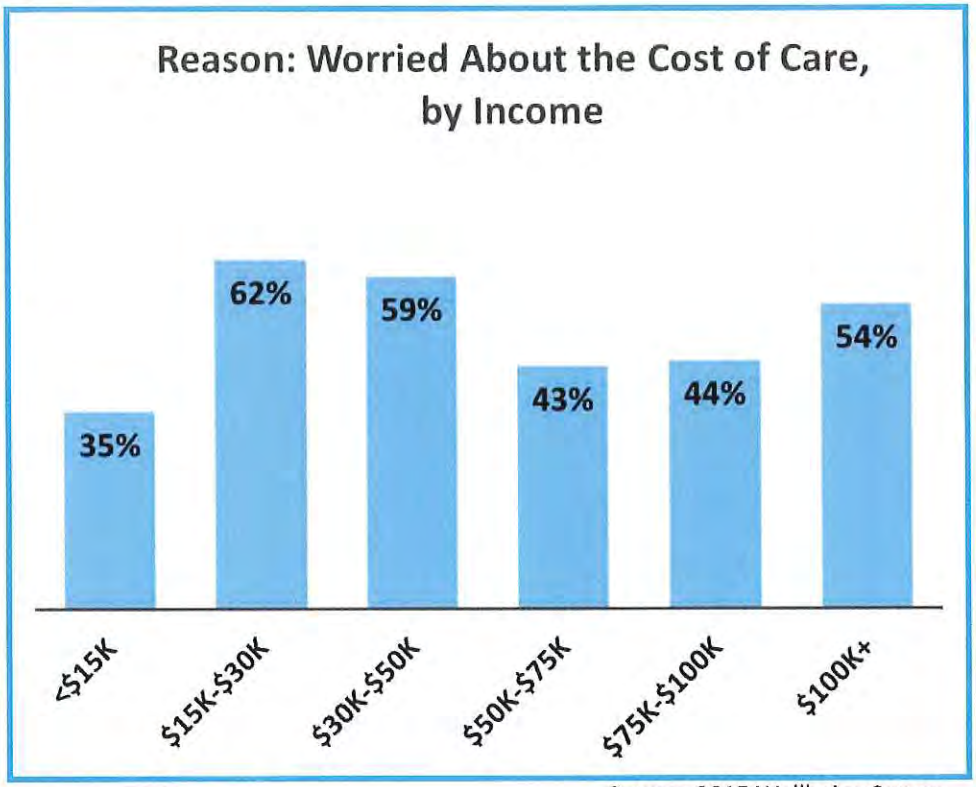
Barriers to Care

Yet another barrier to care has to do with insurance plan coverage, or lack thereof, of certain treatments. More than 1 in 3 residents in the lowest income groups reported that they did not receive treatment because their insurance would not cover it.



Source: 2015 Wellbeing Survey

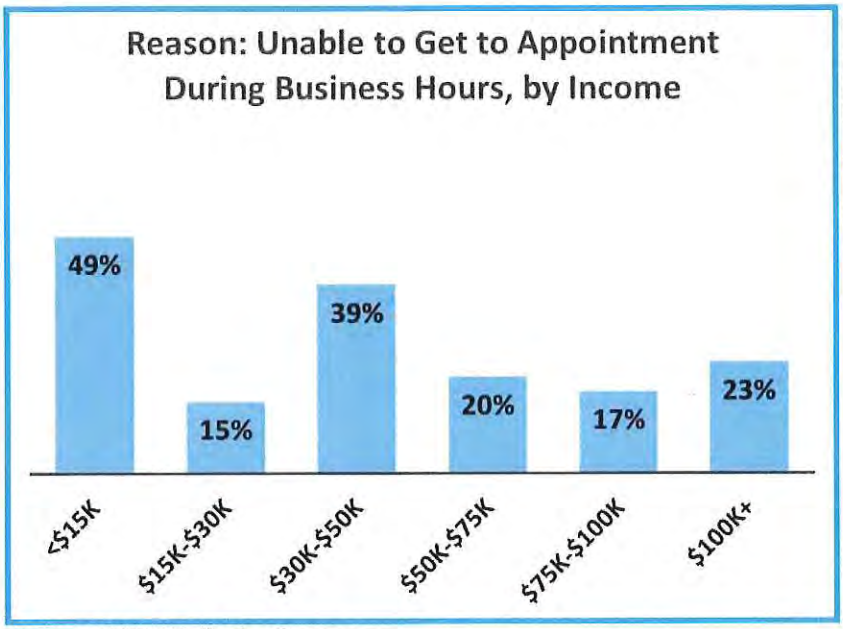
Among those who said they delayed necessary care, concern about cost of care was a evident among all income categories with a slightly higher percentage among the $15,000 to $50,000 income categories and slightly lower concern cited in the lowest income category. This may be associated with people transitioning from Medicaid to high-deductible health insurance plans (and related increases in out-of-pocket costs) as their income increases above the Medicaid eligibility cap.



Source: 2015 Wellbeing Survey

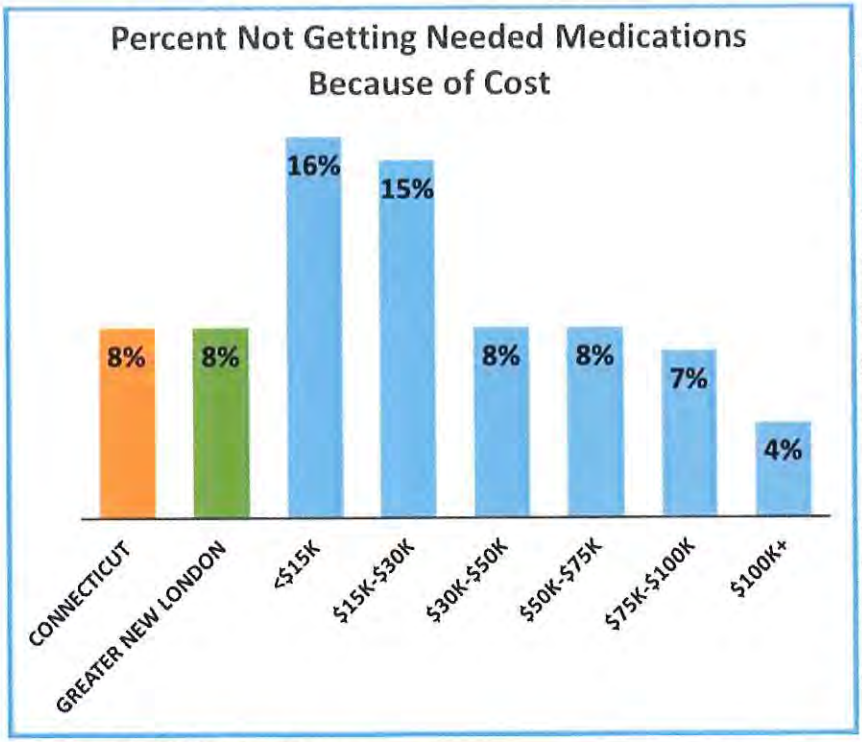
Barriers to Care

Modern economic realities require many to work multiple jobs in order to provide for their families. In addition, lower wage workers typically have jobs that allow less flexibility in schedules and don't provide paid time off for medical appointments. Both of these factors make scheduling healthcare appointments challenging even as providers have begun to make evening and weekend appointment times available.



Source: 2015 Wellbeing Survey

Half of Wellbeing Survey respondents in the <$15,000 income group who said they delayed necessary care indicated that they did so due to an inability to attend an appointment during business hours.



Source: 2015 Wellbeing Survey

Barriers to Care

Even those who don't delay care may face barriers to complying with medical directives. The cost of prescriptions was cited by 1 in 6 respondents to the Wellbeing Survey in the <$15,000 and $15-$30k income categories as a reason for not getting necessary medications. Deductibles, co-payments, and limited health insurance formularies often dictate whether individuals can or will obtain prescribed medications. These can pose considerable economic strain and, as cited in focus groups, result in people making choices between other basic needs such as food, rent, electricity and their medications.

Patient nonadherence to a medical provider's care plan can have a significant impact on the individual's health as well as ultimately resulting in higher costs of care. It is important for healthcare systems and providers to understand the many intersecting barriers their patients experience in order to appreciate reasons for missed appointments and inconsistent adherence to care plans. Contributing factors include misunderstanding instructions, forgetting, or ignoring healthcare advice in addition to costs, beliefs, attitudes, subjective norms, cultural context, social supports, and emotional health challenges.

Patients must be given the opportunity to tell the story of their unique illness experiences and their financial, housing, transportation and social support situations. Knowing the patient as a person allows the health professional to understand elements that are crucial to the patient's adherence. Provider–patient partnerships are essential in designing care plans; mutual collaboration fosters greater patient satisfaction, reduces the risks of nonadherence, and improves patients' healthcare outcomes.

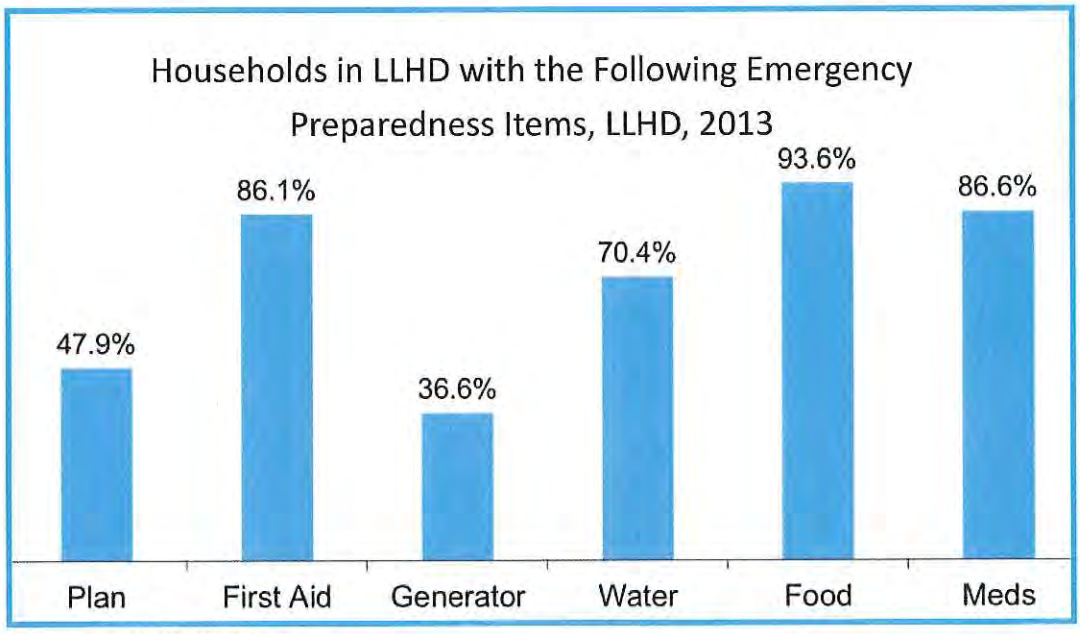
With a significant coastline and several potential targets for terrorism, southeastern Connecticut faces both manmade and naturally occurring public health threats. An emergency or act of terrorism at one of the local military installations, the Millstone Nuclear Power Plant in Waterford or one of the local Casinos could mean the emergency treatment and/or sheltering of thousands. The potential for significant destruction and widespread evacuation caused by a hurricane or other storm increases with each year as climate change results in shifting weather patterns and rising sea levels.

L+M Hospital, LLHD and Uncas Health District have deep staff capacity in emergency preparedness and regularly participate in regional planning meetings and drills with other partners. LLHD and Uncas Health District each have a Medical Reserve Corps (MRC) - a group of volunteers, some of whom are medical professionals, who train and prepare to response to public health emergencies.

Emergency Preparedness

In 2015, the LLHD MRC organized an Epi-Strike Team, which went door-to-door in select neighborhoods in the region surveying residents about their households' level of preparedness. The neighborhoods were selected to provide a statistical representation of the region using the CASPER Model from CDC.

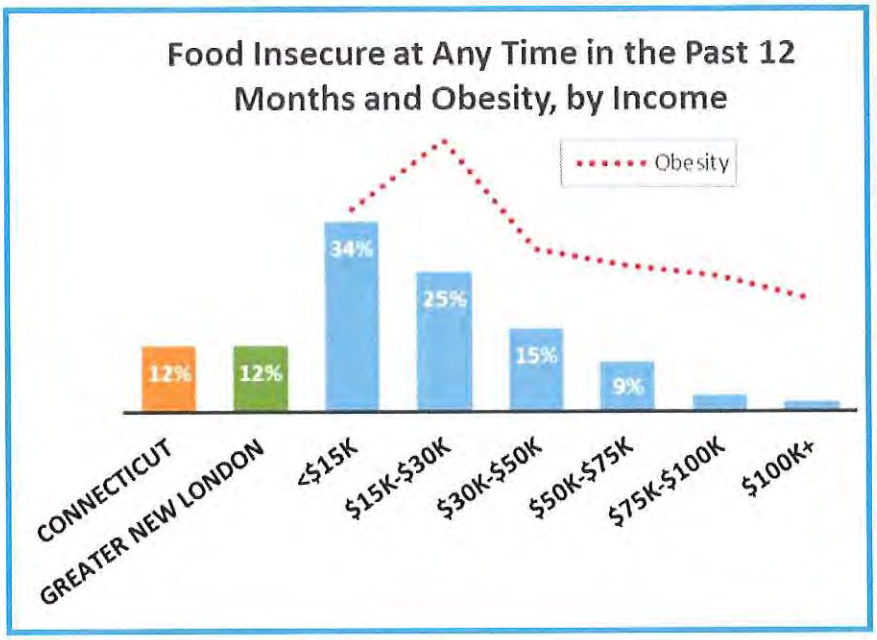
85.7% of households in LLHD consider themselves "somewhat" or "well prepared" for an emergency. Only 47.9% report having an emergency plan and only 70% report having water for everyone in the household for 3 days.



Source: 2015 Wellbeing Survey

Chronic Disease

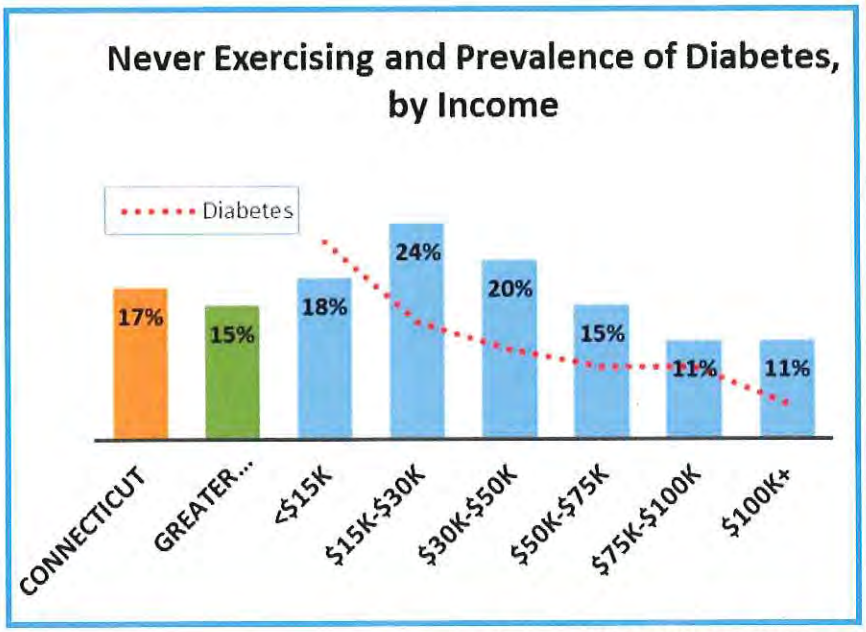
Having inadequate food resources is a risk factor for obesity that disproportionately affects low income residents. The apparent correlation between food insecurity and obesity as seen in Greater New London does not imply causality; they may be instead independent consequences of low income and the resulting lack of access to enough affordable nutritious food or stresses of poverty.



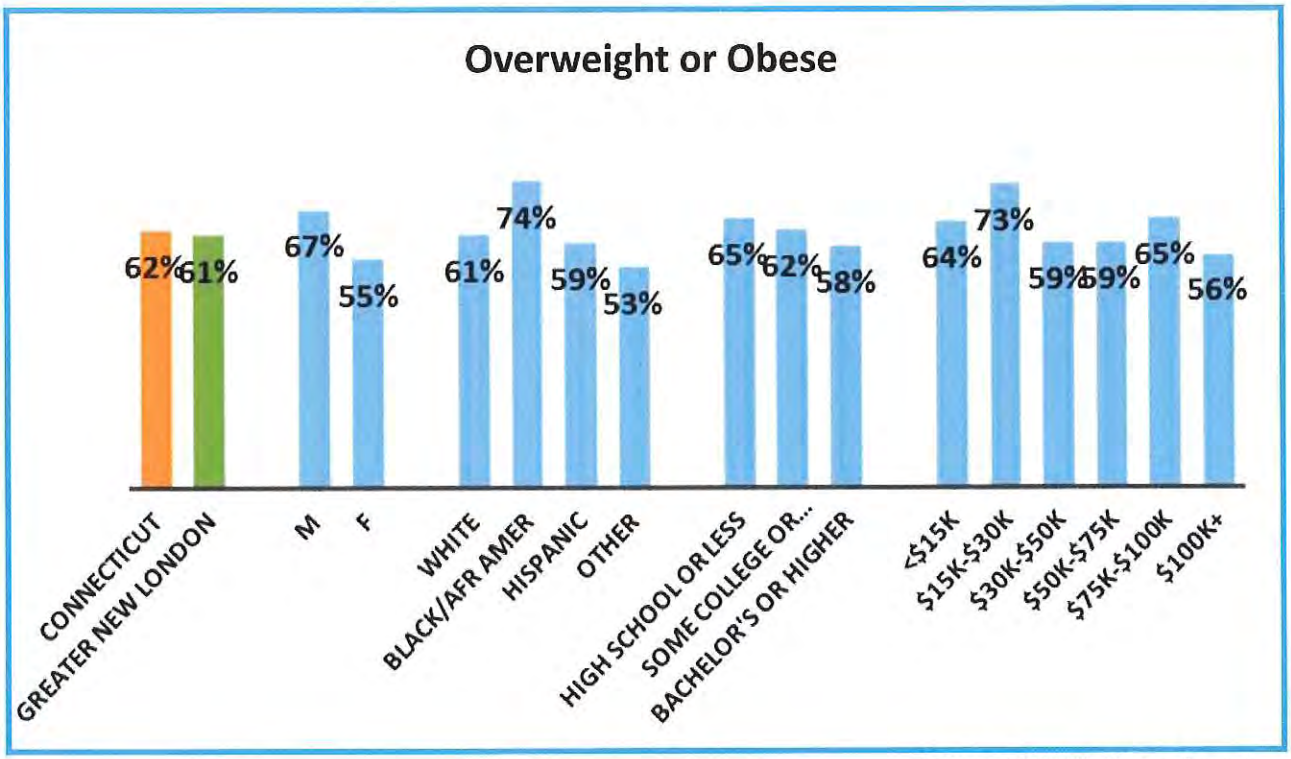
Source: 2015 Wellbeing Survey

Risk Factors: Sedentary Lifestyle, Nutrition and Obesity

According to the Harvard School of Public Health, about 90% of type 2 diabetes diagnoses could be prevented if just a few risk factors were eliminated. These risk factors include being overweight, poor diet, smoking, and not exercising. In Greater New London, there is an apparent correlation between never exercising and the prevalence of diabetes. Again, this correlation does not imply causality—they may also be independent consequences of low income and the resulting lack of access to enough nutritious food, safe recreational opportunities, or stresses of poverty.



Source: 2015 Wellbeing Survey

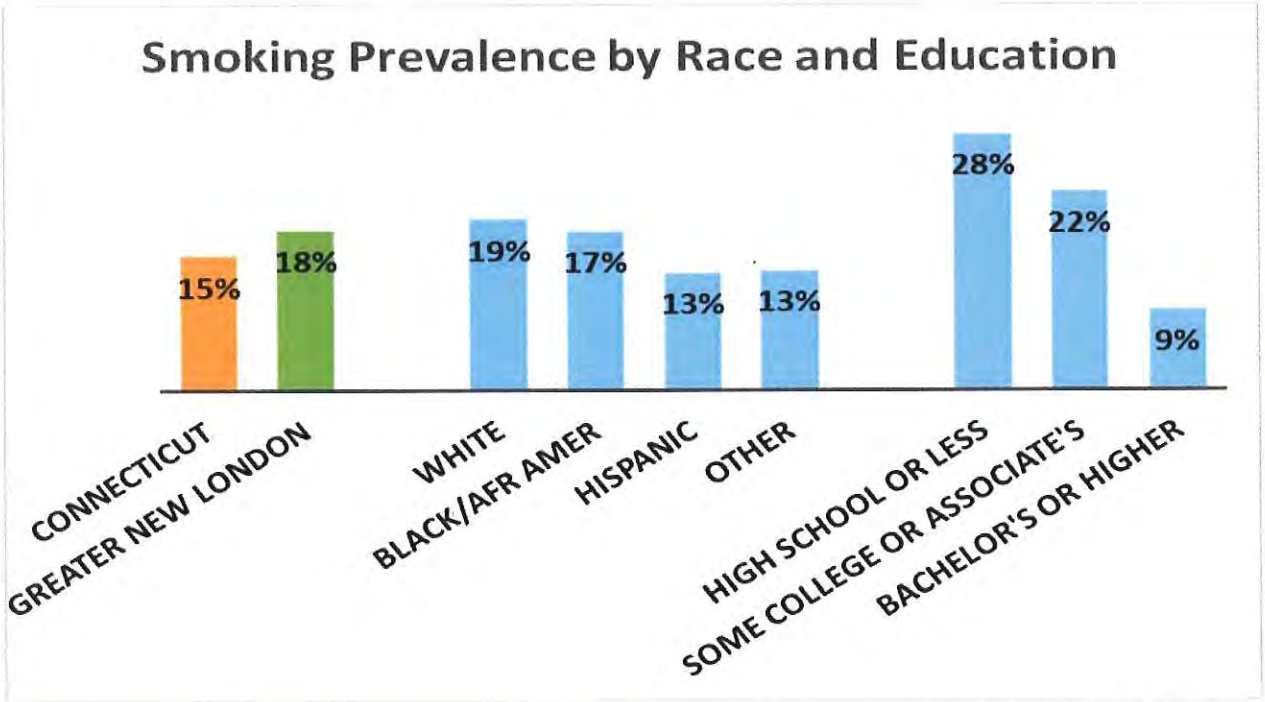


Source: 2015 Wellbeing Survey

Risk Factors: Sedentary Lifestyle, Nutrition and Obesity

In Greater New London, reported obesity is on par with the state with certain sub-populations experiencing higher percentages. Well over half of the population is overweight or obese; higher obesity among the lower income categories may be correlated with limited access to affordable healthy foods. (Wellbeing Survey)

CDC states that "people who are obese, compared to those with a normal or healthy weight, are at increased risk for many serious diseases and health conditions, including...all causes of death". Obesity impacts health outcomes from cardiovascular disease and diabetes to mental health. It carries a heavy economic strain through direct costs related to increased use of the healthcare system to indirect costs like lower productivity in the workplace. Obesity has even been cited as a potential national security issue, with increasing numbers of potential military recruits failing to meet the military's standards for weight and body fat. In the 2013 Youth Risk Behavior Survey, 13.9% of respondents in CT were overweight and 12.5% obese. There may be several intersecting factors contributing to obesity in the community—including individual genetics and behavior but also inequitable access to affordable healthy food and safe opportunities for physical activity.

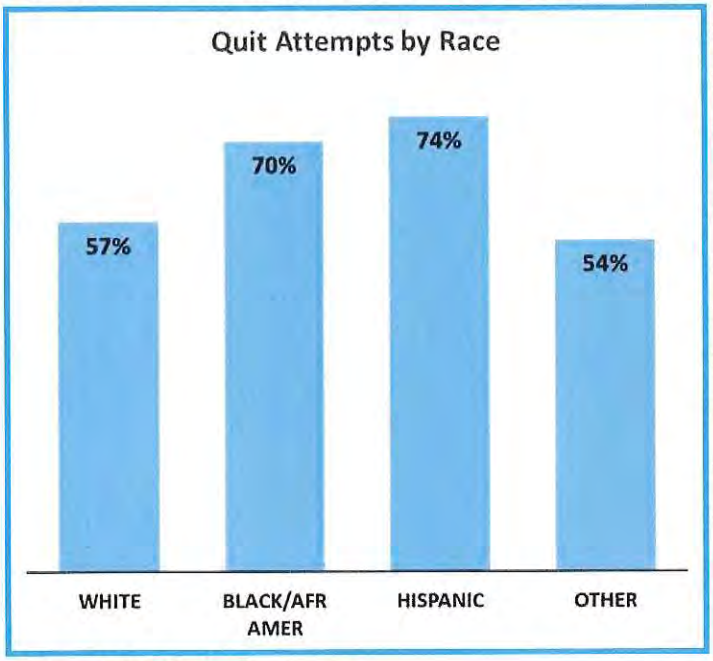


Source: 2015 Wellbeing Survey

Risk Factor: Tobacco Use

The smoking rate in Greater New London is higher than in the state overall. There are disparities related to race, education and income. (Wellbeing Survey)

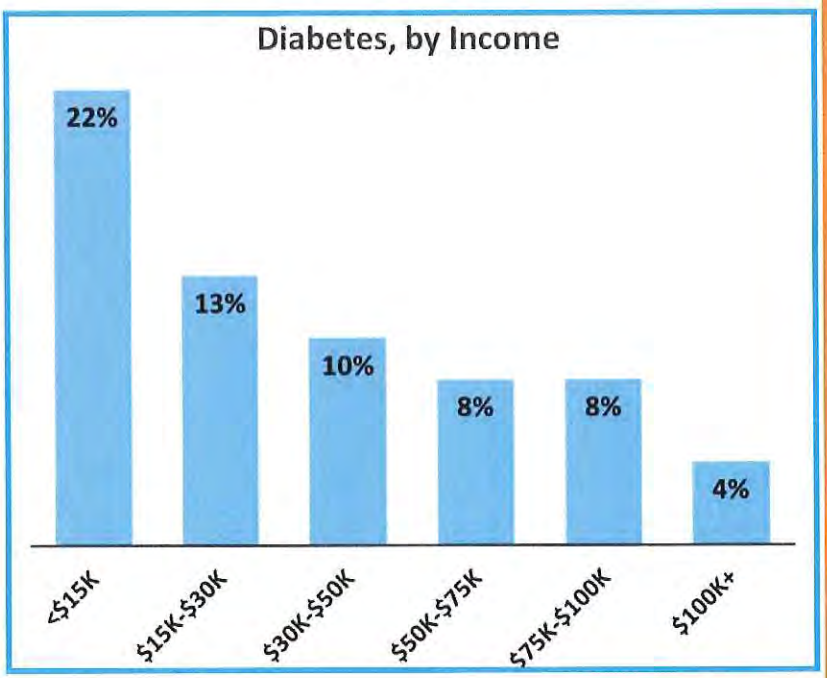
According to CDC, tobacco use remains the single largest preventable cause of death and disease in the United States. Cigarette smoking kills more than 480,000 Americans each year, with more than 41,000 of these deaths occurring from exposure to secondhand smoke. In CT, tobacco use is the top cause of heart disease.



Source: 2015 Wellbeing Survey

Quitting tobacco use has benefits at any age but more if tobacco use is stopped before age 35. On average, smokers make 8-11 quit attempts before success. In Greater New London, there is a an apparent association between quit attempts and smoking prevalence with disparities between racial groups; Hispanics have the highest rate of quit attempts and the lowest rate of smoking.

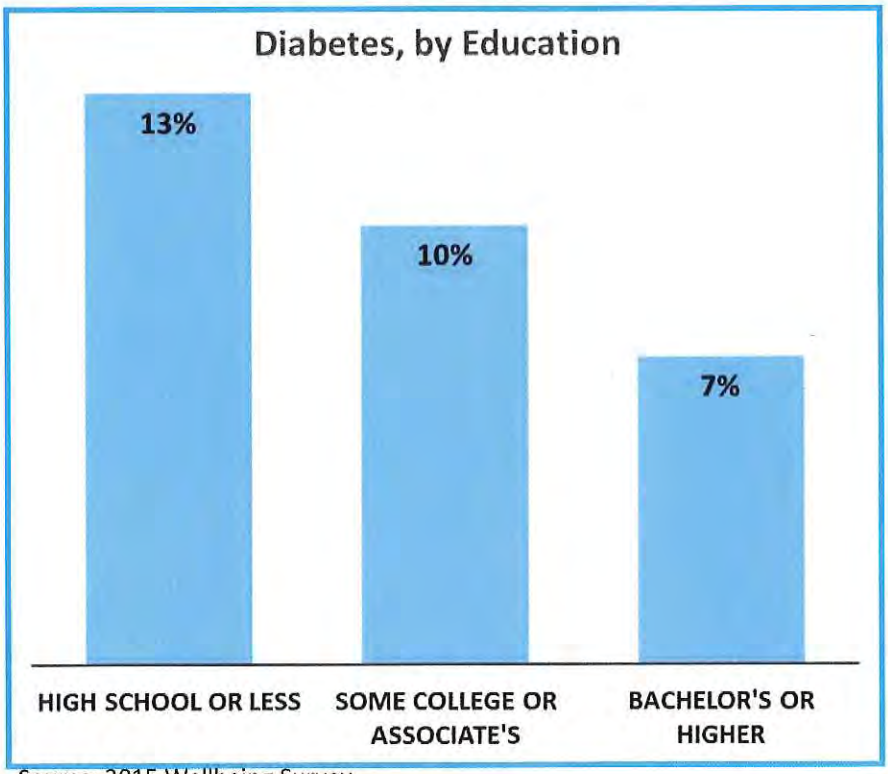
Diabetes affects an estimated 23.6 million people in the United States and is the seventh leading cause of death (CDC). Diabetes can be preventable. Often type 2 diabetes is preceded by pre-diabetes, a condition in which blood glucose is elevated but not yet to the level of diabetes. Regular exercise and modest (5-7% of total body weight) weight loss can dramatically reduce the risk of pre-diabetes progressing to diabetes.



Source: 2015 Wellbeing Survey

Diabetes

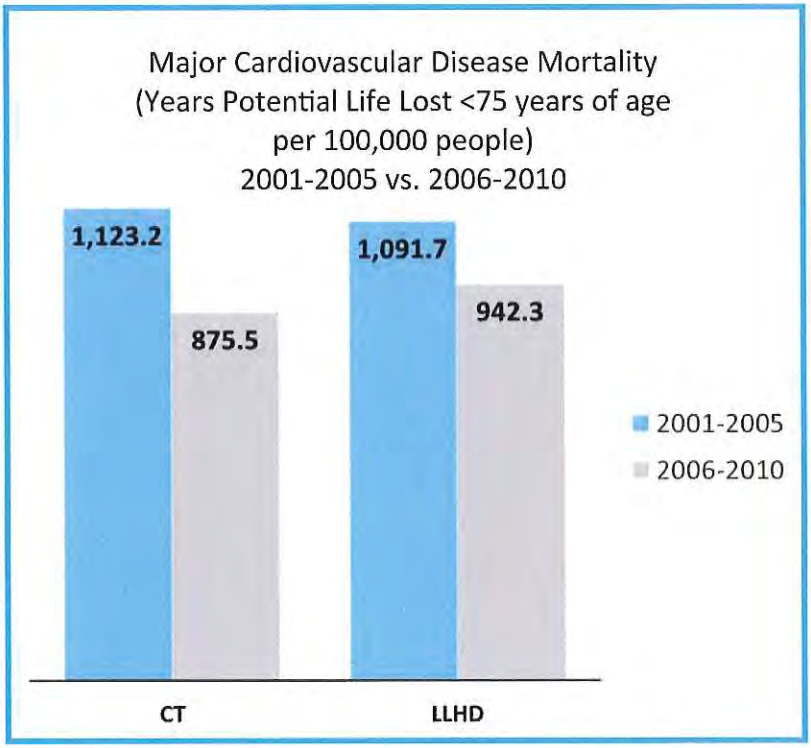
Overall, diabetes prevalence in Greater New London is on par with the state's. However, significant disparities exist by income, race and education. Those in the lowest income categories have experienced the greatest increase in diabetes incidence as well as the most significant impact of the disease. With higher rates of risk factors such as sedentary lifestyle and limited access to healthy foods for lower income individuals, the Wellbeing Survey results are not surprising. National studies have documented correlations with the risk factors to diabetes among those with less formal education.



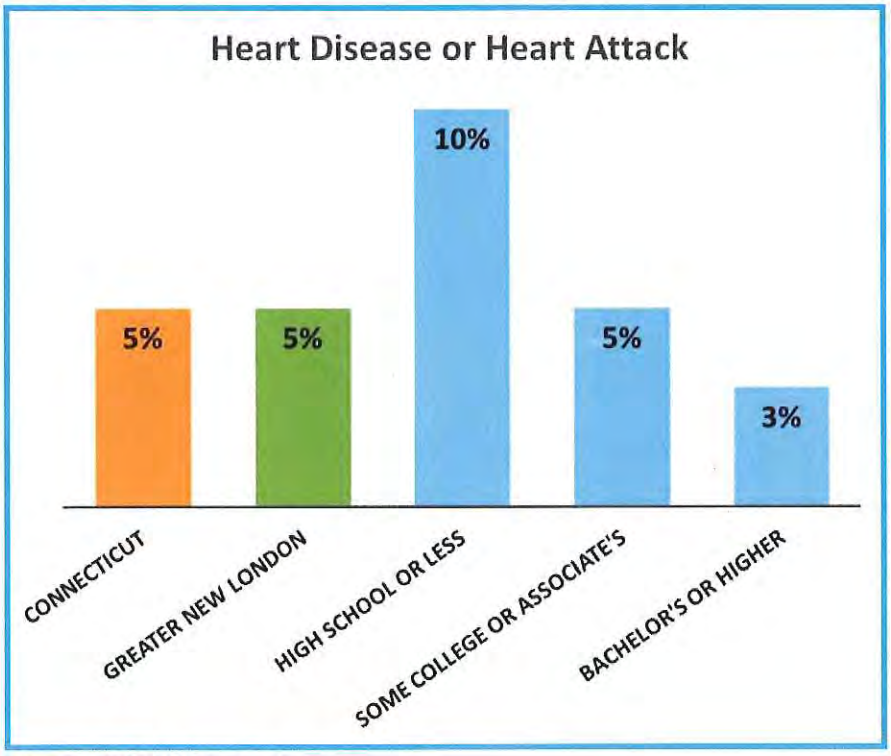
Source: 2015 Wellbeing Survey

Cardiovascular Disease

Cardiovascular disease is the leading cause of death for both women and men in the United States. Cardiovascular disease includes several conditions that affect the heart and blood vessels including heart failure, stroke, coronary artery disease, heart attack, and other conditions. Having high blood pressure, high cholesterol, diabetes, or obesity presents high risk for cardiovascular disease. Most cardiovascular diseases can be prevented by addressing behavioral risk factors such as lack of exercise, poor diet including high consumption of salt, smoking, and excessive alcohol consumption. In the last five years death from major cardiovascular disease decreased in CT; LLHD towns have not kept pace and now rates locally exceed those in CT.



Source: CT DPH



Source: 2015 Wellbeing Survey

In Greater New London, residents with a high school education or less have experienced heart attack or heart disease at double the rate of the general population. (Wellbeing Survey)

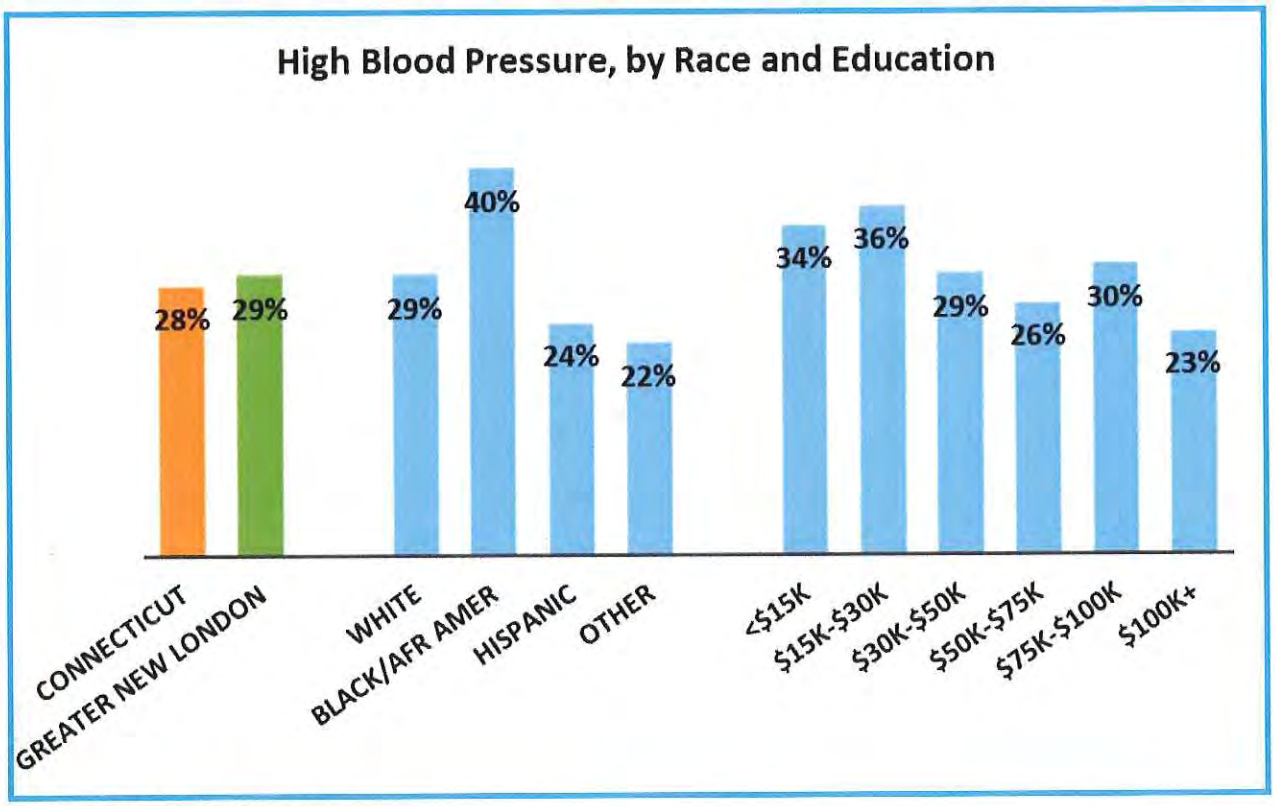
Hypertension, or high blood pressure, is a leading cause of cardiovascular disease and affects nearly one third of U.S. adults. Causes of high blood pressure include behavioral factors as well as environmental and social determinants.

According to CDC, 1 out of every 3 adults in the U.S. have high blood pressure and only about half have their condition under control. Another 1 in 3 American adults have pre-hypertension, defined as blood pressure that is elevated above normal but not yet in the high blood pressure range.

Racial and ethnic disparities exist in blood pressure, awareness, treatment, and control. Locally, disparities are evident by age and income as well.

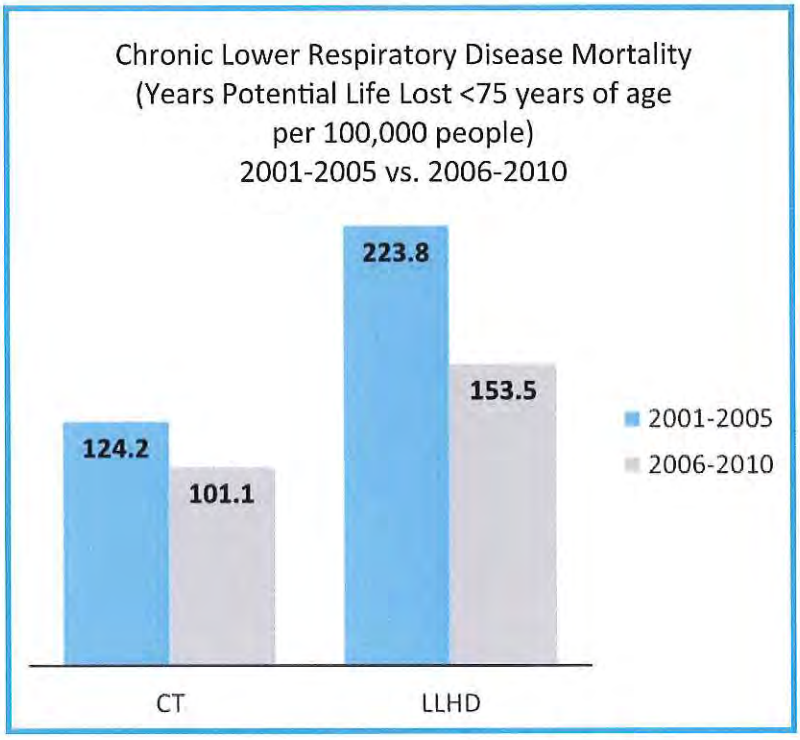
In Greater New London, 40% of Black respondents to the Wellbeing Survey report having been told by a doctor that they have high blood pressure.

Cardiovascular Disease



Source: 2015 Wellbeing Survey

Chronic Lower Respiratory Disease (CLRD) includes three diseases: chronic bronchitis, emphysema and asthma, all of which cause airflow blockage and breathing problems. According to CDC, CLPD is the third leading cause of death in the U.S. In LLHD, from 2001-2010, CLRD mortality rates were 1.5 times the state rate.



Source: 2015 Wellbeing Survey

Chronic Lower Respiratory Disease

Chronic Obstructive Pulmonary Disease (COPD) is used to refer to a subset of the diseases encompassed in the CLPD grouping—chronic bronchitis and emphysema. These disease are often co-occurring. The primary cause of COPD is cigarette smoking however air pollution, chemical fumes, dust, and genetic factors may also contribute. According to the CT Behavioral Risk Factor Surveillance Survey, the risk of COPD is significantly greater for adults over 55 years old, adults in low-income households earning less than $35,000 annually, adults with disabilities, and adults with no more than a high school education.

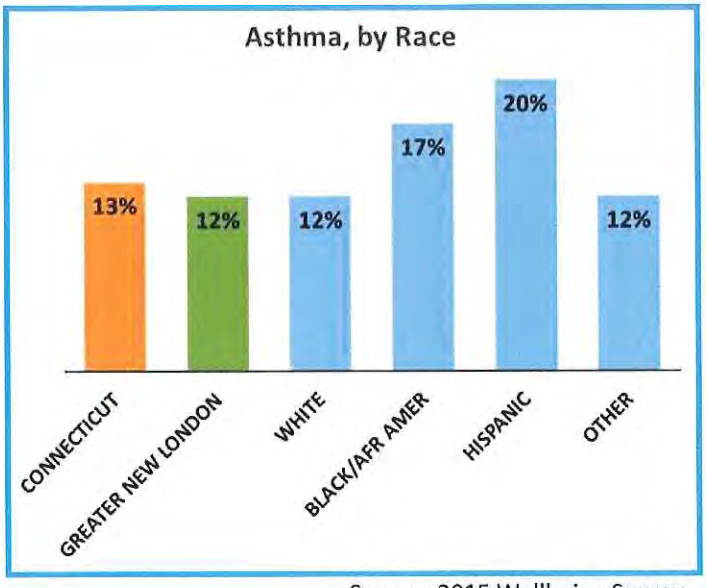
Calendar Year	Total Cases	Total Deaths	Mortality Observed
2012	521	9	1.73%
2013	526	13	2.48%
2014	588	14	2.40%
2015	643	16	2.50%

L+M Hospital
Inpatients with a Discharge Diagnosis of COPD

Source: L+M Hospital

Both the total number of cases and the mortality rate from COPD among patients at L+M Hospital have been increasing in recent years.

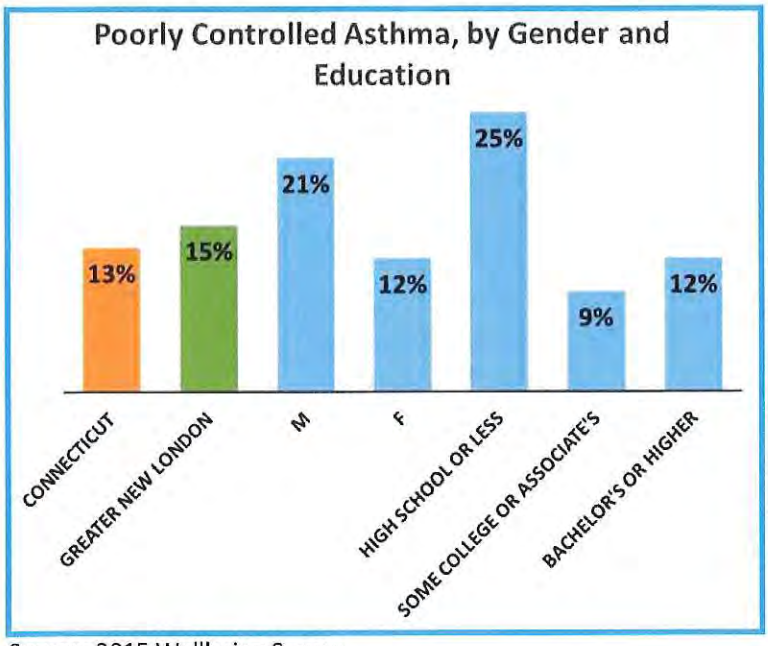
The third disease included in the CLPD grouping is asthma. Far too many area children and adults have poorly managed asthma resulting in missed days of school and work, high use of acute healthcare services for treatment, and a generally degraded quality of life. Both pediatric and adult asthmatics and their caregivers possess gaps in knowledge and comprehension around recognizing environmental triggers, asthma signs and symptoms, and medication and inhaler/ spacer use. A persistent health concern, rates in Greater New London and across the nation are significantly higher among Blacks and Hispanics. Socioeconomic status is a critical determinant of differences in asthma prevalence and severity and race and ethnicity are strongly correlated with socioeconomic status.



Source: 2015 Wellbeing Survey

Asthma

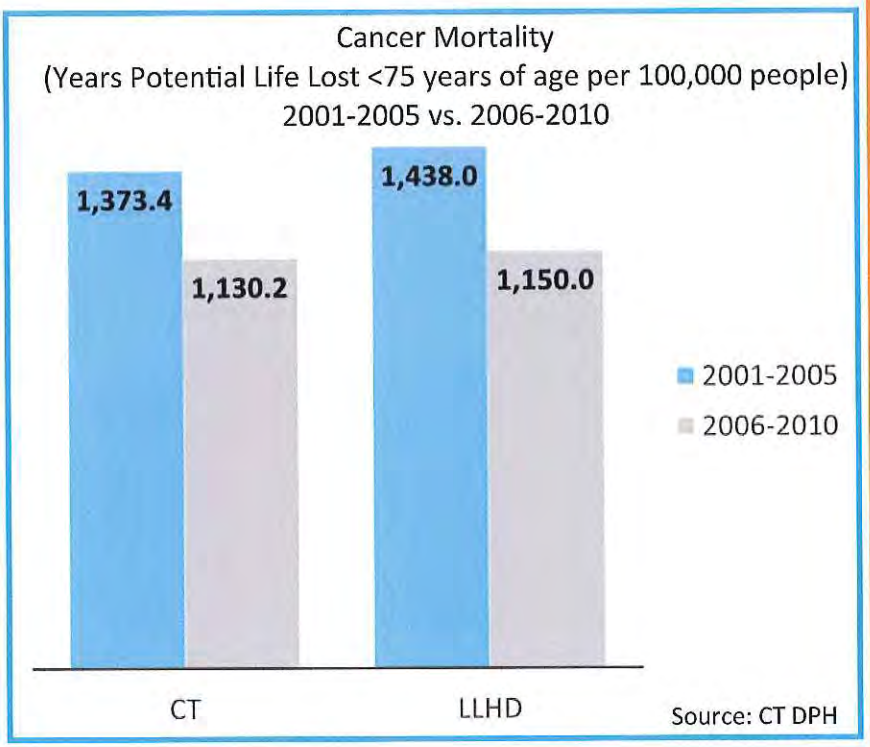
Males were more likely to report poorly controlled asthma in Greater New London than females. There is not conclusive evidence to support a connection between gender and asthma control but there is for education, as a social determinant, and as correlated with risk factors such as smoking and poor quality housing . 25% of residents with less education report poorly controlled asthma.



Source: 2015 Wellbeing Survey

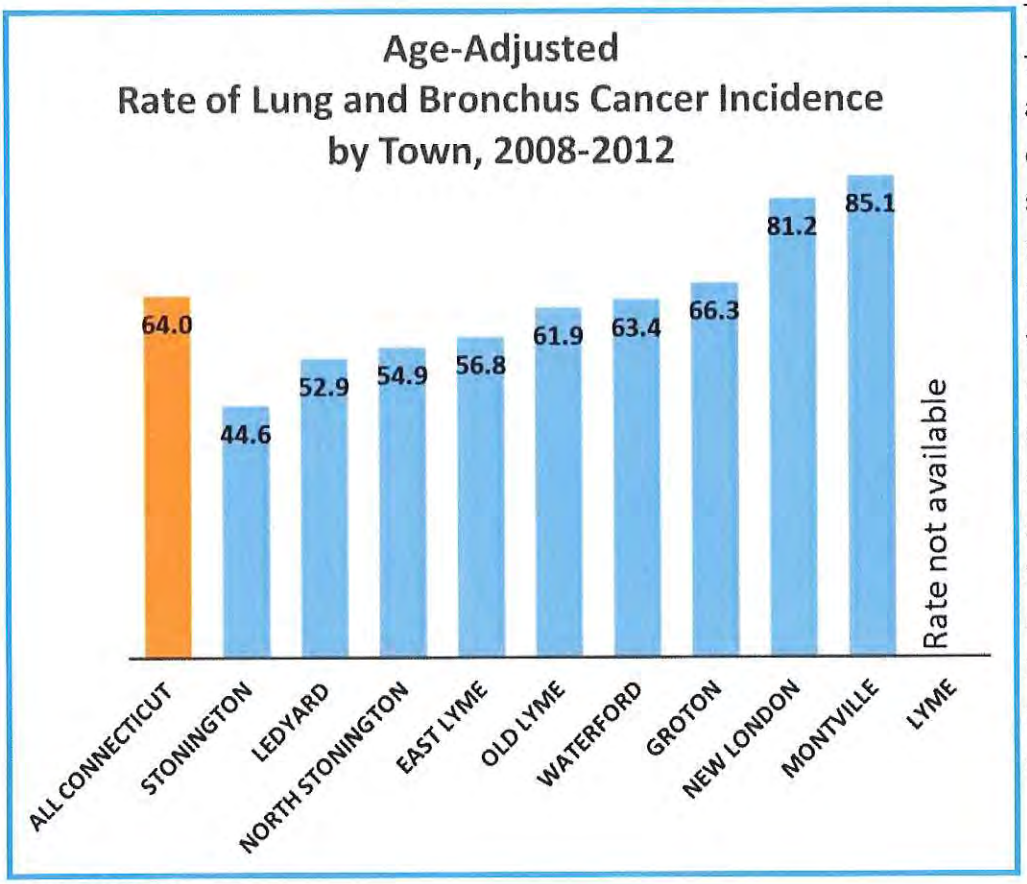
Asthma is a particular concern in area schools, where children with uncontrolled asthma miss classroom and recreational time. In the New London School District, 21% of enrolled students have a diagnosis of asthma. Asthma Management Plans, important asthma control tools, are dramatically under-utilized; only 1% of students in New London School District have one on file. (CT DPH)

Cancer is the second leading cause of death in CT; despite decreases in incidence and mortality rates and improvements in survival from the most common cancers, concerning disparities persist for some CT residents. Cancer related deaths in LLHD are roughly on par with the state but have decreased slightly in last 5 years.



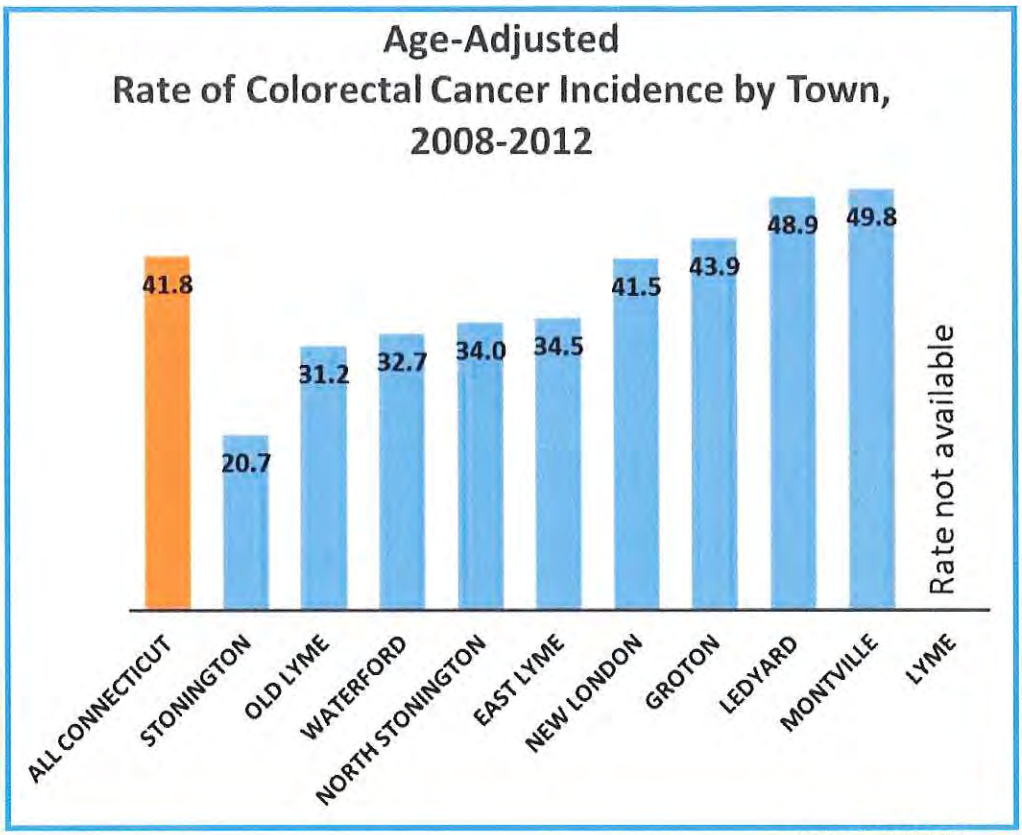
Cancer

In CT and in Greater New London, lung and bronchus cancer is the second most frequently diagnosed cancer. The top two risk factors for lung and bronchus cancer are smoking and radon. In Greater New London, where tobacco use exceeds the CT rate and the risk of radon exposure is high, the rate of lung cancer exceeds the CT rate in three communities.



Source: CT DPH

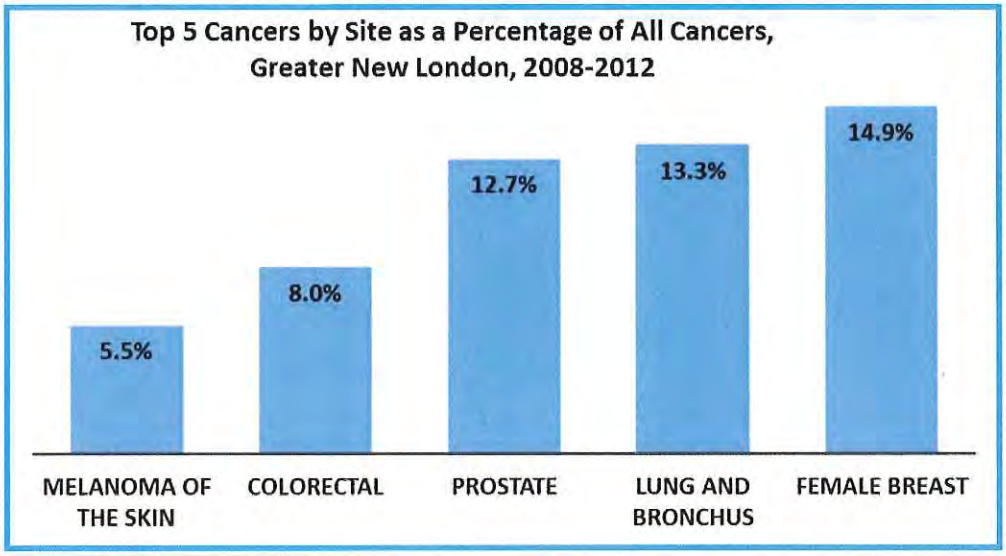
Colorectal cancer incidence rates in CT and in Greater New London are on par with national rates, however there are racial and gender related differences in mortality. Women more than men and Blacks more than other racial groups are more likely to die from colorectal cancer, possibly due to differences in access to screening services and in quality of care.



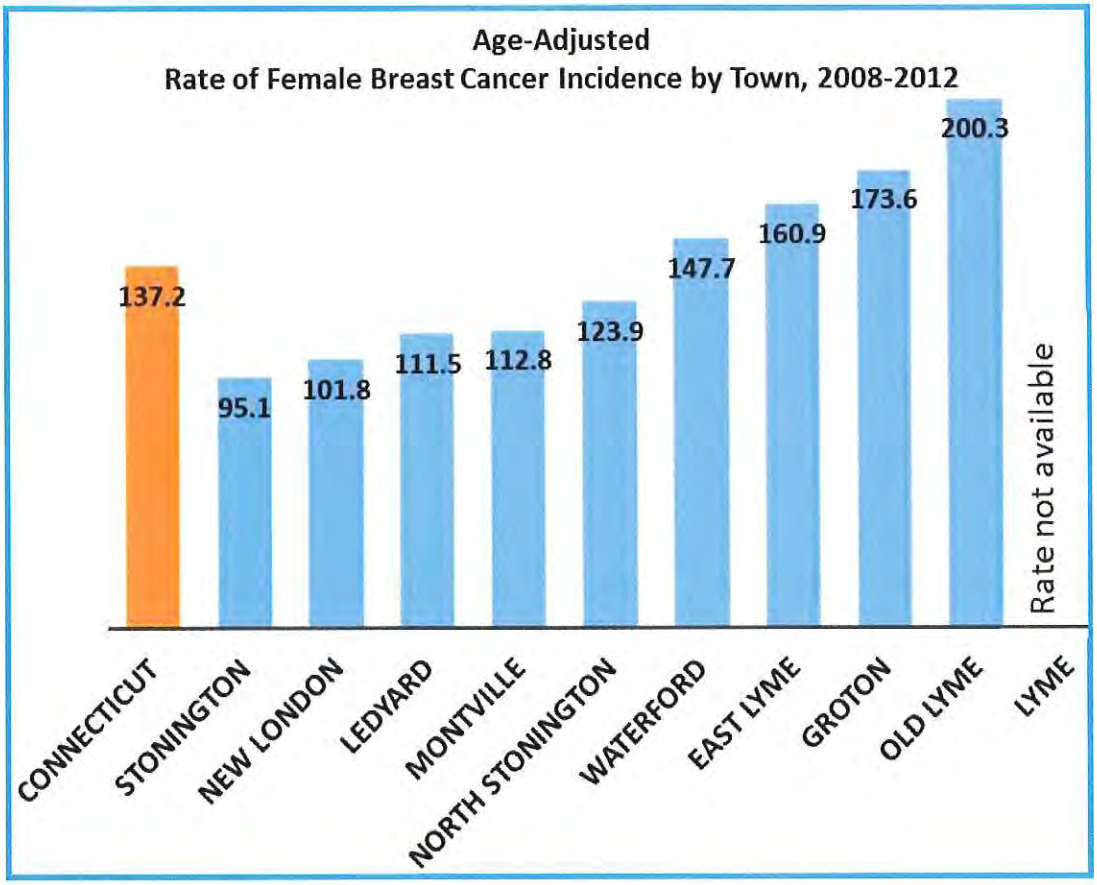
Source: CT DPH

Cancer

The top five cancers diagnosed in Greater New London between 2008 and 2012 were female breast, lung and bronchus, prostate, colorectal, and melanoma of the skin, together accounting for over half of all cancer diagnoses. Both the order and proportions are similar to the state overall, though bladder cancer is more frequently diagnosed than melanoma across the state.



Source: CT DPH



Source: CT DPH

Cancer

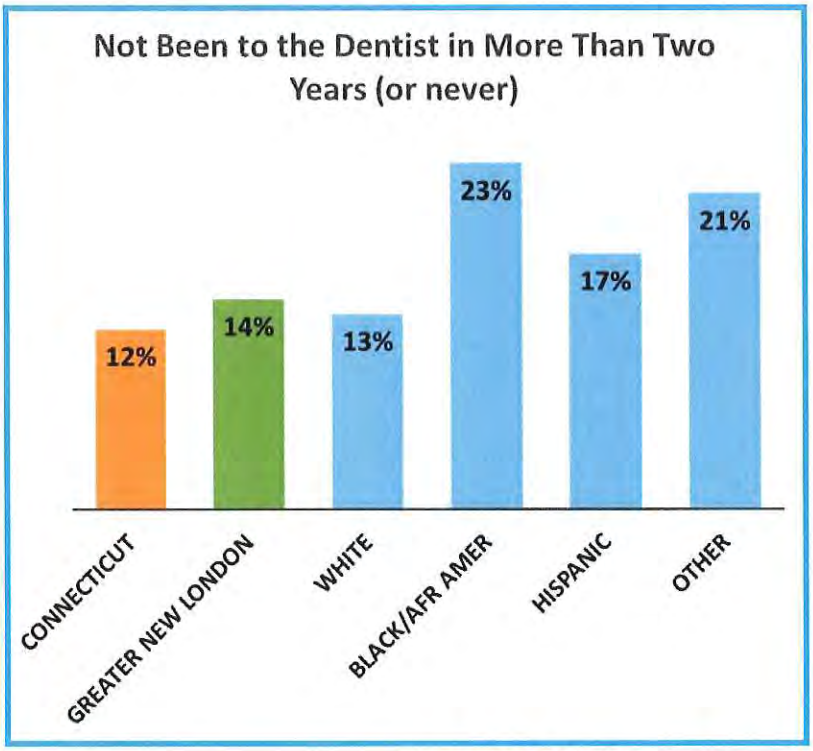
In Southeastern CT, rates of female breast cancer in East Lyme, Groton, Old Lyme and Waterford exceed the state rate. In East Lyme, Ledyard and Old Lyme rates of prostate cancer exceed the state rate. (CT DPH)

The National Cancer Institute estimates that 1 in 8 women will develop breast cancer in their lifetime. Breast cancer incidence rates in CT are higher than in the U.S. but mortality rates are lower. Higher rates of breast cancer are correlated with higher socioeconomic status. Several risk factors for breast cancer are more common among women with higher income including delayed child bearing and bearing fewer children, using birth control pills and/or menopausal hormone therapy, and drinking alcohol. Racial disparities are evident in breast cancer mortality, particularly among Black women who are more frequently diagnosed at a later stage of cancer.

Except for skin cancer, prostate cancer is the most common cancer among American men. Most prostate cancers grow slowly and don't cause any health problems in men who have them. The rate of prostate cancer in CT is higher than in the U.S., with a higher incidence and rate of mortality among Black men.

The higher rates of diagnosed breast cancer and prostate cancer in some towns in the region may reflect a number of factors, including increased access to screening.

Oral health is an essential component of overall good health and well-being. There is growing evidence that oral infections may increase the risk of heart disease, may put pregnant women at greater risk of premature delivery, and can complicate control of blood sugar for people with diabetes.

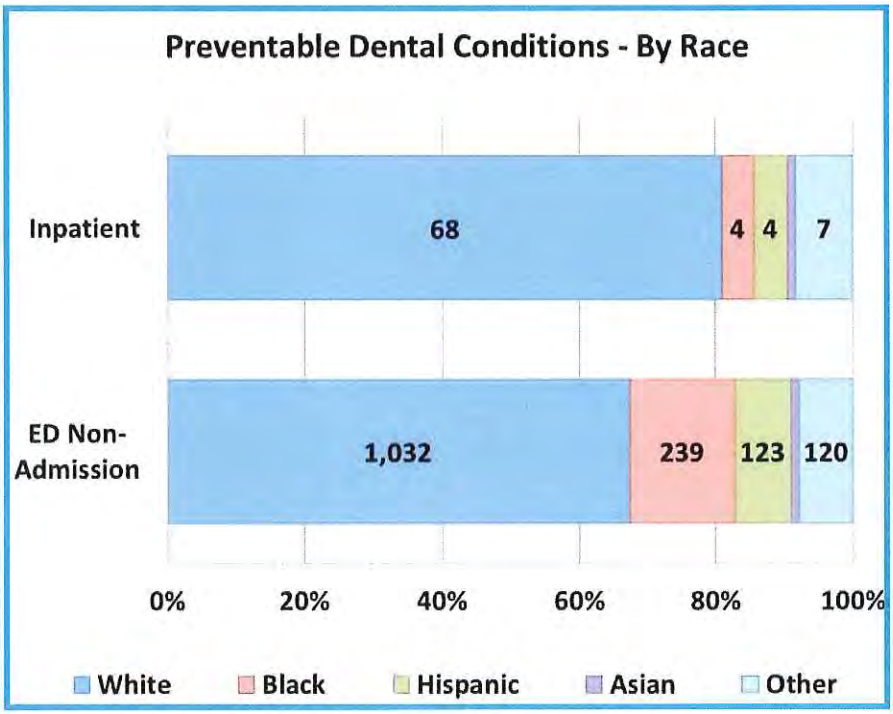


Source: 2015 Wellbeing Survey

Oral Health

In the Wellbeing Survey, 1 in 4 Blacks reported not having been to a dentist in more than 2 years or never having been.

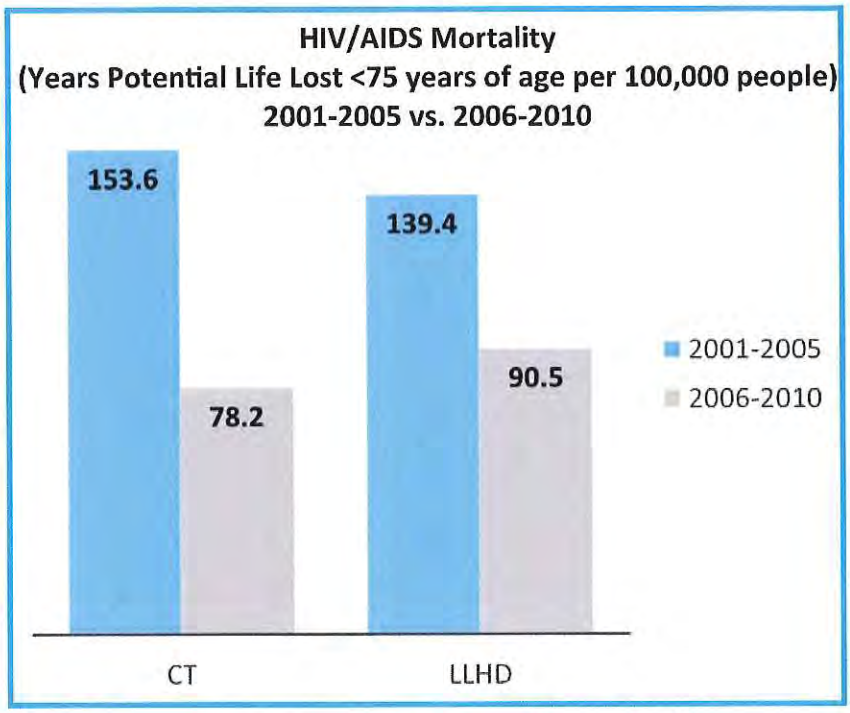
The American Dental Association reports that most dental ED visits are for non-traumatic dental conditions which would be more appropriately treated in a community dental setting. ED visits for dental conditions are increasing, driven primarily by decreases in private dental insurance coverage among young adults combined with significant reductions in adult dental Medicaid programs, making accessing dental offices financially difficult for some. In Greater New London, ED visits for dental conditions disproportionately affects Hispanics, Blacks, and those of "other" races.



Source: CT Hospital Association

Infectious Disease

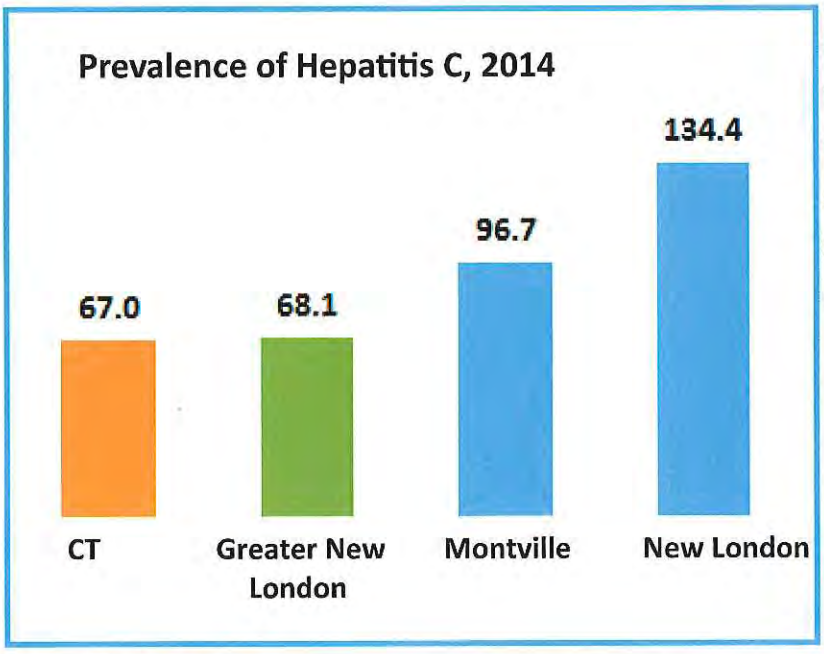
Identification, prevention, and reduction of mortality from HIV infections is a national goal, with several related Healthy People 2020 objectives. Between the five year periods from 2001-05, and 2006-10, mortality from HIV/AIDS dropped in LLHD and the state of CT overall. While mortality from HIV/AIDS in LLHD used to be lower than the state, that has since reversed, with mortality now being higher in LLHD compared to the state. Still, the trend towards lower mortality is clear, and efforts should be made to continue that trend.



Source: CT DPH

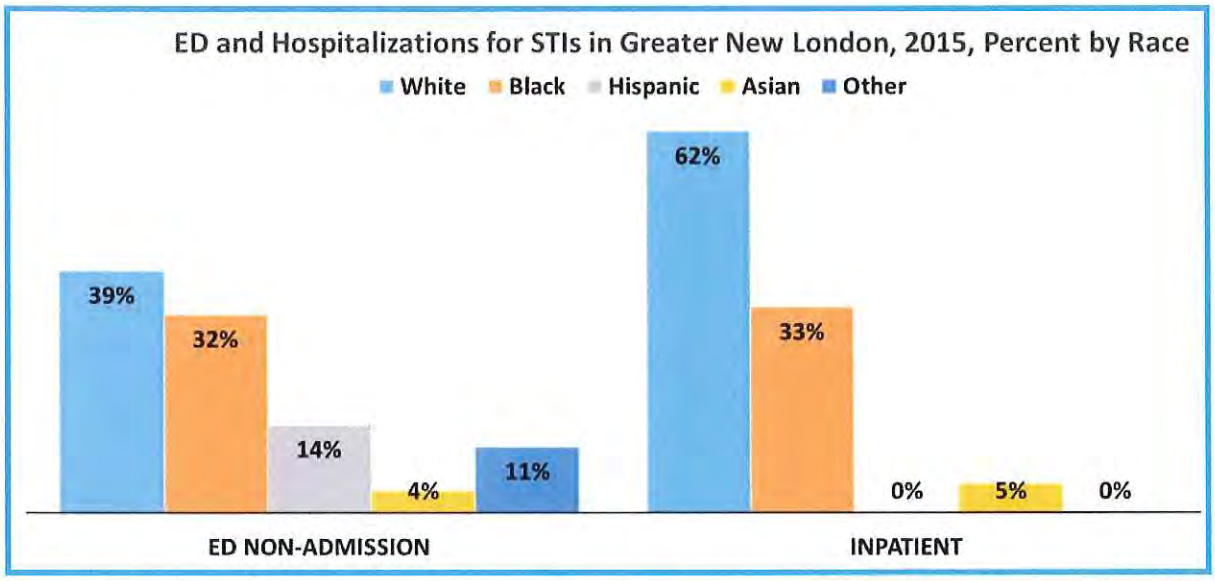
HIV/AIDS and Hepatitis

Hepatitis C is a viral infection that can result in serious health outcomes such as liver disease and even death. It is now most often transmitted through the sharing of needles during drug use, but was historically transmitted during routine medical procedures using donated blood and blood products before screening of the blood supply was implemented in 1992. Hepatitis C and HIV/AIDS share some of the same risk factors for infection and there is a high co-infection rate.



Source: CT DPH

In 2014, New London and Montville had higher rates of Hepatitis C infections than the state overall. (CT DPH)

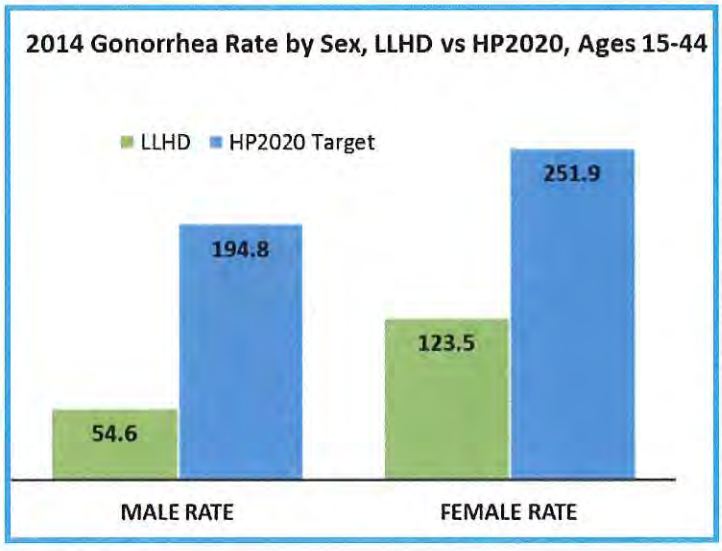


Source: CT Hospital Association

Sexually Transmitted Infections

Because all sexually transmitted infections (STIs) are preventable, and most are curable with appropriate treatment, hospital utilization for these infections should be entirely avoidable. In the Greater New London area, that is approaching the truth, with fewer than 50 hospital encounters in 2015. Still, racial disparities exist. Though Blacks make up 5.5% of the population of the Greater New London area, they accounted for 32% of emergency department visits and 33% of hospitalizations for STIs.

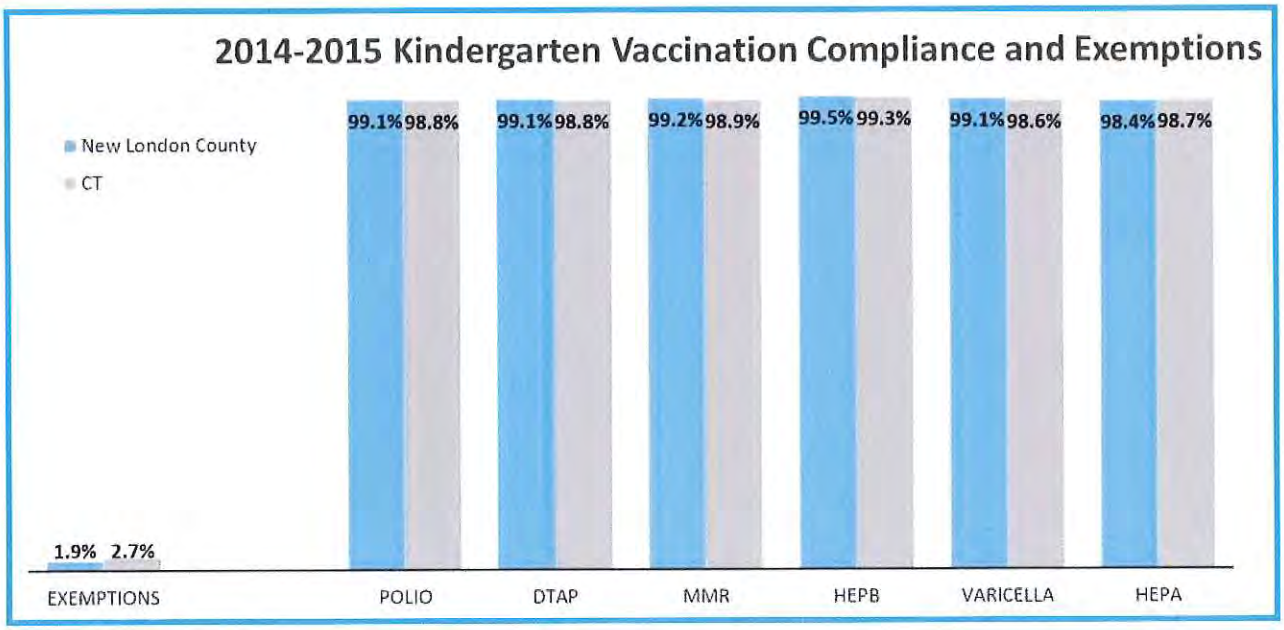
Gonorrhea is a very common sexually transmitted infection. Anyone who is sexually active can get gonorrhea, but it is most often found in people between 15-24 years old. In LLHD, the rate of gonorrhea infections is already below the Healthy People 2020 target for both men and women. Sometimes men, and often women, will not show any symptoms from the infection. Occasionally, however, gonorrhea infection can result in serious outcomes, such as sterility/infertility, ectopic pregnancy, and pelvic inflammatory disease. Gonorrhea is increasingly being recognized as antibiotic resistant. It is important to maintain vigilance in prevention efforts to reduce the spread of the infection, and educate those who are infected about the importance of completing the prescribed course of antibiotics when being treated.



Source: LLHD

The development and use of vaccines as primary prevention of infectious diseases is one of the greatest public health accomplishments of the last 100 years, nearly eliminating morbidity and mortality from vaccine-preventable infections in CT over that time. Though localized outbreaks of some vaccine-preventable infections such as measles, mumps, and whooping cough do happen in CT from time to time, sustained community transmission of these infections no longer occurs. The Healthy People 2020 targets for kindergarten vaccination compliance for polio, DTaP, MMR, HepB, and varicella is 95%. Kindergarten children in New London County already far surpass these goals, with nearly 99% coverage for each vaccine in the 2014-2015 school year. It is necessary to continue emphasizing the importance of following the recommended vaccination schedule for children and adults in order to maintain the gains made in the county and state in preventing these infections from taking hold in our communities.

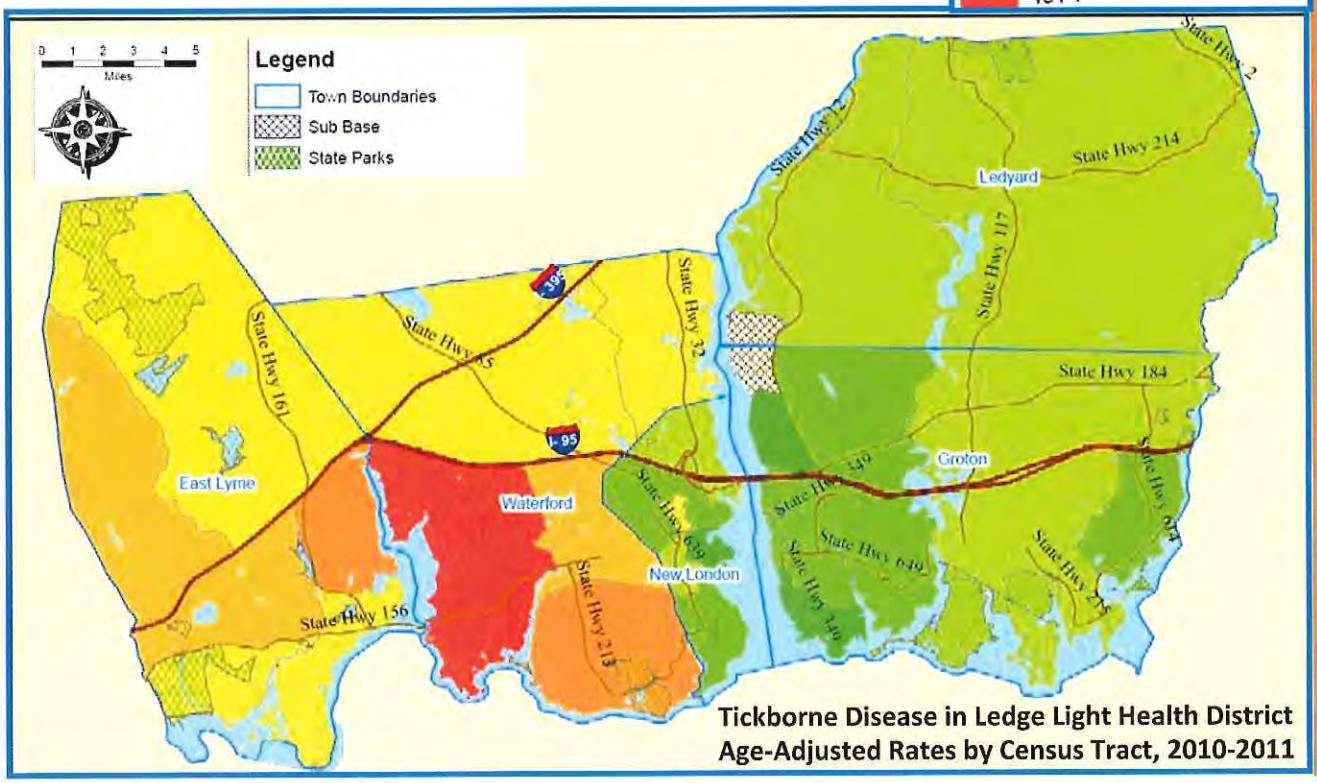
Vaccine Preventable Diseases



Source: CT DPH

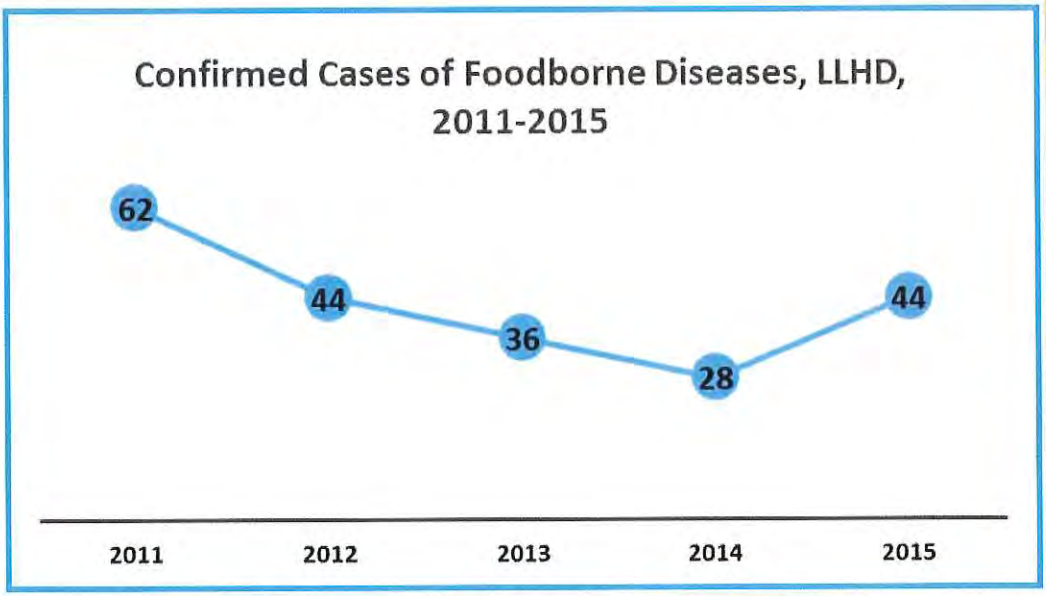
Lyme disease, ehrlichiosis and babesiosis, which are commonly transmitted to humans through deer ticks, account for most cases of tickborne disease in the region and state. Symptoms of these diseases include fever, skin lesions, and flu-like aches and pains. While early diagnosis and antibiotic treatment usually alleviates symptoms, the disease can lead to severe neurological and heart conditions. Several parts of LLHD have particularly high rates of tickborne disease, as detailed in the map below. Tick bites can be prevented through personal protection measures including avoiding covering arms and legs completely when in wooded areas with high grass and/or leaf litter, using DEET or permethrin (as directed), and finding and removing ticks by showering and doing full body tick checks as soon as possible after coming indoors, checking hiking gear and pets for ticks, and putting clothes in the dryer at high heat. Tick-safe zones can be created in yards and community spaces (such as parks) by having borders of wood chips or gravel between wooded areas and play areas, clearing tall grass and leaf litter, and planting deer resistant crops. The Connecticut Agricultural Experiment Station's Tick Management Handbook is a comprehensive guide to preventing ticks and tick bites through landscaping (available at http://www.ct.gov/caes/lib/caes/documents/special_features/

Tickborne Disease



Tickborne Disease in Ledge Light Health District Age-Adjusted Rates by Census Tract, 2010-2011

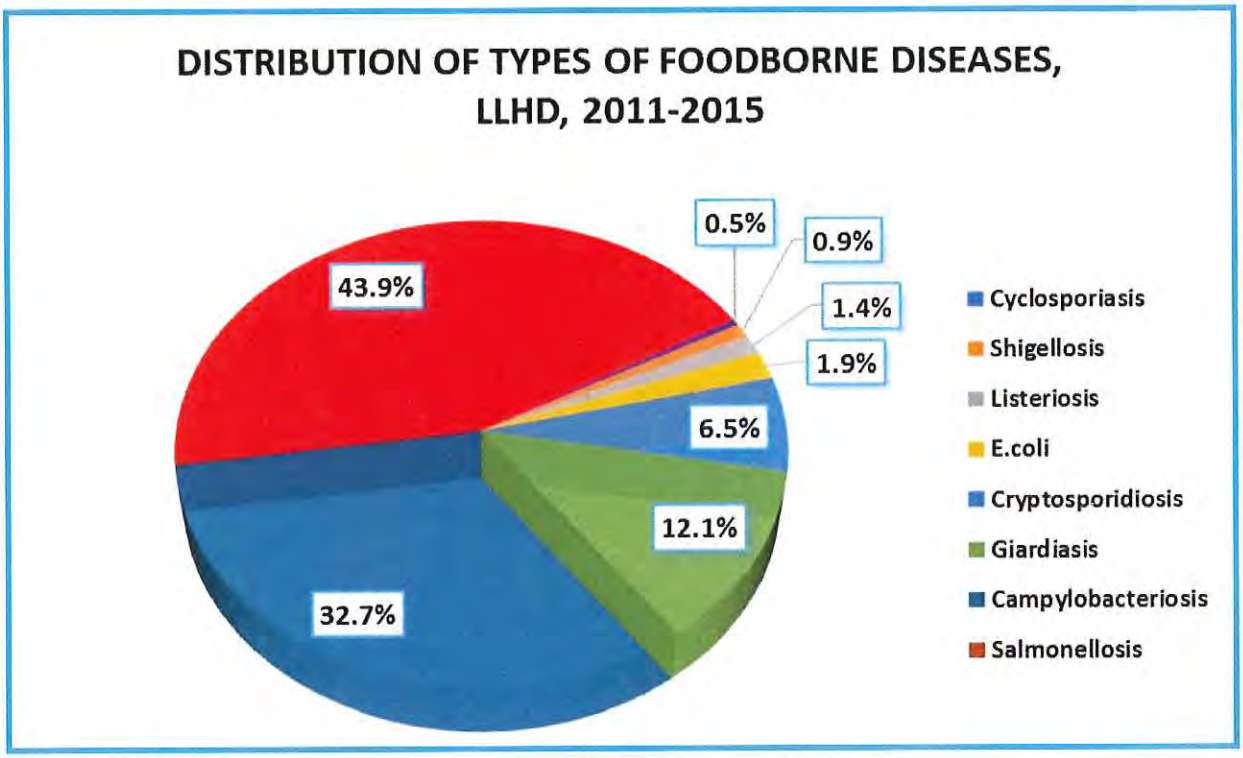
CDC reports that about 1 in 6 Americans get sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases yearly. These illnesses cost the economy over $15 billion each year, according to the U.S. Department of Agriculture Economic Research Service.



Source: LLHD

Foodborne Illness

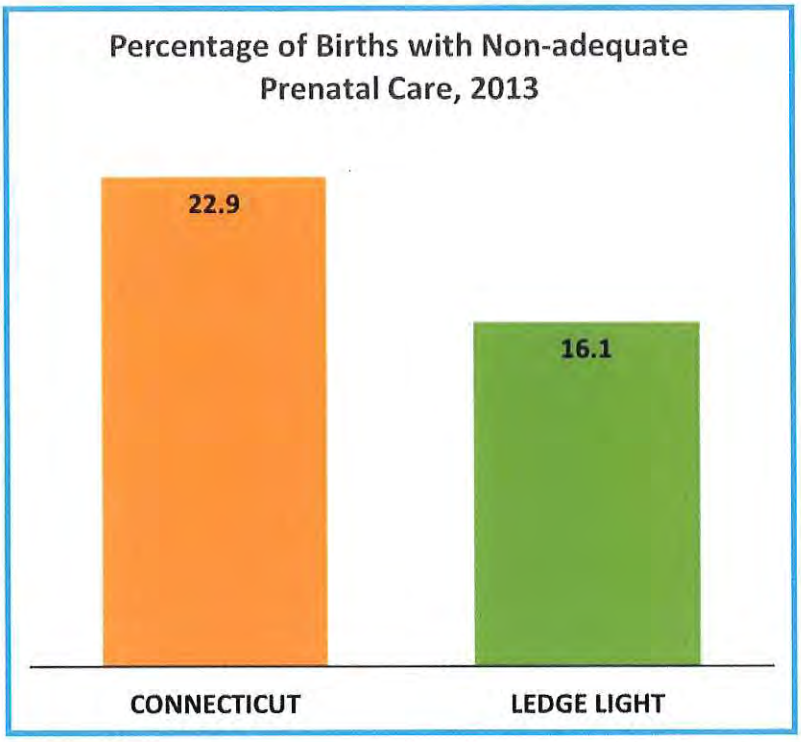
Severity of symptoms from foodborne illness range from mild or even non-existent, to severe and life threatening. The number of laboratory confirmed foodborne diseases in LLHD declined steadily between 2011 and 2014, but then rose slightly in 2015. The two most commonly diagnosed foodborne illnesses in LLHD are Salmonellosis and Campylobacteriosis, together accounting for more than 75% of all reported cases of foodborne disease in the area.



Source: LLHD

Maternal and Infant Health

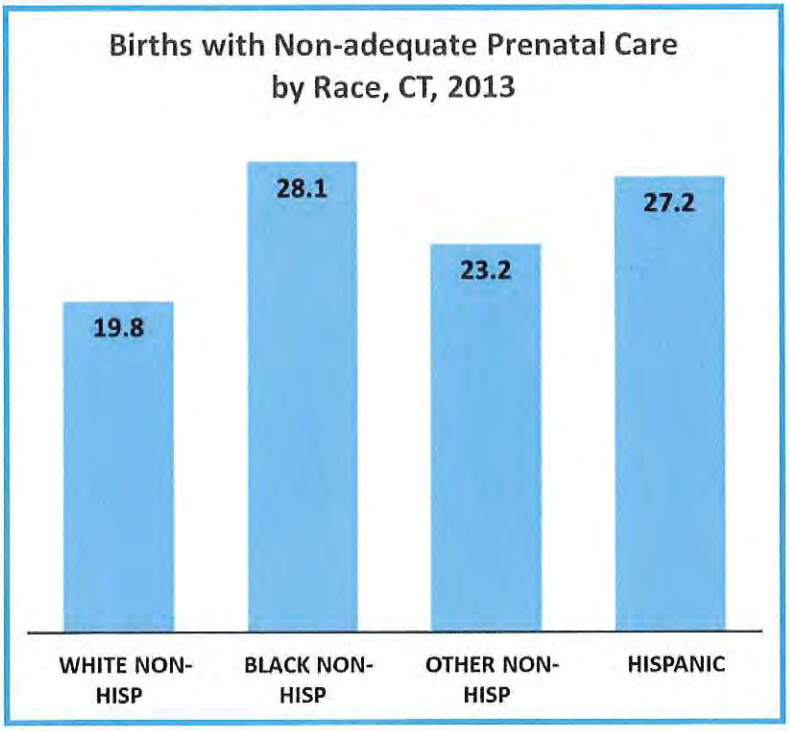
Prenatal care has the potential to reduce the incidence of poor birth outcomes by treating medical conditions, identifying and reducing potential risks, and helping women to address behavioral factors that that impact their pregnancy. It is more likely to be effective if women begin receiving care in the first trimester of pregnancy and continue to receive care throughout pregnancy, according to accepted standards of care.



Source: CT DPH

Prenatal Care

Statewide, fewer women have been accessing early and adequate prenatal care over the last decade. (CT DPH)

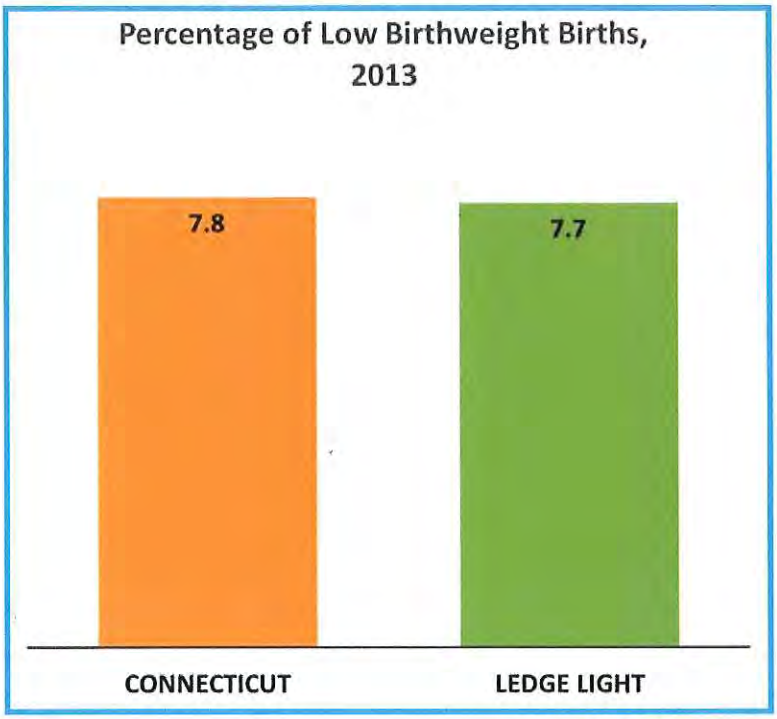


Source: CT DPH

Inadequate prenatal care, defined by a combination of the month of first prenatal care visit and the total number of visits during pregnancy, is associated with an increased risk of preterm delivery. Overall in LLHD adequacy of prenatal care compares favorably with the state. At the state level, there are persistent racial and ethnic disparities as well as disparities related to insurance coverage which are most likely present locally as well.

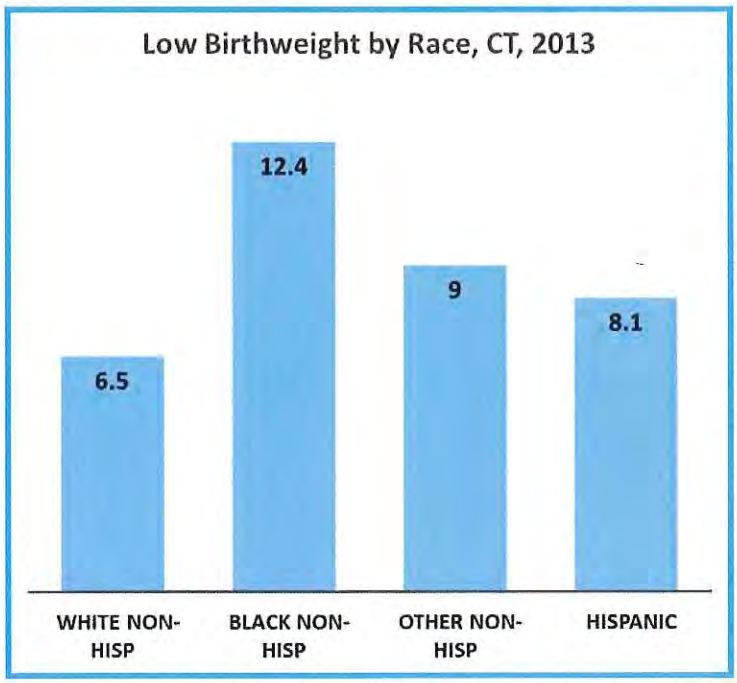
Low Birthweight Babies

Low birthweight, defined as a birth weight of less than 2,500 grams (or about 5.5 pounds), has been a persistent public health problem in Connecticut for many years. Low birthweight may result from pre-term birth or growth restriction in the uterus. Significant risks associated with low birthweight include infant death, developmental disabilities, cerebral palsy, hearing and vision impairments, cognitive deficiencies and poor neuropsychological outcomes, learning disabilities and poor educational performance, and behavioral problems.



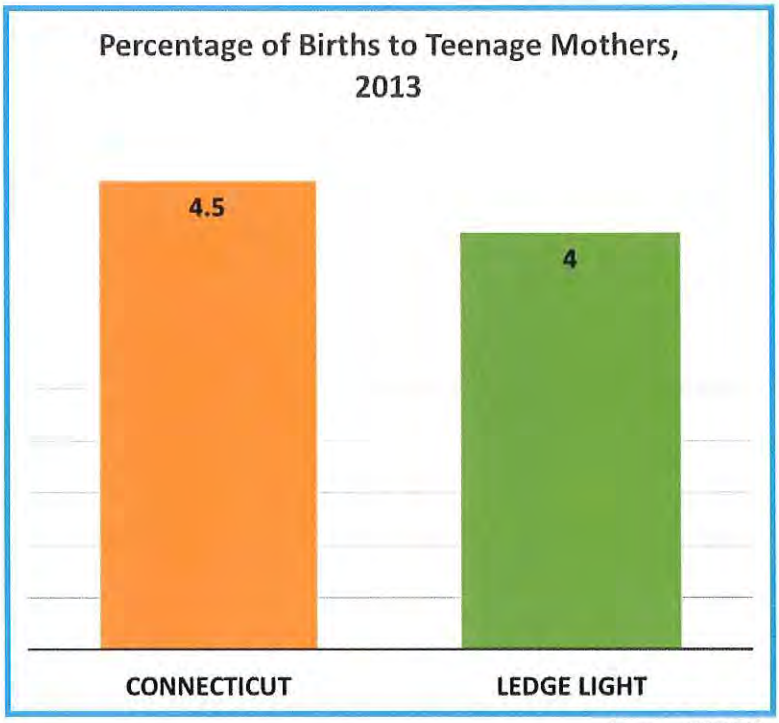
Source: CT DPH

Participation in the WIC program, having strong social support during pregnancy, eliminating tobacco exposure and adequate prenatal care can all significantly reduce the risk of low birthweight.



Source: CT DPH

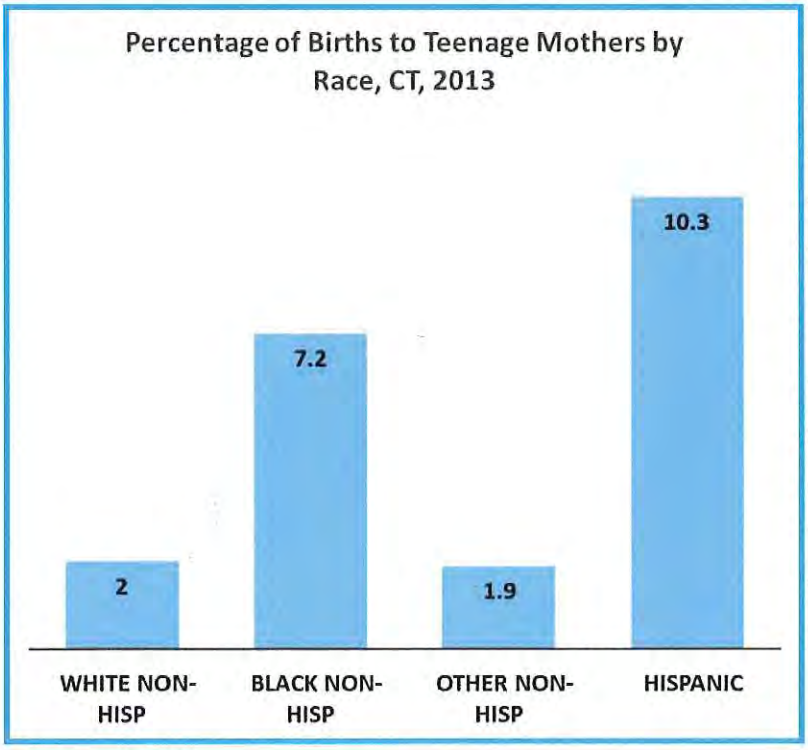
The percentage of low birthweight babies in LLHD is the same as in CT overall, however, here too racial and ethnic disparities are evident across the state, particularly among non-Hispanic Black women. This could be correlated with the racial and ethnic disparities in prenatal care. Further investigation is needed to determine if these disparities exist locally and, if so, why they are occuring.



Source: CT DPH

Births to Teens

The impact of teen pregnancy and birth is significant and multigenerational. Extensive evidence reveals that pregnant teens are at increased risk for premature birth, delivering low birthweight infants, other serious health problems, and death. Pregnant teens are more likely to interrupt or discontinue their education and their children are more likely to drop out of high school. Children born to mothers under age 20 are at greater risk of being in foster care or being a victim of abuse and neglect. According to the CT Department of Public Health "64% of children born to an unmarried, teenage high-school dropout live in poverty, compared to 7% of children born to women over age 20, who are married and are high school graduates." The children of teens are more likely to themselves become teen parents as well as to have higher incarceration rates and lower earnings. It is very positive then that in CT there has been a significant decrease in births to teens in the last decade and that the rate in LLHD is slightly lower than the state rate.



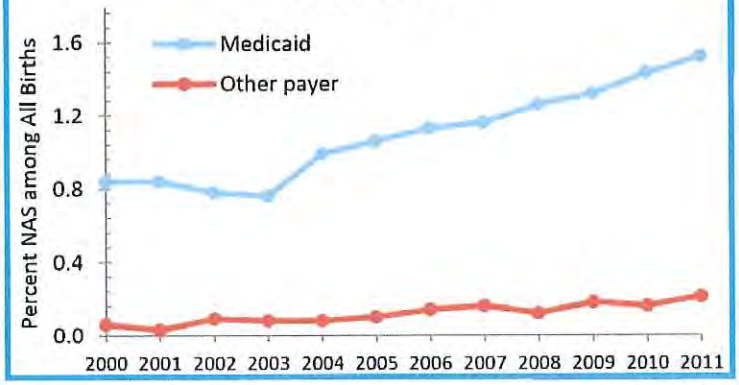
Source: CT DPH

However, despite the downward trend overall and decreases among all racial and ethnic groups, disparities remain at the state level. The high birth rates among Hispanic teens may be consistent with high birth rates among Hispanics overall.

Neonatal abstinence syndrome (NAS) is defined as a group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb. Those drugs may have been prescribed by a medical provider for pain management or may be "street drugs"; in-utero exposure to either can cause serious and long-term health problems for the newborn.

Opioid-dependent babies experience significant withdrawal symptoms after birth and often require a stay in the neonatal intensive care unit.

Percent of Children Born with Neonatal Abstinence Syndrome, By Payer, Connecticut, 2000-2011

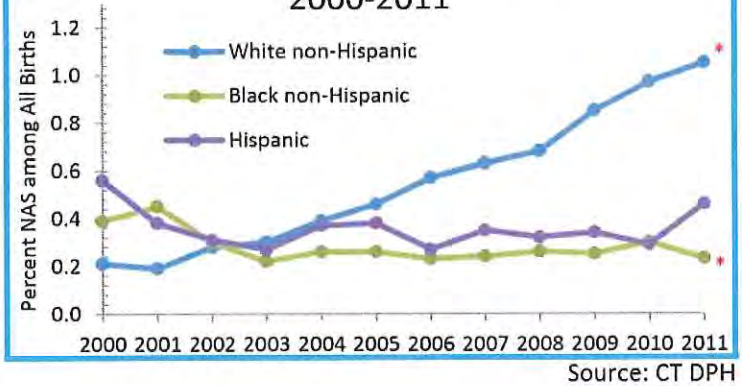


Source: CT DPH

Neonatal Abstinence Syndrome

According to the CT Department of Public Health, NAS has increased in the state in the last decade and is most prevalent among White non-Hispanics and persons with Medicaid insurance coverage.

Percent of Children Born with Neonatal Abstinence Syndrome, By Race, Connecticut, 2000-2011



Source: CT DPH

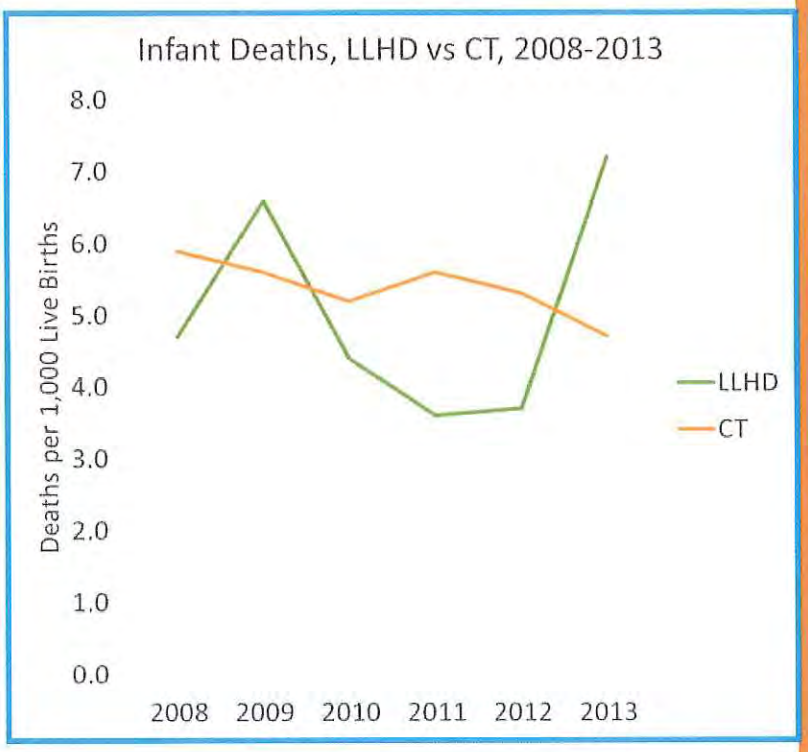
Note: * indicates significant increasing trend for White non-Hispanics and decreasing trend for Black non-Hispanics ($p<0.05$).

Babies born at L+M Hospital

Year	Number of Opioid-dependent babies
2013	20
2014	20
2015	32

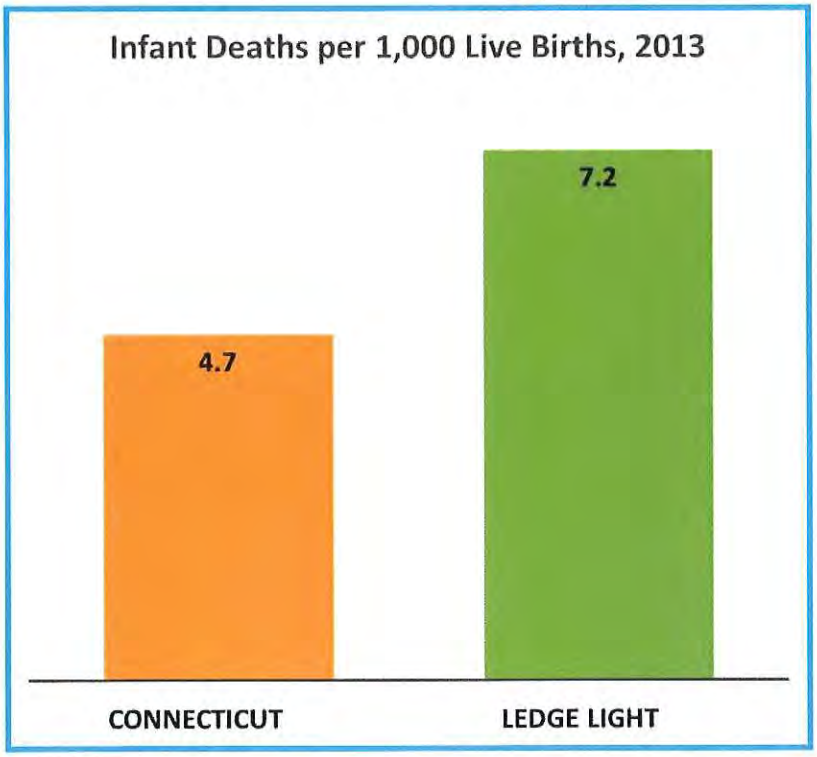
The statewide trend of increasing numbers of opioid-dependent babies is evident locally as well.

Infant mortality is defined as the death of a baby before his or her first birthday. Infant mortality can be an indicator of factors that impact the health of a community as a whole. CDC cites the top five leading causes of infant mortality nationally as birth defects, preterm birth and low birth weight, maternal complications of pregnancy, Sudden Infant Death Syndrome, and injuries. In CT, infant mortality has declined in the last decade and is below the Healthy People 2020 target of 6 per 1,000 live births but there has been a troubling uptick in the local rate.



Infant Mortality

For 2013, LLHD is on par with Lebanon, Malaysia, Kuwait and Chile. This may be a one year statistical anomaly with local trends being highly variable, but it bears monitoring. (World Health Organization)



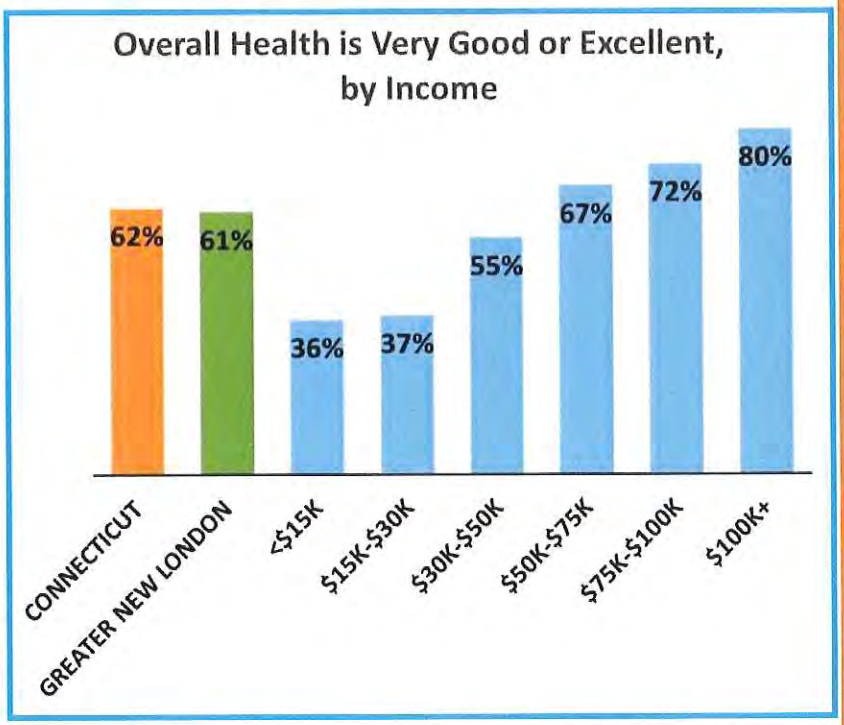
Source: CT DPH

In 2013, the latest year for which data are available, the infant mortality rate in LLHD far exceeded the state rate as well as the rates in the cities of Bridgeport and Hartford. State data indicate that significant racial disparities exist.

Mental Health and Substance Abuse

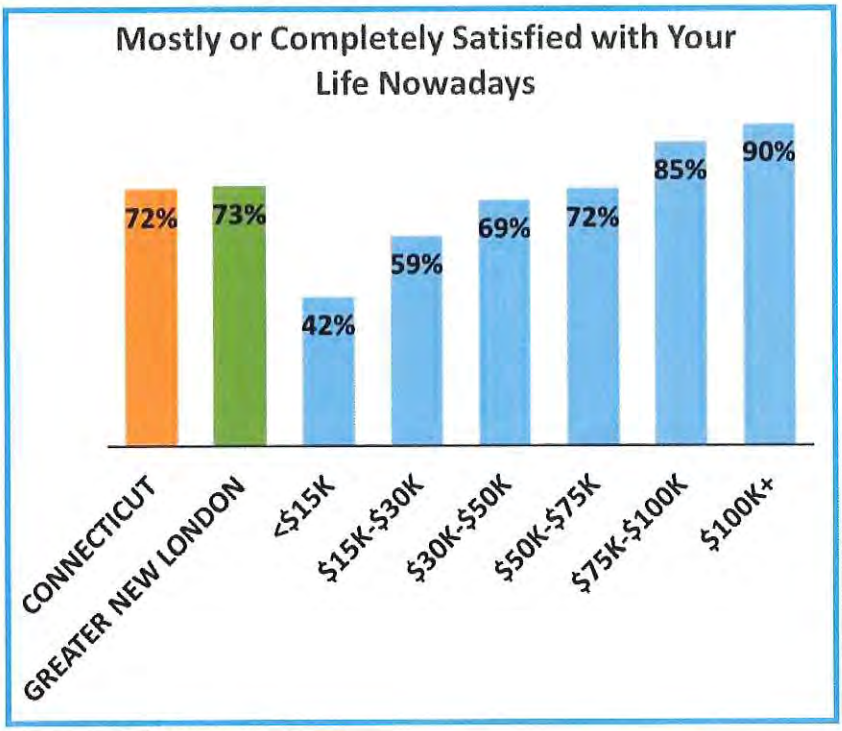
Mental and Emotional Wellbeing

Feeling physically unwell can have significant impact on a person's mental and emotional wellbeing. People with chronic pain or illness may become depressed or have anxiety about their futures, financial situations or families. In Greater New London, there is a direct relationship between reporting that one's overall health is "very good" or "excellent" and income. Those making less than $30,000 per year were half as likely to report general good health than those making $75,000-$100,000. This association is troubling but not surprising; as national studies and other local data presented in this report have shown, income is a significant determinant of health status.



Source: 2015 Wellbeing Survey

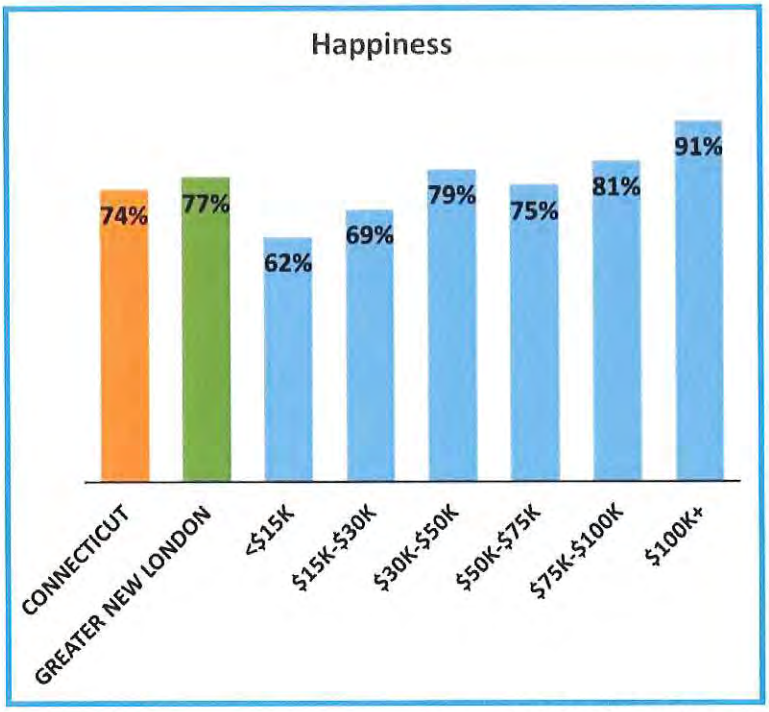
Only 45% of Greater New London residents overall say they have the time to do the things they really enjoy. The percentage is much lower among Hispanics, those who make under $15,000 and those in the $30,000-$50,000 income bracket. (Wellbeing Survey)



Source: 2015 Wellbeing Survey

Again, there is a direct relationship between general satisfaction with one's life and income; those in the highest income bracket were twice as likely as those in the lowest to say they are "mostly" or "completely satisfied with life nowadays".

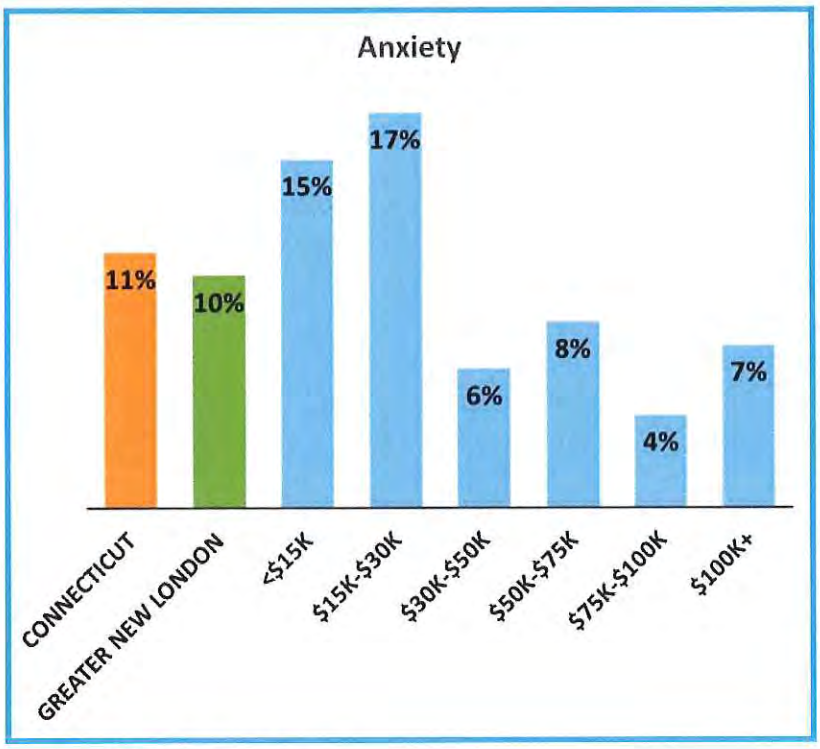
The Wellbeing Survey asked respondents about their overall happiness, anxiety and depression. These are not clinical diagnoses, but provide the best data currently available about how many of our local residents face barriers to good mental and emotional health, and where disparities exist.



Source: 2015 Wellbeing Survey

Mental and Emotional Wellbeing

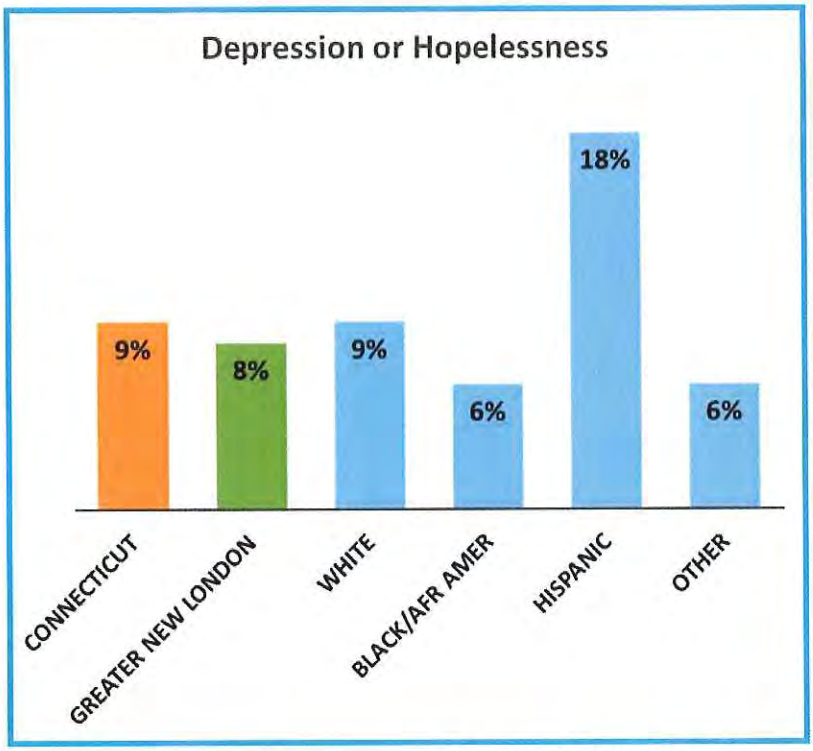
Despite the saying that "money can't buy happiness" it is perhaps not surprising that Wellbeing Survey respondents in the higher income brackets reported better overall emotional wellbeing.



Source: 2015 Wellbeing Survey

The long-term activation of the body's stress-response system, and the subsequent chronic overexposure to the hormones associated with that response, increases the risk of numerous health problems, including anxiety, depression, digestive problems, headaches, heart disease, sleep problems, weight gain, and memory and concentration impairment.

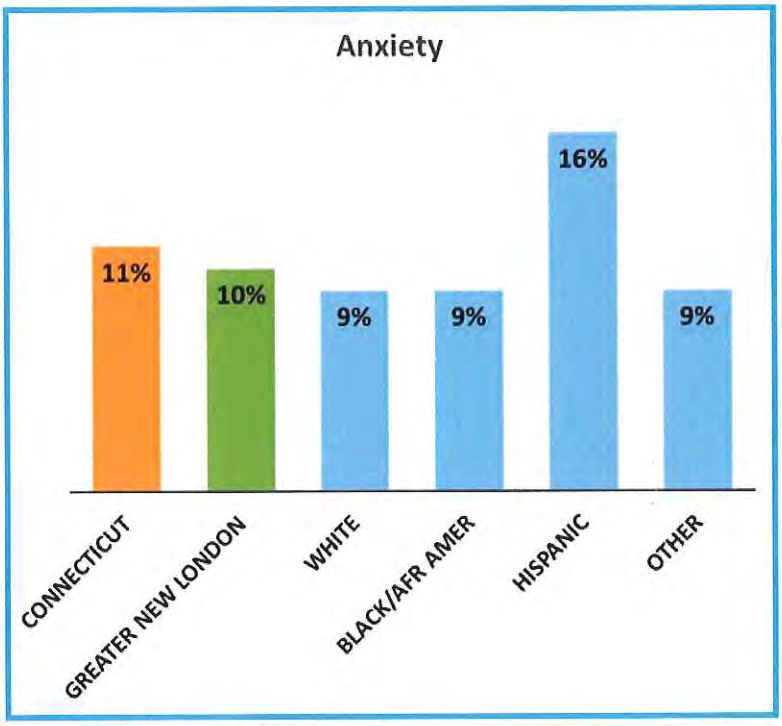
Hispanics were much more likely than the population overall to depression and anxiety in the Wellbeing Survey. Community key informants have theorized that this could be a combination of multiple factors, including, for immigrants, feeling loss associated with leaving their country of origin or concern over their or a family member's immigration status.



Source: 2015 Wellbeing Survey

Mental and Emotional Wellbeing

For 2015, Depression was the 4th most prevalent condition among hospitalizations in the Inpatient and ED Non-Admission settings for area residents. (CT Hospital Association)



Source: 2015 Wellbeing Survey

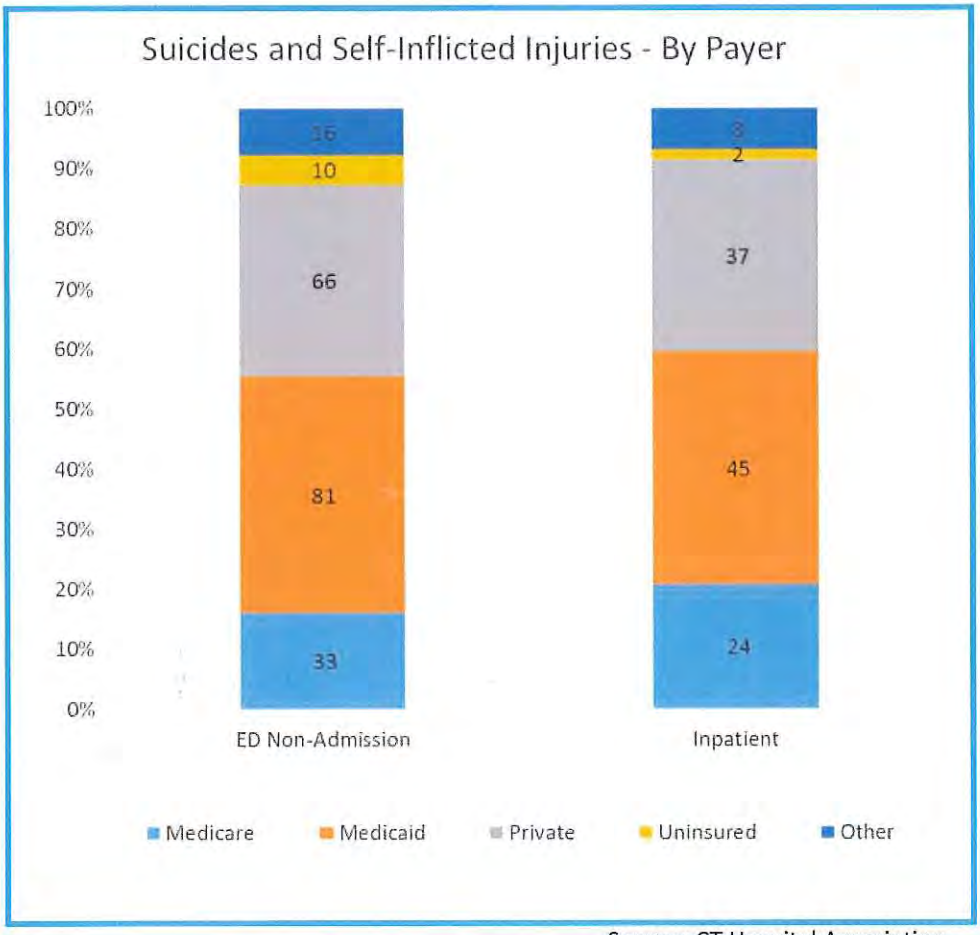
These responses indicate the need for culturally and linguistically sensitive mental health care in Greater New London. In addition to ensuring care is available and accessible, work should be done at the community level to decrease any stigma associated with seeking mental health care.

Suicide and self-inflicted injuries result from multiple intersecting factors. Causes are individualized and may include multiple intersecting health and environmental factors. Common warning signs of suicide include individuals talking about suicide or wanting to hurt themselves, increasing substance abuse, and having changes to their mood, diet or sleeping patterns. Research shows that suicide can be prevented—on-going support as well as crisis intervention can stop someone who is considering suicide from taking their life. In addition to increasing awareness and understanding of suicide and suicide prevention through community education, environmental interventions can be effective in preventing people from taking their lives or hurting themselves. Environmental interventions include suicide prevention hotlines, suicide prevention signage and safety nets on bridges and measure that reduce access to guns and medications.

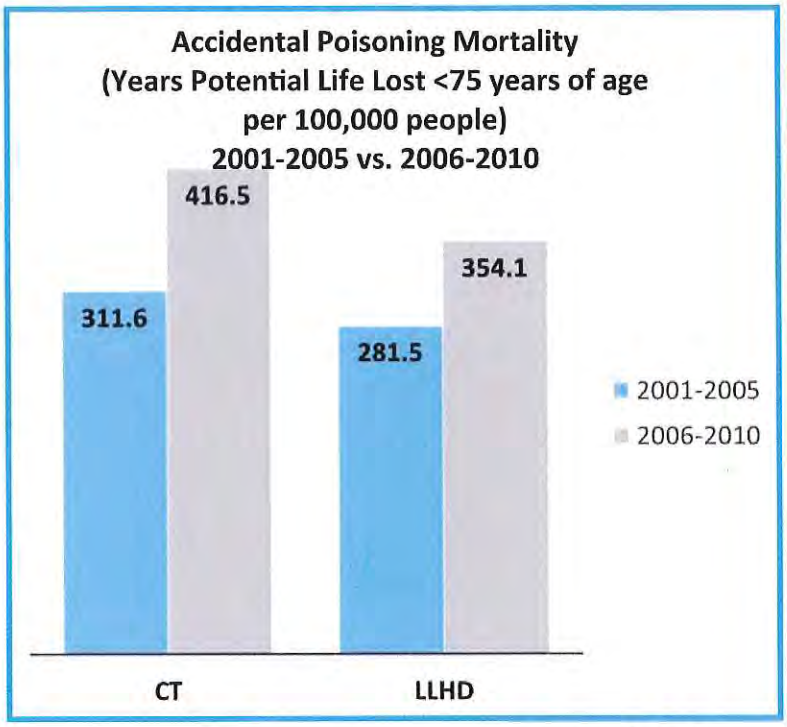
20% of residents in Greater New London have Medicaid but Medicaid beneficiaries account for 40% of all hospital encounters for suicides and self-inflicted injuries.

(CT Hospital Association)

Suicide and Self-Inflicted Injuries



Source: CT Hospital Association



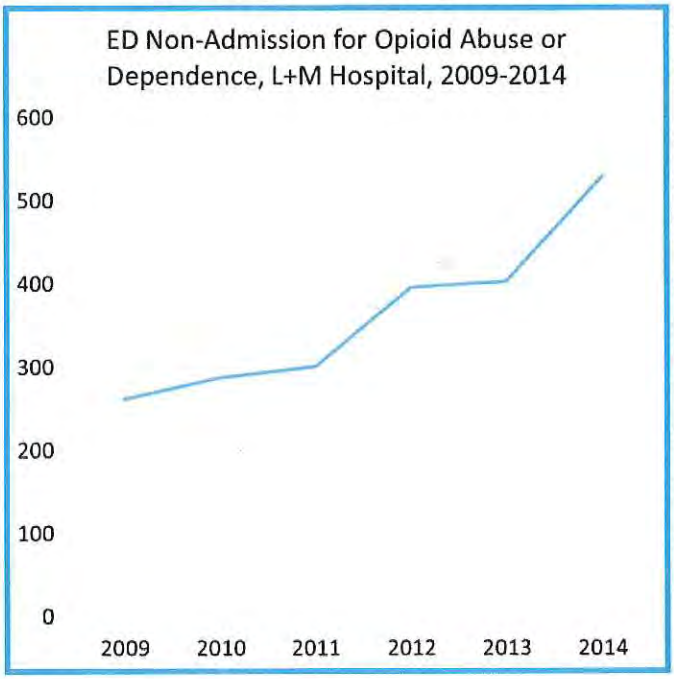
Source: CT DPH

Substance Abuse and Overdoses

A report from the Association for Healthcare Research and Quality states that, nationally, between 2006 and 2011, the rate of ED visits for substance-related disorders (not including alcohol) increased 48%. Over the same time period, ED visits for alcohol-related disorders increased 34%. Accidental poisoning as a cause of death includes overdoses from alcohol or drugs. While not all these cases are related to an overdose, the increase at both the state and local levels between these two five-year periods could indicate a growing problem with use of substances.

For 2015, Alcohol and Substance Abuse was the 5th most prevalent condition among hospitalizations in the Inpatient and ED Non-Admission settings for area residents. (CT Hospital Association)

In 2015, local, state and national news began to focus on a "heroin epidemic". Even before this, ED encounters at L+M for opioid abuse were rising—more than doubling between 2009 and 2014. Opioid abuse includes both the misuse of prescription drugs and use of "street" heroin. Much attention has been paid to the abundance and availability of prescribed opioids. While these medications can be effective in controlling pain, they are also highly addictive. In some cases, the person who is prescribed the medication becomes addicted and in other cases, someone else accesses unused pills. Prescribing practices and disposal of unused medications can both impact access to opioids.



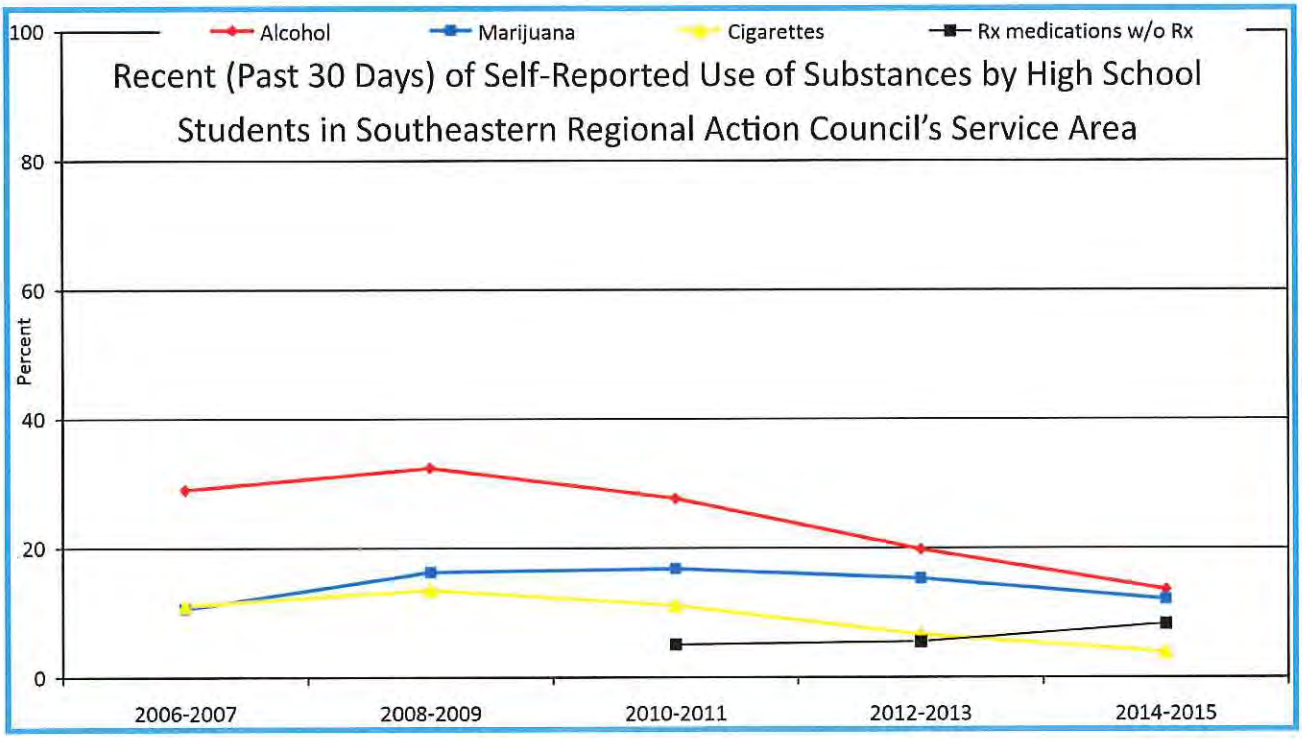
Source: CT Hospital Association

Preventing substance use among youth is seen as particularly important, both in order to prevent illness and injury among teens and to develop healthy habits that will decrease the likelihood of misusing alcohol or drugs as an adult. Across the region, lifetime and recent use of drugs is on par with or lower than U.S. rates. Evidence shows that when youth perceive substances to be harmful, they are less likely to use them. Use of alcohol and tobacco has decreased since 2008, which is associated with a simultaneous increase in the perception of harm of those substances.

Marijuana use by teens has been somewhat steady following an increase between 2006 and 2008. The reported perception of harm of marijuana has been decreasing, possibly a reflection of the growing number of places across the country that have legalized either medical or recreational use.

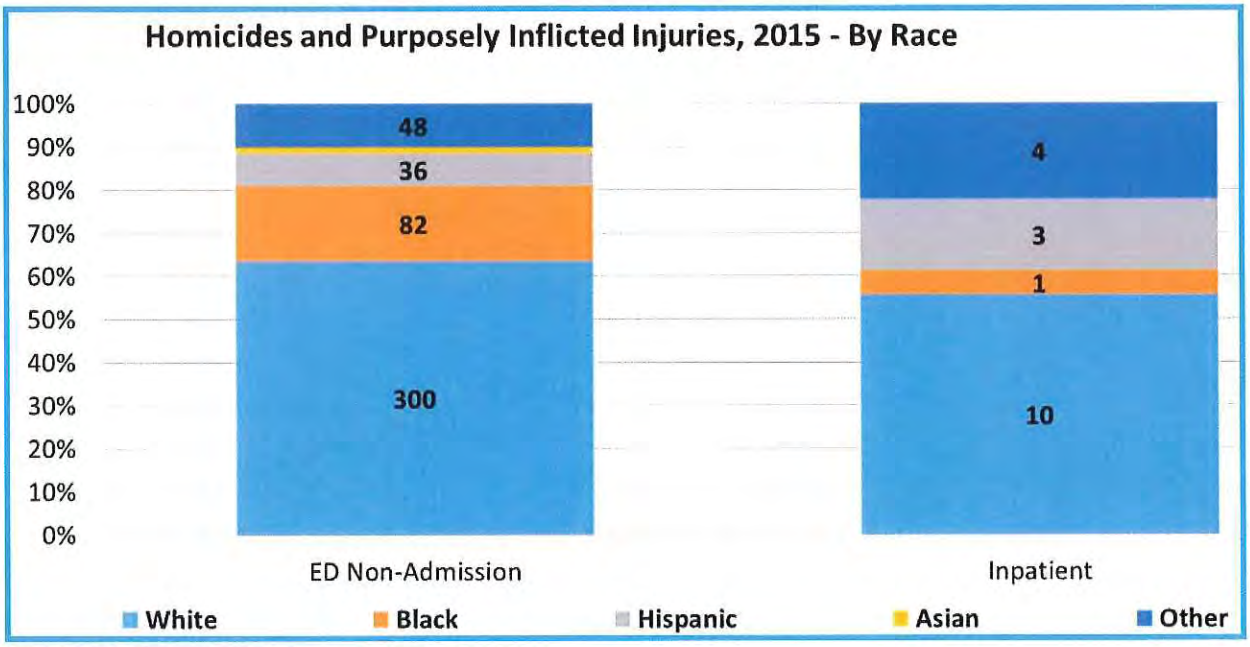
There is a troubling increase in the reported misuse of prescription drugs by teens in the region. This trend is worrisome as the most commonly misused prescription drugs are opioid pain relievers, which are highly addictive. Studies show that addiction to opioid prescription drugs can lead to heroin use, another opioid which can be less expensive than illegally purchased prescription drugs.

Substance Abuse Among Youth



Source: SERAC

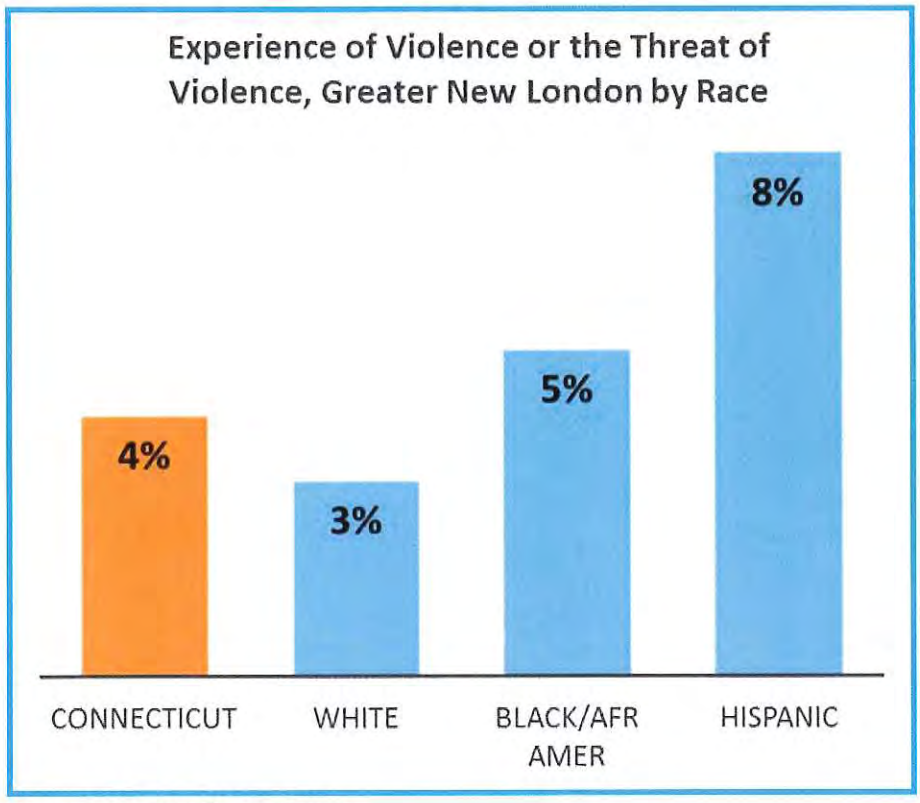
Injury and Violence



Source: CT Hospital Association

Violence

Racial disparities are evident in both the hospital encounters for violence and the reported experience of respondents to the Wellbeing Survey. While Blacks account for 6% of the Greater New London population, they made up 17% of the ED encounters and 22% of hospital admissions for homicides and purposely inflicted injuries. Hispanics reported the experience or threat of violence at double the overall rate.



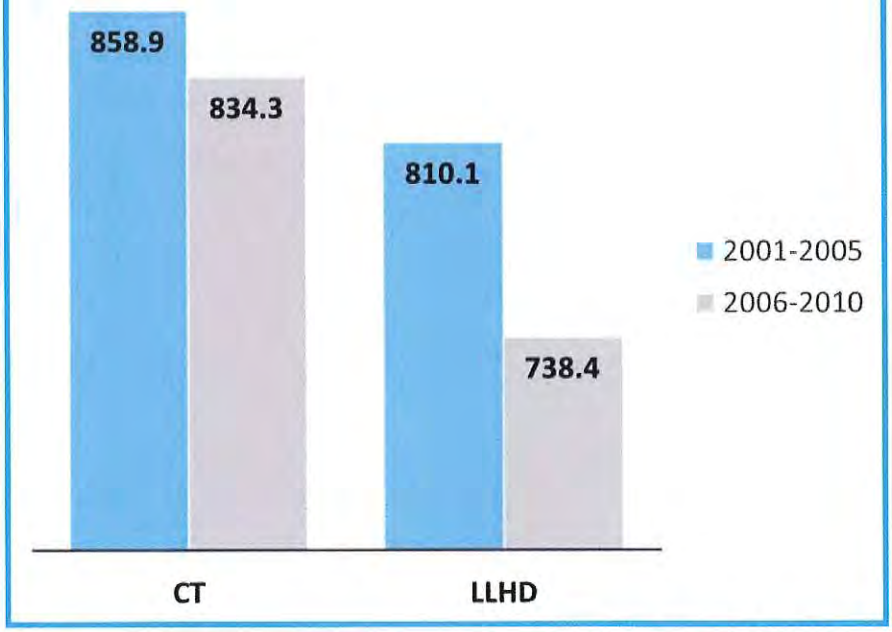
Source: 2015 Wellbeing Survey

Teen focus group participants report feeling less safe in their neighborhoods due to increased drug activity, people being shot at, and "strange people walking around."

While mortality from unintentional injuries overall decreased between the two five year periods 2001-2005 and 2006-2010 at both the state and local levels, mortality in Greater New London related to falls increased.

For 2015, ED non-admissions for falls for residents of Greater New London were almost evenly divided among the age groups 1-18, 19-44, 45-64 and 65+. Inpatient admissions however were heavily skewed toward the 65+ age group, demonstrating the increased likelihood of more severe complications from a fall for the elderly.

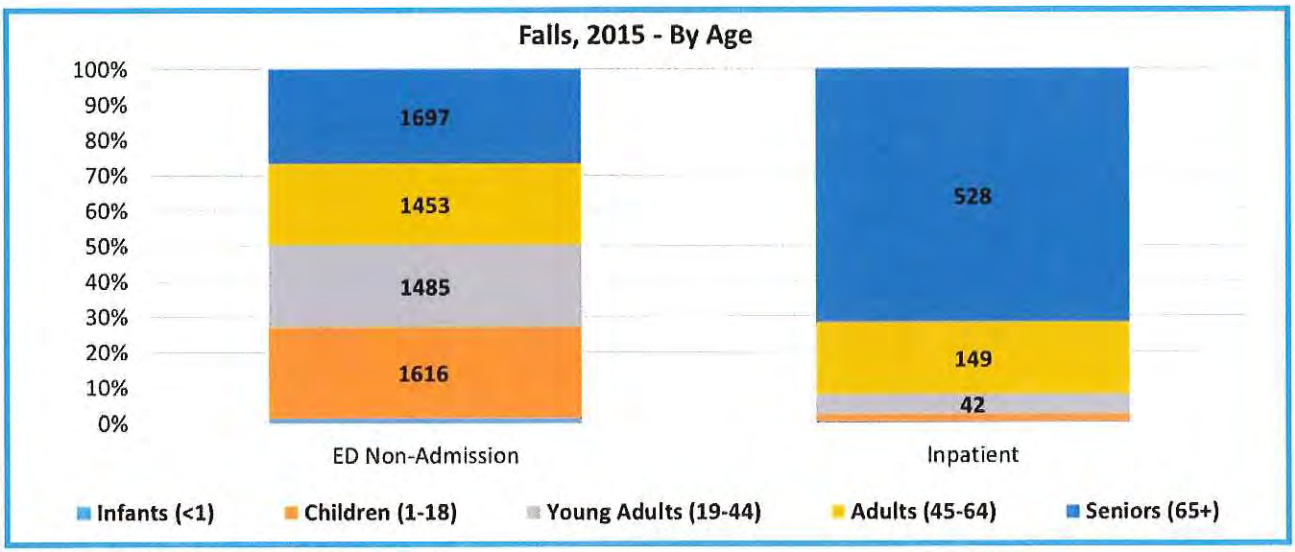
Unintentional Injuries Mortality
(Years Potential Life Lost <75 years of age per 100,000 people)
2001-2005 vs. 2006-2010



Source: CT DPH

Unintentional Injuries

Falls, 2015 - By Age



Source: CT Hospital Association

Environmental Risk Factors and Health

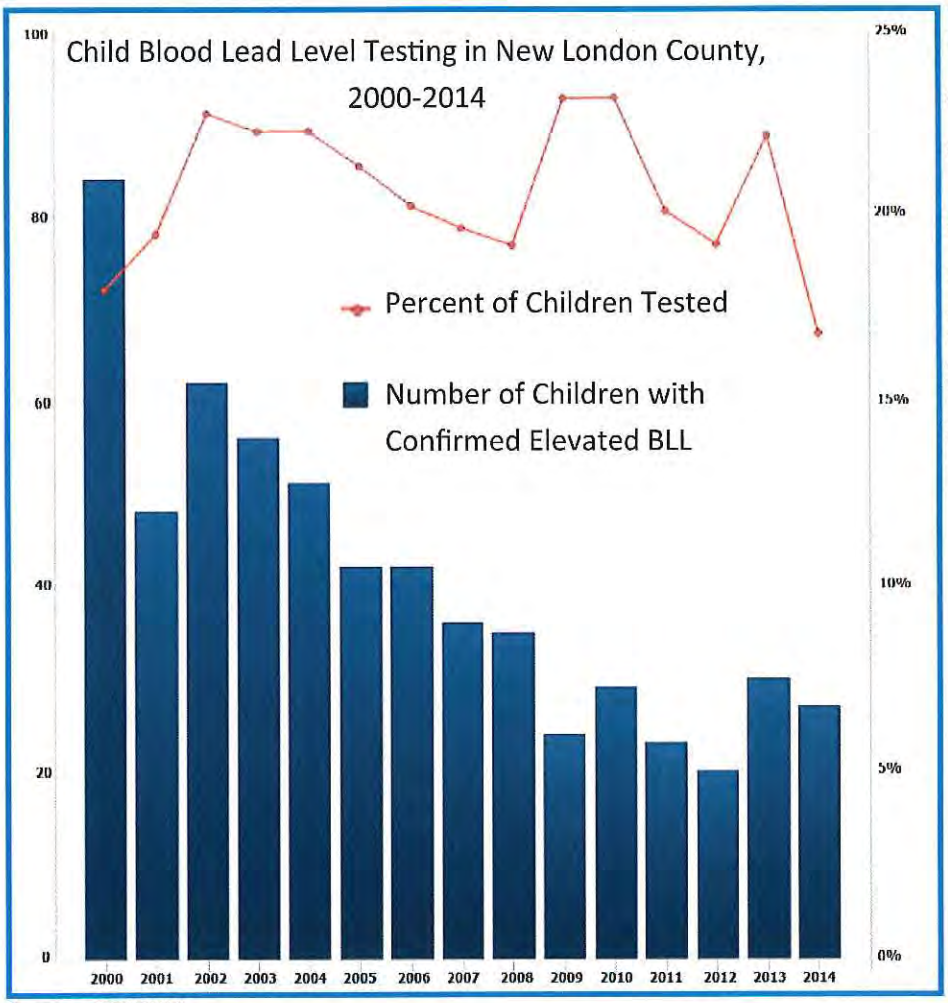
Lead

Before 1978, lead was used as an additive to paint used in houses. The age of the housing stock in Greater New London means that numerous homes may have layers of leaded paint on doors, windows, porches or walls. When this paint chips or peels lead dust can be ingested or inhaled. Lead can also be found in soil outside of older homes and in ceramic dishes, crystal and other items.

Children in Connecticut are required to be tested for lead at about ages one and two. In New London County, less than 20% of children receive both tests as mandated. (CT DPH)

Local health departments including LLHD and Uncas Health District are charged with taking action when a child with elevated blood lead levels is identified. While the numbers of children with elevated blood lead levels in New London County have been under 40 per year for the last 10 years, lead poisoning remains a substantial public health concern as there is potential for severe and life-long health and developmental repercussions. While the Connecticut General Statutes designates certain blood lead levels as actionable by health departments, no level of lead is safe. Lead poisoning can cause growth problems, hearing loss, learning problems, brain and neurological damage and even death.

Extensive research has noted correlations between elevated blood lead levels and poverty and renter-occupied housing.



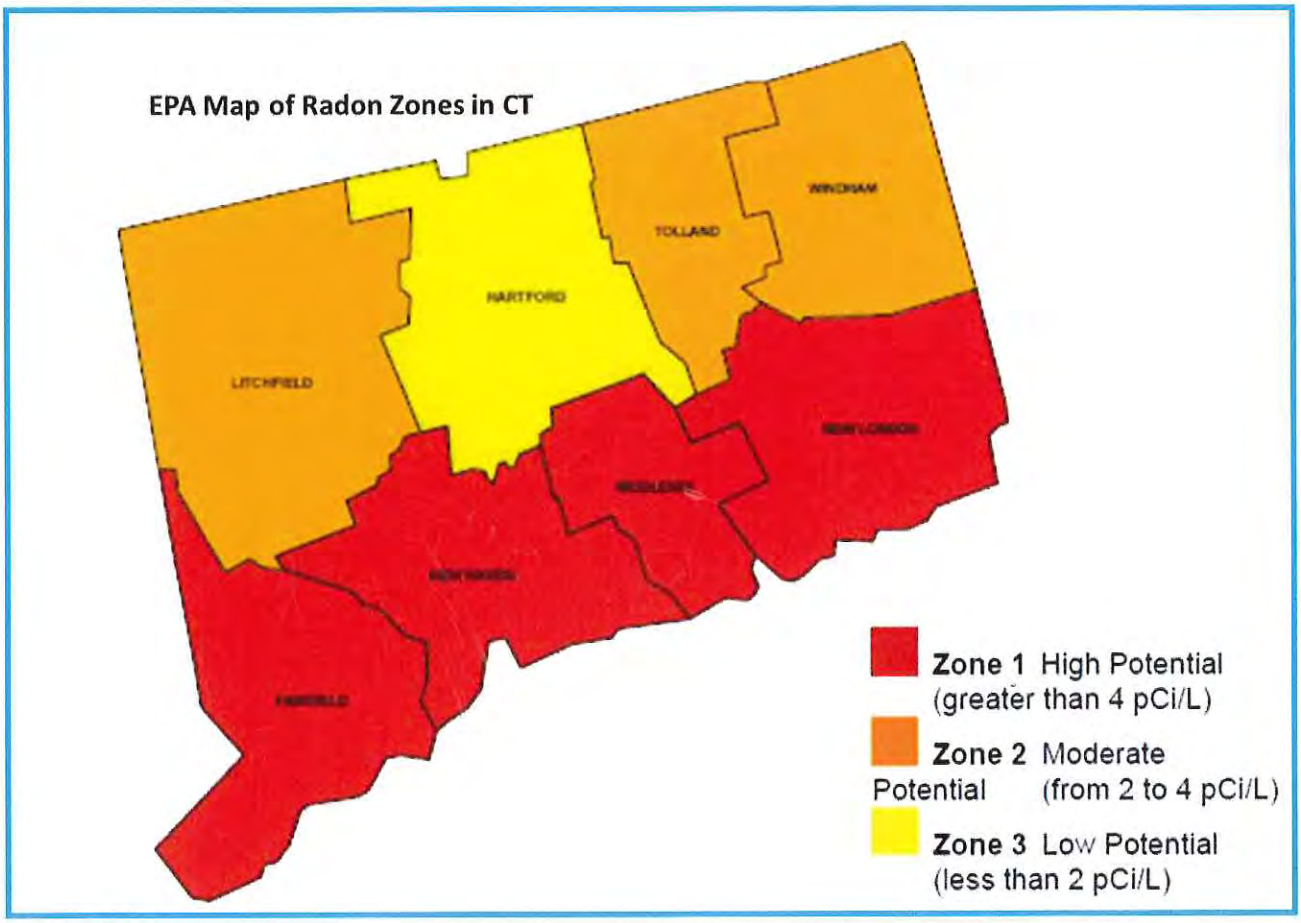
Source: CT DPH

Radon is a gas that forms when radioactive elements break down in rocks, soil and groundwater. Radon occurs naturally in some areas more than others. The EPA designates Greater New London, along with the entire southern coast of Connecticut, as a Zone 1, having high potential for radon exposure.

Radon is the second leading cause of lung cancer after cigarette smoking (CDC); the high potential for exposure in the area may be contributing to the locally high rates of lung cancer.

On the map below, each zone designation reflects the average short-term radon measurement that can be expected to be measured in a building without the implementation of radon control methods. The radon zone designation of the highest priority is Zone 1, which is the designation of New London County.

Radon



Source: EPA

Next Steps

Next Steps

Understanding health and wellbeing and their contributing factors for the southeastern CT region is critical; addressing the question of how to impact identified issues is equally, if not more, important. Following the analysis of data collected through this Community Health Assessment, the Southeastern CT Health Improvement Collaborative (Collaborative) engaged in a process to prioritize issues and develop strategies to improve health and well-being in the region. The Community Health Improvement Plan developed by the Collaborative is a dynamic document that serves as a roadmap for interventions going forward.

Collective Impact

This work follows a collective impact model, one which is effective when addressing entrenched social and community issues. Collective impact begins with the idea that large-scale social change requires broad cross-sector coordination and occurs when organizations from different sectors agree to solve a specific problem. The key elements of collective impact include creating a common agenda, aligning and coordinating efforts, using common measures of success, maintaining excellent communication among partners, and facilitating through a "backbone organization."

Future work should focus on continuing to untangle the complex interactions among socioeconomic status, physical environment, individual health behaviors and clinical care—all factors that impact health and wellbeing.

Community Health Improvement Plan

LAWRENCE + MEMORIAL HOSPITAL

LLHD Ledge Light Health District

Collective Action to Create a Healthier Community

Acknowledgements

SE CT Health Improvement Collaborative Steering Committee Members
Maritza Bond, MPH, Executive Director, Eastern Area Health Education Center
Megan Brown, CFRE, Senior Director of Marketing and Development, Thames Valley Council for Community Action
Constance Capacchione, MS, MPH, Public Health Program Coordinator, Uncas Health District
David Cawley, Program Planner, Thames Valley Council for Community Action
Stephanye Clarke, New London NAACP, Universal Health Care Foundation Communications Coordinator, African American Health Council
Nancy Cowser, Senior Vice President of Strategy, United Community and Family Services
Tammy Daugherty, Director of the Office of Development and Planning, City of New London
Karen Ethier-Waring, LMFT, Director of Clinical Services, Child and Family Agency of SECT
Judelysse Gomez, PhD, Assistant Professor of Psychology, Connecticut College
Jim Haslam, Staff Attorney, CT Legal Services
Juliet Hodge, Director of Economic Development and Marketing, Southeastern CT Enterprise Region
Carol Jones, Director Medical/Housing Case Management, Alliance for Living
Amanda Kennedy, Director of Special Projects, Southeastern CT Council of Governments
Jerry Lokken, Recreation Services Manager, Groton Parks and Recreation
Patrick Lynch, M.ED, Assistant Director of College/School Partnerships, Connecticut College
Tommie Major, Director of Parks and Recreation, City of New London
Alejandro Melendez-Cooper, President, Hispanic Alliance
Jeanne Milstein, Director of Human Services, City of New London
Patrick McCormack, MPH, Director of Health, Uncas Health District
Janeen Ortiz, Center Manager, Planned Parenthood of Southern New England
Michael Passero, Mayor, City of New London
Ocean Pellett, activist, United Action CT
Cherie Poirier, MBA, Development Coordinator, Eastern Area Health Education Center
Ann Pratt, Director of Organizing, Connecticut Citizens Action Group
Tracee Reiser, Associate Dean for Community Learning, Associate Director Holleran Center, Connecticut College
Dianna Rodriguez, LMSW, Behavioral Health Clinician, Community Health Center Inc.
Ariella Rotramel, PhD, Assistant Professor of Gender and Women's Studies, Connecticut College
Michele Scott, MSOL, Community Development Specialist, Mashantucket Pequot Tribal Nation
Jessica Seyfried, MPH, MSW, Community Outreach Coordinator, Thames Valley Council for Community Action
Stephen Smith, MD, Community Health Center New London
Victor Villagra, MD, UCONN Health Disparities Institute
Melinda Wilson, Grant Writer, United Community and Family Services

We are grateful to the many Connecticut College students who have participated in our discussions and work.

Table of Contents

Introduction

Over the course of one year, L+M Hospital (L+M) and Ledge Light Health District (LLHD) worked with the community partners on the SECT Health Improvement Collaborative (Collaborative) to collect and analyze the local health data presented in the Community Health Assessment (CHA) which accompanies this Community Health Improvement Plan (CHIP). The CHA examined leading health indicators in eight domains: social determinants of health; health systems and access to care, chronic disease, infectious disease, maternal and infant health, mental health and substance abuse, injury and violence, and environmental risk factors and health. The indicators explored were limited to those for which there were local data available. As a result of very limited local population health data on children, the CHA is predominately focused on the health status of adults in the community. The CHA brought to light certain areas of concern, where statistical analysis documented a disparate burden of disease, illness, injury, social or economic condition or limitation in healthcare access. While the work to produce the CHA and understand health and well-being and their contributing factors was crucial, addressing the question of how to impact identified issues is equally, if not more, important. This document identifies the health issues selected by the Collaborative for immediate action and objectives and strategies for each.

It is important to note that this Community Health Improvement plan is a dynamic "living document". In the absence of unlimited funding, people resources and influence in social and economic systems, it was necessary to "start some where" and the prioritization process identified in this document helped the Collaborative identify the starting point. Future work will focus on continuing to untangle the complex interactions among the socioeconomic status, physical environment, individual health behaviors and clinical care factors that impact health and well-being as we seek to better understand the priority issues. The CHIP will continue to evolve and reflect that changing understanding as well as new partners and strategies that join the effort.

For questions about this plan or to find out more about the Southeastern Connecticut Health Improvement Collaborative, please contact the leadership team:

Laurel Holmes, MSW, Director of Community Partnerships + Population Health, L+M Healthcare
lholmes@lmhosp.org/860.271.4698
Russell Melmed, MPH, Supervisor Health Education and Community Outreach and Epidemiologist, Ledge Light Health District
rmelmed@llhd.org/860.448.4882, ext. 311
Jennifer Muggeo, MPH, Supervisor Finance and Administration and Special Projects in Population Health, Ledge Light Health District
jmuggeo@llhd.org/860.448.4882, ext. 300

Process

Following the completion of the CHA, the Collaborative engaged in a process to prioritize issues and develop strategies to improve health and well-being in the region. The prioritization process included several rounds of review, discussion and group prioritization exercises:

- As the CHA was being edited and finalized, the leadership team from L+M and LLHD identified 31 indicators from the eight domains on which the region or a group within the region was an outlier. Efforts were taken to define the indicators as specifically as possible and to identify where certain groups were experiencing disparate health outcomes in the community. The 31 indicators are listed as Appendix A.
- In May 2016, 35 community partners (listed in Appendix B) participated in a data review and prioritization process using an objective scoring tool (attached as Appendix C), focused on these 31 indicators. The tool provided a frame for each participant to independently score each indicator on relevance ("how important is the issue?"), impact ("what do we get out of addressing it?"), and feasibility ("can we do it?"). The indicators were ranked according to their overall score—both within their domains and within the complete list.
- The leadership team then took effort to group the eight domains into four categories: social determinants/health systems; chronic disease; maternal-child health/infectious disease/environmental risk; and mental health/substance abuse/injuries and violence. At the June meeting of the Collaborative, members voted by selecting their top three indicators in each category. Following the meeting, members were given another opportunity to vote for their top twelve indicators, this time not categorized.

In addition to these group exercises by the Collaborative, input was solicited from the residents who had participated in the CHA focus groups, the community at large through the LLHD website, the Directors of Health for LLHD and Uncas Health District, and the ACHIEVE New London Collaborative (a group focused on chronic disease prevention). All told, over 65 individuals, presenting a broad range of perspectives, participated in the prioritization work.

Throughout all these prioritization exercises and discussions, five indicators consistently rose to the top of the list. The leadership team grouped them under three areas of focus and presented them to the Collaborative for input and approval:

- Improve the conditions that support mental wellbeing and reduce substance use. Indicators:
  - ⇒ opioid use
  - ⇒ anxiety/depression among minorities
- Support and nurture healthy lifestyles. Indicator:
  - ⇒ contributing factors to diabetes
- Ensure access to care. Indicators:
  - ⇒ prenatal care and related birth outcomes
  - ⇒ access to care for the low-income population

Subsequent meetings of the Collaborative included analysis of strengths, weaknesses, opportunities and threats in the region for each area of focus followed by the definition of goals and objectives, the creation of strategies, and the development of other plan elements. The resulting CHIP is a dynamic document that serves as a roadmap for interventions going forward.

Values and Vision

This work follows a collective impact model, one which is effective when addressing entrenched social and community issues. Collective impact begins with the idea that large-scale social change requires broad cross-sector coordination and occurs when organizations from different sectors agree to solve a specific social problem. The key elements of collective impact include creating and following a common agenda, aligning and coordinating efforts to ensure that they are mutually reinforcing, using common measures of success, maintaining excellent communication among partners, and facilitating through a "backbone organization." The Collaborative shares the responsibility to ensure that the strategies identified are implemented and that impact is measured. It can work to build capacity of existing efforts on a particular issue or take leadership on issues not being addressed. A tracking tool will be developed in order to enable the Collaborative to monitor progress on prioritized issues. The Collaborative leadership team will maintain transparency in all activities, communicate regularly with the Collaborative, and facilitate the ongoing efforts of the group.

Throughout the work of the Collaborative to date and going forward, the group has operated within values that include:

- Intentional creation of a culture of trust
- Authenticity in seeking community involvement
- Inclusiveness
- Respectfulness of cultural considerations and differences
- Social justice

At the June meeting of the Collaborative, members began discussing a vision statement that would reflect these values as well as some of the common themes that emerged from the CHA when residents were asked about their visions of a healthy community. As the work continues, the resulting draft vision statement will be refined and have an accompanying mission statement:

Southeastern Connecticut is a community healthy in body and mind that promotes access, healthy equity, social justice, inclusiveness and opportunities for all!

Priority Area: Mental Well-being and Substance Abuse

Mental Wellbeing and Substance Abuse

Priority Area and Indicators **Improve the conditions that support mental wellbeing and reduce substance use.** **Indicators: Opioid Use and Anxiety/Depression among Minorities**	
Goals	**Objectives**
Ensure systems are in place to support mental and emotional wellbeing in our community	By January 2018, better understand the characteristics of people living with opioid addiction in order to inform prevention activities.
	By January 2018 identify and understand local disparities related to anxiety and depression and take concrete action to improve local mental health systems of care.

Objective 1

By January 2018, better understand the characteristics of people living with opioid addiction in order to inform prevention activities.

Community Needs	Populations at Risk/ Disparities	Root Causes
In 2015, alcohol and substance abuse was the 5th most prevalent condition among hospitalization (inpatient and ED) among area residents.	All residents	trauma, frontal lobe development, experimentation, family stressors, mental health issues, ready access to Rx opioids, vulnerable subpopulations (to be identified)
ED encounters at L+M for opioid abuse more than doubled between 2009 and 2014.		

Existing Community Assets	People to Bring to the Table
various community coalitions including community prevention coalitions, first responders, municipal leaders, social service agencies, healthcare/treatment providers, SERAC, LLHD	entities coordinating the various community efforts, MPH students to contribute to research, first line providers for research collaboration

Mental Wellbeing and Substance Abuse

Objective 2

By January 2018 identify and understand local disparities related to anxiety and depression and take concrete action to improve local mental health systems of care.

Community Needs	Populations at Risk/ Disparities	Root Causes
Substantially fewer people earning less than $30K report trusting people in their neighborhood	Low income residents	poverty, lack of culturally sensitive services, transportation, social isolation, immigration/newcomer issues, emotional stressors, stigma, trauma
Hispanics were much more likely than Whites or Blacks to report depression, hopelessness, and/or anxiety	Hispanics	
Medicaid participants are disproportionately represented-at twice the rate-among residents with ED Non-Admissions for suicides and self-inflicted injuries	Medicaid beneficiaries	

Existing Community Assets	People to Bring to the Table
FQHCs, private providers, L+M/LMMG, Southeastern Mental Health Authority, Sound Community Services	Hispanic provider group through Hispanic Alliance

Mental Wellbeing and Substance Abuse

Priority Area: Healthy Lifestyles

Healthy Lifestyles

Priority Area and Indicators	
Support and nurture healthy lifestyles **Indicators: Contributing factors to diabetes**	
Goals	**Objectives**
Increase healthy food consumption and physical activity—both contributing factors to diabetes, to reduce incidence, particularly among minority populations	By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.
	By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.
	By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.

Objective 1

By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.

Objective 2

By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.

Objective 3

By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.

Community Needs	Populations at Risk/Disparities
59% of residents with incomes below $30K report being food insecure	Low income residents
Higher rates of obesity among lower income populations	
42% of residents with incomes below $30K report never exercising	
34% of residents with incomes below $30K report having diabetes	
Higher rates of obesity among Black/African American population	Black/African Americans
13% of residents with a high school education or less report having diabetes	Residents with less than HS education

Healthy Lifestyles

Objective 1

By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.

Objective 2

By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.

Objective 3

By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.

Root Causes	Existing Community Assets	People to Bring to the Table
Food insecurity, inadequate nutrition education, access to safe spaces to recreate, built environment deficits, food deserts, excessive screen time	Mobile market, community gardens, farm to school programs, school food programs, summer feeding program, produce at food banks, parks and rec programs/scholarships, organized sports, public parks, NLC Food Policy Council, Gemma Moran Food Center, WIC program, Youth centers, Diabetes Prevention Programs, Joslin Diabetes Center, LLHD, L+M Hospital/LMMG, SECT Health Improvement Collaborative,	schools

Priority Area: Access to Care

Access to Care

Priority Area and Indicators	
Ensure Access to Care **Indicators: Prenatal Care and Access to Care for Low-Income Populations**	
Goals	**Objectives**
Increase access to equitable and quality health care for low income residents.	By January 2018, increase understanding of community needs and misalignments between local systems of care, transportation systems and other factors impacting access, and take concrete action to increase access to equitable and quality health care.
Ensure systems are in place to support healthy pregnancies and positive birth outcomes for all SECT residents.	By January 2018, identify and understand local disparities with regard to prenatal care, low birthweight, neonatal abstinence syndrome and infant mortality, and take concrete action to improve local systems that improve these birth outcomes.

Objective 1

By January 2018, increase understanding of community needs and misalignments between local systems of care, transportation systems and other factors impacting access, and take concrete action to increase access to equitable and quality health care.

Community Needs	Populations at Risk/Disparities	Root Causes
31.5% of all ED visits by residents of Greater New London were for Ambulatory Care Sensitive Conditions	Medicaid beneficiaries/Blacks	Insurance status, cost, hours of available appointments, transportation, cultural and linguistic competence of providers
At-risk groups are more than twice as likely to receive care in the ED 3 or more times in the past 12 months compared to the overall population	HS or less education/<$30k income group/Black/Hispanic	
1 in 5 residents of Greater New London delayed getting needed medical care in the past 12 months.	Low income residents	

Existing Community Assets	People to Bring to the Table
FQHCs, private providers, SECT Health Improvement Collaborative, SEAT and other transportation providers, SECOG, SECTER, SMHA	SEAT, SECOG

Access to Care

Objective 2

By January 2018, identify and understand local disparities with regard to prenatal care, low birthweight, neonatal abstinence syndrome and infant mortality, and take concrete action to improve local systems that improve these birth outcomes.

Community Needs	Populations at Risk/ Disparities	Root Causes
Infant mortality rate in LLHD was 7.2 per 1,000 live births in 2013.	State data suggest Blacks and Hispanics	Insurance status, lack of awareness of importance of prenatal care, lack of transportation, maternal mental health, tobacco use, nutrition, food insecurity, maternal chronic illness, pattern of avoidance of Ob/Gyn care, hiding pregnancy, chronic maternal stress
16.1% of births in LLHD did not receive adequate prenatal care in 2013.		
7.7% of births in LLHD resulted in infants of low birth weight in 2013		
There was an increase of 60% in the number of babies born at L+M Hospital with neonatal abstinence syndrome.	State data suggest Whites and Medicaid	Overprescribing/availability/affordability of opiates, limited access to alternative pain management

Existing Community Assets	People to Bring to the Table
L+M, SCADD, Sound Community Services, Private providers, FQHCs	SCADD, Private providers

Appendices

Indicator
ACS Condition ED Visits
Anxiety
Asthma
Births to Teens
Cancer
Cardiovascular Disease
Chronic Lower Respiratory Disease
Depression
Diabetes
Employment
Falls
Food
Gonorrhea
Healthcare Delay
Hepatitis C
Housing
Hypertension
Infant Mortality
Lead Poisoning
Low Birthweight
Opioid Use
Oral Health
Prenatal Care
Repeat ED Visits
Sexually Transmitted Infection
Social Cohesion
Suicide
Tobacco
Transportation
Vandalism
Violence

Community Health Assessment Prioritization Event
Wednesday, May 18, 2016 from 10:30 AM to 1:30 PM (EDT)

Last Name	First Name	Organization
Boushee	Emily	Senator Murphy's Office
Brown	Megan	TVCCA
Clarke	Stephanye	Universal Healthcare Foundation
Cowser	Nancy	UCFS
Crook	Kathleen	L+M Healthcare Board of Directors
Cummings	Bruce	L+M Healthcare
Devine	Michele	SERAC
Eaccarino	JoAnn	Child and Family Agency
Gomez	Judelysse	Connecticut College
Jukoski	Mary Ellen	L+M Healthcare
LENZINI	MARY	Visting Nurse Association of SECT
Lokken	Jerry	Town of Groton Parks and Recreation
Lynch	Patrick	Connecticut College
MacKenzie	C. Stephen	SECTOR
McCarthy	Cathy	L+M Healthcare
Melendez-Cooper	Alejandro	Hispanic Alliance
Milstein	Jeanne	City of New London
OBrien	Jennifer	Community Foundation of ECT
Oefinger	Mark	Town of Groton
Parker	Kathy	Community Foundation of ECT
Pellett	Ocean	United Action CT
Poirier	Cherie	Eastern Area Health Education Center
Pratt	Ann	CT Citizens Action Group
Reiner	Jonathan	Town of Groton Planning
Scott	Michele	Mashantucket Pequot Tribal Nation
Sears-Graves	Dina	United Way of SECT
Sistare	Linda	Citizen
Sistare	Kent	Ledge Light Health District Board of Directors
Smith	Stephen	Community Health Center New London
Smith	Natalie	L+M Healthcare
Soto	Chris	Higher Edge
Stockton	Annie	United Way of SECT
Sullivan	Colleen	UCFS
Taylor	Cindi	Visting Nurse Association of Old Lyme
Wilson	Melinda	UCFS

Rating and Ranking Worksheet

Step 1: Rate Key Findings using Criteria

Instructions: Rate each Key Finding based on how well it meets each of the criteria provided.
Rate 1 – 10, with 1=very low and 10=very high
Add your four ratings for each key finding

Step 2:
Rank key findings

DOMAIN:	**Selection Criteria**					
	Relevance *How important is it?*	**Impact** *What will we get out of it?*	**Feasibility** *Can We do it?*			Referring to your total score numbers, rank order each of the key findings with a 1 being the key finding with the highest total score, 2 being the key finding with the second highest score, etc. In case of identical totals, use your best judgment to assign a unique rank number to each issue to break the tie.
Key Findings	-Burden (magnitude, severity, economic cost, urgency) of the issue -community concern -focus on equity and accessibility	-Effectiveness -Coverage -Builds on or enhances current work -Can move the needle and demonstrate measureable outcomes	-Community capacity -Technical capacity -Economic capacity -Political capacity/will -Socio-cultural aspects -Ethical aspects -Can identify easy short-term wins	**Total Score**		**Rank order of key findings**

Appendix C-prioritization scoring tool used during May 2016 event

Greer, Leslie

Subject: FW: Independent Monitoring Plan for Docket Numbers: 15-32032-CON and 15-32033-CON

Attachments: YNHHS Monitor Quals and Bios draft 10-22-16.pptx; DT-YNHHS Independent Monitor Draft Procedures (102416).pdf

From: Capozzalo, Gayle
Sent: Monday, October 24, 2016 2:52 PM
To: 'kimberly.martone@ct.gov'
Cc: Willcox, Jennifer; Rosenthal, Nancy; O'Connor, Christopher; 'Sauders, Kelly (US - New York)'; Tammaro, Vincent
Subject: Independent Monitoring Plan for Docket Numbers: 15-32032-CON and 15-32033-CON

Attached please find Deloitte's credentials and experience in providing independent monitoring services to other organizations. The second attachment is the Draft Workplan Deloitte would use as the Independent Monitor. We are still working on the Engagement Letter, which should be submitted to you to ty tomorrow. I look forward to speaking with you at your earliest convenience in order to allow us to have the Independent Monitor in place by November 8. Thank you.
Gayle

Gayle Capozzalo
Executive Vice President and
Chief Strategy Officer

789 Howard Avenue
New Haven, CT 06519

Phone: 203-688-2605
Fax: 203-688-3472

Email: gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Deloitte.

Yale New Haven Health System and Lawrence + Memorial Corporation

Independent Monitor Qualifications

October 22, 2016

Qualifications

Related experience

Independent Review Organization (IRO) and Monitor Qualifications

- Deloitte is currently serving as an IRO for a large health care system that entered into a 5 year CIA that requires the IRO to perform claim reviews at various facilities that provide hospital services. Deloitte's specialists are working with key stakeholders, including the OIG, to design a risk-based approach to the facility selection and claims review that will bring value above and beyond that of a simple random review selection.
- Deloitte served as the IRO for a stand-alone hospital in California that entered into a 3 year CIA that required the IRO to perform Claims Reviews, Cost Report Reviews and an Unallowable Cost Review. Deloitte specialists with deep experience in coding and billing were utilized to perform the claims reviews, while specialists with cost reporting and reimbursement experience were utilized to perform the cost report and unallowable cost reviews. The Claims Review included a sample of claims from the population of claims that had been submitted and reimbursed by the Medicare Program during the Reporting Period.
- Deloitte served as the IRO for a hospital that was part of a larger health system that had entered into a 3 year CIA that required the IRO to perform Claims Reviews and an Unallowable Cost Review. Specialists with certifications in inpatient medical record coding performed reviews of inpatient claims that had been billed to and paid by the Medicare Program that were included in the Discovery Samples as required by the CIA. Our work involved also included an Unallowable Cost Review performed by reimbursement and cost reporting specialists.

Related experience

Independent Review Organization (IRO) and Monitor Qualifications (continued)

- Deloitte is currently working with outside legal counsel for a physician-owned hospital in the southern United States and pursuant to a non-prosecution agreement after an investigation by the United States Department of Justice (DOJ) related to alleged violations of the Physician Self-Referral Law (Stark Law), federal and State anti-kickback laws and other anti-bribery anti-corruption (ABAC) laws and regulations. Deloitte was selected to be the ethics and compliance monitor to assess the operation of the compliance program, to conduct proactive monitoring of risk areas, and to make recommendations for improvement. To initiate the project, the Deloitte team conducted a comprehensive assessment of the existing compliance program, including the review of policies and procedures, hotline operations, training programs, and organizational structure. A detailed report was prepared and presented to the executive leadership, the governing board, and the Department of Justice. This report compared the existing compliance program to best practices for hospital compliance programs, and provided a roadmap on where the program met standards or required improvements.
- Deloitte has acted as the Independent Consultant for a Top 5 Bank as required by Consent Orders from both the Federal Reserve Board and the Office of the Comptroller of the Currency in multiple complex areas of mortgage servicing and foreclosure related activities. Activities for this engagement included: performed detailed review of loans with a foreclosure action taken over a five-year period, including reviewing millions of individual mortgage loan files; maintained high quality of work across multiple work streams with diverse U.S. and U.S. India teams; stood up a quality assurance process for the project in line with the expectations and practices required by the regulatory bodies; established a strong PMO for status reporting, metrics, and analysis as part of oversight by the regulatory bodies as well as the Bank; and, developed electronic tools/accelerators for capturing and documenting the results of the individual file reviews.

Related experience

Independent Review Organization (IRO) and Monitor Qualifications (continued)

- Deloitte has acted as the Independent Consultant for a Top 5 Student Loan Servicer as required by Consent Orders from both the Federal Deposit Insurance Corporation and the United States Department of Justice(DOJ). Engagement activities included the following: Performed predictive analytics as part of a multiple year lookback to estimate remediation related to multiple sections within the Servicemembers Civil Relief Act (SCRA); Performed detailed reviews of loans and related documents as well as court documents over multiple years related to multiple SCRA sections; stood up a quality assurance process; established a strong PMO; provided a detailed report as required within the consent order with the results of both the estimated remediation as well as the results of the detailed loan review based on regulatory criteria and direction.

- Deloitte Acted as the Independent Consultant for a Top 5 Bank as required by Consent Order and Judgement from the US Department of Justice (DOJ). Engagement activities included the following: Executed a retrospective review on qualifying military personnel in accordance with § 3937 of the federal SCRA; developed tools which utilized financial data at the transactional level to assess loan attributes, including payment and fees data, to calculate preliminary remediation amounts resulting from misapplied or missing benefits payable to borrowers under the SCRA; performed manual document assessment for select sub-set of loans identified through a data driven waterfall approach to reduce the number of manual touches; designed and executed quality assurance procedures; facilitated monthly meetings between Bank and US DOJ; provided a detailed report as required by the consent order along with full loan information used in the assessment using custom built databases; trained Bank and DOJ on how to utilize the custom built databases.

Project Leadership

Proposed engagement team

We have a core team ready to work with you

Engagement Leadership	
Kelly Sauders *Partner* *Advisory* 	**Lead Engagement Partner** Kelly is a Partner with Deloitte & Touche LLP who has over 20 years of experience in the health care industry. She specializes in providing regulatory compliance and risk services in the health care industry. Kelly has led numerous regulatory compliance program assessments, implementation projects and responses to government investigations. She has also been involved in many enterprise-wide risk assessment and ERM program development projects. In these roles she works frequently with boards of directors and executive teams. She has assisted numerous clients with CIA-readiness, government investigations, OIG audits, and self-disclosures regarding documentation, coding and billing matters and has led a number of Independent Review Organization (IRO) engagements and other projects with health care regulators.
Ed Sullivan *Principal* *Advisory* 	**Quality Assurance Advisor** Ed is a Principal within the Governance & Regulatory Risk Services group of the Advisory Practice. He has over 19 years' experience providing regulatory, internal control, risk services and enforcement action oversight to our largest banking clients. He has lead a numerous of engagements assisting top 5 US banks deal with regulatory matters as both an advisor and independent consultant. Additionally, he has assisted clients in preparation for regulatory examinations, conducted independent testing, provided training and developed policies and procedures directly related to regulatory matters. He routinely serves as an independent consultant related to regulatory matters for Federal Reserve Bank, Office of the Comptroller of Currency, FDIC, Consumer Financial Protection Bureau and the Department of Justice.

ed.

Proposed engagement team

We have a core team ready to work with you

Engagement Leadership	
Kaitlin McCarthy *Manger* *Advisory* 	**Monitor Engagement Lead** Kaitlin has over 8 years of experience in the life science and health care industry, with a specialization in health care compliance and regulatory matters. She has conducted compliance program assessments, enterprise risk assessments, and been engaged by clients for compliance program enhancement and implementation in preparations for pending CIAs. Kaitlin has provided interim compliance program assistance to clients, serving as interim Chief Privacy Officer for a large academic medical center. Kaitlin has participated in OIG investigation responses and remediation. She has also provided litigation support surrounding billing and coding compliance matters.
Ryan DeMerlis *Manger* *Advisory* 	**Subject Matter Expert** Ryan is a certified Project Management Professional (PMP) with more than 9 years of experience in commercial health care and Federal government consulting and management. Ryan principally consults with clients on issues related to regulatory impacts to strategy and operations, including the establishment of effective corporate compliance programs, physician contract compliance related to Stark and anti-kickback regulations, general billing compliance, and organizational responses to Federal regulators. A focus of his work relates to Federal health payment regulations, leading him to manage several engagements related to voluntary refunds, self-disclosures, and organizational monitoring, including managing an Independent Review Organization engagement.

Proposed engagement team (continued)

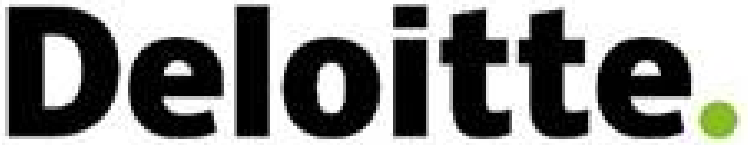
We have a core team ready to work with you

Engagement Leadership

Mark Giguere
Consultant
Advisory

Subject Matter Expert

Mark has over 3 years of experience in the life sciences and health care industry, specifically in the areas of regulatory compliance and risk management. Mark is currently working on an IRO engagement with a large health system. Mark also supports Deloitte's Health Care Regulatory Leader advising clients on emerging health care policy. Prior to joining Deloitte, Mark consulted provider organizations on regulatory matters related to Medicare payments.



The Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.

Deloitte.

DRAFT
10/24/16

INDEPENDENT MONITORING PROCEDURES (per Docket Numbers 15-32032-CON and 15-32033-CON)

Condition	D&T Procedure
Strategic Plan	
15-32033-CON Condition 4: Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHSC. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties. Note 2: Refer to Condition #19 which addresses the same/similar requirements	D&T will obtain a copy of the Services Plan, verify timely submission, verify that it incorporates the required elements and that it meets the 3-5 year requirement.
15-32033-CON Condition 19: L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components: a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such	D&T will obtain the Plan and review the plan for inclusion of these required elements.

Condition	D&T Procedure
period. L+M shall demonstrate annual progress toward achieving these goals. b. YNHHSC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement. NOTE 1: Refer to Condition #4 which addresses the same/similar requirements.	
15-32033-CON Condition 32b: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.
15-32033-CON Condition 7: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment [1]is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures [2]that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending a11d startup/operation dates); and	D&T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. D&T will confirm timely submissions of all required reports.

[1] Per discussion with OHCA, we understand that "capital requirement" per this Order is intended to mean "resource commitment". YNHHSC will describe the plan/resource commitment per Conditions #4 and #19 of this Order.

[2] See footnote 4.

Condition	D&T Procedure
c. The funding source of the capital investment [3]indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning. November 30, 2016. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.	
15-32033-CON Condition 5: Until such time as the Services Plan is submitted[4], YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18	D&T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days. Per related 15-32033-CON Condition #18, D&T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.

[3] Per discussion with OHCA, we understand that "capital investment" per this Order is intended to mean expenditures/investment made".

[4] The Services Plan is due 180 days after the closing date of September 8, 2016. Therefore this provision only applies until the Services Plan per Condition #4 is submitted.

Condition	D&T Procedure
15-32033-CON Condition 18: L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHSC is bound by Condition #4 and the Services Plan created per Condition #4	D&T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data. YNHHSC will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&T will obtain a copy of that Management Representation.
15-32033-CON Condition 32a: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31") and July through December (due January 31' certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation of the continuation of all L+MH services as described herein.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.
Financial Reporting	
15-32033-CON Condition 8: For three (3) years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to equity, long-term debt to capitalization, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements	D&T will obtain the financial measurement report and read to confirm that the required elements are addressed in the report; we will confirm the timely submission of each report.

Condition	D&T Procedure
used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	
15-32033-CON Condition 32f: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report. i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities; ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories; iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Repo1t 150 or successor reports; and	For 15-32033-CON Condition #32F, D&T will obtain the Five-Year Plan prepared by YNHHSC and the ongoing six month reports. We will verify that the required elements are included in the report. We will confirm timely submission to OHCA.

Condition	D&T Procedure
iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.	
15-32032-CON Condition 7c: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and	Refer to procedures for 15-32033-CON Condition #32f in the work plan above.
15-32033-CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price[5] per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015-August 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the	D&T will obtain YNHHSC's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information. D&T will confirm the timely submission of YNHHSC's filings as required by this Order. * 1st filing is due within 180 days (March 2017); 2nd filing is due 60 days after the close of FY2017

[5] Per guidance from OHCA, "total prices per unit of service" is meant to be the weighted average price across all payers per unit of service.

Condition	D&T Procedure
proposed transfer of ownership does not adversely affect health care costs.	which is 11/30/17 and the 3rd filing is due 60 dates after the close of FY2018 which is 11/30/18.
Cost and Market Impact Review	
15-32033-CON Condition 22: Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low	D&T will confirm that YNHHSC initiated this review within 90 days of closing. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.

Condition		D&T Procedure
	margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	
c.	In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.	
d.	The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.	
e.	The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR	

Condition	D&T Procedure
and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.	
15-32032-CON Condition 3: Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in D. below) for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant	Refer to procedures for 15-32033-CON Condition #22 above.

Condition	D&T Procedure
to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut. c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section l 9a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.	

Condition	D&T Procedure
15-32033-CON Condition 23: For purposes of determining the price per unit of service: f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annual with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.
15-32032-CON Condition 4: For purposes of determining the price per unit of service: a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of	

Condition	D&T Procedure
insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	

Condition	D&T Procedure
15-32033-CON Condition 20a: L+M and YNHHSC shall maintain the current L+MH and Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.	D&T will evaluate and verify that contracts are maintained in accordance with this condition.
15-32033-CON Condition 32c: Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.	For 15-32033-CON Condition 32c, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met.
15-32032-CON Condition 1: Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph. Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.	Refer to procedures for 15-32033-CON Condition #20 above.

Condition	D&T Procedure
For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	
15-32032-CON Condition 7a: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.	Refer to procedures for 15-32033-CON Condition #32f.
15-32033-CON Condition 20b: Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut.	D&T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.

Condition	D&T Procedure
15-32033-CON Condition 21a: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	Refer to procedures related to 15-32033-CON Conditions #4 and #19 (the Services Plan). D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.
15-32032-CON Condition 2a: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	Refer to procedures for 15-32033-CON Condition #21a above.
15-32033-CON Condition 21b: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.	D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.

Condition	D&T Procedure
15-32032-CON Condition 2b: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.	Refer to procedures for 15-32033-CON Condition #21 above.
Independent Monitor	
15-32033-CON Condition 15: Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years[6] following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein.	D&T and YNHHSC will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.

[6] The Monitor may be required for only 1 (one) year or up to five (5) years as determined in writing by OHCA.

Condition	D&T Procedure
NOTE: See Condition #33a (appointment of Monitor requirement)	
15-32033-CON Condition 33: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing:	
a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.	For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15.
b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.	15-32033-CON Condition #33b – D&T will meet with CHNA/CHIP Steering Committee in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&T of these meetings and provided to OHCA upon request.
c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.	
d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	With respect to 15-32033-CON #33d, D&T will confirm that YNHHSC has held a public forum including members of the CHIP (Community Health Improvement Program) group.
e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material	With respect to 15-32033-CON #33e, D&T agrees to provide written notice of any deficiencies as required.

Condition	D&T Procedure
negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	
15-32032-CON Condition 8: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings. e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing	Refer to procedures for 15-32033-CON Condition #33 a through e above.

Condition	D&T Procedure
regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	
15-32033-CON Condition 16: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis[7] to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall di with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	D&T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.

[7] The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

Condition	D&T Procedure
Community Benefit	
15-32033-CON Condition 11: The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent. In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	D&T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met. D&T will also obtain the YNHHSC report/summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&T will confirm that these documents are filed in a timely manner and posted to the L+MH website.

Condition	D&T Procedure
15-32033-CON Condition 31: L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.	After obtaining L+M's baseline Schedule H of IRS Form 990, D&T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5). Cross-reference to 15-32033-CON Condition #11.
15-32033-CON Condition 32h: A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.	Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.
15-32033-CON Condition 12: The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.	D&T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain a cultural competency plan, training, as well as related policies. We will also obtain YNHHSC's report and supporting documents and confirm the timely filing of these materials.

Condition	D&T Procedure
Charity Care Policies	
15-32033-CON Condition 9: Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Deloitte will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSC's financial assistance policies (or policies at least as generous as these policies) using management approval of the policies as evidence. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.
15-32033-CON Condition 10: For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.
15-32033-CON Condition 32e: Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.
Employment Conditions	
15-32033-CON Condition 27: L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.

Condition	D&T Procedure
15-32033-CON Condition 32g: Affirmation of the labor and employment commitments described herein, including but not limited to L+M' s service sites continued honoring of collective bargaining agreements in place as of the date hereof.	See others below
15-32033-CON Condition 28: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.
15-32032-CON Condition 6: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	Refer to procedures for 15-32033-CON Condition #28.
15-32033-CON Condition 29: L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.
15-32033-CON Condition 30: L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.
Governance	

Condition	D&T Procedure
15-32033-CON Condition 14: For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Verify that the designated Board member(s) meet this condition, as confirmed by OHCA.
15-32033-CON Condition 17: For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	To confirm compliance with this provision, D&T will obtain minutes from these Joint Board Meetings and confirm that notice of the public meetings is posted with proper notice. D&T will attend the public meetings as part of the Monitor role.
15-32033-CON Condition 26: As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.	D&T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.
Licensure, Physician Office Conversion, Cost Savings Attainment	
15-32033-CON Condition 13: The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA	D&T will obtain the survey/certification results as applicable (if surveys occur). We will confirm licensure via an

Condition	D&T Procedure
is imposing this Condition to ensure that quality health care services are provided to the patient population.	annual YNHHSC Management Representation.
15-32033-CON Condition 24: L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.
15-32033-CON Condition 32d: Affirmation that no L+M physician office has been converted to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.
15-32032-CON Condition 5: L+MH and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	Refer to procedures for 15-32033-CON Condition #24 above.
15-32032-CON Condition 7b: Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: Affirmation that no L+M physician office has been converted to hospital-based status.	Refer to procedures for 15-32033-CON Condition #32f above.
15-32033-CON Condition 25: L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.

Reference documents:

Name	title	Organization	email	comments
Participants in the CHA/CHIP process:				
Megan Brown	Senior Director of Marketing and Development	TVCCA	megan.brown@tvcca.org	neutral on affiliation
Stephanye Clarke	Communications Coordinator	Universal Health Foundation	stephanyerclarke@gmail.com	allied with intervenors; connected to NAACP and NL Housing Authority
Nancy Cowser	Senior VP of Strategy	United Community and Family Services	ncowser@ucfs.org	pro on affiliation
Jim Haslam	Chair	NL County Food Policy Council	jhaslam@connlegalservices.org	neutral; attorney
Jerry Lokken	Recreation Services Manager	Groton Parks and Recreation	jlokken@town.groton.ct.us	neutral to pro
Alejandro Melendez-Cooper	President	Hispanic Alliance	pacopeco48@gmail.com	pro
Russ Melmed	Epidemiologist	Ledge Light Health District	rmelmed@llhd.org	neutral; co-leader of the CHA and CHIP
Pat McCormack	Director of Health	Uncas Health District	doh@uncashd.org	I'm not sure his stance but may be somewhat cautious due to Norwich experience with Hartford HC
Jeanne Milstein	Director, Human Services	City of New London	jmilstein@ci.New-London.ct.us	neutral
Jennifer O'Brien	Program Director	Community Foundation of Eastern CT	jennob@cfect.org	neutral
Tracee Reiser	Associate Dean for Community Learning, Associate Director Holleran Center	Connecticut College	tlrei@conncoll.edu	neutral to cautious; long-time community partner
Dianna Rodriguez	Behavioral health provider	Community Health Center, Inc.	rodrigd@chc1.com	likely neutral
Chris Soto	Director	Higher Edge	chris@higheredgect.org	likely neutral; also likely to be elected State Rep
Victor Villagra, MD	Director	UCONN Health Disparities Institute	victorg.villagra@gmail.com	neutral
Hospital Corporators offered by Bill Stanley				
Jane Lassen Bobruff	volunteer	n/a	nealjane@aol.com	pro
Ann Burdick	volunteer	n/a	860-443-4236	pro
Karen Hatcher		Mashantucket Pequots	khatcher@prxn.com	pro
Dan O'Shea	retired Pfizer exec.		danoshea@snet.net	pro
Ricardo Ochoa	retired Pfizer exec., former board planning committee		860-235-5459	pro
Verna Swann	volunteer, retired L+M employee		vpswann@yahoo.com	pro

Greer, Leslie

Subject: FW: OHCA Conditions Document for Docket Numbers: 15-32033-CON and 15-32032-CON
Attachments: Yale New Haven Summary of Conditions (102116).pptx

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From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Friday, October 21, 2016 2:18 PM
To: Martone, Kim
Cc: Rosenthal, Nancy; Tammaro, Vincent; Willcox, Jennifer; Aseltyne, Bill; O'Connor, Christopher; Perrone, Brett
Subject: OHCA Conditions Document for Docket Numbers: 15-32033-CON and 15-32032-CON

Kim,
Attached please find the document we discussed yesterday. Nancy and I attempted to document the discussions that we have had regarding integrating the conditions and providing a coordinated way of addressing them. Once you've had time to review it, we look forward to discussing it with you. You will receive Deloitte's qualifications and workplan early next week. Thank you very much for working with us on this.
Gayle

Gayle Capozzalo
Executive Vice President and
Chief Strategy Officer

789 Howard Avenue
New Haven, CT 06519

Phone: 203-688-2605
Fax: 203-688-3472

Email: gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Yale NewHaven Health

Review of OHCA Conditions

Docket Numbers: 15-32033-CON and 15-32032-CON

October 21, 2016

Table of Contents

Yale NewHaven Health

Review of OHCA Conditions

Strategic Plan

15-32033-CON
CONDITIONS 4 / 19 / 32b
Submit Strategic Plan by 3/7/2017 and report for 5 years
15-32033-CON
CONDITION 7
Until Capital Commitment Is Satisfied or 5 years

- YNHHSC shall submit a strategic plan by March 7th, 2017 (180 days after Closing Date) demonstrating how health care services will be provided by L+MH for five years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The strategic plan must include recruiting and retaining eight (8) additional PCPs and other providers to Eastern CT (New London, Windham and Tolland counties). The PCPs are defined as physicians in internal medicine, family practice, pediatrics, OB/GYN and geriatrics. The achievements attained in the strategic plan will be reported semi-annually for the 1st year (60 Days after March 31st and September 30th) and annually thereafter for a total of 5 years (Condition 32f), until March 31, 2021
- YNHHSC shall submit to OHCA a narrative report on the resource investments("Resource Investment Report") it has made in L+M in semi-annually and its affiliates from the $300M Commitment Amount. It must include list of expenditures, why the expenditure, and timeframe, and the funding source. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. The first reporting period is through March 31st 2017 (Report due May 31st), the second reporting period is April 1, 2017 – September 30th, 2017 (report due November 30th, 2017). Semi-Annual reporting shall continue for 3 years ending September 30th, 2019 (Report due November 30, 2019).

15-32033-CON
CONDITION 5
Until Services Plan Submitted

- YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date.

15-32033-CON
CONDITIONS 18 / 32a
5 Years

- L+M Hospital shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. Affirmation that these services will continue for 5 years. Reporting periods will be 60 days after March 31, 2017 and September 30, 2017 (Reports due May 31 and November 30th 2017) and on an annual basis thereafter (60 days after September 30) each year thereafter for a total of 5 years. (Ending September 30th 2021)

Yale NewHaven Health

Review of OHCA Conditions

Financial Reporting

15-32033-CON CONDITION 6
3 Years

- The Applicants shall file with OHCA the total price (weighted average price for all government and non-governmental payers) per unit of service for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. This will be reported at the end of each fiscal year for 3 years.

15-32033-CON CONDITIONS 8
3 Years

- YNHHSC shall submit to OHCA a semi-annual financial measurement report. This report must show current month and year-to-date data and comparable prior year period data for L+MH and L+M. It includes various financial indicators related to margins, liquidity, leverage, and other statistics. The first reporting period is through March 31st 2017 (Report due May 31st), the second reporting period is April 1, 2017 – September 30th, 2017 (report due November 30th, 2017). Semi-Annual reporting shall continue for 3 years ending September 30th, 2019 (Report due November 30, 2019).

15-32033-CON CONDITIONS 32f

15-32032-CON CONDITION 7c
5 Years

- A five year synergy financial plan will be submitted by March 7, 2017. This plan will provide a 5 year projection of synergies expected broken down by fiscal year, resulting from non-clinical shared services opportunities such as L+M's integration of YNHHSC Information Technology systems and platforms, supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital and L+M's participation in population health initiatives. Annually, YNHHSC shall also submit reports 100,150,175 or successor reports. The first reporting period for all of the reports is through March 31st (Report due by May 31st). Reporting periods will be 60 days after March 31, 2017 and September 30, 2017 (Report due May 31 and November 30th 2017) and on an annual basis thereafter (60 days after September 30) each year thereafter for a total of 5 years. (Ending September 30th 2021)

Yale NewHaven Health

Review of OHCA Conditions

Cost and Market Impact Review

Continued

15-32033-CON CONDITION 22

15-32032-CON CONDITION 3

5 Years,

Initiate by 12/7/2016

- YNHHS shall initiate a cost and market impact review, within 90 days (12/7/2016) of the Closing date to establish a baseline cost structure and total price per unit of service for L+MH and LMMG, and establish a cap on the annual increase in the total price per unit of service. YNHHS shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline Cost and Market Impact Review ("CMIR") and annual updates and pay all costs associated with the CMIR. The report shall analyze factors relative to L+MH and LMMG and the Eastern CT market including: a) L+MH and LMMG's size and market share within their primary and secondary service areas; b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern CT; c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; d) availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; g) general market conditions for hospitals and medical foundations in the state and in Eastern CT; and h) other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern CT. If the review finds a likelihood of materially increased prices as a result of the affiliation, DPH and YNHHS must meet to create a performance improvement plan to address the conditions and the Commissioner of DPH will determine whether YNHHS is in compliance. Prior to the end of each fiscal year, the consultant will conduct the annual CMIR update and use the results to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. The consultant will report to DPH and provide reports to OHCA within 30 days of completion of the report, which shall be kept confidential. The consultant, in establishing the cap, shall take into consideration the cost reductions resulting from the affiliation and the annual cost of living of the primary service area of Eastern CT.

15-32033-CON CONDITION 23

15-32032-CON CONDITION 4

5 Years

- For purposes of determining the price per unit of service:
  - (a) A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-IO-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures.
  - (b) A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state.
  - (c) A "unit of service" for physician services shall be a work Relative Value Unit (wRVU).
  - (d) The baseline to be established as ofthe Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service.
  - (e) All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.

Yale NewHaven Health

Review of OHCA Conditions

Cost and Market Impact Review

Continued

15-32033-CON CONDITIONS 20a / 32c

15-32032-CON CONDITIONS 1 / 7a

Commercial plan contracts maintained until 12/31/2017, and no rate increase during this period. rate increase subject to price cap until 9/8/2021 for L+MH

- L+MH shall maintain the current L+M Hospital commercial health plan contracts and rates through 12/31/2017, although scheduled increases previously negotiated prior to the date of Closing (9/8/2016) may be maintained. Any L+MH commercial plan contract that expires prior to 12/31/2016 shall be extended to 12/31/2017 and any contracts without an expiration date shall be continued (as of Closing date 9/8/2016), under their current negotiated term, to 12/31/2017. No negotiations for price increases shall take place between 9/8/2016 and 12/31/2017. After 12/31/2017, L+MH shall negotiate new rates based on L+MH's post-Closing cost structure, taking into account price or cost reductions, i.e. efficiencies, achieved as a result of the affiliation . No single system-wide rates shall be imposed and negotiated rates should be reflective of the market conditions of hospitals in Eastern CT. Any annual increase in the total price per unit of service for L+MH shall be subject to a price cap determined through the process identified in OHCA Condition 22 (CMIR process). An annual price cap will remain in place until 9/8/2021 (5 years). Affirmation that commercial Health Plans are in place as of closing date are maintained new contracts and consistent with Conditions 20a, 21a and 22

15-32033-CON CONDITIONS 20b / 32C

15-32032-CON CONDITION 1

Commercial plan contracts maintained until 12/31/2017, and no rate increase during this period. Rate increase subject to price cap until 1/8/2019 for LMMG.

- LMMG shall maintain the current LMMG commercial health plan contracts and rates through 12/31/2017, unless scheduled increases previously negotiated prior to the date of Closing (9/8/2016)shall be maintained. Any LMMG commercial plan contract that expires prior to 12/31/2016 shall be extended to 12/31/2017 and any contracts without an expiration date shall be continued as of 9/8/2016, under their current negotiated term, to 12/31/2017. No negotiations for price increases shall take place between 9/8/2016 and 12/31/2017. After 12/31/2017, LMMG shall negotiate new rates based on LMMG's post-Closing cost structure, taking into account and price or cost reductions, i.e. efficiencies, achieved as a result of the affiliation. Negotiated rates should be reflective of the market conditions of like medical foundations in Eastern CT. Any annual increase in the total price per unit of service for LMMG shall be subject to a price cap determined through the process identified in OHCA Condition 22 (CMIR process). The process to establish annual price cap will remain in effect from 12/31/2017 until 1/8/2019 (28 months). Affirmation that commercial health plans in place as of closing date are maintained and any new plans are consistent with Conditions 20b, 21b, 22

Yale NewHaven Health

Review of OHCA Conditions

Cost and Market Impact Review

Continued

15-32033-CON
CONDITION 21a

15-32032-CON
CONDITION 2a
After Closing

- LMMG and NEMG will align by 1/1/2017. When NEMG is able to charge site specific prices for LMMG physicians and therefore abide by LMMG commercial health plan contracts and price caps, then LMMG and NEMG may merge. OHCA will be notified when the merger is completed.

15-32033-CON
CONDITION 21b

15-32032-CON
CONDITION 2b
28 Months until 1/8/2019.

- Physicians who are hired, recruited, or contracted by YNHHS to provide services in the primary service area (East Lyme, Lyme, Old Lyme, Groton, Ledyard, Montville, New London, North Stonington, Preston, Salem, Stonington and Waterford) in the following specialties: family medicine, general medicine, internal medicine, OBGYN, endocrinology, and psychiatry, shall be required to bill at the same rate as LMMG until 1/8/2019 (28 months).

Yale NewHaven Health

Review of OHCA Conditions

Independent Monitor

15-32033-CON
CONDITION 15 / 33

15-32032-CON
CONDITION 8
By 11/7/16 and for 5 Years

- Within sixty (60) days after the Closing Date, YNHHSC shall contract with an independent Monitor who has experience in hospital administration and regulation to serve as a post-transfer monitor. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.
- The monitor shall meet with community representatives six months after the 9/8/2016 Closing date (March 7, 2017) and annually thereafter and shall report to OHCA: a) L+M's compliance with the CON Order and b) the level of community benefits and uncompensated care provided by L+M during the prior period. The Monitor will report to OHCA within 30 days of its on-site reviews and meet with OHCA and FLIS to discuss its written reports. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out his/her duties. L+MH shall hold a public forum in New London 180 days after the Closing date (March 7, 2017) and not less than annually thereafter during the five year monitoring period to provide public review and comment on the monitor's reports and findings. If the monitor determines that YNHHS and L+MH are substantially out of compliance with the CON conditions, the monitor shall issue a notice to YNHHS and L+MH regarding the deficiency(is). Within two weeks of receiving the notice, the monitor will convene a meeting with representatives of YNHHS and L+MH to determine an appropriate corrective plan of action. If the plan is not implemented by YNHHS and L+MH satisfactory to the monitor within thirty (30) days of the meeting, the monitor shall report the noncompliance and its impact on health care costs and accessibility to OHCA. OHCA will determine whether the non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNMHHS and L+MH into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, and the right to impose and collect a civil penalty. In the event OHCA determines that YNHHS and L+MH are in material non-compliance, OHCA may order YNHHS and L+MH to provide additional community benefits as necessary to mitigate the impact.

15-32033-CON
CONDITION 16
2 Years

- The Independent Monitor will report to both OHCA and FLIS, conduct on-site visits no less than a semi-annual basis, and report to OHCA within 30 days of the on-site review. As necessary, the Independent Monitor will meet with OHCA and FLIS to discuss its written reports. At a minimum, two years duration.

Yale NewHaven Health

Review of OHCA Conditions

Community Benefit

15-32033-CON CONDITION 11
3 years

15-32033-CON CONDITION 31/32h
5 years

- The Applicants shall apply no less than a 1% increase per year, for the next 3 fiscal years, toward the L+MH's community building activities in terms of dollars spent, consistent with L+M's most recent Scheduled H of IRS Form 990 and its Community Health Needs Assessment (CHNA). . Annually, for 3 years (ending September 30, 2019), YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within 30 days of the end of the fiscal year and shall be posted on L+MH's website. Condition 31 – submission to OHCA of the 2016 CHNA and CHIP has been completed.
- After the 3 years, and for the subsequent 2 years of the total 5 year period, L+M and YNHHSC will be provide at least the same level of community benefit consistent with L+MH's most recent Schedule H with IRS Form 990 and its CHNA. The narrative should provide a description of L+MH's community benefit commitments in the communities L+M serves and amounts spent.

15-32033-CON CONDITION 12
3 Years

- The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website.

Yale NewHaven Health

Review of OHCA Conditions

Charity Care Policies

15-32033-CON
CONDITION 9
Following Closing

- L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies. Any new policies will be provided to OHCA once approved by the L+MH Board. Post to L+MH website.

15-32033-CON
CONDITION 10
3 years

15-32033-CON
CONDITION 32e
5 years

- For 3 years, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+M Hospital within 30 days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. All adopted or amended policies are at least as generous as the YNHHS Charity and Free Care policies. Affirmation that L+M has adopted the financial assistance policies to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30th 2021 (Report due November 30th each year.

Yale NewHaven Health

Review of OHCA Conditions

Employment Conditions

15-32033-CON CONDITIONS 27 / 32g
5 Years

- L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30th 2021 (Report due November 30th each year).

15-32033-CON CONDITIONS 28 / 32g

15-32032-CON CONDITION 6
5 Years

- Employees of any L+M affiliate or LMMG shall not be required to reapply for their positions as a result of the affiliation. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30th 2021 (Report due November 30th each year). To the extent that any L+M or LMMG employees leave their employment at L+M or LMMG service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service). Affidavit will be sent in after 12/7/16

15-32033-CON CONDITIONS 29 / 32g
5 Years

- L+MH shall maintain its current wage and salary structures for its non-bargaining or nonrepresented employees based on hospitals of similar scope, size and market conditions in Connecticut. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30th 2021 (Report due November 30th each year).

15-32033-CON CONDITIONS 30 / 32g
5 Years

- L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30th 2021 (Report due November 30th each year).

Yale NewHaven Health

Review of OHCA Conditions

Governance

15-32033-CON CONDITION 14
3 Years

- For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH's Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA shall be notified of the Applicant's choice of the community representative to join the L+MH Board and provide background information.

15-32033-CON CONDITION 17
3 years

- Joint meeting of YNHHSC and L+M Boards to be held at least twice annually for 3 years ending October 7, 2019. Meetings to be followed by a public meeting to which the public is invited in advance and the public is informed of L+MH's activities and may ask questions and comment. Affirmation will be sent to OHCA that these meetings have taken place.

15-32033-CON CONDITION 26
5 Years

- L+M Board continues as a fiduciary board composed of members who reside in the communities served by L+MH and an YNHHS representative. Serving as an ex-officio member. Each Director of the L+MH Board shall have an equal vote, and subject to certain reserved powers for YNHHSC, will have the right to approve any new programs and clinical services, or the discontinuation or consolidation of programs. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. L&M's bylaws will be submitted to OHCA and any future modifications will be sent to OHCA. Affirmation provided annually for 5 years ending September 30th, 2021.

Yale NewHaven Health

Review of OHCA Conditions

Licensure, Physician Office Conversion, Cost Savings Attainment

15-32033-CON CONDITION 13
5 Years

- Abide by all requirements of licensure by FLIS and DPH. Affirmation provided annually, ending September 30th 2021.

15-32033-CON CONDITION 24 / 32d

15-32033-CON CONDITIONS 5 / 7b
5 Years

- L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status. Affirmation provided to OHCA on March 31 and September 30, 2016 and annually thereafter until September 30th 2021 (Report due November 30th each year).

15-32033-CON CONDITION 25
5 Years

- L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application. Affirmation provided annually, ending September 30th 2021.

Yale NewHaven Health

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, October 26, 2016 12:39 PM
To: Greer, Leslie
Subject: FW: Docket Numbers: 15-32032-CON and 15-32033-CON: Independent Monitor Engagement Letter
Attachments: DT-YNHHS Independent Monitor Eng Letter Draft 102416 FINAL (SENT TO OHCA).docx

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Tuesday, October 25, 2016 9:07 AM
To: Martone, Kim; Roberts, Karen
Cc: 'Sauders, Kelly (US - New York)'; Tammaro, Vincent; Rosenthal, Nancy; Willcox, Jennifer; O'Connor, Christopher
Subject: Docket Numbers: 15-32032-CON and 15-32033-CON: Independent Monitor Engagement Letter

Kim and Karen,

For your review, attached please find the Engagement Letter between Yale New Haven Health System and Deloitte to act as Independent Monitor. In the Engagement Letter "Appendix A" is the monitoring plan which I sent to you yesterday.

I look forward to hearing from you regarding next steps.

Thank you.
Gayle

Gayle Capozzalo
Executive Vice President and
Chief Strategy Officer

789 Howard Avenue
New Haven, CT 06519

Phone: 203-688-2605
Fax: 203-688-3472

Email: gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, New York 10112
Tel: 212-436-3180
Fax: 212-653-7033
www.us.deloitte.com

Deloitte.

October 24, 2016

Bill Aseltyne
Senior Vice President & General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

Dear Bill,

This engagement letter is to confirm the engagement of Deloitte & Touche LLP ("D&T" or "we"), effective as of the date hereof, to provide Yale New Haven Health Services Corporation and its subsidiaries (collectively referred to as "YNHHSC" or the "Company") the services described below (the "Services").

Scope and Approach

We understand you are seeking an independent monitor related to the agreed settlement ("Agreement" or "Order") between YNHHSC and State of Connecticut's Office of Health Care Access ("OHCA") to monitor the YNHHSC's compliance with the Conditions of the Order in the transfer of ownership of Lawrence and Memorial Corporation and its subsidiaries to YNHHSC.

Specific anticipated activities we will assist YNHHSC with will include two work streams:

Workstream 1: Assist YNHHSC with the planning and preparing for monitoring reviews

- Hold kick-off with YNHHSC responsible persons to discuss the monitor requirements
- Meet with the Connecticut Office of Health Care Access (OHCA), as requested
- Review and agree upon with YNHHSC and OHCA, as applicable, the elements of monitor services as documented in the work plan in Appendix A.

Workstream 2: Assist YHHHS with the independent monitoring activities

- Refer to Appendix A for a detailed monitor work plan which describes the various required activities and activities associated with each condition of the Order.

We anticipate providing our services both off-site and on-site. Where possible we will perform analysis and preparation activities remotely. We anticipate providing these services for a period of approximately two years (as requested by YNHHSC based on requirements of OHCA).

Engagement Team

Kelly J. Sauders, Partner, Deloitte & Touche LLP, will serve as the lead engagement leader to provide oversight and direction. Ed Sullivan, Principal, Deloitte & Touche LLP will serve as the quality assurance partner, supporting Kelly and the team in the execution of the work. Kaitlin McCarthy, Manager, Deloitte & Touche LLP, will serve as the overall project manager. Additional support will be provided by other professionals from Deloitte & Touche LLP's Regulatory & Compliance practice, as needed, during the course of this engagement.

Deliverables

The following deliverables will be produced during the course of this engagement:

Workstream 1: Assist YNHHS with planning and preparing for monitoring reviews

1. D&T will create and maintain a written plan for fulfilling the duties set forth in the agreement.

Workstream 2: Assist YNHHS with independent monitoring activities

1. D&T will draft and submit a written report within thirty (30) days of the completion of each (semi-annual) on-site review on YNHHSC compliance with the conditions of the Order, totaling two reports per reporting year.

Professional Fees and Timing

The total fees related to this engagement are estimated as follows:

Year 1: $180,000 - $190,000
Years 2 through 5 (as required)* $150,000-$160,000

We will bill for our services based on actual hours incurred at the following billing rates:

Resource Level	Hourly Rate
Partner	$625
Senior Manager	$550
Manager	$510
Senior Consultant	$445
Consultant	$380

* Note that hourly rates will increase approximately 3% per year for years 3, 4 and 5.

This estimated fee and time estimate is based upon our current understanding of the project requirements, our proposed approach, our estimate of the level of effort required, our roles and responsibilities, any assumptions set forth herein, and active participation of Company's management and other personnel. We

plan to meet with you on no less than a quarterly basis to review time incurred and estimates to completion throughout the duration of this engagement.

Based on our experience, issues sometimes arise that require procedures beyond what was initially anticipated. If this should occur, we will discuss it with you promptly and early in the process before we perform any additional work.

We understand that you will reimburse us for all reasonable expenses incurred in performing the Services on this engagement (including, but not limited to, our reasonable travel, meal, lodging, and mileage expenses). Expenses will be noted separately on our invoices and segregated by expense type.

Fees for this engagement will be billed biweekly as the work progresses for fees accrued and expenses incurred by us since our last invoice in performing our Services.

Other Matters

YNHHSC is, among other things, a regulatory/compliance and merger & acquisition services client of D&T and/ or its affiliated and related entities. We do not believe that the proposed services impair the objectivity for D&T to perform the proposed services for YNHHSC. However, we are bringing this to your attention to avoid any misunderstanding.

Should a potential conflict come to the attention of the engagement leader with respect to potential future work being performed or to be performed by D&T or one of its affiliated or related entities for YNHHSC, D&T will advise YNHHSC promptly. YNHHC will, at its option and in consultation with the Connecticut Office of Health Care Access as appropriate, promptly request, in writing, (1) such entity not to proceed with the proposed services or (2) such entity to proceed with the proposed services, provided that such entity agrees to proceed. If YNHHSC requests such entity to proceed with the proposed services, YNHHSC agrees that D&T and its affiliated and related entities' are able to perform the proposed services objectively. If appropriate, such entity will establish an ethical wall and confidentiality safeguards so that the services will be performed by different personnel on the various engagements.

Acknowledgements and Agreements

The Company specifically acknowledges and agrees to the following:

- Substantial and meaningful involvement of management of the Company is critical to the success of this engagement. The Company shall be responsible for ensuring that the identified Company personnel actively participate in both the planning and execution of this engagement.

- D&T will not make any management decisions, perform any management functions, or assume any management responsibilities.

- The Company agrees that any deliverables provided to the Company hereunder by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with an investigation or examination of the Company. To the extent permitted by law, rule, regulation and applicable professional standards, YNHHSC shall be promptly notified in the event such deliverable(s) are provided by D&T to the OHCA.

- Company will limit sensitive information, such as PII, PHI, trade secrets and other information that it considers sensitive or highly confidential, it provides to D&T (or otherwise makes available to D&T to only that which is reasonably necessary to allow D&T to provide the Services. D&T will provide Company with a list of D&T personnel who are authorized to receive or have access to Company sensitive information. Such list may be updated as needed. Any disclosure of sensitive information by Company to D&T will utilize levels of information security and data encryption appropriate to maintain security of Company sensitive information being accessed by or transferred to D&T, and as required by applicable information protection laws.

- The Services will be performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). However, the Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.

- We will not provide any legal advice regarding our Services nor will we provide any assurance regarding the outcome of any future audit or regulatory examination or other regulatory action; the responsibility for all legal issues with respect to these matters, such as reviewing all deliverables and work product for any legal implications to the Company, will be the Company's.

- The Services may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the Company.

*****

During the term of this engagement, the Company may request that D&T perform additional services that are not encompassed by this engagement letter. D&T may perform such additional services upon receipt of a separate signed engagement letter with terms and conditions that are acceptable to D&T and the Company. Our observations and recommendations will be based solely on the results of the assessment performed.

This engagement letter, together with the General Business Terms attached hereto as Appendix B and the Business Associate Addendum attached hereto as Appendix C and made a part hereof constitute the entire agreement between the Company and D&T with respect to this engagement, supersede all other oral and written representations, understandings, or agreements relating to this engagement, and may not be amended except by the mutual written agreement of the Company and D&T.

Please indicate your acceptance of this agreement by signing in the space below and returning a fully executed copy of this engagement letter to us. A duplicate of this engagement letter is provided for your records. We look forward to serving you. If you have any questions please contact Kelly Sauders at (212) 436-3180.

Very truly yours,

Deloitte & Touche LLP

By: Kelly J. Sauders
Partner

Accepted and Agreed to by:

Yale New Haven Health Services Corporation on behalf of itself and its subsidiaries

By: _____

Title: _____

Date: _____

Greer, Leslie

From: Roberts, Karen
Sent: Monday, November 07, 2016 9:41 AM
To: Capozzalo, Gayle; Nancy.Rosenthal@greenwichhospital.org
Cc: Furniss, Wendy; Ortelle, Donna; Cass, Barbara; Martone, Kim; Cotto, Carmen; ksauders@deloitte.com
Subject: Re: Independent Monitor for Certificate of Need Docket #s 15-32032-CON and 15-32033-CON

Dear Gayle and Nancy

Below please find two emails regarding the Yale-New Haven Hospital selection for Independent Monitor for the above noted Docket Numbers. With these two emails, both the Office of Health Care Access (OHCA) and the Health Care Quality and Safety/Facility Licensing and Inspections (FLIS) section of the Department of Public Health provide their approval of the Independent Monitor chosen by YNHHSC, as required by the CON orders for these two CON orders. YNHHSC may now proceed to finalize this contractual arrangement and should provide OHCA with a copy of documents for the CON public records. Thank you for your cooperation in this matter.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Martone, Kim
Sent: Monday, November 07, 2016 7:58 AM
To: Cass, Barbara
Cc: Roberts, Karen; Furniss, Wendy; Ortelle, Donna
Subject: RE: Deloitte

Thank you Barbara. OHCA approves Deloitte as well to serve as the Independent Monitor for the Yale L&M acquisition.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access

Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Cass, Barbara
Sent: Friday, November 04, 2016 5:50 PM
To: Martone, Kim
Cc: Roberts, Karen; Furniss, Wendy; Ortelle, Donna
Subject: Deloitte

Dear Kim:

Thank you very much for including the Department of Public Health Facility Licensing and Investigations Section (FLIS) in the conference call with Deloitte to assess their ability to act as the Independent Monitor (IM) for the Yale New Haven Hospital/Lawrence and Memorial Hospital acquisition. Pursuant to the information Deloitte provided regarding capacity to assess hospital systems and their availability to access clinicians, FLIS approves Deloitte as capable of serving in the capacity of the IM if the Office of Health Care Access is also in agreement.

Best,

Barbara

Barbara S. Cass, R.N.
Section Chief
Facility Licensing and Investigations Section
State of Connecticut, Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Telephone: 860-509-7609
Barbara.cass@ct.gov

Greer, Leslie

From: Roberts, Karen
Sent: Tuesday, November 08, 2016 8:15 AM
To: Greer, Leslie; Cotto, Carmen
Cc: Martone, Kim; Hansted, Kevin
Subject: FW: Independent Monitor for Docket Numbers 15-32032-CON and 15-32033-CON
Attachments: DT-YNHHS Engagement Letter and Workplan.pdf

FYI for Yale's two CON docket #s. Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Monday, November 07, 2016 5:03 PM
To: Martone, Kim; Roberts, Karen
Cc: Rosenthal, Nancy; 'Sauders, Kelly (US - New York)'; Willcox, Jennifer; Anderson, Maureen (LMHOSP); Aseltyne, Bill; Borgstrom, Marna; Cummings, Bruce (L and M); Tammaro, Vincent; O'Connor, Christopher
Subject: Independent Monitor for Docket Numbers 15-32032-CON and 15-32033-CON

Per OHCAs approval of Deloitte as the Independent Monitor for Docket numbers 15-32032-CON and 15-32033-CON, attached please find an executed engagement letter between Yale New Haven Health Services Corporation and Deloitte. Thank you.

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, New York 10112
Tel: 212-436-3180
Fax: 212-653-7033
www.us.deloitte.com

Deloitte.

November 7, 2016

Bill Aseltyne
Senior Vice President & General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

Dear Bill,

This engagement letter is to confirm the engagement of Deloitte & Touche LLP ("D&T" or "we"), effective as of the date hereof, to provide Yale New Haven Health Services Corporation and its subsidiaries (collectively referred to as "YNHHSC" or the "Company") the services described below (the "Services").

Scope and Approach

We understand you are seeking an independent monitor related to the agreed settlement ("Agreement" or "Order") between YNHHSC and State of Connecticut's Office of Health Care Access ("OHCA") to monitor the YNHHSC's compliance with the Conditions of the Order in the transfer of ownership of Lawrence + Memorial Corporation and its subsidiaries to YNHHSC.

Specific anticipated activities we will assist YNHHSC with will include two work streams:

Workstream 1: Assist YNHHSC with the planning and preparing for monitoring reviews

- Hold kick-off with YNHHSC responsible persons to discuss the monitor requirements
- Meet with the Connecticut Office of Health Care Access (OHCA), as requested
- Review and agree upon with YNHHSC and OHCA, as applicable, the elements of monitor services as documented in the work plan in Appendix A.

Workstream 2: Assist YHHHS with the independent monitoring activities

- Refer to Appendix A for a detailed monitor work plan which describes the various required activities and activities associated with each condition of the Order.

We anticipate providing our services both off-site and on-site. Where possible we will perform analysis and preparation activities remotely. We anticipate providing these services for a period of two to five years (as requested by YNHHSC based on requirements of OHCA).

Engagement Team

Kelly J. Sauders, Partner, Deloitte & Touche LLP, will serve as the lead engagement leader to provide oversight and direction. Ed Sullivan, Principal, Deloitte & Touche LLP will serve as the quality assurance partner, supporting Kelly and the team in the execution of the work. Kaitlin McCarthy, Manager, Deloitte & Touche LLP, will serve as the overall project manager. Additional support will be provided by other professionals from Deloitte & Touche LLP's Regulatory & Compliance practice, as needed, during the course of this engagement.

Deliverables

The following deliverables will be produced during the course of this engagement:

Workstream 1: Assist YNHHS with planning and preparing for monitoring reviews

1. D&T will create and maintain a written plan for fulfilling the duties set forth in the agreement.

Workstream 2: Assist YNHHS with independent monitoring activities

1. D&T will draft and submit a written report within thirty (30) days of the completion of each (semi-annual) on-site review on YNHHSC compliance with the conditions of the Order, totaling two reports per reporting year.

Professional Fees and Timing

The total fees related to this engagement are estimated as follows:

Year 1: $180,000 - $190,000
Years 2 through 5 (as required)* $150,000-$160,000

We will bill for our services based on actual hours incurred at the following billing rates:

Resource Level	Hourly Rate
Partner	$625
Senior Manager	$550
Manager	$510
Senior Consultant	$445
Consultant	$380

* Note that hourly rates will increase approximately 3% per year for years 3, 4 and 5.

This estimated fee and time estimate is based upon our current understanding of the project requirements, our proposed approach, our estimate of the level of effort required, our roles and responsibilities, any assumptions set forth herein, and active participation of Company's management and other personnel. We

plan to meet with you on no less than a quarterly basis to review time incurred and estimates to completion throughout the duration of this engagement.

Based on our experience, issues sometimes arise that require procedures beyond what was initially anticipated. If this should occur, we will discuss it with you promptly and early in the process before we perform any additional work.

We understand that you will reimburse us for all reasonable expenses incurred in performing the Services on this engagement (including, but not limited to, our reasonable travel, meal, lodging, and mileage expenses). Expenses will be noted separately on our invoices and segregated by expense type.

Fees for this engagement will be billed biweekly as the work progresses for fees accrued and expenses incurred by us since our last invoice in performing our Services.

Other Matters

YNHHSC is, among other things, a regulatory/compliance and merger & acquisition services client of D&T and/ or its affiliated and related entities. We do not believe that the proposed services impair the objectivity for D&T to perform the proposed services for YNHHSC. However, we are bringing this to your attention to avoid any misunderstanding.

Should a potential conflict come to the attention of the engagement leader with respect to potential future work being performed or to be performed by D&T or one of its affiliated or related entities for YNHHSC, D&T will advise YNHHSC promptly. YNHHC will, at its option and in consultation with the Connecticut Office of Health Care Access as appropriate, promptly request, in writing, (1) such entity not to proceed with the proposed services or (2) such entity to proceed with the proposed services, provided that such entity agrees to proceed. If YNHHSC requests such entity to proceed with the proposed services, YNHHSC agrees that D&T and its affiliated and related entities' are able to perform the proposed services objectively. If appropriate, such entity will establish an ethical wall and confidentiality safeguards so that the services will be performed by different personnel on the various engagements.

Acknowledgements and Agreements

The Company specifically acknowledges and agrees to the following:

- Substantial and meaningful involvement of management of the Company is critical to the success of this engagement. The Company shall be responsible for ensuring that the identified Company personnel actively participate in both the planning and execution of this engagement.

- D&T will not make any management decisions, perform any management functions, or assume any management responsibilities.

- The Company agrees that any deliverables provided to the Company hereunder by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with an investigation or examination of the Company. To the extent permitted by law, rule, regulation and applicable professional standards, YNHHSC shall be promptly notified in the event such deliverable(s) are provided by D&T to the OHCA.

- Company will limit sensitive information, such as PII, PHI, trade secrets and other information that it considers sensitive or highly confidential, it provides to D&T (or otherwise makes available to D&T) to only that which is reasonably necessary to allow D&T to provide the Services. D&T will provide Company with a list of D&T personnel who are authorized to receive or have access to Company sensitive information. Such list may be updated as needed. Any disclosure of sensitive information by Company to D&T will utilize levels of information security and data encryption appropriate to maintain security of Company sensitive information being accessed by or transferred to D&T, and as required by applicable information protection laws.

- The Services will be performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). However, the Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.

- We will not provide any legal advice regarding our Services nor will we provide any assurance regarding the outcome of any future audit or regulatory examination or other regulatory action; the responsibility for all legal issues with respect to these matters, such as reviewing all deliverables and work product for any legal implications to the Company, will be the Company's.

- The Services may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the Company.

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During the term of this engagement, the Company may request that D&T perform additional services that are not encompassed by this engagement letter. D&T may perform such additional services upon receipt of a separate signed engagement letter with terms and conditions that are acceptable to D&T and the Company. Our observations and recommendations will be based solely on the results of the assessment performed.

This engagement letter, together with the General Business Terms attached hereto as Appendix B and the Business Associate Addendum attached hereto as Appendix C and made a part hereof constitute the entire agreement between the Company and D&T with respect to this engagement, supersede all other oral and written representations, understandings, or agreements relating to this engagement, and may not be amended except by the mutual written agreement of the Company and D&T.

Please indicate your acceptance of this agreement by signing in the space below and returning a fully executed copy of this engagement letter to us. A duplicate of this engagement letter is provided for your records. We look forward to serving you. If you have any questions please contact Kelly Sauders at (212) 436-3180.

Very truly yours,

Deloitte & Touche LLP

Kelly J. Sauders

By: Kelly J. Sauders
Partner

Accepted and Agreed to by:

Yale New Haven Health Services Corporation on behalf of itself and its subsidiaries

By: _____

Title: Executive VP | chief Strategy officer

Date: 11/7/16

APPENDIX A. MONITORING PROCEDURES (per Docket Numbers 15-32032-CON and 15-32033-CON)

Condition	D&T Procedure
Strategic Plan	
15-32033-CON Condition 4: Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHSC. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties. Note 2: Refer to Condition #19 which addresses the same/similar requirements	D&T will obtain a copy of the Services Plan/Strategic Plan submitted for Condition #4 and #19, verify timely submission, verify that it incorporates the required elements (e.g. describing any planned consolidation, reduction, or elimination of existing services or introduction of new services) and that it meets the 3 year requirement.
15-32033-CON Condition 19: L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components: a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals.	D&T will obtain the Services Plan/Strategic Plan submitted for Condition #4 and #19 and review the plan for inclusion of these required components (as compared to the needs described within the Community Needs Assessment and the resource commitments within the Affiliation Agreement). .

Condition	D&T Procedure
b. YNHHSC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement. NOTE 1: Refer to Condition #4 which addresses the same requirements.	
15-32033-CON Condition 32b: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met including referencing specific locations of primary care physicians.
15-32033-CON Condition 7: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment [1]is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures [2]that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including	D&T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. We will discuss any questions/need for clarification with Management to ensure the expenditures are verified. D&T will confirm detailed, full and timely submissions, with appropriate signatures of all required reports.

[1] Per discussion with OHCA, we understand that "capital requirement" per this Order is intended to mean "resource commitment". YNHHSC will describe the plan/resource commitment per Conditions #4 and #19 of this Order.

[2] See footnote 4.

Condition	D&T Procedure
estimated beginning, ending a11d startup/operation dates); and c. The funding source of the capital investment [3]indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning May 31, 2017. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.	
15-32033-CON Condition 5: Until such time as the Services Plan is submitted[4], YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18	D&T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days. Per related 15-32033-CON Condition #18, D&T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.

[3] Per discussion with OHCA, we understand that "capital investment" per this Order is intended to mean expenditures/investment made".

[4] The Services Plan is due 180 days after the closing date of September 8, 2016. Therefore this provision only applies until the Services Plan per Condition #4 is submitted.

Condition	D&T Procedure
15-32033-CON Condition 18: L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHSC is bound by Condition #4 and the Services Plan created per Condition #4	D&T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data (e.g. to see continuing patient volume/services). YNHHSC will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&T will obtain a copy of that Management Representation.
15-32033-CON Condition 32a: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 – September 30 with reports due November and May certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation of the continuation of all L+MH services as described herein.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's notarized Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.
Financial Reporting	
15-32033-CON Condition 8: For three (3) years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period (fiscal year). Due dates are May 31st and November 30th, beginning May 2017. The following financial measurements/indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to equity, long-term debt to capitalization,	D&T will obtain the financial measurement report and review work papers to ensure that they are consistent with financial reports being submitted to L+M Hospital Board and that the required elements and financial measurements are appropriately recorded in the report; we will confirm the timely submission of each report.

Condition	D&T Procedure
unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	
15-32033-CON Condition 32f: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report. i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities; ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the	For 15-32033-CON Condition #32F, D&T will obtain the Five-Year Plan prepared by YNHHSC and the ongoing six month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175 and succession reports to OHCA.

Condition	D&T Procedure
specifics of the cost savings for each of these major expense categories; iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.	
15-32032-CON Condition 7c: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, and Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and	Refer to procedures for 15-32033-CON Condition #32f in the work plan above.

Condition	D&T Procedure
15-32033-CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price[5] per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.	D&T will obtain YNHHSC's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information. D&T will review work papers to confirm information and timely filing. * 1st filing is due within 180 days (March 2017); 2nd filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3rd filing is due 60 dates after the close of FY2018 which is 11/30/18.
Cost and Market Impact Review	
15-32033-CON Condition 22: Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.

[5]For purposes of this calculation, "total prices per unit of service" will be the weighted average price across all payers per unit of service.

Condition		D&T Procedure
b.	In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	
c.	In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to	

Condition	D&T Procedure
correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.	
15-32032-CON Condition 3: Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below)	Refer to procedures for 15-32033-CON Condition #22 above.

Condition	D&T Procedure
for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut. c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section l 9a-639f shall be conducted after the Date of Closing, in	

Condition	D&T Procedure
the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.	

Condition	D&T Procedure
15-32033-CON Condition 23: For purposes of determining the price per unit of service: f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.
15-32032-CON Condition 4: For purposes of determining the price per unit of service: a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-	D&T will obtain a copy of the CMIR performed by the Independent Consultant.

Condition	D&T Procedure
10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.

Condition	D&T Procedure
15-32033-CON Condition 20 Paragraph 1: L+M and YNHHSC shall maintain the current L+MH and Lawrence + Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.	D&T will evaluate and verify that contracts are maintained in accordance with this condition. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.
15-32033-CON Condition 32c: Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of Conditions (20), (21) and (22) above.	For 15-32033-CON Condition 32c, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.

Condition	D&T Procedure
15-32033-CON Condition 20 Paragraphs 2/3: Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut. For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to cap determined through the process set forth below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	D&T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.

Condition	D&T Procedure
15-32032-CON Condition 1: Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph. Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut. For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	Refer to procedures for 15-32033-CON Condition #20 outlined here and 1532033-CON Condition 20a, 20b and 20c.

Condition	D&T Procedure
15-32032-CON Condition 7a: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.	Refer to procedures for 15-32033-CON Condition #32c.
15-32033-CON Condition 21a: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	D&T will receive samples of payer submissions for LMMG physicians and obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.

Condition	D&T Procedure
15-32032-CON Condition 2a: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	Refer to procedures for 15-32033-CON Condition #21a above.
15-32033-CON Condition 21b: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.	D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.

Condition	D&T Procedure
15-32032-CON Condition 2b: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.	Refer to procedures for 15-32033-CON Condition #21b above.
Independent Monitor	
15-32033-CON Condition 15: Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years[6] following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the	D&T and YNHHSC will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.

[6] The Monitor may be required for only 1 (one) year or up to five (5) years as determined in writing by OHCA.

Condition	D&T Procedure
Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein. NOTE: See Condition #33a (appointment of Monitor requirement)	
15-32033-CON Condition 16: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis[7] to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	D&T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&T. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.
15-32033-CON Condition 33: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.	For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15. 15-32033-CON Condition #33b – D&T will meet with CHNA/CHIP "participation

[7] The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

Condition		D&T Procedure
b.	Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.	group[8]" in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&T of these meetings and provided to OHCA upon request.
c.	L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.	With respect to 15-32033-CON #33d, D&T will review the public notice and attend the public forum held by YNHHSC and confirm that it includes members of the CHIP (Community Health Improvement Program) group.
d.	L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	
e.	If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce	With respect to 15-32033-CON #33e, D&T agrees to provide written notice of any deficiencies as required.

[8] See attached list.

Condition	D&T Procedure
these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	
15-32032-CON Condition 8: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	Refer to procedures for 15-32033-CON Condition #33 a through e above.

Condition	D&T Procedure
e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	
Community Benefit	
15-32033-CON Condition 11: The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent.	D&T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met. D&T will also obtain the YNHHSC report/summary on

Condition	D&T Procedure
In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&T will evaluate these reports/summaries as compared to the CHNA and defined population health management objectives and will discuss any questions with YNHHSC Management. D&T will confirm that these documents are filed in a timely manner and posted to the L+MH website.
15-32033-CON Condition 31: L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.	After obtaining L+M's baseline Schedule H of IRS Form 990, D&T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5). Cross-reference to 15-32033-CON Condition #11.
15-32033-CON Condition 32h: A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.	Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.

Condition	D&T Procedure
15-32033-CON Condition 12: The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.	D&T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain the cultural competency plan, training and related policies. We will also obtain YNHHSC's report and supporting documents and confirm the timely filing of these materials.
Charity Care Policies	
15-32033-CON Condition 9: Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	D&T will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSC's financial assistance policies (or policies at least as generous as these policies) using L+M Hospital board resolutions. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.

Condition	D&T Procedure
15-32033-CON Condition 10: For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.
15-32033-CON Condition 32e: Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.
Employment Conditions	
15-32033-CON Condition 27: L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.
15-32033-CON Condition 32g: Affirmation of the labor and employment commitments described herein, including but not limited to L+M' s service sites continued honoring of collective bargaining agreements in place as of the date hereof.	See others below

Condition	D&T Procedure
15-32033-CON Condition 28: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.
15-32032-CON Condition 6: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	Refer to procedures for 15-32033-CON Condition #28.
15-32033-CON Condition 29: L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.
15-32033-CON Condition 30: L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.

Condition	D&T Procedure
Governance	
15-32033-CON Condition 14: For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	D&T will confirm the appointment of this individual (community representative) to the L+MH Board as evidenced by Board minutes. We will discuss the selection process with Management and document our understanding of the selection process/qualifications of the individual.
15-32033-CON Condition 17: For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	To confirm compliance with this provision, D&T will obtain minutes from these Joint Board Meetings and confirm that notice of the public meetings is posted with proper notice. D&T will attend the public meetings as part of the Monitor role.
15-32033-CON Condition 26: As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.	D&T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.

Condition	D&T Procedure
Licensure, Physician Office Conversion, Cost Savings Attainment	
15-32033-CON Condition 13: The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population.	D&T will, if necessary, work with DPH to ensure compliance with this Condition.
15-32033-CON Condition 24: L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.
15-32033-CON Condition 32d: Affirmation that no L+M physician office has been converted to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.
15-32032-CON Condition 5: L+MH and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	Refer to procedures for 15-32033-CON Condition #24 above.
15-32032-CON Condition 7b: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31st) and April 1 through September 30 (due November 30th) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: Affirmation that no L+M physician office has been converted to hospital-based status.	Refer to procedures for 15-32033-CON Condition #32f above.
15-32033-CON Condition 25: L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.

Footnote 8 Attachment

Representative	Thames Valley Council of Community Action
Representative	Universal Health Foundation
Representative	United Community and Family Services
Representative	NL County Food Policy Council
Representative	Groton Parks and Recreation
Representative	Hispanic Alliance
Representative	Ledge Light Health District
Representative	Uncas Health District
Representative	City of New London
Representative	Community Foundation of Eastern CT
Representative	Connecticut College
Representative	Community Health Center, Inc.
Representative	Higher Edge
Representative	UCONN Health Disparities Institute

APPENDIX B: GENERAL BUSINESS TERMS

Client: Yale New Haven Health Services Corporation ("Yale New Haven Health" or the "System")

1. **Services.** It is understood and agreed that the services provided by Deloitte & Touche LLP (Deloitte & Touche) (as defined in paragraph 13) (the "Services") under the engagement letter to which these terms are attached (the "Engagement Letter") may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the System. For purposes of these terms and the Engagement Letter, the "System" shall mean Yale New Haven Health Services Corporation and its subsidiaries. Yale New Haven Health Services Corporation represents and warrants that it has the power and authority to execute this agreement on behalf of, and to bind, itself and its subsidiaries.

2. **Exclusion.** Deloitte & Touche represents and warrants that neither Deloitte & Touche nor any of its employees providing the Services: (1) has ever been (A) convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System and (2) shall notify System immediately in the event that the Consultant (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System. System may terminate this Agreement immediately in the event that Deloitte & Touche or any of its employees (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded from or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System.

3. **Payment of Invoices.** Deloitte & Touche's invoices are due upon presentation. Without limiting its rights or remedies, Deloitte & Touche shall have the right to halt or terminate the Services entirely if payment is not received within sixty (60) days of the invoice date. The System shall be responsible for all taxes imposed on the Services or on the transaction, other than Deloitte & Touche's income taxes or tax imposed by employment withholding, and other than taxes imposed on Deloitte & Touche's property.

4. **Term.** Unless terminated sooner in accordance with its terms, this engagement shall terminate on the completion of the Services. This engagement may be terminated by either party at any time, with or without cause, by giving written notice to the other party not less than sixty (60) days before the effective date of termination, provided that, in the event of a termination for cause, the breaching party shall have the right to cure the breach within the notice period. Deloitte & Touche may terminate this engagement upon written notice to the System if it determines that (a) a governmental, regulatory, or professional entity (including, without limitation, the American Institute of Certified Public Accountants, the Public Company Accounting Oversight Board, or the Securities and Exchange Commission), or an entity having the force of law, has introduced a new, or modified an existing, law, rule, regulation, interpretation, or decision, the result of

which would render Deloitte & Touche's performance of any part of the engagement illegal or otherwise unlawful or in conflict with independence or professional rules; or (b) circumstances change (including, without limitation, changes in ownership of the System or any of its affiliates) such that Deloitte & Touche's performance of any part of the engagement would be illegal or otherwise unlawful or in conflict with independence or professional rules. Upon termination of the engagement, the System will compensate Deloitte & Touche under the terms of the Engagement Letter for the Services performed and expenses incurred through the effective date of termination.

5. Deliverables.

a) Deloitte & Touche has created, acquired, or otherwise has rights in, and may, in connection with the performance of the Services, employ, provide, modify, create, acquire, or otherwise obtain rights in, works of authorship, materials, information, and other intellectual property (collectively, the "Deloitte & Touche Technology").

b) Except as provided below, upon full and final payment to Deloitte & Touche hereunder, the tangible items specified as deliverables or work product in the Engagement Letter (the "Deliverables") shall become the property of the System. To the extent that any Deloitte & Touche Technology is contained in any of the Deliverables, Deloitte & Touche hereby grants the System, upon full and final payment to Deloitte & Touche hereunder, a royalty-free, fully paid-up, worldwide, nonexclusive license to use such Deloitte & Touche Technology in connection with the Deliverables.

c) To the extent that Deloitte & Touche utilizes any of its property (including, without limitation, the Deloitte & Touche Technology or any hardware or software of Deloitte & Touche) in connection with the performance of the Services, such property shall remain the property of Deloitte & Touche and, except for the license expressly granted in the preceding paragraph, the System shall acquire no right or interest in such property. Notwithstanding anything herein to the contrary, the parties acknowledge and agree that (1) Deloitte & Touche shall own all right, title, and interest, including, without limitation, all rights under all copyright, patent, and other intellectual property laws, in and to the Deloitte & Touche Technology and (2) Deloitte & Touche may employ, modify, disclose, and otherwise exploit the Deloitte & Touche Technology (including, without limitation, providing services or creating programming or materials for other clients). Deloitte & Touche does not agree to any terms that may be construed as precluding or limiting in any way its right to (1) provide consulting or other services of any kind or nature whatsoever to any person or entity as Deloitte & Touche in its sole discretion deems appropriate or (2) develop for itself, or for others, materials that are competitive with or similar to those produced as a result of the Services, irrespective of their similarity to the Deliverables.

d) To the extent any Deloitte & Touche Technology provided to the System hereunder is a product (to the extent it constitutes merchandise within the meaning of section 471 of the Internal Revenue Code), such Deloitte & Touche Technology is licensed to the System by Deloitte & Touche as agent for Deloitte & Touche Products Company LLC on the terms and conditions herein. The assignment and license grant in this paragraph 5 do not apply to any works of authorship, materials, information, or other intellectual property (including any modifications or enhancements thereto or derivative works based thereon) that is subject to a separate license agreement between the System and a third party, including without limitation, Deloitte & Touche Products Company LLC.

6. Limitation on Warranties. THIS IS A SERVICES ENGAGEMENT. DELOITTE & TOUCHE WARRANTS THAT IT SHALL PERFORM THE SERVICES IN GOOD FAITH AND WITH DUE PROFESSIONAL CARE. DELOITTE & TOUCHE DISCLAIMS ALL OTHER WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

7. Limitation on Damages and Indemnification.

a) The System agrees that Deloitte & Touche, its subcontractors, and their respective personnel shall not be liable to the System for any claims, liabilities, or expenses relating to this engagement ("Claims") for an aggregate amount in excess of two (2) times the fees paid by the System to Deloitte & Touche pursuant to this engagement, except to the extent finally judicially determined to have resulted primarily from the bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

b) Except with respect to Claims for which a party has an indemnification obligation hereunder, in no event shall either party, its subcontractors, or their respective personnel be liable for any loss of use, data, goodwill, revenues, or profits (whether or not deemed to constitute a direct Claim), or any consequential, special, indirect, incidental, punitive, or exemplary loss, damage, or expense relating to this engagement.

c) Except for those claims for which Deloitte & Touche has agreed to indemnify the System pursuant to paragraph 7(d) and, 7(e), the System shall indemnify and hold harmless Deloitte & Touche, its subcontractors, and their respective personnel from all Claims of third parties arising from the use or disclosure of the Services or the Deliverables, except to the extent finally judicially determined to have resulted primarily from the recklessness, bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

d) Deloitte & Touche shall indemnify, defend and hold harmless the System, its directors, officers, employees and agents from and against any and all Claims, including reasonable attorneys' fees, in each case solely for bodily injury, death or physical damage to real or tangible personal property, to the extent such Claims are caused by Deloitte & Touche's negligent acts, negligent errors or negligent omissions. In the event such Claims are caused by the joint or concurrent negligence of the parties, they shall be borne by each party in proportion to such party's negligence.

e) Deloitte & Touche agrees to defend the System, its officers and employees from and against any and all claims and pay any settlement costs or any final judgments, including reasonable defense costs and reasonable legal fees, arising out of infringement by the Deliverables of any U.S. patent known to Deloitte & Touche or copyright or any unauthorized use of any trade secret or trademark, except to the extent that such infringement or unauthorized use arises from (i) the System's modification of the Deliverables or use thereof in a manner not contemplated by this engagement, (ii) the failure of the System to use any corrections or modifications made available by Deloitte & Touche, (iii) information, materials, instructions or specifications provided by or on behalf of the System, (iv) the System's distribution, marketing or use for the benefit of third parties of the Deliverables, or (v) the use of the Deliverable in combination with any product or data not provided by Deloitte & Touche whether or not with Deloitte & Touche's consent. If any such Deliverable, or any portion thereof, becomes, or in Deloitte & Touche's reasonable judgment, is likely to become the subject of a claim based upon infringement or unauthorized use, or if any such Deliverable or

any portion thereof, is found by final, non-appealable order of a court of competent jurisdiction to be such an infringement or unauthorized use, Deloitte & Touche, at its option and expense, shall have the right to (x) procure for the System the continued use of such Deliverable, (y) replace or modify such Deliverable provided that the replacement or modified Deliverable is reasonably capable of performing substantially the same function, or (z) require the System to cease use of such Deliverable and refund an appropriate portion of the fee paid with respect to the affected Deliverable. The foregoing provisions of this Paragraph constitute the sole and exclusive remedy of the System, and the sole and exclusive obligation of Deloitte & Touche, relating to a claim that a Deliverable infringes any patent, copyright or other intellectual property right of a third party.

8. Client Responsibilities. The System shall cooperate with Deloitte & Touche in the performance by Deloitte & Touche of the Services, including, without limitation, providing Deloitte & Touche with reasonable facilities and timely access to data, information, and personnel of the System. The System shall be responsible for the performance of its personnel and agents and for the accuracy and completeness of all data and information provided to Deloitte & Touche for purposes of the performance by Deloitte & Touche of the Services. The System acknowledges and agrees that Deloitte & Touche's performance is dependent upon the timely and effective satisfaction of the System's responsibilities hereunder and timely decisions and approvals of the System in connection with the Services. Deloitte & Touche shall be entitled to rely on all decisions and approvals of the System. The System shall be solely responsible for, among other things (a) making all management decisions and performing all management functions, (b) designating a competent management member to oversee the Services, (c) evaluating the adequacy and results of the Services, (d) accepting responsibility for the results of the Services, and (e) establishing and maintaining internal controls, including, without limitation, monitoring ongoing activities.

9. Force Majeure. Neither party shall be liable for any delays or nonperformance directly or indirectly resulting from circumstances or causes beyond its reasonable control, including, without limitation, acts or omissions or the failure to cooperate by the other party (including, without limitation, entities or individuals under its control, or any of their respective officers, directors, employees, other personnel and agents), acts or omissions or the failure to cooperate by any third party, fire, epidemic or other casualty, act of God, strike or labor dispute, war or other violence, or any law, order, or requirement of any governmental agency or authority.

10. [Reserved]

11. Independent Contractor.

(a) Deloitte & Touche and System acknowledge and agree that Deloitte & Touche is being retained as an independent contractor, and that Deloitte & Touche shall be responsible for determining the manner and means by which Deloitte & Touche performs the Services. Nothing herein shall be construed to make Deloitte & Touche an employee or agent of System, to entitle Deloitte & Touche to receive the benefits of any employee benefit plan of System, or to create a joint venture or partnership or fiduciary relationship between the parties. Neither party shall not make an unauthorized representation or warranty concerning the products or services of the other party or commit the other party to any agreement or obligation.

(b) No payroll or employment taxes of any kind shall be withheld or paid with respect to payments to Deloitte & Touche hereunder. Deloitte & Touche agrees to indemnify System against, and to defend and hold System harmless from, any liabilities, claims, costs or expenses (including reasonable attorneys' fees) which may be made against System, or incurred by System, in respect of any such payroll or employment taxes.

(c) No workers' compensation insurance has been or will be obtained by System on account of Deloitte & Touche.

12. Confidentiality and Internal Use.

a) The System agrees that all Services and Deliverables shall be solely for the System's informational purposes and internal use, and are not intended to be, and should not be, used by any person or entity other than the System. Except as otherwise specifically provided in the Engagement Letter, the System further agrees that such Services and Deliverables shall not be circulated, quoted, disclosed, or distributed to, nor shall reference to such Services or Deliverables be made to, any person or entity other than the System and other contractors of the System to whom the System may disclose the Deliverables solely for the purpose of such contractors providing services to the System relating to the subject matter of this engagement, provided that the System shall ensure that such contractors do not further circulate, quote, disclose, or distribute such Deliverables, or make reference to such Deliverables, to any person or entity other than the System. Notwithstanding the foregoing, the System shall not be prohibited from creating its own materials based on the content of such Services and Deliverables and using and disclosing such System-created materials for external purposes, provided that the System does not, expressly or by implication, in any manner whatsoever, attribute such materials to Deloitte & Touche or otherwise refer to or identify Deloitte & Touche in connection with such materials.

b) To the extent that, in connection with this engagement, either party (each, the "receiving party") comes into possession of any trade secrets or other proprietary or confidential information of the other (the "disclosing party"), it will not disclose such information to any third party without the disclosing party's consent. The disclosing party hereby consents to the receiving party disclosing such information (1) to subcontractors, whether located within or outside of the United States, that are providing services in connection with this engagement and that have agreed to be bound by confidentiality obligations similar to those in this paragraph 12(b); (2) as may be required by law, regulation, judicial or administrative process, or in accordance with applicable professional standards or rules, or in connection with litigation or arbitration pertaining hereto; or (3) to the extent such information (i) shall have otherwise become publicly available (including, without limitation, any information filed with any governmental agency and available to the public) other than as the result of a disclosure in breach hereof, (ii) becomes available to the receiving party on a nonconfidential basis from a source other than the disclosing party that the receiving party believes is not prohibited from disclosing such information to the receiving party by obligation to the disclosing party, (iii) is known by the receiving party prior to its receipt from the disclosing party without any obligation of confidentiality with respect thereto, or (iv) is developed by the receiving party independently of any disclosures made by the disclosing party to the receiving party of such information. In satisfying its obligations under this paragraph 12(b), each party shall maintain the other's trade secrets and proprietary or

confidential information in confidence using at least the same degree of care as it employs in maintaining in confidence its own trade secrets and proprietary or confidential information, but in no event less than a reasonable degree of care. Nothing in this paragraph 12(b) shall alter the System's obligations under paragraph 12(a). Notwithstanding anything to the contrary herein, the System acknowledges that Deloitte & Touche, in connection with performing the Services, may develop or acquire experience, skills, knowledge, and ideas that are retained in the unaided memory of its personnel. The System acknowledges and agrees that Deloitte & Touche may use and disclose such experience, skills, knowledge, and ideas.

13. Survival and Interpretation. All paragraphs herein relating to payment of invoices, deliverables, limitation on warranties, limitation on damages and indemnification, limitation on actions, confidentiality and internal use, survival and interpretation, assignment, nonexclusivity, waiver of jury trial and governing law shall survive the expiration or termination of this engagement. For purposes of these terms, "Deloitte & Touche" shall mean Deloitte & Touche LLP and, for purposes of paragraph 7, shall also mean Deloitte & Touche Products Company LLC, one of its subsidiaries. The System acknowledges and agrees that no affiliated or related entity of Deloitte & Touche, whether or not acting as a subcontractor, or such entity's personnel shall have any liability hereunder to the System or any other person and the System will not bring any action against any such affiliated or related entity or such entity's personnel in connection with this engagement. Without limiting the foregoing, affiliated and related entities of Deloitte & Touche are intended third-party beneficiaries of these terms, including, without limitation, the limitation on liability and indemnification provisions of paragraph 7, and the agreements and undertakings of the System contained in the Engagement Letter. Any affiliated or related entity of Deloitte & Touche may in its own right enforce such terms, agreements, and undertakings. **The provisions of paragraphs 7, 13, 15, and 18 hereof shall apply to the fullest extent of the law, whether in contract, statute, tort (such as negligence), or otherwise, notwithstanding the failure of the essential purpose of any remedy.**

14. Assignment and Subcontracting. Except as provided below, neither party may assign, transfer, or delegate any of its rights or obligations hereunder (including, without limitation, interests or Claims) without the prior written consent of the other party. The System hereby consents to Deloitte & Touche subcontracting any of Deloitte & Touche's rights or obligations hereunder to (a) any affiliate or related entity, whether located within or outside of the United States. Services performed hereunder by Deloitte & Touche's subcontractors shall be invoiced as professional fees on the same basis as Services performed by Deloitte & Touche's personnel, unless otherwise agreed.

15. Waiver of Jury Trial. THE PARTIES HEREBY IRREVOCABLY WAIVE, TO THE FULLEST EXTENT PERMITTED BY LAW, ALL RIGHTS TO TRIAL BY JURY IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM RELATING TO THIS ENGAGEMENT.

16. Nonsolicitation. During the term of this engagement and for a period of one (1) year thereafter, each party agrees that its personnel (in their capacity as such) who had direct and substantive contact in the course of this engagement with personnel of the other party shall not, without the other party's consent, directly or indirectly employ, solicit, engage, or retain the services of such personnel of the other party. In the event a party breaches this provision, the breaching party shall be liable to the aggrieved party for an amount equal to thirty percent (30%) of the annual base compensation of the relevant personnel in his or her new position. Although such payment shall be the aggrieved party's exclusive means of monetary recovery from the breaching party for breach of this provision, the aggrieved party shall be entitled to seek injunctive or other

equitable relief. This provision shall not restrict the right of either party to solicit or recruit generally in the media.

17. Entire Agreement, Amendment, and Notices. These terms, and the Engagement Letter, including exhibits, constitute the entire agreement between the parties with respect to this engagement; supersede all other oral and written representations, understandings, or agreements relating to this engagement; and may not be amended except by written agreement signed by the parties. In the event of any conflict, ambiguity, or inconsistency between these terms and the Engagement Letter, these terms shall govern and control. All notices, requests, demands and other communications hereunder shall be in writing and shall be deemed to have been duly given when either personally served or mailed by certified or registered mail, return receipt requested to the addresses first set forth above.

18. Governing Law, Jurisdiction and Venue, and Severability. These terms, the Engagement Letter, including exhibits and all matters relating to this engagement shall be governed by, and construed in accordance with, the laws of the State of Connecticut (without giving effect to the choice of law principles thereof). Any action based on or arising out of this engagement or the Services provided or to be provided hereunder shall be brought and maintained exclusively in any court of the State of Connecticut or any federal court of the United States, in each case located in the State of Connecticut. Each of the parties hereby expressly and irrevocably submits to the jurisdiction of such courts for the purposes of any such action and expressly and irrevocably waives, to the fullest extent permitted by law, any objection which it may have or hereafter may have to the laying of venue of any such action brought in any such court and any claim that any such action has been brought in an inconvenient forum. If any provision of these terms or the Engagement Letter is found by a court of competent jurisdiction to be unenforceable, such provision shall not affect the other provisions, but such unenforceable provision shall be deemed modified to the extent necessary to render it enforceable, preserving to the fullest extent permissible the intent of the parties set forth herein.

19. Non-Use of YNHHS Name. Deloitte & Touche shall not use YNHHS name or logo, or the name of any YNHHS facility, in any way other than in connection with the Services, including in any advertising or promotional media as a customer or client of Deloitte & Touche, without obtaining the prior written consent of System.

20. False Claims. Deloitte & Touche acknowledges that System has provided it with access to its policy on False Claims and Payment Fraud Prevention (the "Policy") located on its internet site at www.ynhhs.org/FalseClaims.pdf. The False Claims Act imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.

21. Personal Inducements. Deloitte & Touche represents and warrants that no cash, equity interest, merchandise, equipment, services or other forms of remuneration have been offered, shall be offered or will be paid or distributed by or on behalf of Deloitte & Touche to YNHHS and/or the employees, officers, or directors of YNHHS or its member hospitals, or to any other person, party or entity affiliated with YNHHS or its member hospitals, as an inducement to purchase or to influence the purchase of services by YNHHS or its member hospitals from Deloitte & Touche.

22. No Undisclosed Relationships. Deloitte & Touche represents and warrants to the System that, except for those relationships (if any) Deloitte & Touche has disclosed to the System in writing, as of the date of this Agreement the Deloitte & Touche and Deloitte FAS personnel that provide services under this Agreement: (i) do not have a financial relationship with any of the System's trustees, officers, employees, or medical staff members, (ii) will not establish or otherwise create any such relationship after the Effective Date without disclosing such relationship to the System in writing, and (iii) Deloitte & Touche will promptly notify the System in writing if its Engagement Partner for the Services becomes aware of the existence of any such relationship during the course of the services provided under this Agreement. Notwithstanding any other provision of this Agreement or any other agreement between the System and Deloitte & Touche, the System may terminate this Agreement upon written notice to Deloitte & Touche in the event the System becomes aware of any such relationship (through disclosure by Deloitte & Touche or otherwise).

23. General Compliance. Deloitte & Touche shall comply with all applicable standards, statutes, rules, regulations, acts and orders of the United States, its departments, agencies, and bureaus, and of any applicable state or political subdivision thereof, including without limitation, laws and regulations pertaining to labor, wages, hours, conditions of employment, environmental protection, hazardous and infectious materials, identity theft, as applicable to Deloitte & Touche in its performance of the Services hereunder.

24. Equal Employment Opportunities. Deloitte LLP (the parent company of Deloitte & Touche) and its subsidiaries (together, referred to as "Deloitte" for purposes of this Section 24) are equal opportunity employers. Deloitte recruits, employs, trains, compensates, and promotes without regard to race, religion, creed, color, citizenship, national origin, age, gender, gender identity/expression, sexual orientation, marital status, disability, veteran status, or any other legally protected basis, in accordance with applicable federal, state, or local law. Deloitte makes reasonable attempts to accommodate the expression of religious beliefs, as long as that expression does not harass or intimidate coworkers or place an undue hardship on its business.

As a federal contractor, Deloitte also provides an affirmative action program for minorities, women, disabled and Vietnam-era veterans, and persons with disabilities.

In response to a request from a qualified individual with a disability, Deloitte will make a reasonable accommodation that would allow that individual to perform the essential functions of his or her job, unless doing so would create undue hardship on its business.

25. Access to Records. In the event that the Engagement Letter provides for services to be performed by Vendor worth $10,000 or more over a 12-month period, Deloitte & Touche agrees, until the expiration of four years after the termination of the Arrangement, to make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General and their representatives, pursuant to a proper request, the Agreement, if any, and all books, documents and records necessary to certify the nature and extent of the cost of those services. If Deloitte & Touche carries out any of the duties described herein through a subcontract worth $10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives pursuant to a proper request to the related organization's books, documents and records necessary to certify the nature and extent of the cost of those services. In the event Deloitte & Touche receives a request for access, Deloitte & Touche agrees to notify YNHHS immediately and to consult with YNHHS regarding the response to the request.

26. Security and Access. Deloitte & Touche shall comply with all YNHHS policies and procedures pertaining to visitation, confidentiality, security and vendor identification as are provided to it in writing prior to execution of the Engagement Letter. YNHHS may issue non-employee identification badges under certain conditions; in the event that any non-employee identification badge is issued to an employee of Deloitte & Touche, Deloitte & Touche agrees to cause such employee to prominently display such badge at all times while on YNHHS premises. All badges must be surrendered by Deloitte & Touche when requested by YNHHS. Non-compliance with any of the above policies shall be deemed a breach of the Engagement Letter.

APPENDIX C: Business Associate Addendum

This Appendix ("Appendix C") is part of the attached engagement letter dated November 7, 2016 between Deloitte & Touche LLP ("D&T"), Yale-New Haven Health System ("YNHH"). If and to the extent, and so long as, required by HIPAA or HITECH (each as defined below), and not otherwise, D&T and YNHH hereby agree to the following in connection with D&T's performance of services under the engagement letter to which this Business Associate Appendix is attached (such engagement letter, the "Engagement Letter," together with this Business Associate Appendix and all other attachments, appendices, and exhibits to the Engagement Letter, this "Agreement"). D&T agrees that for purposes of this Appendix C, D&T is a business associate of YNHH to the extent that, in performance of the Services, D&T qualifies as a "business associate" as that term is defined at 45 C.F.R §160.103.

(A) Unless otherwise specified in this Business Associate Appendix, all capitalized terms used in this Business Associate Appendix shall have the meanings established for purposes of HIPAA or HITECH, as applicable. Specific statutory or regulatory citations used in this Business Associate Appendix shall mean such citations as amended and in effect from time to time.

1. "Compliance Date" shall mean, with respect to any applicable provision in this Business Associate Appendix, the later of the date by which compliance with such provision is required under HITECH and the effective date of this Agreement.

2. "Electronic Protected Health Information" shall mean Protected Health Information that is transmitted or maintained in electronic media.

3. "HIPAA" shall mean the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d through 1320d-8, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.

4. "HITECH" shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.

5. "Protected Health Information" shall mean the term as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, the Client by D&T pursuant to performance of the Services.

6. "Privacy Rule" shall mean the federal privacy regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and E).

7. "Security Rule" shall mean the federal security regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and C).

8. "Services" shall have the meaning set forth in the attached engagement letter, and, if not therein defined, shall mean the services described in the Engagement Letter to be performed by D&T for the Client.

9. "Unsecured Protected Health Information" shall mean Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a

technology or methodology specified by the Secretary in the regulations or guidance issued pursuant to 42 U.S.C. § 17932(h)(2).

(B) With regard to D&T's use and disclosure of Protected Health Information:

1. D&T may use and disclose Protected Health Information as reasonably required or contemplated in connection with the performance of the Services, excluding the use or further disclosure of Protected Health Information in a manner that would violate the requirements of the Privacy Rule, if done by the Client. Notwithstanding the foregoing, D&T may use and disclose Protected Health Information for the proper management and administration of D&T as provided in 45 C.F.R. § 164.504(e)(4).

2. D&T will not use or further disclose Protected Health Information other than as permitted or required by this Business Associate Appendix, and in compliance with each applicable requirement of 45 C.F.R. § 164.504(e), or as otherwise Required by Law.

3. D&T will implement and use appropriate administrative, physical, and technical safeguards to (1) prevent use or disclosure of Protected Health Information other than as permitted or required by this Business Associate Appendix; (2) reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that D&T creates, receives, maintains, or transmits on behalf of the Client; and (3) as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.

4. D&T will, without unreasonable delay report to the Client (1) any use or disclosure of Protected Health Information not provided for by this Business Associate Appendix of which it becomes aware in accordance with 45 C.F.R. § 164.504(e) (2) (ii) (C); and/or (2) any Security Incident affecting Electronic Protected Health Information of which D&T becomes aware in accordance with 45 C.F.R. § 164.314(a) (2) (C).

5. D&T will, without unreasonable delay, and in any event no later than ten (10) business days after Discovery, notify the Client of any Breach of Unsecured Protected Health Information. The notification shall include, to the extent possible (and subsequently as the information becomes available), the identification of all individuals whose Unsecured Protected Health Information is reasonably believed by D&T to have been Breached along with any other available information that is required to be included in the notification to the Individual, the Secretary, and/or the media, all in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. Parts 160 and 164 (Subparts A, D, and E), as of their respective Compliance Dates.

6. D&T will ensure that any subcontractors or agents to whom D&T provides Protected Health Information agree to the same restrictions and conditions that apply to D&T with respect to such Protected Health Information. To the extent that D&T provides Electronic Protected Health Information to a subcontractor or agent, it will require the subcontractor or agent to implement reasonable and appropriate safeguards to protect the Electronic Protected Health Information consistent with the requirements of this Business Associate Appendix.

7. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information in accordance with 45 C.F.R. § 164.524.

8. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will provide an electronic copy of such Protected Health Information in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date.

9. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information for amendment and incorporate any amendments to such information as directed by the Client, all in accordance with 45 C.F.R. § 164.526.

10. D&T will document and make available the information required to provide an accounting of disclosures of Protected Health Information, in accordance with 45 C.F.R. § 164.528.

11. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will make an accounting of disclosures of such Protected Health Information in accordance with the requirements for accounting of disclosures made through an Electronic Health Record in 42 U.S.C. § 17935(c), as of its Compliance Date.

12. D&T will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary for purposes of determining the Client's compliance with the Privacy Rule.

13. D&T will, as of the Compliance Date of 42 U.S.C. § 17935(b), limit any request, use, or disclosure by D&T of Protected Health Information, to the extent practicable, to the Limited Data Set of such Protected Health Information (as defined in 45 C.F.R. § 164.514(e)(2)), or, if the request, use, or disclosure by D&T of Protected Health Information, not in a Limited Data Set, is necessary for D&T's performance of the Services, D&T will limit the amount of such Protected Health Information requested, used, or disclosed by D&T to the minimum necessary to accomplish the intended purpose of such request, use, or disclosure, respectively; provided, however, that the requirements set forth above in this subsection (13) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.

14. D&T will not directly or indirectly receive remuneration in exchange for any Protected Health Information as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

15. D&T will not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

16. D&T will not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

(C) In addition to any other obligation set forth in this Agreement, including this Business Associate Appendix, the Client agrees that it will: (1) not make any disclosure of Protected Health Information to

D&T if such disclosure would violate HIPAA, HITECH, or any applicable federal or state law or regulation; (2) not request D&T to use or make any disclosure of Protected Health Information in any manner that would not be permissible under HIPAA, HITECH, or any applicable federal or state law or regulation if such use or disclosure were done by the Client; and (3) limit any disclosure of Protected Health Information to D&T, to the extent practicable, to the Limited Data Set of such Protected Health Information, or, if the disclosure of Protected Health Information that is not in a Limited Data Set is necessary for D&T's performance of the Services, to limit the disclosure of such Protected Health Information to the minimum necessary to accomplish the intended purpose of such disclosure, provided, however, that the requirements set forth above in this part (3) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.

(D) If either the Client or D&T knows of either a violation of a material term of this Business Associate Appendix by the other party or a pattern of activity or practice of the other party that constitutes a material breach or violation of this Business Associate Appendix, the non-breaching party will provide written notice of the breach or violation to the other party that specifies the nature of the breach or violation. In the event that the breaching party does not cure the breach or end the violation on or before thirty (30) days after receipt of the written notice, the non-breaching party may do the following:

(i) if feasible, terminate this Agreement; or

(ii) if termination of this Agreement is infeasible, report the issue to the Secretary.

(E) D&T will, at termination of this Agreement, if feasible, return or destroy all Protected Health Information that D&T still maintains in any form and retain no copies of Protected Health Information or, if such return or destruction is not feasible (such as in the event that the retention of Protected Health Information is required for archival purposes to evidence the Services), D&T may retain such Protected Health Information and shall thereupon extend the protections of this Business Associate Appendix to such Protected Health Information and limit further uses and disclosures to those purposes that make the return or destruction of such Protected Health Information infeasible.

(F) Any other provision of this Agreement that is directly contradictory to one or more terms of this Business Associate Appendix shall be superseded by the terms of this Business Associate Appendix to the extent and only to the extent of the contradiction and only for the purpose of the Client's and D&T's compliance with HIPAA and HITECH. The terms of this Business Associate Appendix, to the extent they are unclear, shall be construed to allow for compliance by the Client and D&T with HIPAA and HITECH.

In addition, the Client agrees to compensate D&T for any time and expenses that we may incur in responding to requests for documents or information under HIPAA, HITECH, or any regulations promulgated under HIPAA or HITECH.

Nothing contained in this Business Associate Appendix is intended to confer upon any person (other than the parties hereto) any rights, benefits, or remedies of any kind or character whatsoever, whether in contract, statute, tort (such as negligence), or otherwise, and no person shall be deemed a third-party beneficiary under or by reason of this Business Associate Appendix.

DPH

Connecticut Department of Public Health

Scheduled Meeting
Lawrence + Memorial and Yale-New Haven Health System
Certificate of Need Transfer of Ownership
Docket Numbers 15-32033-CON and 15-32032-CON

Date of Meeting: 11/15/2016

Name (Please Print)	Affiliation
Tia Sawhney	Milliman
Bruce Pyenson	Milliman
Kelly Sauders	Deloitte
Gayle Capozzalo	YNHHS
Nancy Rosenthal	YNHHS
Vincent Nammaro	YNHHS

Present from OHCA were:

Carmen Cotto	C. Cotto
Shauna Walker	

Michaela Mitchell

Karen Roberts

Meeting Start Time: 1:30
Meeting End Time: 3:00

Kim Mastone

Greer, Leslie

From: Roberts, Karen
Sent: Wednesday, November 16, 2016 3:22 PM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Compliance reporting element in Docket # 15-32033-CON

Hi Leslie – this is for the #15-32033-CON PDF file. Karen

From: Roberts, Karen
Sent: Wednesday, November 16, 2016 2:24 PM
To: 'Capozzalo, Gayle'; 'Rosenthal, Nancy'
Cc: Cotto, Carmen; Martone, Kim
Subject: Compliance reporting element in Docket # 15-32033-CON

Hi Nancy and Gayle – as mentioned in the meeting yesterday, we were going to look to see if Bad Debts really need to be reported as a Cost Saving element.

Stipulation #32 (f) of the decision says
Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: ….A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report.

Part ii of Stipulation #32 says:
ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories;

Note that Bad Debt is no longer treated as an expense on HRS Report 175 and will not have to be treated as an expense for this compliance reporting submission. Hope that clarifies that and we will include this email in the record for 15-32033-CON. Thanks.

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308

P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

Greer, Leslie

Subject: FW: CMIR Independent Consultant: CON Docket #s 15-32032-CON and 15-32033-CON

From: Martone, Kim [mailto:Kimberly.Martone@ct.gov]
Sent: Thursday, November 17, 2016 11:08 AM
To: Capozzalo, Gayle
Cc: Rosenthal, Nancy; Roberts, Karen; Cotto, Carmen
Subject: RE: CMIR Independent Consultant: CON Docket #s 15-32032-CON and 15-32033-CON

Hi Gayle, it was a pleasure as well. It was very informative and comprehensive. The presentation and discussion with Milliman regarding their expertise in this field and approach to conducting the CMIR is acceptable to OHCA therefore their engagement is approved.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Thursday, November 17, 2016 10:02 AM
To: Martone, Kim
Cc: Rosenthal, Nancy
Subject: CMIR Independent Consultant: CON Docket #s 15-32032-CON and 15-32033-CON

Dear Kim,
It was a pleasure meeting with you on Tuesday. We would like to request your approval to engage Milliman to complete the initial CMIR and appropriate updates.
Sincerely,
Gayle

Gayle Capozzalo
Executive Vice President and
Chief Strategy Officer

789 Howard Avenue
New Haven, CT 06519

Phone: 203-688-2605

Fax: 203-688-3472

Email: gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Greer, Leslie

From: Martone, Kim
Sent: Friday, November 18, 2016 2:44 PM
To: Roberts, Karen; Cotto, Carmen
Cc: Greer, Leslie
Subject: FW: DT-YNHHS Independent Monitor - slightly updated contract for your records
Attachments: DT-YNHHS Independent Monitor Eng Ltr REVISED FINAL 111816.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, November 18, 2016 2:43 PM
To: Martone, Kim
Cc: Capozzalo, Gayle; Rosenthal, Nancy
Subject: RE: DT-YNHHS Independent Monitor - slightly updated contract for your records

Dear Kim - per OHCAs approval of Deloitte as the Independent Monitor for Docket numbers 15-32032-CON and 15-32033-CON, please see the attached updated engagement letter which corrects for a few minor edits (to correct the parties to the BAA and update the Appendix of community groups to reflect the appropriate parties/groups). There are no other changes – just wanted to make sure OHCA has the latest/final copy.

Please feel free to call me directly with any questions.

Thanks,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, New York 10112
Tel: 212-436-3180
Fax: 212-653-7033
www.us.deloitte.com

Deloitte.

November 7, 2016

Bill Aseltyne
Senior Vice President & General Counsel
Yale-New Haven Hospital/Yale New Haven Health System
789 Howard Ave., CB 230
New Haven, CT 06519

Dear Bill,

This engagement letter is to confirm the engagement of Deloitte & Touche LLP ("D&T" or "we"), effective as of the date hereof, to provide Yale New Haven Health Services Corporation and its subsidiaries (collectively referred to as "YNHHSC" or the "Company") the services described below (the "Services").

Scope and Approach

We understand you are seeking an independent monitor related to the agreed settlement ("Agreement" or "Order") between YNHHSC and State of Connecticut's Office of Health Care Access ("OHCA") to monitor the YNHHSC's compliance with the Conditions of the Order in the transfer of ownership of Lawrence + Memorial Corporation and its subsidiaries to YNHHSC.

Specific anticipated activities we will assist YNHHSC with will include two work streams:

Workstream 1: Assist YNHHSC with the planning and preparing for monitoring reviews

- Hold kick-off with YNHHSC responsible persons to discuss the monitor requirements
- Meet with the Connecticut Office of Health Care Access (OHCA), as requested
- Review and agree upon with YNHHSC and OHCA, as applicable, the elements of monitor services as documented in the work plan in Appendix A.

Workstream 2: Assist YHHHS with the independent monitoring activities

- Refer to Appendix A for a detailed monitor work plan which describes the various required activities and activities associated with each condition of the Order.

We anticipate providing our services both off-site and on-site. Where possible we will perform analysis and preparation activities remotely. We anticipate providing these services for a period of two to five years (as requested by YNHHSC based on requirements of OHCA).

Engagement Team

Kelly J. Sauders, Partner, Deloitte & Touche LLP, will serve as the lead engagement leader to provide oversight and direction. Ed Sullivan, Principal, Deloitte & Touche LLP will serve as the quality assurance partner, supporting Kelly and the team in the execution of the work. Kaitlin McCarthy, Manager, Deloitte & Touche LLP, will serve as the overall project manager. Additional support will be provided by other professionals from Deloitte & Touche LLP's Regulatory & Compliance practice, as needed, during the course of this engagement.

Deliverables

The following deliverables will be produced during the course of this engagement:

Workstream 1: Assist YNHHS with planning and preparing for monitoring reviews

1. D&T will create and maintain a written plan for fulfilling the duties set forth in the agreement.

Workstream 2: Assist YNHHS with independent monitoring activities

1. D&T will draft and submit a written report within thirty (30) days of the completion of each (semi-annual) on-site review on YNHHSC compliance with the conditions of the Order, totaling two reports per reporting year.

Professional Fees and Timing

The total fees related to this engagement are estimated as follows:

Year 1: $180,000 - $190,000
Years 2 through 5 (as required)* $150,000-$160,000

We will bill for our services based on actual hours incurred at the following billing rates:

Resource Level	Hourly Rate
Partner	$625
Senior Manager	$550
Manager	$510
Senior Consultant	$445
Consultant	$380

* Note that hourly rates will increase approximately 3% per year for years 3, 4 and 5.

This estimated fee and time estimate is based upon our current understanding of the project requirements, our proposed approach, our estimate of the level of effort required, our roles and responsibilities, any assumptions set forth herein, and active participation of Company's management and other personnel. We

plan to meet with you on no less than a quarterly basis to review time incurred and estimates to completion throughout the duration of this engagement.

Based on our experience, issues sometimes arise that require procedures beyond what was initially anticipated. If this should occur, we will discuss it with you promptly and early in the process before we perform any additional work.

We understand that you will reimburse us for all reasonable expenses incurred in performing the Services on this engagement (including, but not limited to, our reasonable travel, meal, lodging, and mileage expenses). Expenses will be noted separately on our invoices and segregated by expense type.

Fees for this engagement will be billed biweekly as the work progresses for fees accrued and expenses incurred by us since our last invoice in performing our Services.

Other Matters

YNHHSC is, among other things, a regulatory/compliance and merger & acquisition services client of D&T and/ or its affiliated and related entities. We do not believe that the proposed services impair the objectivity for D&T to perform the proposed services for YNHHSC. However, we are bringing this to your attention to avoid any misunderstanding.

Should a potential conflict come to the attention of the engagement leader with respect to potential future work being performed or to be performed by D&T or one of its affiliated or related entities for YNHHSC, D&T will advise YNHHSC promptly. YNHHC will, at its option and in consultation with the Connecticut Office of Health Care Access as appropriate, promptly request, in writing, (1) such entity not to proceed with the proposed services or (2) such entity to proceed with the proposed services, provided that such entity agrees to proceed. If YNHHSC requests such entity to proceed with the proposed services, YNHHSC agrees that D&T and its affiliated and related entities' are able to perform the proposed services objectively. If appropriate, such entity will establish an ethical wall and confidentiality safeguards so that the services will be performed by different personnel on the various engagements.

Acknowledgements and Agreements

The Company specifically acknowledges and agrees to the following:

- Substantial and meaningful involvement of management of the Company is critical to the success of this engagement. The Company shall be responsible for ensuring that the identified Company personnel actively participate in both the planning and execution of this engagement.

- D&T will not make any management decisions, perform any management functions, or assume any management responsibilities.

- The Company agrees that any deliverables provided to the Company hereunder by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with an investigation or examination of the Company. To the extent permitted by law, rule, regulation and applicable professional standards, YNHHSC shall be promptly notified in the event such deliverable(s) are provided by D&T to the OHCA.

- Company will limit sensitive information, such as PII, PHI, trade secrets and other information that it considers sensitive or highly confidential, it provides to D&T (or otherwise makes available to D&T) to only that which is reasonably necessary to allow D&T to provide the Services. D&T will provide Company with a list of D&T personnel who are authorized to receive or have access to Company sensitive information. Such list may be updated as needed. Any disclosure of sensitive information by Company to D&T will utilize levels of information security and data encryption appropriate to maintain security of Company sensitive information being accessed by or transferred to D&T, and as required by applicable information protection laws.

- The Services will be performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). However, the Services will not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, we will not express an opinion or any other form of assurance as a result of performing the Services.

- We will not provide any legal advice regarding our Services nor will we provide any assurance regarding the outcome of any future audit or regulatory examination or other regulatory action; the responsibility for all legal issues with respect to these matters, such as reviewing all deliverables and work product for any legal implications to the Company, will be the Company's.

- The Services may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the Company.

*****

During the term of this engagement, the Company may request that D&T perform additional services that are not encompassed by this engagement letter. D&T may perform such additional services upon receipt of a separate signed engagement letter with terms and conditions that are acceptable to D&T and the Company. Our observations and recommendations will be based solely on the results of the assessment performed.

This engagement letter, together with the General Business Terms attached hereto as Appendix B and the Business Associate Addendum attached hereto as Appendix C and made a part hereof constitute the entire agreement between the Company and D&T with respect to this engagement, supersede all other oral and written representations, understandings, or agreements relating to this engagement, and may not be amended except by the mutual written agreement of the Company and D&T.

Please indicate your acceptance of this agreement by signing in the space below and returning a fully executed copy of this engagement letter to us. A duplicate of this engagement letter is provided for your records. We look forward to serving you. If you have any questions please contact Kelly Sauders at (212) 436-3180.

Very truly yours,

Deloitte & Touche LLP

By: Kelly J. Sauders
Partner

Accepted and Agreed to by:

Yale New Haven Health Services Corporation on behalf of itself and its subsidiaries

By: _____

Title: Executive VP | Chief Strategy Officer

Date: 11/7/16

APPENDIX A. MONITORING PROCEDURES (per Docket Numbers 15-32032-CON and 15-32033-CON)

Condition	D&T Procedure
Strategic Plan	
15-32033-CON Condition 4: Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHSC. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties. Note 2: Refer to Condition #19 which addresses the same/similar requirements	D&T will obtain a copy of the Services Plan/Strategic Plan submitted for Condition #4 and #19, verify timely submission, verify that it incorporates the required elements (e.g. describing any planned consolidation, reduction, or elimination of existing services or introduction of new services) and that it meets the 3 year requirement.
15-32033-CON Condition 19: L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components: a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals.	D&T will obtain the Services Plan/Strategic Plan submitted for Condition #4 and #19 and review the plan for inclusion of these required components (as compared to the needs described within the Community Needs Assessment and the resource commitments within the Affiliation Agreement). .

Condition	D&T Procedure
b. YNHHSC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement. NOTE 1: Refer to Condition #4 which addresses the same requirements.	
15-32033-CON Condition 32b: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met including referencing specific locations of primary care physicians.
15-32033-CON Condition 7: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment [1]is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures [2]that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including	D&T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. We will discuss any questions/need for clarification with Management to ensure the expenditures are verified. D&T will confirm detailed, full and timely submissions, with appropriate signatures of all required reports.

[1] Per discussion with OHCA, we understand that "capital requirement" per this Order is intended to mean "resource commitment". YNHHSC will describe the plan/resource commitment per Conditions #4 and #19 of this Order.

[2] See footnote 4.

Condition	D&T Procedure
estimated beginning, ending a11d startup/operation dates); and c. The funding source of the capital investment [3]indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning May 31, 2017. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.	
15-32033-CON Condition 5: Until such time as the Services Plan is submitted[4], YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18	D&T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days. Per related 15-32033-CON Condition #18, D&T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.

[3] Per discussion with OHCA, we understand that "capital investment" per this Order is intended to mean expenditures/investment made".

[4] The Services Plan is due 180 days after the closing date of September 8, 2016. Therefore this provision only applies until the Services Plan per Condition #4 is submitted.

Condition	D&T Procedure
15-32033-CON Condition 18: L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHSC is bound by Condition #4 and the Services Plan created per Condition #4	D&T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data (e.g. to see continuing patient volume/services). YNHHSC will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&T will obtain a copy of that Management Representation.
15-32033-CON Condition 32a: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 – September 30 with reports due November and May certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation of the continuation of all L+MH services as described herein.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's notarized Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.
Financial Reporting	
15-32033-CON Condition 8: For three (3) years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period (fiscal year). Due dates are May 31st and November 30th, beginning May 2017. The following financial measurements/indicators should be addressed in the report: (i) **Operating performance** to include operating margin, non-operating margin, and total margin; (ii) **Liquidity** to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) **Leverage and capital structure** to include long-term debt to equity, long-term debt to capitalization,	D&T will obtain the financial measurement report and review work papers to ensure that they are consistent with financial reports being submitted to L+M Hospital Board and that the required elements and financial measurements are appropriately recorded in the report; we will confirm the timely submission of each report.

Condition	D&T Procedure
unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) **Additional Statistics** to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	
15-32033-CON Condition 32f: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report. i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities; ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the	For 15-32033-CON Condition #32F, D&T will obtain the Five-Year Plan prepared by YNHHSC and the ongoing six month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175 and succession reports to OHCA.

Condition	D&T Procedure
specifics of the cost savings for each of these major expense categories; iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.	
15-32032-CON Condition 7c: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, and Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and	Refer to procedures for 15-32033-CON Condition #32f in the work plan above.

Condition	D&T Procedure
15-32033-CON Condition 6: Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price[5] per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.	D&T will obtain YNHHSC's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information. D&T will review work papers to confirm information and timely filing. * 1st filing is due within 180 days (March 2017); 2nd filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3rd filing is due 60 dates after the close of FY2018 which is 11/30/18.
Cost and Market Impact Review	
15-32033-CON Condition 22: Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.

[5]For purposes of this calculation, "total prices per unit of service" will be the weighted average price across all payers per unit of service.

Condition		D&T Procedure
b.	In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	
c.	In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to	

Condition	D&T Procedure
correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.	
15-32032-CON Condition 3: Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below)	Refer to procedures for 15-32033-CON Condition #22 above.

Condition	D&T Procedure
for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut. c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section l 9a-639f shall be conducted after the Date of Closing, in	

Condition	D&T Procedure
the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.	

Condition	D&T Procedure
15-32033-CON Condition 23: For purposes of determining the price per unit of service: f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.
15-32032-CON Condition 4: For purposes of determining the price per unit of service: a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-	D&T will obtain a copy of the CMIR performed by the Independent Consultant.

Condition	D&T Procedure
10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.

Condition	D&T Procedure
15-32033-CON Condition 20 Paragraph 1: L+M and YNHHSC shall maintain the current L+MH and Lawrence + Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.	D&T will evaluate and verify that contracts are maintained in accordance with this condition. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.
15-32033-CON Condition 32c: Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of Conditions (20), (21) and (22) above.	For 15-32033-CON Condition 32c, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.

Condition	D&T Procedure
15-32033-CON Condition 20 Paragraphs 2/3: Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut. For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to cap determined through the process set forth below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	D&T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.

Condition	D&T Procedure
15-32032-CON Condition 1: Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph. Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut. For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	Refer to procedures for 15-32033-CON Condition #20 outlined here and 1532033-CON Condition 20a, 20b and 20c.

Condition	D&T Procedure
15-32032-CON Condition 7a: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.	Refer to procedures for 15-32033-CON Condition #32c.
15-32033-CON Condition 21a: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	D&T will receive samples of payer submissions for LMMG physicians and obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.

Condition	D&T Procedure
15-32032-CON Condition 2a: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	Refer to procedures for 15-32033-CON Condition #21a above.
15-32033-CON Condition 21b: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.	D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.

Condition	D&T Procedure
15-32032-CON Condition 2b: With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.	Refer to procedures for 15-32033-CON Condition #21b above.
Independent Monitor	
15-32033-CON Condition 15: Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years[6] following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the	D&T and YNHHSC will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.

[6] The Monitor may be required for only 1 (one) year or up to five (5) years as determined in writing by OHCA.

Condition	D&T Procedure
Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein. NOTE: See Condition #33a (appointment of Monitor requirement)	
15-32033-CON Condition 16: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis[7] to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	D&T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&T. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.
15-32033-CON Condition 33: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor.	For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15. 15-32033-CON Condition #33b – D&T will meet with CHNA/CHIP "participation

[7] The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

Condition		D&T Procedure
b.	Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.	group[8]" in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&T of these meetings and provided to OHCA upon request.
c.	L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties.	With respect to 15-32033-CON #33d, D&T will review the public notice and attend the public forum held by YNHHSC and confirm that it includes members of the CHIP (Community Health Improvement Program) group.
d.	L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	
e.	If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce	With respect to 15-32033-CON #33e, D&T agrees to provide written notice of any deficiencies as required.

[8] See attached list.

Condition	D&T Procedure
these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	
15-32032-CON Condition 8: In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	Refer to procedures for 15-32033-CON Condition #33 a through e above.

Condition	D&T Procedure
e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	
Community Benefit	
<u>15-32033-CON Condition 11:</u> The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent.	D&T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met. D&T will also obtain the YNHHSC report/summary on

Condition	D&T Procedure
In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&T will evaluate these reports/summaries as compared to the CHNA and defined population health management objectives and will discuss any questions with YNHHSC Management. D&T will confirm that these documents are filed in a timely manner and posted to the L+MH website.
15-32033-CON Condition 31: L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.	After obtaining L+M's baseline Schedule H of IRS Form 990, D&T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5). Cross-reference to 15-32033-CON Condition #11.
15-32033-CON Condition 32h: A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.	Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.

Condition	D&T Procedure
15-32033-CON Condition 12: The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.	D&T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain the cultural competency plan, training and related policies. We will also obtain YNHHSC's report and supporting documents and confirm the timely filing of these materials.
Charity Care Policies	
15-32033-CON Condition 9: Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	D&T will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSC's financial assistance policies (or policies at least as generous as these policies) using L+M Hospital board resolutions. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.

Condition	D&T Procedure
15-32033-CON Condition 10: For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.
15-32033-CON Condition 32e: Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.
Employment Conditions	
15-32033-CON Condition 27: L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.
15-32033-CON Condition 32g: Affirmation of the labor and employment commitments described herein, including but not limited to L+M' s service sites continued honoring of collective bargaining agreements in place as of the date hereof.	See others below

Condition	D&T Procedure
15-32033-CON Condition 28: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.
15-32032-CON Condition 6: Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	Refer to procedures for 15-32033-CON Condition #28.
15-32033-CON Condition 29: L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.
15-32033-CON Condition 30: L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.

Condition	D&T Procedure
Governance	
15-32033-CON Condition 14: For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	D&T will confirm the appointment of this individual (community representative) to the L+MH Board as evidenced by Board minutes. We will discuss the selection process with Management and document our understanding of the selection process/qualifications of the individual.
15-32033-CON Condition 17: For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	To confirm compliance with this provision, D&T will obtain minutes from these Joint Board Meetings and confirm that notice of the public meetings is posted with proper notice. D&T will attend the public meetings as part of the Monitor role.
15-32033-CON Condition 26: As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.	D&T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.

Condition	D&T Procedure
Licensure, Physician Office Conversion, Cost Savings Attainment	
15-32033-CON Condition 13: The Applicants shall abide by all requirements of licensure that may be imposed by the Facility Licensing and Investigations Section ("FLIS") of the Department of Public Health ("DPH") in any Pre-Licensing Consent Order or similar agreement that FLIS may enter with these parties. OHCA is imposing this Condition to ensure that quality health care services are provided to the patient population.	D&T will, if necessary, work with DPH to ensure compliance with this Condition.
15-32033-CON Condition 24: L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.
15-32033-CON Condition 32d: Affirmation that no L+M physician office has been converted to hospital-based status.	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.
15-32032-CON Condition 5: L+MH and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	Refer to procedures for 15-32033-CON Condition #24 above.
15-32032-CON Condition 7b: Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31st) and April 1 through September 30 (due November 30th) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: Affirmation that no L+M physician office has been converted to hospital-based status.	Refer to procedures for 15-32033-CON Condition #32f above.
15-32033-CON Condition 25: L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.

Footnote 8 Attachment

Representative	Thames Valley Council of Community Action
Representative	Universal Health Foundation
Representative	United Community and Family Services
Representative	NL County Food Policy Council
Representative	Groton Parks and Recreation
Representative	Hispanic Alliance
Representative	Ledge Light Health District
Representative	Uncas Health District
Representative	City of New London
Representative	Community Foundation of Eastern CT
Representative	Connecticut College
Representative	Community Health Center, Inc.
Representative	Higher Edge
Representative	UCONN Health Disparities Institute
Representative	Chamber of Commerce of Eastern Connecticut
Representative	Greater Mystic Chamber of Commerce
Representative	Rotary Clubs of New London and Groton
Representative	Southeastern Connecticut Women's Network
Representative	Tribal Councils

APPENDIX B: GENERAL BUSINESS TERMS

Client: Yale New Haven Health Services Corporation ("Yale New Haven Health" or the "System")

1. Services. It is understood and agreed that the services provided by Deloitte & Touche LLP (Deloitte & Touche) (as defined in paragraph 13) (the "Services") under the engagement letter to which these terms are attached (the "Engagement Letter") may include advice and recommendations, but all decisions in connection with the implementation of such advice and recommendations shall be the responsibility of, and made by, the System. For purposes of these terms and the Engagement Letter, the "System" shall mean Yale New Haven Health Services Corporation and its subsidiaries. Yale New Haven Health Services Corporation represents and warrants that it has the power and authority to execute this agreement on behalf of, and to bind, itself and its subsidiaries.

2. Exclusion. Deloitte & Touche represents and warrants that neither Deloitte & Touche nor any of its employees providing the Services: (1) has ever been (A) convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System and (2) shall notify System immediately in the event that the Consultant (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System. System may terminate this Agreement immediately in the event that Deloitte & Touche or any of its employees (A) is convicted of a criminal offense related to health care and/or related to the provision of services paid for by Medicare, Medicaid or another federal health care program; (B) is excluded from or debarred from participation in any federal health care program, including Medicare and Medicaid; or (C) is otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System.

3. Payment of Invoices. Deloitte & Touche's invoices are due upon presentation. Without limiting its rights or remedies, Deloitte & Touche shall have the right to halt or terminate the Services entirely if payment is not received within sixty (60) days of the invoice date. The System shall be responsible for all taxes imposed on the Services or on the transaction, other than Deloitte & Touche's income taxes or tax imposed by employment withholding, and other than taxes imposed on Deloitte & Touche's property.

4. Term. Unless terminated sooner in accordance with its terms, this engagement shall terminate on the completion of the Services. This engagement may be terminated by either party at any time, with or without cause, by giving written notice to the other party not less than sixty (60) days before the effective date of termination, provided that, in the event of a termination for cause, the breaching party shall have the right to cure the breach within the notice period. Deloitte & Touche may terminate this engagement upon written notice to the System if it determines that (a) a governmental, regulatory, or professional entity (including, without limitation, the American Institute of Certified Public Accountants, the Public Company Accounting Oversight Board, or the Securities and Exchange Commission), or an entity having the force of law, has introduced a new, or modified an existing, law, rule, regulation, interpretation, or decision, the result of

which would render Deloitte & Touche's performance of any part of the engagement illegal or otherwise unlawful or in conflict with independence or professional rules; or (b) circumstances change (including, without limitation, changes in ownership of the System or any of its affiliates) such that Deloitte & Touche's performance of any part of the engagement would be illegal or otherwise unlawful or in conflict with independence or professional rules. Upon termination of the engagement, the System will compensate Deloitte & Touche under the terms of the Engagement Letter for the Services performed and expenses incurred through the effective date of termination.

5. Deliverables.

a) Deloitte & Touche has created, acquired, or otherwise has rights in, and may, in connection with the performance of the Services, employ, provide, modify, create, acquire, or otherwise obtain rights in, works of authorship, materials, information, and other intellectual property (collectively, the "Deloitte & Touche Technology").

b) Except as provided below, upon full and final payment to Deloitte & Touche hereunder, the tangible items specified as deliverables or work product in the Engagement Letter (the "Deliverables") shall become the property of the System. To the extent that any Deloitte & Touche Technology is contained in any of the Deliverables, Deloitte & Touche hereby grants the System, upon full and final payment to Deloitte & Touche hereunder, a royalty-free, fully paid-up, worldwide, nonexclusive license to use such Deloitte & Touche Technology in connection with the Deliverables.

c) To the extent that Deloitte & Touche utilizes any of its property (including, without limitation, the Deloitte & Touche Technology or any hardware or software of Deloitte & Touche) in connection with the performance of the Services, such property shall remain the property of Deloitte & Touche and, except for the license expressly granted in the preceding paragraph, the System shall acquire no right or interest in such property. Notwithstanding anything herein to the contrary, the parties acknowledge and agree that (1) Deloitte & Touche shall own all right, title, and interest, including, without limitation, all rights under all copyright, patent, and other intellectual property laws, in and to the Deloitte & Touche Technology and (2) Deloitte & Touche may employ, modify, disclose, and otherwise exploit the Deloitte & Touche Technology (including, without limitation, providing services or creating programming or materials for other clients). Deloitte & Touche does not agree to any terms that may be construed as precluding or limiting in any way its right to (1) provide consulting or other services of any kind or nature whatsoever to any person or entity as Deloitte & Touche in its sole discretion deems appropriate or (2) develop for itself, or for others, materials that are competitive with or similar to those produced as a result of the Services, irrespective of their similarity to the Deliverables.

d) To the extent any Deloitte & Touche Technology provided to the System hereunder is a product (to the extent it constitutes merchandise within the meaning of section 471 of the Internal Revenue Code), such Deloitte & Touche Technology is licensed to the System by Deloitte & Touche as agent for Deloitte & Touche Products Company LLC on the terms and conditions herein. The assignment and license grant in this paragraph 5 do not apply to any works of authorship, materials, information, or other intellectual property (including any modifications or enhancements thereto or derivative works based thereon) that is subject to a separate license agreement between the System and a third party, including without limitation, Deloitte & Touche Products Company LLC.

6. Limitation on Warranties. THIS IS A SERVICES ENGAGEMENT. DELOITTE & TOUCHE WARRANTS THAT IT SHALL PERFORM THE SERVICES IN GOOD FAITH AND WITH DUE PROFESSIONAL CARE. DELOITTE & TOUCHE DISCLAIMS ALL OTHER WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

7. Limitation on Damages and Indemnification.

a) The System agrees that Deloitte & Touche, its subcontractors, and their respective personnel shall not be liable to the System for any claims, liabilities, or expenses relating to this engagement ("Claims") for an aggregate amount in excess of two (2) times the fees paid by the System to Deloitte & Touche pursuant to this engagement, except to the extent finally judicially determined to have resulted primarily from the bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

b) Except with respect to Claims for which a party has an indemnification obligation hereunder, in no event shall either party, its subcontractors, or their respective personnel be liable for any loss of use, data, goodwill, revenues, or profits (whether or not deemed to constitute a direct Claim), or any consequential, special, indirect, incidental, punitive, or exemplary loss, damage, or expense relating to this engagement.

c) Except for those claims for which Deloitte & Touche has agreed to indemnify the System pursuant to paragraph 7(d) and, 7(e), the System shall indemnify and hold harmless Deloitte & Touche, its subcontractors, and their respective personnel from all Claims of third parties arising from the use or disclosure of the Services or the Deliverables, except to the extent finally judicially determined to have resulted primarily from the recklessness, bad faith, or intentional misconduct of Deloitte & Touche or its subcontractors.

d) Deloitte & Touche shall indemnify, defend and hold harmless the System, its directors, officers, employees and agents from and against any and all Claims, including reasonable attorneys' fees, in each case solely for bodily injury, death or physical damage to real or tangible personal property, to the extent such Claims are caused by Deloitte & Touche's negligent acts, negligent errors or negligent omissions. In the event such Claims are caused by the joint or concurrent negligence of the parties, they shall be borne by each party in proportion to such party's negligence.

e) Deloitte & Touche agrees to defend the System, its officers and employees from and against any and all claims and pay any settlement costs or any final judgments, including reasonable defense costs and reasonable legal fees, arising out of infringement by the Deliverables of any U.S. patent known to Deloitte & Touche or copyright or any unauthorized use of any trade secret or trademark, except to the extent that such infringement or unauthorized use arises from (i) the System's modification of the Deliverables or use thereof in a manner not contemplated by this engagement, (ii) the failure of the System to use any corrections or modifications made available by Deloitte & Touche, (iii) information, materials, instructions or specifications provided by or on behalf of the System, (iv) the System's distribution, marketing or use for the benefit of third parties of the Deliverables, or (v) the use of the Deliverable in combination with any product or data not provided by Deloitte & Touche whether or not with Deloitte & Touche's consent. If any such Deliverable, or any portion thereof, becomes, or in Deloitte & Touche's reasonable judgment, is likely to become the subject of a claim based upon infringement or unauthorized use, or if any such Deliverable or

any portion thereof, is found by final, non-appealable order of a court of competent jurisdiction to be such an infringement or unauthorized use, Deloitte & Touche, at its option and expense, shall have the right to (x) procure for the System the continued use of such Deliverable, (y) replace or modify such Deliverable provided that the replacement or modified Deliverable is reasonably capable of performing substantially the same function, or (z) require the System to cease use of such Deliverable and refund an appropriate portion of the fee paid with respect to the affected Deliverable. The foregoing provisions of this Paragraph constitute the sole and exclusive remedy of the System, and the sole and exclusive obligation of Deloitte & Touche, relating to a claim that a Deliverable infringes any patent, copyright or other intellectual property right of a third party.

8. Client Responsibilities. The System shall cooperate with Deloitte & Touche in the performance by Deloitte & Touche of the Services, including, without limitation, providing Deloitte & Touche with reasonable facilities and timely access to data, information, and personnel of the System. The System shall be responsible for the performance of its personnel and agents and for the accuracy and completeness of all data and information provided to Deloitte & Touche for purposes of the performance by Deloitte & Touche of the Services. The System acknowledges and agrees that Deloitte & Touche's performance is dependent upon the timely and effective satisfaction of the System's responsibilities hereunder and timely decisions and approvals of the System in connection with the Services. Deloitte & Touche shall be entitled to rely on all decisions and approvals of the System. The System shall be solely responsible for, among other things (a) making all management decisions and performing all management functions, (b) designating a competent management member to oversee the Services, (c) evaluating the adequacy and results of the Services, (d) accepting responsibility for the results of the Services, and (e) establishing and maintaining internal controls, including, without limitation, monitoring ongoing activities.

9. Force Majeure. Neither party shall be liable for any delays or nonperformance directly or indirectly resulting from circumstances or causes beyond its reasonable control, including, without limitation, acts or omissions or the failure to cooperate by the other party (including, without limitation, entities or individuals under its control, or any of their respective officers, directors, employees, other personnel and agents), acts or omissions or the failure to cooperate by any third party, fire, epidemic or other casualty, act of God, strike or labor dispute, war or other violence, or any law, order, or requirement of any governmental agency or authority.

10. [Reserved]

11. Independent Contractor.

(a) Deloitte & Touche and System acknowledge and agree that Deloitte & Touche is being retained as an independent contractor, and that Deloitte & Touche shall be responsible for determining the manner and means by which Deloitte & Touche performs the Services. Nothing herein shall be construed to make Deloitte & Touche an employee or agent of System, to entitle Deloitte & Touche to receive the benefits of any employee benefit plan of System, or to create a joint venture or partnership or fiduciary relationship between the parties. Neither party shall not make an unauthorized representation or warranty concerning the products or services of the other party or commit the other party to any agreement or obligation.

(b) No payroll or employment taxes of any kind shall be withheld or paid with respect to payments to Deloitte & Touche hereunder. Deloitte & Touche agrees to indemnify System against, and to defend and hold System harmless from, any liabilities, claims, costs or expenses (including reasonable attorneys' fees) which may be made against System, or incurred by System, in respect of any such payroll or employment taxes.

(c) No workers' compensation insurance has been or will be obtained by System on account of Deloitte & Touche.

12. Confidentiality and Internal Use.

a) The System agrees that all Services and Deliverables shall be solely for the System's informational purposes and internal use, and are not intended to be, and should not be, used by any person or entity other than the System. Except as otherwise specifically provided in the Engagement Letter, the System further agrees that such Services and Deliverables shall not be circulated, quoted, disclosed, or distributed to, nor shall reference to such Services or Deliverables be made to, any person or entity other than the System and other contractors of the System to whom the System may disclose the Deliverables solely for the purpose of such contractors providing services to the System relating to the subject matter of this engagement, provided that the System shall ensure that such contractors do not further circulate, quote, disclose, or distribute such Deliverables, or make reference to such Deliverables, to any person or entity other than the System. Notwithstanding the foregoing, the System shall not be prohibited from creating its own materials based on the content of such Services and Deliverables and using and disclosing such System-created materials for external purposes, provided that the System does not, expressly or by implication, in any manner whatsoever, attribute such materials to Deloitte & Touche or otherwise refer to or identify Deloitte & Touche in connection with such materials.

b) To the extent that, in connection with this engagement, either party (each, the "receiving party") comes into possession of any trade secrets or other proprietary or confidential information of the other (the "disclosing party"), it will not disclose such information to any third party without the disclosing party's consent. The disclosing party hereby consents to the receiving party disclosing such information (1) to subcontractors, whether located within or outside of the United States, that are providing services in connection with this engagement and that have agreed to be bound by confidentiality obligations similar to those in this paragraph 12(b); (2) as may be required by law, regulation, judicial or administrative process, or in accordance with applicable professional standards or rules, or in connection with litigation or arbitration pertaining hereto; or (3) to the extent such information (i) shall have otherwise become publicly available (including, without limitation, any information filed with any governmental agency and available to the public) other than as the result of a disclosure in breach hereof, (ii) becomes available to the receiving party on a nonconfidential basis from a source other than the disclosing party that the receiving party believes is not prohibited from disclosing such information to the receiving party by obligation to the disclosing party, (iii) is known by the receiving party prior to its receipt from the disclosing party without any obligation of confidentiality with respect thereto, or (iv) is developed by the receiving party independently of any disclosures made by the disclosing party to the receiving party of such information. In satisfying its obligations under this paragraph 12(b), each party shall maintain the other's trade secrets and proprietary or

confidential information in confidence using at least the same degree of care as it employs in maintaining in confidence its own trade secrets and proprietary or confidential information, but in no event less than a reasonable degree of care. Nothing in this paragraph 12(b) shall alter the System's obligations under paragraph 12(a). Notwithstanding anything to the contrary herein, the System acknowledges that Deloitte & Touche, in connection with performing the Services, may develop or acquire experience, skills, knowledge, and ideas that are retained in the unaided memory of its personnel. The System acknowledges and agrees that Deloitte & Touche may use and disclose such experience, skills, knowledge, and ideas.

13. Survival and Interpretation. All paragraphs herein relating to payment of invoices, deliverables, limitation on warranties, limitation on damages and indemnification, limitation on actions, confidentiality and internal use, survival and interpretation, assignment, nonexclusivity, waiver of jury trial and governing law shall survive the expiration or termination of this engagement. For purposes of these terms, "Deloitte & Touche" shall mean Deloitte & Touche LLP and, for purposes of paragraph 7, shall also mean Deloitte & Touche Products Company LLC, one of its subsidiaries. The System acknowledges and agrees that no affiliated or related entity of Deloitte & Touche, whether or not acting as a subcontractor, or such entity's personnel shall have any liability hereunder to the System or any other person and the System will not bring any action against any such affiliated or related entity or such entity's personnel in connection with this engagement. Without limiting the foregoing, affiliated and related entities of Deloitte & Touche are intended third-party beneficiaries of these terms, including, without limitation, the limitation on liability and indemnification provisions of paragraph 7, and the agreements and undertakings of the System contained in the Engagement Letter. Any affiliated or related entity of Deloitte & Touche may in its own right enforce such terms, agreements, and undertakings. **The provisions of paragraphs 7, 13, 15, and 18 hereof shall apply to the fullest extent of the law, whether in contract, statute, tort (such as negligence), or otherwise, notwithstanding the failure of the essential purpose of any remedy.**

14. Assignment and Subcontracting. Except as provided below, neither party may assign, transfer, or delegate any of its rights or obligations hereunder (including, without limitation, interests or Claims) without the prior written consent of the other party. The System hereby consents to Deloitte & Touche subcontracting any of Deloitte & Touche's rights or obligations hereunder to (a) any affiliate or related entity, whether located within or outside of the United States. Services performed hereunder by Deloitte & Touche's subcontractors shall be invoiced as professional fees on the same basis as Services performed by Deloitte & Touche's personnel, unless otherwise agreed.

15. Waiver of Jury Trial. THE PARTIES HEREBY IRREVOCABLY WAIVE, TO THE FULLEST EXTENT PERMITTED BY LAW, ALL RIGHTS TO TRIAL BY JURY IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM RELATING TO THIS ENGAGEMENT.

16. Nonsolicitation. During the term of this engagement and for a period of one (1) year thereafter, each party agrees that its personnel (in their capacity as such) who had direct and substantive contact in the course of this engagement with personnel of the other party shall not, without the other party's consent, directly or indirectly employ, solicit, engage, or retain the services of such personnel of the other party. In the event a party breaches this provision, the breaching party shall be liable to the aggrieved party for an amount equal to thirty percent (30%) of the annual base compensation of the relevant personnel in his or her new position. Although such payment shall be the aggrieved party's exclusive means of monetary recovery from the breaching party for breach of this provision, the aggrieved party shall be entitled to seek injunctive or other

equitable relief. This provision shall not restrict the right of either party to solicit or recruit generally in the media.

17. Entire Agreement, Amendment, and Notices. These terms, and the Engagement Letter, including exhibits, constitute the entire agreement between the parties with respect to this engagement; supersede all other oral and written representations, understandings, or agreements relating to this engagement; and may not be amended except by written agreement signed by the parties. In the event of any conflict, ambiguity, or inconsistency between these terms and the Engagement Letter, these terms shall govern and control. All notices, requests, demands and other communications hereunder shall be in writing and shall be deemed to have been duly given when either personally served or mailed by certified or registered mail, return receipt requested to the addresses first set forth above.

18. Governing Law, Jurisdiction and Venue, and Severability. These terms, the Engagement Letter, including exhibits and all matters relating to this engagement shall be governed by, and construed in accordance with, the laws of the State of Connecticut (without giving effect to the choice of law principles thereof). Any action based on or arising out of this engagement or the Services provided or to be provided hereunder shall be brought and maintained exclusively in any court of the State of Connecticut or any federal court of the United States, in each case located in the State of Connecticut. Each of the parties hereby expressly and irrevocably submits to the jurisdiction of such courts for the purposes of any such action and expressly and irrevocably waives, to the fullest extent permitted by law, any objection which it may have or hereafter may have to the laying of venue of any such action brought in any such court and any claim that any such action has been brought in an inconvenient forum. If any provision of these terms or the Engagement Letter is found by a court of competent jurisdiction to be unenforceable, such provision shall not affect the other provisions, but such unenforceable provision shall be deemed modified to the extent necessary to render it enforceable, preserving to the fullest extent permissible the intent of the parties set forth herein.

19. Non-Use of YNHHS Name. Deloitte & Touche shall not use YNHHS name or logo, or the name of any YNHHS facility, in any way other than in connection with the Services, including in any advertising or promotional media as a customer or client of Deloitte & Touche, without obtaining the prior written consent of System.

20. False Claims. Deloitte & Touche acknowledges that System has provided it with access to its policy on False Claims and Payment Fraud Prevention (the "Policy") located on its internet site at www.ynhhs.org/FalseClaims.pdf. The False Claims Act imposes civil penalties on people and companies who knowingly submit a false claim or statement to a federally funded program, or otherwise conspire to defraud the government, in order to receive payment. It also protects people who report suspected fraud.

21. Personal Inducements. Deloitte & Touche represents and warrants that no cash, equity interest, merchandise, equipment, services or other forms of remuneration have been offered, shall be offered or will be paid or distributed by or on behalf of Deloitte & Touche to YNHHS and/or the employees, officers, or directors of YNHHS or its member hospitals, or to any other person, party or entity affiliated with YNHHS or its member hospitals, as an inducement to purchase or to influence the purchase of services by YNHHS or its member hospitals from Deloitte & Touche.

22. No Undisclosed Relationships. Deloitte & Touche represents and warrants to the System that, except for those relationships (if any) Deloitte & Touche has disclosed to the System in writing, as of the date of this Agreement the Deloitte & Touche and Deloitte FAS personnel that provide services under this Agreement: (i) do not have a financial relationship with any of the System's trustees, officers, employees, or medical staff members, (ii) will not establish or otherwise create any such relationship after the Effective Date without disclosing such relationship to the System in writing, and (iii) Deloitte & Touche will promptly notify the System in writing if its Engagement Partner for the Services becomes aware of the existence of any such relationship during the course of the services provided under this Agreement. Notwithstanding any other provision of this Agreement or any other agreement between the System and Deloitte & Touche, the System may terminate this Agreement upon written notice to Deloitte & Touche in the event the System becomes aware of any such relationship (through disclosure by Deloitte & Touche or otherwise).

23. General Compliance. Deloitte & Touche shall comply with all applicable standards, statutes, rules, regulations, acts and orders of the United States, its departments, agencies, and bureaus, and of any applicable state or political subdivision thereof, including without limitation, laws and regulations pertaining to labor, wages, hours, conditions of employment, environmental protection, hazardous and infectious materials, identity theft, as applicable to Deloitte & Touche in its performance of the Services hereunder.

24. Equal Employment Opportunities. Deloitte LLP (the parent company of Deloitte & Touche) and its subsidiaries (together, referred to as "Deloitte" for purposes of this Section 24) are equal opportunity employers. Deloitte recruits, employs, trains, compensates, and promotes without regard to race, religion, creed, color, citizenship, national origin, age, gender, gender identity/expression, sexual orientation, marital status, disability, veteran status, or any other legally protected basis, in accordance with applicable federal, state, or local law. Deloitte makes reasonable attempts to accommodate the expression of religious beliefs, as long as that expression does not harass or intimidate coworkers or place an undue hardship on its business.

As a federal contractor, Deloitte also provides an affirmative action program for minorities, women, disabled and Vietnam-era veterans, and persons with disabilities.

In response to a request from a qualified individual with a disability, Deloitte will make a reasonable accommodation that would allow that individual to perform the essential functions of his or her job, unless doing so would create undue hardship on its business.

25. Access to Records. In the event that the Engagement Letter provides for services to be performed by Vendor worth $10,000 or more over a 12-month period, Deloitte & Touche agrees, until the expiration of four years after the termination of the Arrangement, to make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General and their representatives, pursuant to a proper request, the Agreement, if any, and all books, documents and records necessary to certify the nature and extent of the cost of those services. If Deloitte & Touche carries out any of the duties described herein through a subcontract worth $10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General and their representatives pursuant to a proper request to the related organization's books, documents and records necessary to certify the nature and extent of the cost of those services. In the event Deloitte & Touche receives a request for access, Deloitte & Touche agrees to notify YNHHS immediately and to consult with YNHHS regarding the response to the request.

26. Security and Access. Deloitte & Touche shall comply with all YNHHS policies and procedures pertaining to visitation, confidentiality, security and vendor identification as are provided to it in writing prior to execution of the Engagement Letter. YNHHS may issue non-employee identification badges under certain conditions; in the event that any non-employee identification badge is issued to an employee of Deloitte & Touche, Deloitte & Touche agrees to cause such employee to prominently display such badge at all times while on YNHHS premises. All badges must be surrendered by Deloitte & Touche when requested by YNHHS. Non-compliance with any of the above policies shall be deemed a breach of the Engagement Letter.

APPENDIX C: Business Associate Addendum

This Appendix ("Appendix C") is part of the attached engagement letter dated November 7, 2016 between Deloitte & Touche LLP ("D&T") and Yale New Haven Health Services Corporation and its subsidiaries ("YNHH"). If and to the extent, and so long as, required by HIPAA or HITECH (each as defined below), and not otherwise, D&T and YNHH hereby agree to the following in connection with D&T's performance of services under the engagement letter to which this Business Associate Appendix is attached (such engagement letter, the "Engagement Letter," together with this Business Associate Appendix and all other attachments, appendices, and exhibits to the Engagement Letter, this "Agreement"). D&T agrees that for purposes of this Appendix C, D&T is a business associate of YNHH to the extent that, in performance of the Services, D&T qualifies as a "business associate" as that term is defined at 45 C.F.R §160.103.

(A) Unless otherwise specified in this Business Associate Appendix, all capitalized terms used in this Business Associate Appendix shall have the meanings established for purposes of HIPAA or HITECH, as applicable. Specific statutory or regulatory citations used in this Business Associate Appendix shall mean such citations as amended and in effect from time to time.

1. "Compliance Date" shall mean, with respect to any applicable provision in this Business Associate Appendix, the later of the date by which compliance with such provision is required under HITECH and the effective date of this Agreement.

2. "Electronic Protected Health Information" shall mean Protected Health Information that is transmitted or maintained in electronic media.

3. "HIPAA" shall mean the Health Insurance Portability and Accountability Act, 42 U.S.C. §§ 1320d through 1320d-8, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.

4. "HITECH" shall mean Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, as amended from time to time, and all associated existing and future implementing regulations, when effective and as amended from time to time.

5. "Protected Health Information" shall mean the term as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, the Client by D&T pursuant to performance of the Services.

6. "Privacy Rule" shall mean the federal privacy regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and E).

7. "Security Rule" shall mean the federal security regulations issued pursuant to HIPAA, as amended from time to time, codified at 45 C.F.R. Part 164 (Subparts A and C).

8. "Services" shall have the meaning set forth in the attached engagement letter, and, if not therein defined, shall mean the services described in the Engagement Letter to be performed by D&T for the Client.

9. "Unsecured Protected Health Information" shall mean Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a

technology or methodology specified by the Secretary in the regulations or guidance issued pursuant to 42 U.S.C. § 17932(h)(2).

(B) With regard to D&T's use and disclosure of Protected Health Information:

1. D&T may use and disclose Protected Health Information as reasonably required or contemplated in connection with the performance of the Services, excluding the use or further disclosure of Protected Health Information in a manner that would violate the requirements of the Privacy Rule, if done by the Client. Notwithstanding the foregoing, D&T may use and disclose Protected Health Information for the proper management and administration of D&T as provided in 45 C.F.R. § 164.504(e)(4).

2. D&T will not use or further disclose Protected Health Information other than as permitted or required by this Business Associate Appendix, and in compliance with each applicable requirement of 45 C.F.R. § 164.504(e), or as otherwise Required by Law.

3. D&T will implement and use appropriate administrative, physical, and technical safeguards to (1) prevent use or disclosure of Protected Health Information other than as permitted or required by this Business Associate Appendix; (2) reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that D&T creates, receives, maintains, or transmits on behalf of the Client; and (3) as of the Compliance Date of 42 U.S.C. § 17931, comply with the Security Rule requirements set forth in 45 C.F.R. §§ 164.308, 164.310, 164.312, and 164.316.

4. D&T will, without unreasonable delay report to the Client (1) any use or disclosure of Protected Health Information not provided for by this Business Associate Appendix of which it becomes aware in accordance with 45 C.F.R. § 164.504(e) (2) (ii) (C); and/or (2) any Security Incident affecting Electronic Protected Health Information of which D&T becomes aware in accordance with 45 C.F.R. § 164.314(a) (2) (C).

5. D&T will, without unreasonable delay, and in any event no later than ten (10) business days after Discovery, notify the Client of any Breach of Unsecured Protected Health Information. The notification shall include, to the extent possible (and subsequently as the information becomes available), the identification of all individuals whose Unsecured Protected Health Information is reasonably believed by D&T to have been Breached along with any other available information that is required to be included in the notification to the Individual, the Secretary, and/or the media, all in accordance with the data breach notification requirements set forth in 42 U.S.C. § 17932 and 45 C.F.R. Parts 160 and 164 (Subparts A, D, and E), as of their respective Compliance Dates.

6. D&T will ensure that any subcontractors or agents to whom D&T provides Protected Health Information agree to the same restrictions and conditions that apply to D&T with respect to such Protected Health Information. To the extent that D&T provides Electronic Protected Health Information to a subcontractor or agent, it will require the subcontractor or agent to implement reasonable and appropriate safeguards to protect the Electronic Protected Health Information consistent with the requirements of this Business Associate Appendix.

7. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information in accordance with 45 C.F.R. § 164.524.

8. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will provide an electronic copy of such Protected Health Information in accordance with 42 U.S.C. § 17935(e) as of its Compliance Date.

9. D&T will, to the extent that Protected Health Information in D&T's possession constitutes a Designated Record Set, make available such Protected Health Information for amendment and incorporate any amendments to such information as directed by the Client, all in accordance with 45 C.F.R. § 164.526.

10. D&T will document and make available the information required to provide an accounting of disclosures of Protected Health Information, in accordance with 45 C.F.R. § 164.528.

11. In the event that D&T, in connection with the Services, uses or maintains an Electronic Health Record of Protected Health Information of or about an Individual, D&T will make an accounting of disclosures of such Protected Health Information in accordance with the requirements for accounting of disclosures made through an Electronic Health Record in 42 U.S.C. § 17935(c), as of its Compliance Date.

12. D&T will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary for purposes of determining the Client's compliance with the Privacy Rule.

13. D&T will, as of the Compliance Date of 42 U.S.C. § 17935(b), limit any request, use, or disclosure by D&T of Protected Health Information, to the extent practicable, to the Limited Data Set of such Protected Health Information (as defined in 45 C.F.R. § 164.514(e)(2)), or, if the request, use, or disclosure by D&T of Protected Health Information, not in a Limited Data Set, is necessary for D&T's performance of the Services, D&T will limit the amount of such Protected Health Information requested, used, or disclosed by D&T to the minimum necessary to accomplish the intended purpose of such request, use, or disclosure, respectively; provided, however, that the requirements set forth above in this subsection (13) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.

14. D&T will not directly or indirectly receive remuneration in exchange for any Protected Health Information as prohibited by 42 U.S.C. § 17935(d) as of its Compliance Date.

15. D&T will not make or cause to be made any communication about a product or service that is prohibited by 42 U.S.C. § 17936(a) as of its Compliance Date.

16. D&T will not make or cause to be made any written fundraising communication that is prohibited by 42 U.S.C. § 17936(b) as of its Compliance Date.

(C) In addition to any other obligation set forth in this Agreement, including this Business Associate Appendix, the Client agrees that it will: (1) not make any disclosure of Protected Health Information to

D&T if such disclosure would violate HIPAA, HITECH, or any applicable federal or state law or regulation; (2) not request D&T to use or make any disclosure of Protected Health Information in any manner that would not be permissible under HIPAA, HITECH, or any applicable federal or state law or regulation if such use or disclosure were done by the Client; and (3) limit any disclosure of Protected Health Information to D&T, to the extent practicable, to the Limited Data Set of such Protected Health Information, or, if the disclosure of Protected Health Information that is not in a Limited Data Set is necessary for D&T's performance of the Services, to limit the disclosure of such Protected Health Information to the minimum necessary to accomplish the intended purpose of such disclosure, provided, however, that the requirements set forth above in this part (3) shall be superseded and replaced by the requirements of the "minimum necessary" regulations or guidance to be issued by the Secretary (pursuant to 42 U.S.C. § 17935(b)(1)(B)) on and after its Compliance Date.

(D) If either the Client or D&T knows of either a violation of a material term of this Business Associate Appendix by the other party or a pattern of activity or practice of the other party that constitutes a material breach or violation of this Business Associate Appendix, the non-breaching party will provide written notice of the breach or violation to the other party that specifies the nature of the breach or violation. In the event that the breaching party does not cure the breach or end the violation on or before thirty (30) days after receipt of the written notice, the non-breaching party may do the following:

(i) if feasible, terminate this Agreement; or

(ii) if termination of this Agreement is infeasible, report the issue to the Secretary.

(E) D&T will, at termination of this Agreement, if feasible, return or destroy all Protected Health Information that D&T still maintains in any form and retain no copies of Protected Health Information or, if such return or destruction is not feasible (such as in the event that the retention of Protected Health Information is required for archival purposes to evidence the Services), D&T may retain such Protected Health Information and shall thereupon extend the protections of this Business Associate Appendix to such Protected Health Information and limit further uses and disclosures to those purposes that make the return or destruction of such Protected Health Information infeasible.

(F) Any other provision of this Agreement that is directly contradictory to one or more terms of this Business Associate Appendix shall be superseded by the terms of this Business Associate Appendix to the extent and only to the extent of the contradiction and only for the purpose of the Client's and D&T's compliance with HIPAA and HITECH. The terms of this Business Associate Appendix, to the extent they are unclear, shall be construed to allow for compliance by the Client and D&T with HIPAA and HITECH.

In addition, the Client agrees to compensate D&T for any time and expenses that we may incur in responding to requests for documents or information under HIPAA, HITECH, or any regulations promulgated under HIPAA or HITECH.

Nothing contained in this Business Associate Appendix is intended to confer upon any person (other than the parties hereto) any rights, benefits, or remedies of any kind or character whatsoever, whether in contract, statute, tort (such as negligence), or otherwise, and no person shall be deemed a third-party beneficiary under or by reason of this Business Associate Appendix.

Greer, Leslie

From: Roberts, Karen
Sent: Wednesday, November 23, 2016 8:41 AM
To: Greer, Leslie
Cc: Cotto, Carmen
Subject: FW: Yale and L&M acquisition
Attachments: union.pdf

Please put in the Yale/L+M records (both records). Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Martone, Kim
Sent: Tuesday, November 22, 2016 3:06 PM
To: Capozzalo, Gayle (Gayle.Capozzalo@ynhh.org)
Subject: Yale and L&M acquisition

Gayle, please see the attached letter from multiple organizations and individuals objecting to the approval of Deloitee and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. Please address all allegations in full detail with supporting documentation as needed. As I advised when we met on November 15th, I do feel it is important for you and/or your community representative to meet with these organizations and individuals to inform them of such decisions as this acquisition moves forward. In light of the assertions made in the attached letter, I am hereby restating my request and ask that your discussions include the points outlined in the letter. Further, OHCA reserves the right to reverse its approval of the monitor based on your response to the attached letter.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

November 17, 2016

Honorable Raul Pino
Commissioner of Public Health
State of Connecticut
410 Capitol Ave.
PO Box 340308
Hartford CT 06134

Dear Commissioner Pino:

The undersigned organizations and individuals write to express our strong objection to your approval of Deloitee & Touche as the Independent Monitor for the Yale New Haven Hospital System settlement agreement.

We are local and statewide community leaders and organizations, committed to ensuring quality, affordable health care services continue to be provided in this region. We believe the appointment of Deloitee & Touche undermines this essential objective. Deloitte & Touch have been one of Yale-New Haven Health's top five outside contractors for each of the past 10 years, earning $30 million over that time. Last year the Securities and Exchange Commission charged these consultants with violating auditor independence rules — charges that Deloitte agreed to settle by paying the federal agency more than $1 million. We do not believe these are the appropriate credentials for the important task of overseeing the transformation of our region's health care.

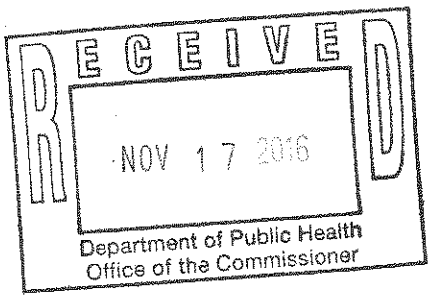
The Independent Monitor and Independent Consultant required by the Agreement must act with, and be perceived to act with unimpeachable integrity. The enforcement burdens on the Independent Monitor and Consultant are extremely heavy – the Agreement contains unprecedented consumer protections, and as the first in the history of the state, the Cost and Market Impact Review will establish the standard for future analyses under the statute. Financial or other conflicts of interest between Yale New Haven Health and the Independent Monitor and Consultant will create powerful incentives to weaken the protections. Even the appearance of conflict will severely damage public confidence in the Office of Health Care Access, the statute and the integrity of Yale New Haven Health Services Corporation.

We urge you, Commissioner Pino, to reject Yale's proposal to assign any consultant with such a clear conflict of interest or a record of violating independent auditing rules

Please feel free to contact us with any questions.

Thank you in advance for your consideration of our request.

Sincerely,



Tom Swan, Executive Director
Connecticut Citizen Action Group

David Pickus, President
SEIU Healthcare 1199NE

Ellen Andrews, Executive Director
Connecticut Health Policy Project

Connie Holt, Secretary-Treasurer
UNITE HERE Local 217

Ocean Pellet
United Action Connecticut

Jan Hochadel, President
AFT Connecticut

Olejarz, Barbara

From: Roberts, Karen
Sent: Wednesday, November 23, 2016 1:07 PM
To: Olejarz, Barbara
Subject: FW: Role of Community Representative - OHCA CT Docket #15-32033-CON Condition 14
Attachments: Role of Comm Rep sent to OHCA 112216.docx

From: Martone, Kim
Sent: Wednesday, November 23, 2016 9:33 AM
To: Roberts, Karen; Cotto, Carmen
Subject: FW: Role of Community Representative - OHCA CT Docket #15-32033-CON Condition 14

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Tuesday, November 22, 2016 5:05 PM
To: Martone, Kim
Cc: Cummings, Bruce (L and M); Petrini, Vincent; 'Sauders, Kelly (US - New York)'; O'Connor, Christopher; Willcox, Jennifer; Anderson, Maureen (LMHOSP); Aseltyne, Bill
Subject: Role of Community Representative - OHCA CT Docket #15-32033-CON Condition 14

Kim,

Attached please find our "position description" for the community representative. Please call if you have any questions. Thank you.

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605

Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Role of Community Representative
OHCA CT Docket #15-32033-CON Condition 14

Condition 14 states: **For three years following the Closing Date the applicant shall allow for one community representative to serve as a voting member of L+M Hospital's Board of Directors with rights and obligations consistent with other voting members under L+M Hospital's Board of Directors bylaws. The applicants shall select a community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interest of the community served by L+M Hospital. OHCA is imposing this Condition to ensure continued access to healthcare services for the patient population.**

The underlying purpose of the "community representative," even though the vast majority of L+M Hospital's Trustees are independent Trustees from the community, is to ensure that community interests are voiced at Board meetings as the Board makes decisions.

The definition of community is the population being served by L+M Hospital. It is not restricted to particular advocacy, interest or organized groups, specific demographics, programs or organizations. L+M has a history of working with the community and regularly completes its Community Needs Analysis and has developed a community health improvement plan, which has input from more than 50 community representatives. The community is also represented by schools, government and other non-profits. The community representative will consider a broad and inclusive definition of community. The Condition requires that the community representative will be "an unbiased individual who will fairly represent the interests of the community served by Lawrence + Memorial Hospital."

The Condition does not detail the role for the "community representative." However, the community representative should be actively engaged and reach out to any and all community groups to discuss the advancements YNHHS/L+M Hospital is making, receive input regarding issues and concerns that the community may have in order to provide information to the L+M Hospital Board.

The Independent Monitor is required to meet with community representatives within six months following the transaction and annually thereafter for up to five years. The Independent Monitor is also required to hold a public forum within six months following the transaction and not less than annually thereafter for five years to provide public review and comment on the Monitor's report and findings and information on what is happening at L+M. In addition, for the next three years, Yale New Haven Health System and L+M Hospital Boards will meet together twice per year and following these meetings a public meeting will be held to update the public on what is happening at the Hospital. The "community representative" should be actively engaged in all of these meetings.

Greer, Leslie

From: Martone, Kim
Sent: Wednesday, November 23, 2016 10:44 AM
To: Olejarz, Barbara; Greer, Leslie
Subject: FW: Yale and L&M acquisition
Attachments: union.pdf

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
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November 17, 2016

Honorable Raul Pino
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State of Connecticut
410 Capitol Ave.
PO Box 340308
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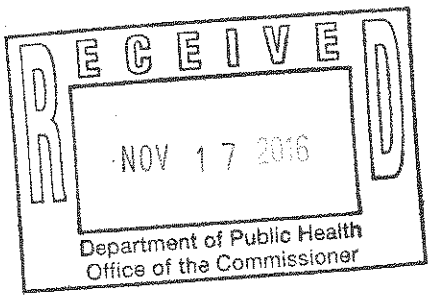
Please feel free to contact us with any questions.

Thank you in advance for your consideration of our request.

Sincerely,



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Connie Holt, Secretary-Treasurer
UNITE HERE Local 217

Ocean Pellet
United Action Connecticut

Jan Hochadel, President
AFT Connecticut

Greer, Leslie

From: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Sent: Tuesday, November 29, 2016 4:49 PM
To: User, OHCA; Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: O'Connor, Christopher; Cummings, Bruce (L and M); Borgstrom, Marna; Petrini, Vincent; Tammaro, Vincent; Willcox, Jennifer; Aseltyne, Bill; Anderson, Maureen (LMHOSP); 'Tia.Sawhney@milliman.com'; 'Bruce Pyenson'; Rosenthal, Nancy; 'Sauders, Kelly (US - New York)'
Subject: CMIR Independent Consultant: CON Docket #s 15-32033-CON and 15-32032-CON
Attachments: Milliman Consulting Svs Agreement SIGNED 112916.pdf

Kim and Karen,

To comply with Docket #15-32033 CON Condition 20.a., Condition 20.b., Condition 21.a., Condition 21.b., Condition 22, Condition 23, Condition 32.c., and Docket #15-32032 CON Condition 1, Condition 2.a., Condition 2.b., Condition 3, Condition 4, and Condition 7.a., attached please find the signed engagement letter and scope of work for Milliman to conduct the initial and annual updates of the CMIR for the next five years. The attached document also includes their detailed proposal. If you have any questions, please don't hesitate to call. Thank you.

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement (this "***Agreement***") is entered into as of this 28th day of November, 2016 (the "***Effective Date***") by and between Yale New Haven Health Services Corporation with a principal place of business at 789 Howard Avenue, New Haven, CT ("***Customer***") and Milliman, Inc., a Washington corporation with a place of business at One Pennsylvania Plaza, 38th Floor, New York, NY 10119 ("***Contractor***").

1. Scope of Services.

(a) Statement of Work. Contractor shall furnish the services (the "***Services***") described and further specified in the Statement of Work or proposal (whether or not separately executed) attached hereto as **Exhibit A** ("***SOW***"). If either party reasonably believes the performance of additional services not described in any applicable SOW are advisable or desirable, then such party shall request a written change order, in a form mutually agreed upon, that describes the services requested to be performed and the terms upon which such services shall be performed. Any such change order, if executed by both parties, shall be incorporated into the SOW. In the event of conflict between a provision in the SOW (or change order) and a provision in this Agreement, the provision in this Agreement prevails, unless the SOW (or change order) expressly refers to the provision in this Agreement and states the parties' intention to supersede such provision.

(b) Performance of Services. The Services shall be performed in a professional manner by personnel of Contractor having a level of skill in the area commensurate with the requirements of the scope of work to be performed. Contractor and any personnel engaged to perform the Services shall at all times maintain any and all licenses, certifications, and/or other qualifications required under applicable federal, state or local laws or rules to perform the Services.

2. Compensation. Customer shall pay Contractor the fees for the Services specified in the applicable SOW. Unless otherwise specified in the SOW, Contractor shall invoice Customer on a monthly basis, and payment on all uncontested invoices shall be made by Customer within sixty (60) days of receipt of a complete invoice.

3. Term and Termination.

(a) Term. This Agreement shall commence on the Effective Date and shall continue in full force and effect until the later of: (i) the expiration or termination of the last SOW or (ii) [one year] following the Effective Date, unless earlier terminated pursuant to this Section 3.

(b) Termination for Non-Performance. Customer may terminate this Agreement at its option, in the event Contractor ceases providing services hereunder for any reason whatsoever, immediately upon notice to Contractor to that effect

(c) Termination by Customer. Customer may terminate this Agreement at any time for any or no reason by providing the Contractor thirty (30) days' prior written notice of termination, provided that such termination is consistent with the terms of the Agreed Settlement with the Connecticut Office of Health Care Access (OHCA) under Docket Number 15-32033-CON (the "Order").

(d) Termination for Cause. Either party may terminate this Agreement, if the other party is in material breach of this Agreement and the breaching party has not cured such breach to the non-breaching party's reasonable satisfaction within thirty (30) days after the non-breaching party's

notice of the breach to the breaching party. Customer reserves the right to stop all work if any bill goes unpaid for 90 days. In the event of such termination, Contractor shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

(e) Effects of Termination. Upon termination or expiration of this Agreement, all rights and obligations of the parties hereunder shall terminate; provided, that, Sections 3(d), 4, 5, 6, 8, 9, 10, 11, 12 13, 14 and 15 shall survive any such expiration or termination. Notwithstanding anything herein to the contrary, expiration or termination of this Agreement shall not relieve either party of any obligations that may have accrued prior to such termination or expiration.

4. Ownership.

(a) Work Made For Hire. Contractor is performing the Services for Customer on a work-for-hire basis. Except as otherwise set forth herein, Customer shall be the sole owner of all rights (including copyright and any other intellectual property and proprietary rights) in all final deliverables created by Contractor during its performance of the Services and provided to Customer as set forth in Exhibit A (the "*Work Product*"). To the extent any Work Product does not qualify as a work made for hire, to transfer all rights in the Work Product to Customer, Contractor hereby irrevocably assigns to Customer all rights (including copyright and any other intellectual property and proprietary rights) in all such Work Product.

(b) Contractor Tools. Contractor shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Contractor or developed during the course of the provision of the Services ("Contractor Tools") provided such Contractor Tools do not contain any Customer Confidential Information or proprietary data. Rights and ownership by Contractor of Contractor Tools shall not extend to or include all or any part of Customer's proprietary data or Customer Confidential Information. To the extent that Contractor may include in the Work Product any Contractor Tools, Contractor agrees that Customer shall be deemed to have a fully paid up license to make copies of the Contractor Tools as part of its use of the Work Product for its internal business purposes and provided that such Contractor Tools cannot be modified or distributed outside Customer without the written permission of Contractor or as otherwise permitted herein.

(c) Third Party Distribution. Work Product is prepared solely for the internal business use of Customer and for purposes of Customer's compliance with the terms of the Order. Work Product may not be provided to third parties without Contractor's prior written consent, which consent may be conditioned on execution by the third party of Contractor's standard Third Party Release Agreement; provided, however, Customer may share Contractor's work with its parent or affiliates, but only if either (a) the Customer has the full power and authority to bind such parent or affiliate to the terms of this agreement and does bind such affiliate to the terms, or (b) the parent or affiliate acknowledges in writing that the work of Contractor is subject to certain limitations and restrictions contained in this Agreement and that the parent or affiliate acquires no greater rights than are possessed by Customer under this Agreement. Contractor does not intend to benefit any third party recipient of Work Product, even if Contractor consents to the release of Work Product to such third party. Notwithstanding anything herein to the contrary, Contractor agrees that Customer may provide Work Product to OHCA and to the independent monitor retained by Customer pursuant to, and consistent with, the terms of the Order.

5. Indemnification. Customer agrees to indemnify and hold Contractor, its officers, directors, agents and employees, harmless from and against all loss, damages, liability, and Expense, with respect to the work in question where such loss, damages, liability or Expense was incurred by reason of any claims, actions, suits or governmental investigations or proceedings, brought by any third party against or involving Contractor, its officers, directors, agents and employees, which relate to or arise out of the engagement of Contractor by Customer. Provided, however, that Customer shall not be required to indemnify Contractor, its officers, directors, agents and employees, for any damages determined by a court or an arbitration panel to have resulted from Contractor's intentional fraud or willful misconduct. For purposes of this paragraph, "Expense" shall include: all legal expenses incurred by Contractor in the investigation, defense or settlement of any claim, action, suit or proceeding, and all other reasonable costs and expenses, including the services of Contractor based on normal hourly rates, together with its out-of-pocket expenses, incurred in the investigation, defense or settlement of same.

6. Confidentiality. Each party shall be bound by the confidentiality and non-disclosure obligations in Section 3 of the Compliance Addendum (as defined in Section 7 hereof).

7. Compliance Addendum. If required by Customer, Contractor shall each execute and deliver a mutually agreeable Compliance Addendum contemporaneous with the execution of this Agreement (the "***Compliance Addendum***").

8. Notices. Any notice required or permitted under this Agreement or required by law shall be made in writing and shall be: delivered in person; sent by first class registered mail; sent by overnight air courier; or sent by telefax or e-mail with a confirmation copy sent by one of the foregoing methods within twenty-four (24) hours of transmission, in each case to the appropriate address as set forth in this Agreement or as notified by the other party from time to time. Notices shall be deemed given at the time of actual delivery in person, by telefax or e-mail; three (3) business days after deposit in the mail; or one (1) day after delivery to an overnight air courier service.

9. Governing Law and Dispute Resolution. This Agreement shall be interpreted and construed in accordance with the laws of the State of Connecticut, without regard to its conflict of laws principles. In the event of any dispute arising out of or relating to the engagement of Contractor by Customer, the parties agree that the dispute will be resolved by final and binding arbitration under the Commercial Arbitration Rules of the American Arbitration Association. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Federal Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.

10. Assignment. Neither party may assign its rights or obligations pursuant to this Agreement without the other party's prior written consent; except that either party may, upon notice to the

other party, assign its rights and obligations to any of its affiliates or subsidiaries. Any attempted transfer or assignment contrary to the terms of this Section 10 shall be void and of no effect.

11. Entire Agreement. This Agreement, including any SOWs or other exhibits hereto, and the Compliance Addendum shall contain the entire agreement between the parties in respect of the subject matter hereof. No amendments or modifications to this Agreement shall be effective unless made in writing and signed by authorized representatives of both parties.

12. Waiver. The failure of either Party hereto to enforce at any time, or for any period of time, any provision of this Agreement shall not be construed as a waiver of such provision or of the right of such Party thereafter to enforce each and every provision. Any waiver by a Party of any of its rights under this Agreement in one or more instances shall be made in a writing signed by such Party and shall not be construed as constituting a continuing waiver or as a waiver in other instances.

13. Independent Contractors.

(a) The Contractor and Customer acknowledge and agree that the Contractor is being retained as an independent contractor, and that the Contractor shall be responsible for determining the manner and means by which the Contractor performs the duties and responsibilities assigned to the Contractor under this Agreement. Nothing in this Agreement shall be construed to make the Contractor an employee or agent of Customer, to entitle the Contractor to receive the benefits of any employee benefit plan of Contractor, or to create a joint venture or partnership between the parties. The Contractor shall not make an unauthorized representation or warranty concerning the products or services of Customer or commit Customer to any agreement or obligation without the express authorization of an authorized officer of Customer.

(b) No payroll or employment taxes of any kind shall be withheld or paid with respect to payments to the Contractor. The Contractor shall be responsible for the payment of all taxes, including but not limited to any income, sales or use tax, levied with respect to the services provided hereunder by the Contractor. The Contractor agrees to indemnify Customer against, and to defend and hold Customer harmless from, any liabilities, claims, costs or expenses (including reasonable attorneys' fees) which may be made against Customer, or incurred by Customer, in respect to any such payroll or employment taxes.

(c) No workers' compensation insurance has been or will be obtained by Customer on account of the Contractor.

14. Limitation of Liability. In the event of any claim arising from services provided by Contractor at any time, the total liability of Contractor, its officers, directors, agents and employees to Customer shall not exceed three million dollars ($3,000,000). This limit applies regardless of the theory of law under which a claim is brought, including negligence, tort, contract or otherwise. In no event shall Contractor be liable for lost profits of Customer or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Contractor.

15. Use of Name. Customer agrees that it shall not use Contractor's name, trademarks or service marks, or refer to Contractor directly or indirectly in any media release, public announcement or public disclosure, including in any promotional or marketing materials, customer lists, referral lists, websites or business presentations without Contractor's prior written consent for each such use or release, which consent shall be given in Contractor's sole discretion. Contractor shall not use or

permit the use of Customer's name, logo or likeness, or that of any Customer facility, in any way, including, without limitation, advertising or promotional media identifying Customer as a customer or client of Contractor, without obtaining the prior written consent of Customer.

16. **Counterparts.** This Agreement may be executed in multiple counterparts, each of which shall be deemed an original but all of which, when taken together shall constitute one and the same agreement. Delivery of a signature page to this Agreement via facsimile or other electronic image transmission is legal, valid and binding execution and delivery for all purposes.

[Signature Page follows.]

IN WITNESS WHEREOF, the duly authorized representative of each party has executed this Agreement as of the Effective Date.

Yale New Haven Health Services Corporation

By: _____

Name: GAYLE CAPOZZALO

Title: EXEC VP / CHIEF STRATEGY OFFICER

Milliman, Inc.

By: _____

Name: BRUCE PYENSON

Title: PRINCIPAL & CONSULTING ACTUARY.

[Signature Page of the Master Consulting Services Agreement]

Exhibit A

Form of Statement of Work

TERM: The services set forth in this Statement of Work shall begin as of Click here to enter text. and shall be completed by Click here to enter text..

SERVICES:

[List here services to be provided by Contractor.]

PAYMENTS:

[Include here payment terms and fee schedule]

The duly authorized representatives of each party hereby agree to the terms of this Statement of Work.

Choose an item.	**[CONTRACTOR]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

CLICK HERE TO ACCESS COMPLIANCE ADDENDUM.docx

EXHIBIT A

Lawrence+Memorial Cost and Market Impact Review
Statement of Work

TERM: The services set forth in this Statement of Work shall begin as of December 7, 2016 and shall be completed by December 31, 2020.

SERVICES:

Milliman will serve as an independent consultant, as required under YNHHSC's Agreed Settlement with the Connecticut Office of Health Care Access (OHCA), evaluate the non-governmental fee levels of services provided by L+MC's Lawrence + Memorial Hospital (L+MH) and Lawrence & Memorial Medical Group (LMMG), and annually set maximum fee increases, for 5 years for L+MH and 28 months for LMMG. Milliman's work will be summarized in Cost and Market Impact Review (CMIR) reports. The services are further described in Milliman's Proposal "Lawrence+Memorial Cost and Market Impact Review" dated November 28, 2016.

PAYMENTS:

Milliman bills for time and travel expenses. Time is tracked by professional on a quarter-hour basis and billed monthly. We estimate the following prices by deliverable.

Phase	Deliverables	Estimated Price
Baseline CMIR: L+MH	Report to OHCA	$200,000
Baseline CMIR: LMMG	Report to OHCA	$100,000
3 annual updates: L+MH*	Report to OHCA	$120,000 each

The estimates are based on the following hourly rates and budgeted hours.

2016 Hourly Billing Rates

Professional	Role	Hourly Billing Rate for 2016
Bruce Pyenson, FSA, MAAA Principal and Consulting Actuary	Project oversight and communications	$650
Rong Yi, PhD Principal and Consultant	Analytics manager	$460
Tia Sawhney, DrPH, FSA, MAAA Healthcare Consultant and Actuary	Policy, technical and design	$385
Maggie Alston Manager, Data Analysis	Project manager	$260
Feng Han, MS Data Scientist	Statistical methods and analysis	$225
Other Consultants	As needed	$280-$650
Analysts	SAS data extraction and Excel modeling	$160-$280

Budgeted Hours

CMIR	Staff	Hours	Avg. Hourly Rate	Cost
Baseline LM+H	Consultant	202	$500	$101,000
	Analyst	450	$220	$99,000
	Total	652		$200,000
Baseline LMMG	Consultant	101	$500	$50,500
	Analyst	225	$220	$49,500
	Total	326		$100,000
LM+H Update	Consultant	100	$500	$50,000
	Analyst	318	$220	$69,960
	Total	418		$119,960

Substantial revisions and work outside the proposal will be billed at Milliman's usual hourly rates plus travel expenses at price.

The duly authorized representatives of each party hereby agree to the terms of this Statement of Work.

Yale New Haven Health System

By: _____

Name: GAYLE CAPOZZALO

Title: EXEC VP / CHIEF STRATEGY OFFICER

Milliman

By: _____

Name: BRUCE PYENSON

Title: PRINCIPAL & CONSULTING ACTUARY

Milliman

Lawrence+Memorial Cost and Market Impact Review

Proposal to:

Yale New Haven Health Services Corporation
Gale Capozzalo, Chief Strategy Officer
Vincent Tammaro, EVP and CFO

Presented by:

Bruce Pyenson, FSA, MAAA
Principal
Rong Yi, PhD
Principal
Tia Sawhney, DrPH, FSA, MAAA
Healthcare Consultant and Actuary

Milliman, Inc.
New York, NY

REVISED
November 28, 2016

One Pennsylvania Plaza, 38th Floor
New York, NY 10121
Tel +1 646-473-3000

milliman.com

TABLE OF CONTENTS

A. BACKGROUND

In early September 2016, The Connecticut Office of Health Care Access (OHCA) granted Yale New Haven Health Services Corporation (YNHHSC) approval to acquire Lawrence + Memorial Corporation (L+MC). The "Agreed Settlement" had a number of terms, including requiring YNHHSC to engage an independent consultant to evaluate the non-governmental fee levels of services provided by L+MC's Lawrence + Memorial Hospital (L+MH) and Lawrence & Memorial Medical Group (LMMG) and to annually set maximum fee increases, for 5 years for L+MH and 28 months for LMMG . This proposal sets out the Milliman proposal to serve as the independent consultant.

B. ABOUT MILLIMAN

Milliman is, by a large margin, the dominant source of health actuarial expertise with more qualified health actuaries than any other organization in the world. We have active health practices across the globe (including Europe, Japan and Brazil). With almost 3000 employees, 2015 revenue of close to $1 billion, and a focus on professional services, we have the expertise and resources to support the biggest challenges.

We have been pioneers in the pricing of ACA exchange products, Medicare Part D, Medicare Advantage, and managed care strategies. We have been leaders in actuarial consulting to provider organization including ACOs; in particular, we are supporting hundreds of provider organizations in their bundled payment and risk contracts. We have contributed significant leadership to the Actuarial profession, including presidents plus many officers of all professional actuarial bodies. Milliman provides more MA-PD and PDP bids than any other consulting firm, and we have certified hundreds of Exchange bids.

To support our consulting work, we have accumulated and organized huge datasets and developed detailed price, utilization and bid development tools. We also have normative actuarial models that contain detailed utilization and cost figures, along with models that allow actuaries to calculate the impact of benefit designs, utilization management, area factors, delivery systems, and demographics. These tools are part of our *Health Cost Guidelines* suite, which are licensed to over 100 health plans for use by actuaries. For more details, see http://www.milliman.com/expertise/healthcare/products-tools/health-cost-guidelines/.

Our proposed team has worked with numerous insurers, ACOs, and state agencies and has the expertise and stature to provide independent, objective, and authoritative analytic reports. The team, from the New York City office of Milliman, is led by the following individuals:

> **Bruce Pyenson**, FSA, MAAA, Principal and Consulting Actuary. Bruce has consulted across the healthcare spectrum. His publications include monographs on provider risk sharing (published by the American Hospital Association), columns on scientific method for the Society of Actuaries health newsletter, and over 30 peer-reviewed publications. This is Bruce's 30th year at Milliman. He was recently appointed to serve on the Medicare Payment

Advisory Commission (MedPAC), which advises Congress on policy. Bruce will advise and guide the project and communications.

Tia Goss Sawhney, DrPH, FSA, MAAA, Healthcare Consultant and Actuary. Tia is dual credentialed as a doctor of public health and an actuary. Before joining Milliman 2 years ago she was a member of the executive leadership team of Illinois Medicaid. Her diverse background includes using medical claims databases to identify treatment patterns and cost drivers and due diligence reviews in healthcare. Tia frequently writes and speaks on policy issues. Tia will lead the policy and technical design portions of the project.

Rong Yi, PhD, Principal and Healthcare Consultant. Rong is a national expert on risk adjustment, predictive modeling and other quantitative methods. She led the development of the Massachusetts Connector's risk adjustment methodology and is instrumental its on-going operations, working with several state agencies, the carriers and other stakeholders in Massachusetts. She is also leading several projects for the Minnesota Department of Health, using the MN all-payer claims database for purposes of rate review, risk adjustment and understanding market dynamics. Rong has been at Milliman for 7 years and will lead the data analytics portion of the project.

Bruce, Tia, and Rong will be supported by the Milliman New York City office's highly-experienced team of healthcare analysts.

Milliman, with about 3,000 employees, serves as an objective, analytically focused, independent advisor to a myriad of organizations in healthcare and insurance. We establish fire-walls to preserve the independence and confidentiality of particular projects and to avoid the appearance of conflicts of interest. The above team has no conflicts in performing this project and we will maintain the independence of our team throughout the project.

c. HIGH LEVEL SUMMARY OF RELEVENT SECTIONS OF AGREED SETTLEMENT

Detailed settlement conditions are spelled out in the Order section of the Agreed Settlement. Below, we summarize conditions that directly relate to our potential work as independent consultant. (This summary is for general informational purposes and context and is neither a legal interpretation nor intended to be a complete description.)

Condition 22:

a. Describes the role of the independent consultant that YNHHSC must hire to conduct a baseline Cost and Market Impact Review (CMIR) for each of L+MH and LMMG. It acknowledges that there may be initial data limitations.
b. Describes the baseline and updated CMIRs and the basis for establishing maximum market price increases, including the various factors that the independent consultant should consider.
c. Describes the development of maximum price increases, the monitoring of price increases, and possible corrective actions.
d. Describes the role of the independent consultant, including that the consultant will report to and take direction from the DPH Commissioner.
e. Describes CMIR distribution and confidentiality: OHCA shall keep all nonpublic information obtained as part of the CMIR and the CMIR report confidential and not release without the consent of YNHHSC and L+MC, unless required to do so by law.

> **Only our final report will be public.** Our analysis will rely on non-public data, data that we will describe and reference in our final report, including summary data tables.

Condition 23:

Defines key terms for the CMIR analysis described in Section 22, including the units of service for inpatient hospital, outpatient hospital, and physician services

Condition 20:

Maintains L+MH and LMMG pre-affiliation commercial health plan negotiated contracts as of the date of closing through December 31, 2017. Caps fee increases for a period of five years from the date of closing in the case of L+MH and twenty-eight months from the date of closing in the case of LMMG. (The date of closing was September 8, 2016.)

D. ANALYSIS METHODOLOGY

This section details our analysis methodology. The methodology aligns with Sections 22 and 23 of the Agreed Settlement and may change somewhat based on the limitations of the data and direction from OHCA.

Calculation of Pre-Affiliation Fee Ratios

1. For inpatient hospital, outpatient hospital, and physician services we will define a basket of services.
    a. IP: Using the Department of Insurance (DOI) service lists as prescribed by the Agreed Settlement,[1] we will map the top inpatient primary diagnoses, top procedures, and top surgical DRGs to a basket of DRG codes.
    b. OP: Using the DOI service lists as prescribed by the Agreed Settlement,[2] we will map the top outpatient procedures to a basket of HCPCS codes.
    c. Physicians: Using Milliman data, we will create a basket of the 50 most frequent physician service procedure codes and the wRVU for the services.

2. For the most recent pre-affiliation period that we have data, we will calculate the average market fee for each basket as a weighted average across payers and among the services in the basket.
    a. IP: Fee per average admission.
    b. OP: Fee per average service.
    c. Physicians: Fee per average wRVU.

3. For the pre-affiliation period we will calculate the average L+M fee for each basket as a weighted average across payers and among the services in the basket.

4. For the pre-affiliation period we will calculate the ratio of the average L+M fee for each basket to other providers in the market. We will calculate the maximum commercial fee increase that will maintain (not exceed) this ratio.

Calculation of Maximum Commercial Fee Increase for CY 2018 (First CMIR Year)

1. For each payer within each basket we will project market fee increases from the pre-affiliation period through 2018 and any anticipated shifts between payers. We will then calculate a 2018 average market fee.

2. For each non-commercial payer within each basket we will project L+M fee increases from the pre-affiliation period through 2018 and any anticipated shifts among payers. We will then calculate the L+M maximum fee increase for the pre-affiliation period through 2018 that will produce a L+M average market fee that maintains the pre-affiliation ratio.

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[1] Connecticut Acute Care Hospital and Outpatient Surgical Facility Data: FY2015, August 1, 2016.
[2] Ibid.

3. We will reduce the maximum fee increase, as necessary, to reflect any increases that L+M has already received or will receive after the pre-affiliation period and before 2018.

Calculation of Maximum Commercial Fee Increase for CY's 2019+ (Subsequent CMIR Years)

1. For the most recent period that we have data (update period) we will calculate the average market fee for each basket as a weighted average across payers and among the services in the basket.

2. For the update period, we will calculate the average L+M fee for each basket as a weighted average across payers and among the services in the basket.

3. For each payer within each basket we will project market fee increases from the update period through the CMIR year and any observed or anticipated shifts between payers. We will then calculate a CMIR year average market fee.

4. For each non-commercial payer within each basket we will project L+M fee increases from the update period through the CMIR year and any observed or anticipated shifts between payers. We will then calculate the L+M maximum fee increase for the update period through CMIR year that will produce a L+M average market fee that maintains the pre-affiliation ratio.

5. We will reduce the maximum fee increase, as necessary, to reflect any increases that L+M has already received or will receive after the update period and before the CMIR year.

Note: The CMIR methodology is inherently self-correcting. If L+M provides less Medicaid or uninsured care than anticipated in a period, their average fee for that period will increase, reducing their next year's maximum commercial fee increase.

Note: The above CMIR methodology is aligned with the Agreed Settlement and, where required by the Agreed Settlement, with Connecticut General Statute Section 19a-639f. It is therefore different than the methodologies for Massachusetts CMIRs, which are aligned with Massachusetts regulation[3] and law,[4] and which are completed prior to affiliation. We will, however, examine Massachusetts CMIRs for potential learnings and practices.[5]

[3] Massachusetts Health Policy Commission, Technical Bulletin for 958 CMR 7.00: Notices of Material Change and Cost and Market Impact Reviews.
[4] Massachusetts General Laws, Part I, Title II, Chapter 6D, Section 13.
[5] Mass.gov, Administration and Finance, Material Change Notices/Cost and Market Impact Reviews.

E. DATA SOURCES

While Section 22.a of the Agreed Settlement acknowledges that there may be limitations in data available to the independent consultant, we believe there are a number of potential data sources and these limitation can be overcome. We will spend substantial time early in the project identifying potential data sources and assessing their reliability, usability, appropriateness, and timeliness.

Market prices are central to our analysis. Prices are assigned to services and paid by payers as claims; claims data therefore is ideal for understanding market prices. Other data sources, such as the hospital discharge dataset, can illuminate payer mix, uncompensated care, and the volume of select services in the market.

Potential data sources and their potential uses include:

Potential Data Source	Potential Use of the Data
1. Pricing and other data provided by L+MH and LMMG*	L+MH and LMMG prices; payer mix; uncompensated care; service mix
2. CMS Medicare 5% sample and 100% data* and fee schedules	Prices for Medicare; market share and service mix for Medicare
3. CT Medicaid fee schedules	Prices for Medicaid
4. Truven Health Analytics MarketScan claims database as licensed by Milliman*	Provider prices for multiple payers
5. Milliman's proprietary Consolidated Health Cost Guidelines Sources Database (CHSD), a "MarketScan-like" claims database*	Provider prices for multiple payers
6. Connecticut hospital discharge dataset*	Hospital size and market share; payer mix; uncompensated care; service mix
7. Connecticut hospital reports submitted to OHCA and Medicare Cost Reports	Hospital size and market share; payer mix; uncompensated care
8. Connecticut All Payer Claims Database (APCD)*	Prices for all payers; market share; payer mix; uncompensated care; service mix
9. Connecticut employee health benefits program claims database*	Prices for payers covering state employees; market share and service mix for employee population
10. Other data submitted to OHCA or other Connecticut state agencies by Connecticut healthcare providers or payers**	TBD

* Non-public data. Non-public = restricted to certain users and/or uses.
** May include non-public data.

While the APCD (#8 above) and employee health claims database (#9 above) would be excellent data sources, if they are not available or insufficiently populated we can proceed without them.

Milliman has, for about two decades, licensed the Truven MarketScan commercial database and predecessor databases, and has developed routine processing to speed its use, improve its accuracy, and increase its utility. In recent years, this data source has included claims for about 50 million lives. Milliman also has a similar, non-overlapping, database (CHSD) with about 20 million lives of data from Milliman client data contributors across the U.S.

We will review data sources annually for relevant changes, including the possibility of incorporating new data sources into our analysis.

F. PRICE

Milliman bills for time and travel expenses. Time is tracked by professional on a quarter-hour basis and billed monthly.

Phase	Deliverables	Estimated Price
Baseline CMIR: L+MH	Report to OHCA	$200,000
Baseline CMIR: LMMG	Report to OHCA	$100,000
3 annual updates: L+MH*	Report to OHCA	$120,000 each

* The L+MH fee monitoring period is 5 years from September, 2016. L+MH pre-affiliation negotiated contracts are maintained through December 31, 2017. The baseline L+MH CMIR is applicable to fee increases for calendar year 2018 and updates are applicable for 2019, 2020, and 2021 through August.

The LMMG fee monitoring period is 28 months from September, 2016. LMMG pre-affiliation negotiated contracts are maintained through December 31, 2017. The Baseline LMG CMIR is applicable to fee increases for calendar year 2018. There will be no updates.

Substantial revisions and work outside the above will be billed at Milliman's usual hourly rates plus travel expenses at price.

G. TIMING

We will deliver the CMIRs by June each year, with the first CMIR delivered in June 2017.

H. CONSULTING SERVICES AGREEMENT

This work will be subject to the terms of a Milliman – YNHHSC consulting services agreement.

COMPLIANCE ADDENDUM

COMPLIANCE ADDENDUM

THIS COMPLIANCE ADDENDUM (this "Addendum") is made as of November 28, 2016 (the "**Effective Date**"), by and between Yale-New Haven Health Services Corporation, Inc., acting on behalf of Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, Inc. and/or Northeast Medical Group, Inc. ("**YNHHS**") and Milliman, Inc., having offices at One Pennsylvania Plaza, 38th Floor, New York, NY 10119 ("**Vendor**").

YNHHS and Vendor have entered into an agreement for November 28th, 2016, dated as of the Effective Date ("**Agreement**"), pursuant to which the Vendor will provide certain goods and/or services to YNHHS.

YNHHS and Vendor understand that the Agreement is subject to numerous requirements imposed by federal law, state law, and accreditation agencies, and YNHHS and Vendor desire to perform their respective obligations under the Agreement in full compliance with those requirements.

Therefore, the parties agree as follows:

1. **Exclusion**. Vendor agrees as follows:

(a) Vendor represents and warrants that neither it nor any of its employees or representatives performing services under the Agreement has ever been: (1) convicted of a criminal offense related to health care or related to the provision of services paid for by Medicare, Medicaid or another federal health care program ("**Government Health Care Programs**"); (2) excluded or debarred from participation in any Government Health Care Program; or (3) otherwise sanctioned by the federal government, including being listed on the General Services Administration's Excluded Party Listing System or Office of Foreign Assets Control (OFAC) list of Specially Designated Nationals and Blocked Persons List.

(b) Vendor shall notify YNHHS immediately if any representation or warranty in paragraph (a) above is or becomes untrue at any time during the term of the Agreement.

(c) If any representation or warranty in paragraph (a) above is or becomes untrue at any time during the term of the Agreement, YNHHS may, in its sole discretion, either terminate the Agreement or require Vendor to replace any employee or representative causing the breach of warranty with another appropriate employee or representative acceptable to YNHHS.

2. **Access to Records**. If the Agreement provides for services to be performed by Vendor worth $10,000 or more over a 12-month period, Vendor will, until the expiration of four years after the termination of the Agreement, make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General and their representatives, the Agreement and all books, documents and records necessary to certify the nature and extent of the cost of those services. If Vendor carries out any of the duties described herein through a subcontract worth $10,000 or more over a 12-month period with a related organization, the subcontract must also

contain an access clause to permit access by the Secretary, Comptroller General and their representatives to the related organization's books, documents and records. In the event Vendor receives a request for access, Vendor will notify YNHHS immediately and consult with YNHHS regarding the response to the request.

3. **Confidentiality**. Each party expressly undertakes to retain in confidence all information and know-how transmitted to it by the disclosing party that the disclosing party has identified as being proprietary and/or confidential or that, by the nature of the circumstances surrounding disclosure or the nature of the information disclosed, ought in good faith to be treated as proprietary or confidential ("Confidential Information") and will make no use of such information and know-how except under the terms and during the existence of the Agreement. The parties' obligations under this Section shall survive termination or expiration of the Agreement. Confidential Information shall include, by way of example and not limitation, any and all information regarding a party's finances, practices, employees, or management. Confidential Information shall not include information which (i) at the time of disclosure was, is or thereafter becomes disclosed or available to or known by the public (other than as a result of a disclosure in violation of any of obligations hereunder), (ii) was or is or thereafter becomes available on a non-confidential basis from a source that is not and was not prohibited from disclosing such information by a contractual, legal or fiduciary obligation, or (iii) has been or thereafter becomes independently acquired or developed without access to any of the information provided by the disclosing party. Notwithstanding anything herein to the contrary, or any prior understanding or agreement between the parties, YNHHS shall have the right to disclose all pricing and other terms stated in or relating to the Agreement to any of YNHHS' attorneys, accountants, Consultants (including members of the medical staff and physicians members of clinical evaluation committees or other committees evaluating purchases), group purchasing organizations, and other third parties retained by YNHHS in the ordinary course, on a need-to-know basis (that is, their duties, requirements or contract for services require such disclosure), and, with the exception of group purchasing organizations, agree to take appropriate action by instruction or agreement with such individuals permitted access to the Confidential Information to satisfy the obligations under this Section. Unauthorized use of Confidential Information is a material breach of the Agreement resulting in irreparable harm for which the payment of money damages is inadequate. It is agreed that the non-breaching party, upon adequate proof of unauthorized use, may immediately obtain injunctive relief in any court of competent jurisdiction enjoining any continuing or further breaches and may obtain entry of judgment for injunctive relief. Nothing in the Agreement shall be construed to limit remedies at law or equity in the event of a breach.

4. **Security**. If Vendor personnel will be on YNHHS's premises, Vendor and Vendor personnel must comply with all YNHHS policies and procedures pertaining to visitation, confidentiality, security and vendor identification. YNHHS may issue non-employee identification badges under certain conditions. If YNHHS provides an identification badge, Vendor will require its personnel to prominently display such badge at all times while on YNHHS premises. Vendor shall surrender any badge immediately upon request by YNHHS. Vendor's or Vendor Personnel's non-compliance with any of the policies described in this Section is to be construed as a breach of the Agreement.

5. **Relationship to Agreement**. To the extent there is any conflict between the terms and conditions of this Addendum and the Agreement, the terms and conditions of this Addendum shall control. All other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, each of the parties has caused this Addendum to be executed as of the date set forth above.

YALE-NEW HAVEN HEALTH SERVICES CORPORATION

By: _____

Name:
GAYLE CAPOZZALO

Title:
EXEC VP / CHIEF STRATEGY OFFICER

Milliman, Inc.

By: _____

Name:
Bruce Pyenson

Title:
Principal & Consulting Actuary

Greer, Leslie

From: Martone, Kim
Sent: Thursday, December 01, 2016 8:50 AM
To: Roberts, Karen
Cc: Greer, Leslie
Subject: FW: Yale and L&M acquisition
Attachments: Response to intevenors 113016.pdf

FYI

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Wednesday, November 30, 2016 4:13 PM
To: Martone, Kim
Cc: Borgstrom, Marna; Petrini, Vincent; Cummings, Bruce (L and M); 'Sauders, Kelly (US - New York)'; Tammaro, Vincent; Aseltyne, Bill; Rosenthal, Nancy; Willcox, Jennifer; O'Connor, Christopher
Subject: RE: Yale and L&M acquisition

Kim,

Attached please find a letter addressing the issues you raised in your email. I look to hearing from you at your convenience.

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

From: Martone, Kim [mailto:Kimberly.Martone@ct.gov]
Sent: Tuesday, November 22, 2016 3:06 PM
To: Capozzalo, Gayle
Subject: Yale and L&M acquisition

Gayle, please see the attached letter from multiple organizations and individuals objecting to the approval of Deloitee and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. Please address all allegations in full detail with supporting documentation as needed. As I advised when we met on November 15th, I do feel it is important for you and/or your community representative to meet with these organizations and individuals to inform them of such decisions as this acquisition moves forward. In light of the assertions made in the attached letter, I am hereby restating my request and ask that your discussions include the points outlined in the letter. Further, OHCA reserves the right to reverse its approval of the monitor based on your response to the attached letter.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

Yale
NewHaven
Health

November 30, 2016

Ms. Kimberly Martone
Office of Healthcare Access
State of Connecticut
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

Dear Ms. Martone:

I am writing in response to concerns raised by a group of former intervenors regarding the selection of Deloitte and Touche as the Independent Monitor for the affiliation of Lawrence + Memorial Healthcare with Yale New Haven Health System. As you know, the appointment of the Monitor was made in compliance with the detailed conditions set forth in the Agreed Settlement which approved the affiliation on September 8, 2016.

Deloitte and Touche was recommended for this role because of its unique and comprehensive set of skills and knowledge of the healthcare environment. Deloitte and Touche has been engaged by healthcare organizations throughout the United States, including the State of Connecticut Health Exchange, for its expertise and broad perspective on changes affecting the delivery of healthcare. Deloitte has worked for 10 out of the 11 largest non-profit healthcare systems in the nation, 75 percent of all honor roll hospitals and more than 90 percent of the Fortune 500 life sciences and healthcare companies. Deloitte also has been a national leader in transaction monitoring and has thoroughly reviewed its ability to fulfill the responsibilities of the Independent Monitor to ensure that there are no conflicts of interest.

The group of former intervenors has cited work that Deloitte has done in the past for Yale New Haven Health as disqualifying the firm from serving as the Independent Monitor. They cite $30 million in billings over the past decade-plus. To put this number in perspective, during that time, Yale New Haven Health grew from a $1.5 billion system to more than $4 billion. The System spent more than $340 million on professional fees during that period of which approximately $30 million was paid to Deloitte, which is less than .0815% of its 2016 U.S. revenue of $36.8 billion.

Deloitte has been engaged by Yale New Haven Health for the following matters. From 2005 through 2015, Deloitte provided internal audit services, averaging approximately $1.7 million annually – nearly half the amount cited in the letter. In this capacity, Deloitte reported directly to the Audit Committee of the Board to preserve independence from management. In 2015, Yale New Haven Health selected Ernst & Young to replace Deloitte in this role.

In 2012, Deloitte provided consulting services in connection with Yale New Haven Hospital's integration with the former Hospital of Saint Raphael. This role included identifying opportunities for economic efficiencies while preserving access to care and jobs. The Saint Raphael transaction was subject to OHCA approval and post-approval monitoring, and by all accounts, the integration has been successful. In 2015, Deloitte provided similar services in pre-closing discussions with Lawrence and Memorial regarding potential synergies.

In 2013, Deloitte was selected from a competitive bidding process to provide consultation as Yale New Haven Health implemented a new, System-wide electronic health record. That same year, Deloitte also provided transitional support for the Chief Information and Chief Compliance Officer roles.

We firmly believe that none of this past work would interfere with the proposed role for Deloitte as the Independent Monitor. Further, it is our understanding that Deloitte's internal conflict assessment review would have resulted in their withdrawing from this engagement if a conflict was identified.

Finally, unrelated to this work, the former intervenors cite a $1 million fine that Deloitte received from the Securities Exchange Commission back in 2015. It is important to note that this isolated event was self-disclosed by Deloitte and was part of a series of cases reviewed by regulators at the time, including a $4 million fine against Ernst & Young and an $8.2 million fine against KPMG.

While the organizations that have raised concerns about Deloitte uniformly opposed the affiliation during the approval process, we are committed to listening to their perspectives, along with those of community leaders throughout southeastern Connecticut. Our goal is simple. We want this affiliation to succeed. To do so we intend to demonstrate that we will keep the commitments we made to the State, just as we did in 2012 during the integration with the Hospital of Saint Raphael. In fact, just two months into our formal affiliation with Lawrence + Memorial Healthcare, we have already made important investments and recruitments to support access to cost-effective healthcare services in the communities served by Lawrence + Memorial Healthcare.

We hope this provides helpful context by the concerns raised by the former intervernors. We stand ready to continue to work with OHCA to ensure that this affiliation achieves the lofty goals we have jointly set for it in the years to come.

Sincerely,

Gayle Capozzalo
Chief Strategy Officer

Greer, Leslie

From: Roberts, Karen
Sent: Thursday, December 01, 2016 2:59 PM
To: Greer, Leslie
Subject: FW: Docket Number 15-32033-CON Stipulation #12

For public record

From: Roberts, Karen
Sent: Thursday, December 01, 2016 2:58 PM
To: 'Rosenthal, Nancy'
Cc: Cotto, Carmen; Martone, Kim
Subject: Docket Number 15-32033-CON Stipulation #12

Hi Nancy

Please be informed that for purposes of submission of the report on culturally and linguistically appropriate services available at L+MH, required by Stipulation #12, OHCA will accept submission at the same time as the material which will be due each **November 30th** (for example, material required by Stipulations 7 and 8 are due each November 30th and May 31st). Please note that Stipulation #12 material is an annual submission for three years, not a semi-annual submission. This email will be placed in the record for DN 15-32033-CON for clarification purposes.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Monday, December 05, 2016 3:36 PM
To: 'andrews@chhealthpolicy.org'; 'jhochadel@svft.org'
Cc: Martone, Kim
Subject: FW: Yale and L&M acquisition

12/5/26
Ellen Andrews and Jan Hochadel,

Kimberly Martone of the Office of Health Care Access asked me to forward this email to you. For more information regarding the Yale-New Haven Hospital System Agreement and Gayle Capozzalo's response to the issues please click the link below to the OHCA website. Please forward to other organizations and individuals we did not have the email addresses for.

Thank you

http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32033_con.pdf

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

From: Martone, Kim
Sent: Monday, December 05, 2016 12:12 PM
To: 'Capozzalo, Gayle' <Gayle.Capozzalo@ynhh.org>
Cc: Borgstrom, Marna <Marna.Borgstrom@ynhh.org>; Petrini, Vincent <Vincent.Petrini@ynhh.org>; Cummings, Bruce (L and M) <bcummings@lmhosp.org>; 'Sauders, Kelly (US - New York)' <ksauders@deloitte.com>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>; Aseltyne, Bill <Bill.Aseltyne@ynhh.org>; Rosenthal, Nancy <Nancy.Rosenthal@greenwichhospital.org>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>; O'Connor, Christopher <christopher.oconnor@ynhh.org>
Subject: RE: Yale and L&M acquisition

Hi Gayle, thank you for your response and additional information on the issues raised in the letter. The Office confirms the approval of Deloitee and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. We continue to recommend that you meet with the organizations and individuals who signed the letter to inform them of decisions made regarding the acquisition of L&M.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134

Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov Website: www.ct.gov/ohca

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Wednesday, November 30, 2016 4:13 PM
To: Martone, Kim
Cc: Borgstrom, Marna; Petrini, Vincent; Cummings, Bruce (L and M); 'Sauders, Kelly (US - New York)'; Tammaro, Vincent; Aseltyne, Bill; Rosenthal, Nancy; Willcox, Jennifer; O'Connor, Christopher
Subject: RE: Yale and L&M acquisition

Kim,

Attached please find a letter addressing the issues you raised in your email. I look to hearing from you at your convenience.

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

From: Martone, Kim [mailto:Kimberly.Martone@ct.gov]
Sent: Tuesday, November 22, 2016 3:06 PM
To: Capozzalo, Gayle
Subject: Yale and L&M acquisition

Gayle, please see the attached letter from multiple organizations and individuals objecting to the approval of Deloitee and Touche as the Independent Monitor for the Yale-New Haven Hospital System settlement agreement. Please address all allegations in full detail with supporting documentation as needed. As I advised when we met on November 15th, I do feel it is important for you and/or your community representative to meet with these organizations and individuals to inform them of such decisions as this acquisition moves forward. In light of the assertions made in the attached letter, I am hereby restating my request and ask that your discussions include the points outlined in the letter. Further, OHCA reserves the right to reverse its approval of the monitor based on your response to the attached letter.

Kim

Kimberly R. Martone
Director of Operations, Office of Health Care Access

Olejarz, Barbara

From: Microsoft Outlook
To: andrews@cthealthpolicy.org
Sent: Monday, December 05, 2016 3:38 PM
Subject: Relayed: FW: Yale and L&M acquisition

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

andrews@cthealthpolicy.org (andrews@cthealthpolicy.org)

Subject: FW: Yale and L&M acquisition

Olejarz, Barbara

From: postmaster@svft.org
To: jhochadel@svft.org
Sent: Monday, December 05, 2016 3:47 PM
Subject: Undeliverable: FW: Yale and L&M acquisition

Delivery has failed to these recipients or groups:

jhochadel@svft.org
This message was rejected by the recipient email system. Please check the recipient's email address and try resending this message, or contact the recipient directly.

Diagnostic information for administrators:

Generating server: CO2PR03MB2165.namprd03.prod.outlook.com

jhochadel@svft.org
Remote Server returned '< #5.1.10 smtp;550 5.1.10 RESOLVER.ADR.RecipientNotFound; Recipient not found by SMTP address lookup>'

Original message headers:

```
Received: from DM2PR03CA0033.namprd03.prod.outlook.com (10.141.96.32) by
 CO2PR03MB2165.namprd03.prod.outlook.com (10.166.92.12) with Microsoft SMTP
 Server (version=TLS1_2, cipher=TLS_ECDHE_RSA_WITH_AES_256_CBC_SHA384_P384) id
 15.1.761.9; Mon, 5 Dec 2016 20:46:42 +0000
Received: from BN1BFFO11FD039.protection.gbl (2a01:111:f400:7c10::1:182) by
 DM2PR03CA0033.outlook.office365.com (2a01:111:e400:2428::32) with Microsoft
 SMTP Server (version=TLS1_2,
 cipher=TLS_ECDHE_RSA_WITH_AES_256_CBC_SHA384_P384) id 15.1.721.10 via
 Frontend Transport; Mon, 5 Dec 2016 20:46:42 +0000
Authentication-Results: spf=pass (sender IP is 159.247.0.202)
 smtp.mailfrom=ct.gov; svft.org; dkim=none (message not signed)
 header.d=none;svft.org; dmarc=bestguesspass action=none header.from=ct.gov;
Received-SPF: Pass (protection.outlook.com: domain of ct.gov designates
 159.247.0.202 as permitted sender) receiver=protection.outlook.com;
 client-ip=159.247.0.202; helo=DeltaconX4.ct.gov;
Received: from DeltaconX4.ct.gov (159.247.0.202) by
 BN1BFFO11FD039.mail.protection.outlook.com (10.58.144.102) with Microsoft
 SMTP Server (version=TLS1_2, cipher=TLS_RSA_WITH_AES_256_CBC_SHA256) id
 15.1.734.4 via Frontend Transport; Mon, 5 Dec 2016 20:46:41 +0000
X-IncomingTopHeaderMarker:
OriginalChecksum:;UpperCasedChecksum:;SizeAsReceived:1920;Count:24
Received: from mailgate2.doit.ct.gov (unknown [159.247.5.89]) by DeltaconX4.ct.gov with
smtp
         id 21d3_31cb_6a5c3dd1_f9f0_4890_8487_b380059fa63a;
        Mon, 05 Dec 2016 15:46:39 -0500
X-WSS-ID: 0OHQCDP-02-OBB-02
```

Olejarz, Barbara

From: Ellen Andrews <andrews@cthealthpolicy.org>
Sent: Monday, December 05, 2016 3:57 PM
To: Olejarz, Barbara
Subject: Re: Yale and L&M acquisition

Thanks, I will get it to the folks in the coalition.
Ellen

Ellen Andrews, PhD
CT Health Policy Project
cthealthpolicy.org
@cthealthnotes

From: "Olejarz, Barbara" <Barbara.Olejarz@ct.gov>
Date: Monday, December 5, 2016 at 3:37 PM
To: Ellen Andrews <andrews@cthealthpolicy.org>
Subject: FW: Yale and L&M acquisition

From: Olejarz, Barbara
Sent: Monday, December 05, 2016 3:36 PM
To: 'andrews@chhealthpolicy.org' <andrews@chhealthpolicy.org>; 'jhochadel@svft.org' <jhochadel@svft.org>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>
Subject: FW: Yale and L&M acquisition

12/5/26
Ellen Andrews and Jan Hochadel,

Kimberly Martone of the Office of Health Care Access asked me to forward this email to you. For more information regarding the Yale-New Haven Hospital System Agreement and Gayle Capozzalo's response to the issues please click the link below to the OHCA website. Please forward to other organizations and individuals we did not have the email addresses for.

Thank you

http://www.ct.gov/dph/lib/dph/ohca/con_completed/2016/15_32033_con.pdf

Barbara K. Olejarz
Administrative Assistant to Kimberly Martone
Office of Health Care Access
Department of Public Health
Phone: (860) 418-7005
Email: Barbara.Olejarz@ct.gov

Greer, Leslie

From: Roberts, Karen
Sent: Thursday, December 08, 2016 2:39 PM
To: Greer, Leslie; Cotto, Carmen
Cc: Martone, Kim
Subject: FW: Docket #15-32033-CON
Attachments: Community Representative Letter to OHCA 120816.pdf

Leslie for the OHCA website for the Yale/L+M compliance filings. Karen

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Thursday, December 08, 2016 2:37 PM
To: User, OHCA; Martone, Kim; Roberts, Karen; Cotto, Carmen
Cc: Cummings, Bruce (L and M); O'Connor, Christopher; Stanley, William (LMHOSP); Petrini, Vincent; Willcox, Jennifer; Anderson, Maureen (LMHOSP); 'Sauders, Kelly (US - New York)'; 'Cathy Zall'; Rosenthal, Nancy
Subject: Docket #15-32033-CON

The attached is being submitted in compliance with Condition 14. Thank you.

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

Yale
NewHaven
Health

December 8, 2016

Ms. Kimberly Martone
Office of Healthcare Access
State of Connecticut
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

RE: Docket #15-32033-CON (L+M)

Dear Ms. Martone:

In compliance with Condition 14 allowing for one (1) community representative to serve as a voting member of Lawrence + Memorial Hospital, we have identified Catherine Zall as the Community Representative. Accordingly, Ms. Zall will be appointed to a three-year term on the Lawrence + Memorial Hospital Board.

Ms. Zall brings a perspective that uniquely qualifies her for this important position. She has a deep and thorough understanding of the rapidly evolving healthcare landscape from her service as a member of the L+M Corporation Board and understands the roles that different providers play in this environment.

Ms. Zall is a widely respected member of the New London community and has served as the Executive Director of the New London Homeless Hospitality Center since 2007. She additionally serves as a Pastor of the First Congregational Church of New London. Her expansive experience is outlined in the attached CV, and includes experience as a project manager for the Connecticut Department of Social Services and as a program director for the Connecticut Child Care Assistance Program. Prior to that Ms. Zall served for nearly a decade as the Deputy Commissioner of the New York City Department of Social Services.

Ms. Zall's impressive academic background features a master of Divinity degree from Yale University, an MBA from New York University and a bachelor's degree from Brown University. Her CV is attached.

The process to vet her appointment was thorough and comprehensive. Representatives from Lawrence + Memorial and Yale New Haven Health reached out to a multitude of

789 Howard Avenue
1059 CB
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472

ynhhs.org

community non-profits, social service organizations, healthcare providers and business interests. Ms. Zall received wide acclaim for her community commitment and her passion for the provision of high quality healthcare in the region. A description of the role she will assume is Attachment 2.

She has been described by those we reached out to as a wonderful choice, someone who is thoughtful and does great work in the community. Even those who did not know her well had heard great things about her. She brings a true passion to her work and a strong commitment to serving the community.

Sincerely,

Gayle Capozzalo
Executive Vice President / Chief Strategy Officer

GC/lm/eg

Catherine Zall

Experience

2007-Present *Executive Director*
New London Homeless Hospitality Center

Responsible for the overall management of the overnight shelter and day time hospitality center with a special emphasis on fundraising, public outreach, coordination with other providers, procedure development, strategic planning, high priority project management and staff development.

Direct multiple health related initiatives to help improve health outcomes for individuals experiencing homelessness.

- Established partnership with local VNA to provide nursing services to emergency shelter guests.
- Designed and implemented special respite section of the emergency shelter designed to support recuperation and linkage to ongoing community based services for individuals facing both homelessness and illness.
- Facilitated the creation of an on-site clinic in the shelter staffed by medical personnel from the Community Health Center.
- Established a community care team that brings together providers from various sectors to coordinate care for individuals with complex medical and/or social needs.
- Manage one site of a demonstration project funded by the President's Social Innovation Fund testing the impact of housing on health outcomes and costs for individuals with annual Medicaid costs over $50,000.

2007-Present *Pastor*
First Congregational Church of New London

Serve as part-time pastor to downtown church.

2002-2007 *Associate Minister*
First Congregational Church of Old Lyme

Responsible for religious education programs for children and adults—including Sunday school, adult bible study, retreats, family programs and small groups. Participate in the pastoral care and worship ministry of the church. Provide administrative supervision for selected church staff.

1998-1999 *Project Manager*
Connecticut Department of Social Services

Developed comprehensive new regulations for the state's $150 million child care subsidy program. Prepared request for proposals for the acquisition of a new automated childcare information system.

1997 *Local Program Director*
Connecticut Child Care Assistance Program

Directed the state funded, but privately operated, program to administer childcare subsidies payments to over 18,000 low-income Connecticut residents. Responsibilities included staff supervision, training, procedure development and public outreach.

1995-1997 *Chief Financial Officer*
Telesis Medical Management

Managed corporate finance and management information systems for a private sector start-up company assisting primary care physicians with managed care contracting.

1986-1995 *Deputy Commissioner, Office of Employment Services*
New York City Department of Social Services

Directed 650 city staff and 50 not-for-profit contracted service providers in efforts to help recipients of public assistance secure unsubsidized employment. Programs included job search, education, skills training and work experience. Job placements and program participation levels increased dramatically while maintaining existing staffing levels.

1982-1986 *Director, Office of Administration*
Division of School Buildings, NYC Board of Education

Directed finance, capacity planning, competitive bidding, leasing, data processing and personnel for a division responsible for the maintenance of over 1,000 school buildings and management of a $200 million capital budget.

1980-1982 *Deputy Assistant Commissioner*
New York City Department of Employment

Supervised monitoring of federally funded job training contractors.

1979-1980 *Management Consultant*
Arthur Young & Company (New York City)

Provided private sector financial consulting services with a special emphasis on the design and implementation of automated financial management systems.

Education

Master of Divinity
Yale Divinity School

Master of Business Administration, with honors
Stern School of Business, New York University
Major: Accounting

Bachelor of Arts
Brown University
Major: English

Role of Community Representative
OHCA CT Docket #15-32033-CON Condition 14

Condition 14 states: **For three years following the Closing Date the applicant shall allow for one community representative to serve as a voting member of L+M Hospital's Board of Directors with rights and obligations consistent with other voting members under L+M Hospital's Board of Directors bylaws. The applicants shall select a community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interest of the community served by L+M Hospital. OHCA is imposing this Condition to ensure continued access to healthcare services for the patient population.**

The underlying purpose of the "community representative," even though the vast majority of L+M Hospital's Trustees are independent Trustees from the community, is to ensure that community interests are voiced at Board meetings as the Board makes decisions.

The definition of community is the population being served by L+M Hospital. It is not restricted to particular advocacy, interest or organized groups, specific demographics, programs or organizations. L+M has a history of working with the community and regularly completes its Community Needs Analysis and has developed a community health improvement plan, which has input from more than 50 community representatives. The community is also represented by schools, government and other non-profits. The community representative will consider a broad and inclusive definition of community. The Condition requires that the community representative will be "an unbiased individual who will fairly represent the interests of the community served by Lawrence + Memorial Hospital."

The Condition does not detail the role for the "community representative." However, the community representative should be accessible to any and all community groups to discuss the advancements YNHHS/L+M Hospital is making, receive input regarding issues and concerns that the community may have in order to provide information to the L+M Hospital Board.

The Independent Monitor is required to meet with community representatives within six months following the transaction and annually thereafter for up to five years. The Independent Monitor is also required to hold a public forum within six months following the transaction and not less than annually thereafter for five years to provide public review and comment on the Monitor's report and findings and information on what is happening at L+M. In addition, for the next three years, Yale New Haven Health System and L+M Hospital Boards will meet together twice per year and following these meetings a public meeting will be held to update the public on what is happening at the Hospital. The "community representative" should be actively engaged in all of these meetings.

Greer, Leslie

Subject: FW: L+M New London Community Leaders invitation - January 24th @5pm - please see below

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Monday, January 09, 2017 1:55 PM
To: tsheridan@chamberect.com; calvertr@childandfamilyagency.org; jmilstein@ci.New-London.ct.us; jennob@cfect.org; rodrigd@chc1.com; tlrei@conncoll.edu; andrews@cthealthpolicy.org; president@mysticchamber.org; jlokken@town.groton.ct.us; chris@higheredgect.org; pacopeco48@gmail.com; rmelmed@llhd.org; rodneybutler@mptn-nsn.gov; steinmayer_j@mitchell.edu; cbunnell@moheganmail.com; stephen_r_smith@brown.edu; jhaslam@connlegalservices.org; pdavis@rcda.co; johnpsilsby@yahoo.com; nickfischer@yahoo.com; g.demaio@soundcommunityservices.org; president@sectwomensnetwork.org; megan.brown@tvcca.org; victorg.villagra@gmail.com; doh@uncashd.org; oceanpellett@yahoo.com; ncowser@secter.org; virginia.mason@uwsect.org; stephanyerclarke@gmail.com; jfischer@jfec.com; edwardtessman@ccfsn.org; czeiner@safefuturesct.org; kthompson@allianceforliving.org; jackmalone@scadd.org; jgranger@ucfs.org; jpkamish@hotmail.com; lauren.pereira@ppsne.org; carolyn.patierno@allsouls.net; riveram@newlondon.org; unit2010@newlondonnaacp.org; kstauffer@thearcnlc.org; rmoller@noankcss.org; director@newlondonmainstreet.org
Cc: Martone, Kim; Cathy Zall; Mitchell, Kelly Rose (US - Boston)
Subject: RE: L+M New London Community Leaders invitation - January 24th @5pm - please see below

Dear Community Leaders:

As you may be aware, the formal affiliation between Yale New Haven Health Services Corporation ("YNHHSC") and Lawrence + Memorial Corporation ("L+M") was finalized on September 8, 2016. As part of the conditions for State approval for this affiliation, YNHHSC and L+M entered into a Settlement Agreement (Docket Number 15-32033-CON). In accordance with Condition 15 of the Settlement Agreement, YNHHSC contracted with Deloitte & Touche LLP on November 7, 2016 to serve as the Independent Monitor. As the Independent Monitor, Deloitte & Touche LLP is responsible for monitoring YNHHSC's compliance with the Conditions of the Settlement Agreement. Per Condition 33(b), the Independent Monitor is required to meet with representatives of the L+M Community to address L+M's compliance with the Settlement and to provide an update regarding community benefits and uncompensated care.

As the Partner from Deloitte & Touche LLP serving as the Independent Monitor for L+M and YNHHSC, I would like to invite you to join me on Tuesday, January 24th for the first Community Representatives meeting. As community leaders, you serve a valuable role in helping identify and meet the health care needs of those within the New London area. The objective of this meeting is to represent a wide range of perspectives and constituencies in the community, even extending beyond New London, and as such you have been identified as a valuable participant in this process.

The objectives of this meeting will include the following:

- Formal introduction of Catherine Zall, the designated Community Representative/voting member for L+MH's Board of Directors
- Overview of the Independent Monitor roles and responsibilities, including a description of activities to be conducted by the Independent Monitor
- Overview of YNHHSC and L+M's Community Health Needs Assessment implementation plan and strategies relative to Community Benefit and Community Building activities

This meeting will be held at the Holiday Inn, 35 Governor Winthrop Blvd, New London, CT. Check-in will begin promptly at 5:00 p.m. and dinner will be served. We anticipate the meeting will end no later than 8:00 p.m. We are scheduling ample time for this initial meeting to allow time for questions and discussion.

As the leader of your organization, I ask that you make every effort to personally attend. If you are unable to do so, please send a representative in your place. I respectfully ask that you not forward this invitation. If there is anyone you believe should be included, please contact me so that I may extend a personal invitation. In later February or early March, we will be holding a public forum where anyone interested in learning about the Monitor role and hearing a report of initial activities relative to the YNHHSC/L+M affiliation can attend.

Please RSVP to this meeting via email to my colleague, Kelly Mitchell, at kellmitchell@deloitte.com. If you need to reach me directly, I am available via phone at (212) 436-3180 or via email ksauders@deloitte.com.

Sincerely,

Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

v.E.1

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Thursday, January 12, 2017 2:09 PM
To: 'gayle.capozzalo@ynhh.org'
Cc: Roberts, Karen; Cotto, Carmen
Subject: FW: Clarification of the timing of submissions

1/12/17

Gayle,

Regarding the Independent Monitor's request from OHCA related to timeframes for submission of a number of conditions under Docket Number 15-32033-CON. After reviewing the conditions, OHCA staff has prepared the following to clarify the timing of condition submissions, which I am in agreement with. The yellow highlights show where the words "following the Closing Date" appear in the conditions. OHCA's clarifying statements appear in Red/Bold. Please let me know if you need anything else in order to clarify the Hospital's and Independent Monitor's filing obligations.

Kimberly R. Martone
Director of Operations, Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13 CMN, Hartford, Connecticut 06134
Phone: 860-418-7029 Fax: 860-418-7053
Email: Kimberly.Martone@ct.gov *Website:* www.ct.gov/ohca

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1. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, YNHHSC shall submit schedules to OHCA setting forth L+MH's inpatient bed allocation and the location and hours of operation. ***N/A -THIS MATERIAL WAS FILED AND IS UNDER REVIEW***
2. Within twenty (20) days following the Closing Date of the transfer of ownership authorized by this Order, YNHHSC shall notify OHCA of the Closing, in writing, and shall supply final execution copies…:
    a. the Affiliation Agreement, including any and all schedules and exhibits; and
    b. Bylaws or similar governance documents for L+M as well as for L+MH. …

    N/A - THIS MATERIAL WAS FILED AND IS UNDER REVIEW

3. Following the completion of L+MH's 2016 Community Health Needs Assessment (CHNA), YNHHSC shall participate with L+MH, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion ..…. In the event that L+MH has already substantially completed its

2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum within six (6) months of the Closing Date. The CHNA and the Implementation Strategy shall be published on the website of L+MH… ***THIS REFERENCE TO SIX MONTHS OF THE CLOSING DATE REMAINS APPLICABLE***.

4. Within one hundred and eighty (180) days following the Closing Date, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH …. ***THE FILING MAY BE MADE 180 DAYS FOLLOWING THE END OF THE FISCAL YEAR INSTEAD OF THE CLOSING DATE***.

6. Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015-August 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. ***THE INITIAL FILING FOR THE DATA FOR THE PRE-CLOSING PERIOD (9/1/2015 – 8/30/2016) MAY BE FILED 180 DAYS FOLLOWING THE END OF THE FISCAL YEAR INSTEAD OF THE CLOSING DATE. THE SUBSEQUENT ANNUAL FILINGS ARE ALREADY BASED ON A FISCAL YEAR AND MAY BE FILED 60 DAYS FOLLOWING THE FY END AS INDICATED (WHICH IS NOVEMBER 30TH).***

7. Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount. ….:For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016…. ***THE INITIAL FILING MAY BE MADE 180 DAYS FOLLOWING THE END OF THE FISCAL YEAR INSTEAD OF THE CLOSING DATE. ANY UPDATES WILL BE FILED ON THE SEMI-ANNUAL SCHEDULE ALREADY NOTED IN THE STIPULATION. THE NOVEMBER 30, 2016 REFERENCE FOR THIS INITIAL FILING IS INCORRECT.***

8. For three (3) years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The following financial measurements/indicators should be addressed in the report: …

Financial Measurement/Indicators

THIS IS A SEMI-ANNUAL FINANCIAL REPORT IS BASED ON THE FISCAL YEAR AND IS DUE MAY 31ST AND NOVEMBER 30TH. THE NOVEMBER 30, 2016 REFERENCE FOR THIS INITIAL FILING IS INCORRECT.

11. The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 …

    c. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building …. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. …

THIS ANNUAL REPORT MAY INSTEAD BE FILED ON NOVEMBER 30TH FOR THE THREE YEAR. THIS IS IN KEEPING WITH THE OTHER FINANCIAL INFORMATION THAT WILL BE FILED EACH NOVEMBER 30TH AND IS 60 DAYS AFTER THE CLOSE OF THE FISCAL YEAR.

12. The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. … For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. ***THIS ANNUAL REPORT MAY INSTEAD BE FILED ON NOVEMBER 30TH FOR THE THREE YEAR. THIS IS IN KEEPING WITH THE OTHER FINANCIAL INFORMATION FILED EACH NOVEMBER 30TH AND IS 60 DAYS AFTER THE CLOSE OF THE FISCAL YEAR.***

32. Every six months (the "six month reports") until December 1, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of January to June (due July 31st) and July through December (due January 31st) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: ***THIS NOTARIZED REPORT INCLUDING THE FINANCIAL INFORMATION OUTLINED IN 32(f) MAY INSTEAD BE FILED ON THE SAME SEMI-ANNUAL FISCAL YEAR PERIOD. SO AT THE SAME TIME AS THE FINANCIAL REPORTS (DUE MAY 31ST AND NOVEMBER 30TH) UNTIL THE REFERENCED DECEMBER 1, 2018 DATE.***

Olejarz, Barbara

From: Microsoft Outlook
To: 'gayle.capozzalo@ynhh.org'
Sent: Thursday, January 12, 2017 2:09 PM
Subject: Relayed: FW: Clarification of the timing of submissions

Delivery to these recipients or groups is complete, but no delivery notification was sent by the destination server:

'gayle.capozzalo@ynhh.org' (gayle.capozzalo@ynhh.org)

Subject: FW: Clarification of the timing of submissions

Greer, Leslie

From: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Sent: Thursday, January 19, 2017 11:33 AM
To: User, OHCA
Cc: 'YNHHSCOHCAMonitor@deloitte.com'; Willcox, Jennifer; O'Connor, Christopher; Comerford, Matthew; D'Aquila, Richard; Fiore, Denise; Petrini, Vincent; Cummings, Bruce (L and M); Stanley, William (LMHOSP)
Subject: Docket #15-32033-CON: Conditions 4 & 19 and Conditions 7 & 32b
Attachments: Condition 4 & 19 - Eastern CT 5-Year Plan (010617) SENT TO OHCA 011917.pdf; Strategic Plan Reporting Template (Conditions 7 32b) SENT TO OHCA 011917.pdf

Attached please find the YNHHS / L+M services and strategy plan for eastern Connecticut for FY 2017-2021 (Attachment 1). This is being submitted to comply with Docket #15-32033-CON Condition 4 and Condition 19. This is the plan.

I've also included a template on how we will report on the plan which complies with Condition 7 and Condition 32b (Attachment 2). It is our intention to provide a narrative description of each expenditure and each accomplishment of the plan and at the same time provide the resource expenditure that is associated with that initiative as required in Condition 7.

If you have any questions, don't hesitate to call me.

Thank you.
Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

YNHHS/L+M Services and Strategy Plan for Eastern CT
FY 2017 – FY 2021

OHCA Condition 4 reads:

> "Within one hundred and eighty (180) days following the Closing Date, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or infrastructure of new services (the "Services Plan")."

OHCA Condition 19 reads:

> "L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e., towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M services sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally."

YNHHS/L+M Services and Strategy Plan for Eastern CT
FY 2017 – FY 2021

L+M Services / Strategy / Plan Initiatives	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
1. Primary Care Clinical Services Expansion of primary care network focusing on geriatric, general internal medicine, including the recruitment of 8 primary care physicians in Eastern CT. The primary care sites will ensure primary care availability as the population ages and physicians retire. Many sites will be established as medical neighborhoods, allowing easy access to part-time and full-time specialists.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
2. Specialty Clinical Services Increased access to specialists within Eastern CT, including pediatrics; multi-disciplinary muscular-skeletal services, including orthopedics, neurosurgery, spine, physiatry; behavioral health, including psychiatrists, psychologists, etc.; vascular and cardiac services; enhanced obstetrics and maternal fetal medicine; expanded oncology services; neuromuscular and stroke programs; endocrinology/thyroid services; general surgery and specialized internal medicine. These part-time and full-time specialty services will be increased, taking advantage of primary care referrals and using technology to ensure access throughout the region. In addition, telestroke, tele-ICU and tele-ED coverage will be continued at L+M.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
3. Ambulatory Services Expansion of laboratory, diagnostic, urgent care, ambulatory surgery centers to enhance access to ancillary services in the region.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		

YNHHS/L+M Services and Strategy Plan for Eastern CT
FY 2017 – FY 2021

L+M Services / Strategy / Plan Initiatives	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
4. Post Acute Services Creation of an integrated network of post-acute services to manage care across the continuum in order to reduce the total cost of care for community residents.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
5. Infrastructure within LMHC Facilities Renovations and infrastructure repair to hospital.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
6. Information Technology Investment in Epic throughout L+M facilities, LMMG and independent physicians. In addition, the business systems will be replaced and fully integrated with Yale New Haven Health. Telehealth services will help reduce travel to YNHH.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
7. Population Health Development of risk contracting capabilities and participation in the YNHHS Population Health infrastructure and Clinically Integrated Network.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		

YNHHS/L+M Services and Strategy Plan for Eastern CT
FY 2017 – FY 2021

L+M Services / Strategy / Plan Initiatives	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
8. Branding Re-branding of all facilities and services as Yale New Haven Health to enhance the identity of the organizations with Yale New Haven Health.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
9. Operational Improvements Operational improvements in structures and processes to effectively provide high quality, safe patient care.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		
10. Community Need / Community Building* Community health needs focused on improved services to support mental well-being and reduce substance abuse (opioid use and anxiety/depression); support and nurture healthy life styles specifically reducing contributing factors to diabetes; ensure access to care, particularly pre-natal care and related birth outcomes and access to care for low-income population to address socio-economic factors that have the greatest impact on the health and well-being of the communities.	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated	No elimination, consolidation or reduction of services anticipated		

***Called for identification of Community Need/Community Building of activities in Condition 11 and annual reporting for three years.

Templates for Reporting on YNHHS/L+M Services and
Strategy Plan for Eastern CT and Western RI
Docket #15-32033-CON: Condition 7 / 32b
FY 2017-FY 2021

OHCA will receive a narrative of strategy plan accomplishments per Condition 32b semi-annually for FY 2017 and then annually for FY 2018 - FY 2021. In addition, OHCA will receive a semi-annual report each fiscal year through the end of FY 2019 providing the information requested regarding the allocation of $300 M resources to support the strategic plan, per Condition 7. Templates for these submissions are attached.

Condition 7: Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount.

Condition 32b: A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.

SUMMARY of Resource Commitment and Strategic Plan Accomplishments: Docket # 15-32033-CON, Condition 7/32b

Resource Commitment Summary Made to Strategic Investments		10/1/16-3/31/17	4/1/17-9/30/17	10/1/17-3/31/18	4/1/18-9/30/18	10/1/18-3/31/19	4/1/19-9/30/19	Total
1. Primary Care Clinical Services: Expansion of primary care network focusing on geriatric, general internal medicine, including the recruitment of 8 primary care physicians in Eastern CT. The primary care sites will ensure primary care availability as the population ages and physicians retire. Many sites will be established as medical neighborhoods, allowing easy access to part-time and full-time specialists.	Eastern CT							
	Western RI							
2. Specialty Clinical Services: Increased access to specialists within Eastern CT, including pediatrics; multi-disciplinary muscular-skeletal services, including orthopedics, neurosurgery, spine, physiatry; behavioral health, including psychiatrists, psychologists, etc.; vascular and cardiac services; enhanced obstetrics and maternal fetal medicine; expanded oncology services; neuromuscular and stroke programs; endocrinology/thyroid services; general surgery and specialized internal medicine. These part-time and full-time specialty services will be increased, taking advantage of primary care referrals and using technology to ensure access throughout the region. In addition, telestroke, tele-ICU and tele-ED coverage will be continued at L+M.	Eastern CT							
	Western RI							
3. Ambulatory Services: Expansion of laboratory, diagnostic, urgent care, ambulatory surgery centers to enhance access to ancillary services in the region.	Eastern CT							
	Western RI							
4. Post Acute Services: Creation of an integrated network of post-acute services to manage care across the continuum in order to reduce the total cost of care for community residents.	Eastern CT							
	Western RI							
5. Infrastructure within LMHC Facilities: Renovations and infrastructure repair to hospital.	Eastern CT							
	Western RI							

SUMMARY of Resource Commitment and Strategic Plan Accomplishments: Docket # 15-32033-CON, Condition 7/32b

Resource Commitment Summary Made to Strategic Investments		10/1/16-3/31/17	4/1/17-9/30/17	10/1/17-3/31/18	4/1/18-9/30/18	10/1/18-3/31/19	4/1/19-9/30/19	Total
6. Information Technology: Investment in Epic throughout L+M facilities, LMMG and independent physicians. In addition, the business systems will be replaced and fully integrated with Yale New Haven Health. Telehealth services will help reduce travel to YNHH.	Eastern CT							
	Western RI							
7. Population Health: Development of risk contracting capabilities and participation in the YNHHS Population Health infrastructure and Clinically Integrated Network.	Eastern CT							
	Western RI							
8. Branding: Re-branding of all facilities and services as Yale New Haven Health to enhance the identity of the organizations with Yale New Haven Health.	Eastern CT							
	Western RI							
9. Operational Improvements: Operational improvements in structures and processes to effectively provide high quality, safe patient care.	Eastern CT							
	Western RI							
10. Community Need / Community Building: Community health needs focused on improved services to support mental well-being and reduce substance abuse (opioid use and anxiety/depression); support and nurture healthy life styles specifically reducing contributing factors to diabetes; ensure access to care, particularly pre-natal care and related birth outcomes and access to care for low-income population to address socio-economic factors that have the greatest impact on the health and well-being of the communities.	Eastern CT							
	Western RI							
TOTAL								

SIGNATURE: _____

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

Summary due to OHCA with detailed narrative semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

NAME OF PROJECT	DESCRIPTION OF AND RATIONAL FOR PROJECT	EXPENDITURE AMOUNT	ROLLOUT OF EXPENSES			FUNDING SOURCE*
			Est. Beg. Date	Est. End Date	Est. Startup Date	
Primary Care Clinical Services						
Specialty Clinical Services						
Ambulatory Services						
Post Acute Services						

Operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source.

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

NAME OF PROJECT	DESCRIPTION OF AND RATIONAL FOR PROJECT	EXPENDITURE AMOUNT	ROLLOUT OF EXPENSES			FUNDING SOURCE*
			Est. Beg. Date	Est. End Date	Est. Startup Date	
Infrastructure within LMHC Facilities						
Information Technology						
Population Health						
Branding						

Operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source.

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

NAME OF PROJECT	DESCRIPTION OF AND RATIONAL FOR PROJECT	EXPENDITURE AMOUNT	ROLLOUT OF EXPENSES			FUNDING SOURCE*
			Est. Beg. Date	Est. End Date	Est. Startup Date	
Operational Improvements						
Community Need / Community Building						

SIGNATURE: _____

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

SIGNATURE: _____

Christopher O'Connor, Exec VP & Chief Operating Officer, YNHHS

Detailed narrative due to OHCA with summary page semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

Operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source.

Olejarz, Barbara

From: Olejarz, Barbara
Sent: Tuesday, April 04, 2017 3:28 PM
To: Olejarz, Barbara
Subject: FW: Deloitte/L+MH monitor presentation and meeting minutes
Attachments: Deloitte as Monitor for LMH Community Leaders meeting minutes 1-24-17.pdf; DT YNHHSC LMH Monitor Overview for 1-24-17 FINAL (2).pdf

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From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, January 27, 2017 4:01 PM
To: Martone, Kim
Cc: Mitchell, Kelly Rose (US - Boston)
Subject: RE: Deloitte/L+MH monitor presentation and meeting minutes

Hi Kim – please see the attached for the presentation materials and minutes from 1/24/17. Let me know if you have any questions.
We do have actual sign-in sheets on file if you need those for any reason.

Thank you,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, NY 10112

Tel: +212 436 3180
Fax: +212 653 7033
www.deloitte.com

Minutes

Meeting:	L+M New London Community Leaders Meeting
Held on:	January 24, 2017 at 5:00 pm
Location:	Holiday Inn, New London, CT
Present:	Kelly Sauders, Kelly Mitchell, Bill Stanley, Vin Petrini, Gayle Capozzalo, Laurel Holmes, Cathy Zall, Alejandro Melendez-Cooper, Chris Soto, Janet Steinmayer, Jean Jordan, Jeanne Milstein, Jennifer Granger, Jerry Fischer, Jerry Lokken, Jim Haslam, Kathy Greene, Kelly Thompson, Lisa D'Abrosca, Megan Brown, Nancy Cowser, Ocean Pellett, Peter Davis, Regina Moller, Russ Melmed, Stephen Smith, MD, Tony Sheridan, Tracee Reiser, Victor Villagra, MD, Virginia Mason, Yvette Highsmith-Francis, Shirley Gillis, Harry Rodriguez, Jay Levin, Dina Sears-Graves, Mary Ellen Masciale
Introduction	The meeting began at 5:30pm EST. Vin Petrini provided a brief introduction to the group. He shared a few early accomplishments of the affiliation including the recent EPIC go-live. He then introduced Cathy Zall as Community Representative and Kelly Sauders as Independent Monitor. Bill Stanley made a few remarks about the affiliation and introduced Chris Soto, State Representative as a guest for the meeting. Kelly Sauders provided a brief overview of her background and that of Deloitte related to this type of role. She then introduced Cathy Zall, Community Representative.
Community Representative	Cathy Zall stated that the partnership between the community and health system is a key that will help make incredible process and that she hopes to do what she can to make this partnership effective. Kelly Sauders took several questions from the audience regarding the process of selecting the Community Representative. The questions/concern were about process, not about the ultimate selection. Kelly Sauders confirmed that OHCA had the opportunity to review Cathy Zall's bio prior to appointment and were comfortable with her appointment as the Community Representative.
Overview of Independent Monitor	Kelly noted that the Independent Monitor is an extension of OHCA. It is Deloitte's role to verify that all parties are abiding by the requirements of the Affiliation Agreement and Settlement Order. Kelly clarified the difference between the Independent Monitor and Independent Consultant (Milliman) roles. There was a question about what benchmarks Milliman will use. Kelly Sauders stated that Milliman will study the relative market conditions and pricing and noted the process is complex and challenging. Kelly stated that active discussions are underway between Milliman

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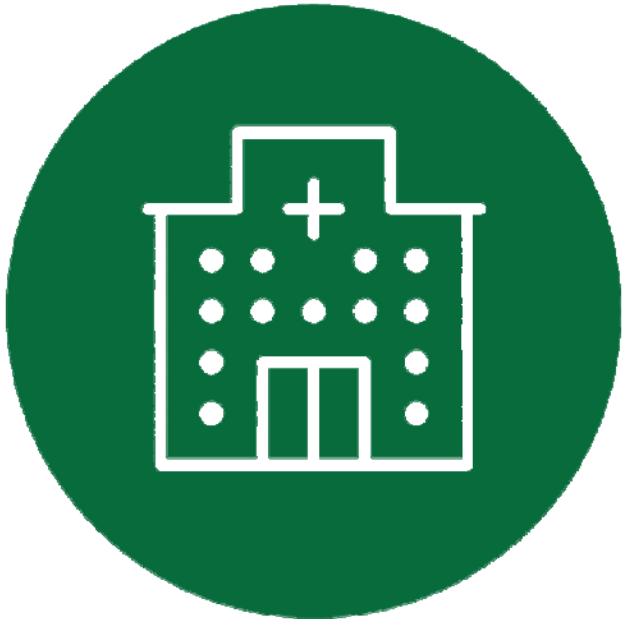
	and the State to assess what data may be available for this study. She then explained the reporting process and described Deloitte's direct line of reporting to OHCA. Kelly stated that there is little to report at this point but there will be more activity and reporting in March/April of this year. She also noted that as information is filed, it will be available on the OHCA website. There was a discussion regarding the interpretation of the conditions. Kelly clarified that it is not Deloitte's role to provide interpretation. If there is any ambiguity or conflict within the Order, she will reach out to OHCA to obtain formal guidance. Kelly also noted that this forum is meant to be an initial meeting and there will also be a public forum in late February/early March.
Community Benefit & Community Building	Kelly provided an overview of the conditions regarding Community Benefit and Community Building. A question was raised regarding examples of community benefit programs, which was answered by Laurel Holmes. There was additional discussion from the attendees regarding favorable places to allocate funds for Community Benefit and Community Building and the hope that there were more funds for these purposes. Kelly stated that the baseline/minimum is what is outlined in the Affiliation Agreement and Order. There was discussion surrounding who will make these financial decisions. Kelly noted that the Board provides oversight but it is ultimately leadership who makes management decisions. Further clarification will be provided on the role of the board and reserve powers. There was a question regarding the Independent Monitor and if a change can be made for future periods. Kelly responded that OHCA absolutely can make a change. She also provided an overview of the process by which Deloitte was chosen as Independent Monitor. Cathy Zall reminded the group that the community leaders should focus on the big picture of the affiliation rather than overly focusing on the Monitor role, which is one piece only.
Closing	Kelly closed the meeting by stating her hope is that the affiliation is successful for all and that she will carry out the Monitor role to the best of her ability. She also shared her contact information and stated that individuals are welcome to reach out with any questions or concerns. The meeting was adjourned at 7:20pm EST.

Deloitte.



YNHHSC/L+MH Independent Monitor
Community Representatives Meeting

January 24, 2017

Meeting Agenda

Meeting Agenda
Formal Introduction of the Designated Community Representative to the L+MH Board of Directors
Overview of the Independent Monitor Roles & Responsibilities
Overview of Monitoring Procedures
Overview of YNHHSC and L+MH's Community Benefit/Community Building
Questions

Formal Introduction: Designated Community Representative to the L+MH Board of Directors

15-32033-CON Condition 14	For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as a voting member of L+MH's Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. Office of Health Care Access is imposing this Condition to ensure continued access to health care services for the patient population.

Designated Community Representative: Cathy Zall

Experience:

Executive Director of the New London Homeless Hospitality Center since 2007

Pastor of the First Congregational Church of New London

Project Manager for the Connecticut Department of Social Services

Program Director for the Connecticut Child Care Assistance Program

Deputy Commissioner of the New York City Department of Social Services

Academic Background:

Master of Divinity degree from Yale University

MBA from New York University

Bachelor's Degree from Brown University

Independent Monitor Roles & Responsibilities

15-32033-CON CONDITIONS 15/33

Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of Office of Health Care Access and Facilities Licensing and Inspection Section will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at Office of Health Care Access and/or Facilities Licensing and Inspection Section's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. Office of Health Care Access is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.

In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post Closing: L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by Office of Health Care Access) to serve as a post-transfer compliance monitor. Such monitor shall, at a minimum meet with representatives of the L+M community at 6 months after the Date of Closing and annually and shall report to Office of Health Care Access in accordance with Section 19a-639(e) of the general statutes and specifically address (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. L+MH shall hold a public forum in New London 6 months after the Closing date and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings. If the Independent Monitor determines that YNHHS and L+MH are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHS and L+MH in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHS and L+MH for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to Office of Health Care Access. Office of Health Care Access shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L+M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event Office of Health Care Access determines YNHHSC and L+M are in material non-compliance, Office of Health Care Access may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.

Independent Monitor Roles & Responsibilities

15-32032-CON CONDITION 8	L+M and YNHHSC make the following commitment for a period of five years post-Closing: L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by Office of Health Care Access) to serve as a post-transfer compliance monitor. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to Office of Health Care Access in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to Office of Health Care Access. Office of Health Care Access shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L+M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn Gen. Stat. 19a-653. In addition, in the event Office of Health Care Access determines YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.

Independent Monitor Roles & Responsibilities

15-32033-CON CONDITION 16	The Independent Monitor will report to both Office of Health Care Access and Facilities Licensing and Inspection Section. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to Office of Health Care Access and Facilities Licensing and Inspection Section within 30 days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As Office of Health Care Access deems necessary, the Independent Monitor shall meet with Office of Health Care Access and Facilities Licensing and Inspection Section personnel to discuss the written report and will perform additional periodic reviews. Office of Health Care Access is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.

Monitor Procedures

Ongoing oversight and Analysis:

- Office of Health Care Access is imposing conditions in an effort to ensure continued access to health care services for the patient population and to monitor compliance with the conditions set forth herein.
- As the Independent Monitor, D&T will be responsible for monitoring YNHHSC's compliance with the conditions set forth in the Order. Additional monitoring activities include:
  - Meet regularly with YNHHSC leadership team.
  - Set deadlines for YNHHSC prior to Office of Health Care Access submission due dates in an effort to ensure timeliness.

Reporting:

- D&T will obtain and evaluate documentation for accuracy and completeness prior to submission to Office of Health Care Access.
- D&T will report to both Office of Health Care Access and Facilities Licensing and Inspection Section and will conduct on-site visits of L+MH.
- D&T shall furnish a written report of an assessment to Office of Health Care Access and Facilities Licensing and Inspection Section within 30 days of the on-site review.
- YNHHSC will have the opportunity to review and provide written responses to the report.
- As Office of Health Care Access deems necessary, D&T shall meet with Office of Health Care Access and Facilities Licensing and Inspection Section personnel to discuss the written report.

Monitoring Procedures: Meetings

Meeting	Frequency
Independent Monitor Meeting with Community Representatives	Annual: Such monitor shall, at a minimum meet with representatives of the L+MH community at six months after the Date of Closing (by March 7, 2017) and annually and shall report to Office of Health Care Access in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+MH's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+MH during the prior period.
Independent Monitor Public Forum	Annual: L+MH shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.
Joint Meeting of YNHHSC and L+MH Boards with additional public meeting	Semi-annual: For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+MH Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. Office of Health Care Access is imposing this Condition to ensure continued access to health care services for the patient population.

YNHHSC & L+MH: Community Building/Community Benefit

15-32033-CON CONDITION 11	The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date **consistent with L+MH's most recent Schedule H of IRS Form 990** or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1 % increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent. In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such Investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. Office of Health Care Access is imposing this Condition to ensure continued access to health care services for the patient population.
15-32033-CON CONDITION 31	L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide Office of Health Care Access with its updated CHNA within thirty days of its approval.

YNHHSC & L+MH: Community Building/Community Benefit

15-32033-CON CONDITION 12	The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. Office of Health Care Access is imposing this Condition so as to ensure continued access to health care services for the patient population.

YNHHSC & L+MH: Community Building/Community Benefit

SCHEDULE H (Form 990) — **Hospitals** — OMB No. 1545-0047 — **2014**

Department of the Treasury, Internal Revenue Service

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
▶ Attach to Form 990.
▶ Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990.*

Open to Public Inspection

Name of the organization: LAWRENCE & MEMORIAL HOSPITAL
Employer identification number: 06-0646704

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b	If "Yes," was it a written policy?	X	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. [X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities [ ] Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: [ ] 100% [ ] 150% [ ] 200% [X] Other 250.0000 %	X	
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: [ ] 200% [ ] 250% [ ] 300% [ ] 350% [X] 400% [ ] Other ____%	X	
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a	Did the organization prepare a community benefit report during the tax year?		X
b	If "Yes," did the organization make it available to the public?		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		1624	822,218.		822,218.	.23
b Medicaid (from Worksheet 3, column a)		26445	55,626,089.	27,389,825.	28,236,264.	8.06
c Costs of other means-tested government programs (from Worksheet 3, column b)		818	1,720,395.	847,108.	873,287.	.25
d **Total** Financial Assistance and Means-Tested Government Programs		28887	58,168,702.	28,236,933.	29,931,769.	8.54
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	45	6406	1,503,450.	338,156.	1,165,294.	.33
f Health professions education (from Worksheet 5)	24	3869	1,568,350.	3,500.	1,564,850.	.45
g Subsidized health services (from Worksheet 6)	9	5739	8,971,377.	2,850,362.	6,121,015.	1.75
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)	8	560	51,340.		51,340.	.01
j **Total.** Other Benefits	86	16574	12,094,517.	3,192,018.	8,902,499.	2.54
k **Total.** Add lines 7d and 7j	86	45461	70,263,219.	31,428,951.	38,834,268.	11.08

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule H (Form 990) 2014

JSA 4E1284 1.000

LAWRENCE & MEMORIAL HOSPITAL 06-0646704

Schedule H (Form 990) 2014 Page 2

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support	2	896	46,004.		46,004.	.01
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	3		12,870.		12,870.	
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total	5	896	58,874.		58,874.	.01

Source: L+MH IRS Form 990 for period ending September 30, 2015, Schedule H

YNHHSC & L+MH: Community Building/Community Benefit

Category	FY15 (actual)	FY16 (estimated)
Total Community Benefit	$38,893,142	$43.6 Million (est.)
Financial Services (Medicaid, uncompensated care)	$30,121,139	$35 million (est.)
Community Building	$58,874	$57,795 (est.)
Total Community Benefit (less Financial Services)	$8,772,003	$9.1 million (est.)

Notes:

- FY15 information is from the IRS form 990 Schedule H
- FY16 estimates have been provided by YNHHSC/L+MH Management

Appendix

1. L+MH Office of Health Care Access Order can be found **here.**

2. Hospital Group Office of Health Care Access Order can be found **here.**

Independent Monitor Contact Information

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

This document was created pursuant to the engagement letter dated November 7, 2016 between Deloitte & Touche LLP ("D&T") and Yale New Haven Health Services Corporation and its subsidiaries. This document is not intended to be and should not be used or relied on by any other person or entity. D&T and its affiliated and related entities shall not be responsible for any loss sustained by any person or entity that relies on this document.

User, OHCA

From: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Sent: Wednesday, February 01, 2017 11:39 AM
To: User, OHCA
Cc: 'YNHHSCOHCAMonitor@deloitte.com'; Salsgiver, Carolyn; 'Holmes, Laurel (lholmes@lmhosp.org)'; Fiore, Denise; O'Connor, Christopher; Cummings, Bruce (L and M); Willcox, Jennifer
Subject: Docket #15-32033-CON: Condition 3
Attachments: Condition 3_Integration of 6-18 initiative in CHIP (SENT TO OHCA 020117).pdf

Follow Up Flag: Follow up
Flag Status: Completed

The attached is being forwarded in compliance with Docket #15-32033-CON: Condition 3 – Integration of CDC 6/18 Initiative in the Health Improvement Collaboration of Southeastern CT Community Health Improvement Plan.
Thank you,
Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Docket #15-32033-CON: Condition 3

Integration of the CDC 6|18 Initiative in the Health Improvement Collaborative of Southeastern CT Community Health Improvement Plan

Condition 3:

Following completion of L+MH's 2016 Community Health Needs Assessment (CHNA), YNHHSC shall participate with L+MH, and the key community stakeholders and health organizations, in conducting future CHNAs and shall provide a copy of the 2016 CHNA and its Implementation Strategy to OHCA within thirty (30) days of completion. YNHHSC and the participants shall utilize Healthy Connecticut State Health Improvement Plan data and priorities as the starting point for the new CHNA (available at http://www.ct.gov/dph/lib/dph/state_health_planning/sha-ship/hct2020/hct2020_state_hlth_impv_032514.pdf), as well as any applicable community health improvement plan issues by any local health department in the Service Area. **The Implementation Strategy shall also adopt the evidence-based interventions identified in the Centers for Disease Control 6/18 initiative (available at http://www.cdc.gov/sixeighteen) to the extent the health priorities identified in the CHNA correlate to the health conditions identified by the CDC and provide information on how any patient outcomes related to the Implementation Strategy will be measured and reported to the community.** In the event that L+MH has already substantially completed its 2016 Implementation Strategy at the time of the signing of this Order, it may submit the information requested in the 6/18 initiative as an addendum within six (6) months of the Closing Date. The CHNA and the Implementation Strategy shall be published on the website of L+MH. Until such time as the CHNA and Implementation Strategy are submitted to OHCA, YNHHSC shall continue to support and implement L+MH's current CHNA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.

Response

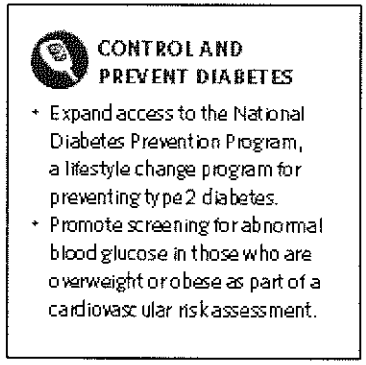
The CDC 6|18 Initiative identifies six high-burden health conditions and eighteen evidence-based prevention interventions with the desired outcomes of improving health and reducing healthcare related costs; diabetes is one of the six high-burden areas. In the 2016 Community Health Improvement Plan ("Implementation Strategy" or CHIP) of the multi-sector Health Improvement Collaborative of Southeastern CT, healthy lifestyles was identified as a priority area for intervention. Specifically, due to significant disparities by income, race and education as it relates to diabetes prevalence, the group is focusing on reducing diabetes risk factors in four targeted populations: low income, African American, Hispanic and pre-diabetics.

Both 6|18 Initiative evidence-based interventions on diabetes have been incorporated into the CHIP as strategies (as noted in the excerpt from the CHIP below) because of the alignment of these interventions and the CHIP priority area. As is the case for each of the strategies in the CHIP, process and outcome measures will be tracked and publicly reported in the form of a dashboard to be developed by the Health Improvement Collaborative of SE CT.

Docket #15-32033-CON: Condition 3

Integration of the CDC 6|18 Initiative in the Health Improvement Collaborative of Southeastern CT Community Health Improvement Plan

Excerpt from the CDC 6 /18 Strategies:



Diabetes Goal from the Health Improvement Collaborative of SE CT/L+M Hospital Community Health Improvement Plan 2016

Priority Area: Support and nurture healthy lifestyles to reduce contributing factors to diabetes, particularly among persons with low-incomes and African Americans

Goal: Increase healthy food consumption and physical activity and improve the system of care for diabetes

Objectives	Strategies (Programs, Services, Partnerships)	Target Populations	Tactics (Specific Action Steps)	Anticipated Impact	Measures (P=process, O=outcome)	
By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.	Quarterly screening events at locations where low-income persons frequent to include pre-diabetes awareness education	Low-income, African American, Hispanic	Collaboration with primary care providers; safety net provider organizations (e.g. food pantries, community meal sites, social services); collaboration with NAACP and immigration resource center	Increased identification of pre-diabetics	# screenings (P), # prediabetics referred for care (P)	2017-2019
	Support enhanced diabetes prevention program opportunities	Pre-diabetics	Identify resources to expand area diabetes prevention programming; develop referral mechanisms to build participation	Reduced progression of pre-diabetes to diabetes	# DPP sessions held (P) Diabetes prevalence (O)	2017-2019

Docket #15-32033-CON: Condition 3

Integration of the CDC 6|18 Initiative in the Health Improvement Collaborative of Southeastern CT Community Health Improvement Plan

User, OHCA

From: PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Sent: Tuesday, February 21, 2017 2:07 PM
To: User, OHCA
Cc: 'ynhhscohcamonitor@deloitte.com'; Capozzalo, Gayle; Gonsalves, Elizabeth; Willcox, Jennifer; Anderson, Maureen (LMHOSP); Tammaro, Vincent; McCabe, Patrick
Subject: Docket #15-32033-CON: Condition 9
Attachments: Condition 9 - L+MH Adoption of YNHHSC Financial Assistance Policies (021717) SENT TO OHCA 022117.pdf

Attached please find the L+MH financial assistance policies, as well as LMC and L+MH Board resolutions ratifying adoption of said policies. This is being submitted to comply with Docket #15-32033-CON: Condition 9 - L+MH adoption of YNHHSC's financial assistance policies.

The financial assistance policies are posted on L+MH's website.

If you have any questions, please feel free to contact me.

Thank you,
Shraddha Patel

Shraddha Patel, FACHE
Director of Strategy and Regulatory Planning & Reporting
2 Howe 3rd Floor
New Haven, CT 06519
Phone: 860-912-5324
Email: shraddha.patel@ynhh.org

YaleNewHavenHealth

Submission to Comply with Docket #15-32033-CON: Condition 9

Condition 9 reads:

Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.

Yale NewHaven Health

Service Area: Corporate Business Services	**YALE NEW HAVEN HEALTH SYSTEM POLICIES & PROCEDURES**
Title: Financial Assistance Programs Policy	
Date Approved: 09/20/2013	**Approved by:** Boards of Trustees Senior Vice President, Finance
Date Effective: 09/20/2013 1/1/2017 Lawrence + Memorial Hospital and Westerly Hospital	**Date Reviewed/Revised:** 01/21//2015, 09/30/2016, 12/16/2016
Distribution: MCN Policy Manager	**Policy Type (I or II):** Type I
Supersedes: Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4) Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13) Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services Lawrence + Memorial Hospital and Westerly Hospital Charity Care, Financial Assistance, Free Bed Fund Policy	

PURPOSE

Yale New Haven Health System ("YNHHS") recognizes that patients may not be able to pay for medically necessary health care without financial assistance. Consistent with its mission, YNHHS is committed to assuring that the ability to pay will be considered carefully when setting amounts due for emergency and other medically necessary hospital services.

In furtherance of its mission, YNHHS has established the Financial Assistance Programs ("FAP") to assist individuals with paying for emergency and other medically necessary care. The objectives of the FAP are to:

(i) Specify all financial assistance available under the FAP;

(ii) Provide clear information regarding eligibility criteria, application requirements and the method for applying for financial assistance;

(iii) Describe the basis for calculating amounts charged to FAP-eligible patients for emergency or other medically necessary care; and

(iv) Describe the steps YNHHS hospitals take to widely publicize this FAP within the communities served by YNHHS.

APPLICABILITY

This policy applies to each licensed hospital affiliated with YNHHS, including Bridgeport Hospital ("BH"), Greenwich Hospital ("GH"), Lawrence + Memorial Hospital ("LMH"), Yale-New Haven Hospital ("YNHH") and Westerly Hospital ("WH") (each a "Hospital").

POLICY

I. Scope and Provider List

A. **Emergency and Other Medically Necessary Care**. The FAP apply to emergency and other medically necessary care, including inpatient and outpatient services, billed by a Hospital. The FAP exclude: (a) private room or private duty nurses; (b) services that are not medically necessary, such as elective cosmetic surgery; (c) other elective convenience fees, such as television or telephone charges, and (d) other discounts or reductions in charges not expressly described in this policy.

B. **Provider List**. A list of providers who provide emergency and other medically necessary care at a Hospital can be found here: https://www.ynhh.org/~/media/files/ynhhs/forms/financial/011117/ynhh_fap_policy_list_2017.pdf
The list indicates if the provider is covered under the FAP. If the provider is not covered under this FAP, patients should contact the provider's office to determine if the provider offers financial assistance and if so what the provider's financial assistance policy covers.

II. Financial Assistance Programs and Eligibility

Financial assistance is available to individuals who are residents of the United States of America, or citizens of the Unites States residing abroad, who complete the required financial assistance application and meet the additional eligibility requirements described below.

A. **Free Care.** The Free Care program provides care at no cost to Hospital patients with gross annual family income less than or equal to 250% of the Federal Poverty Guidelines (*see* Attachment 1), and who have applied and been approved or receive a valid denial for State medical assistance, within the last six months.

In addition, YNHHS on behalf of BH, GH, and YNHH uses a third party screening tool to assist in identifying individuals with self-pay balances who have not applied for financial assistance, but whose income is less than or equal to 250% of the Federal Poverty Level (*i.e.*, eligible for free care). If a patient is identified through this process outstanding hospital balances may be adjusted to charity (free) care.

B. **Discounted Care.** If a Hospital patient does not have insurance and his or her gross annual family income is more than 250% of the Federal Poverty Level the Hospital will discount care to the Hospital's AGB (as defined in Section III below and on Attachment 1 hereto).

C. **Restricted Bed Funds.** You may be eligible to receive restricted bed funds, which are funds that have been donated to the Hospital to provide free or discounted care to individuals who meet the individual fund criteria. There are no specific income limits for receipt of restricted bed funds. Eligibility is determined on a case-by-case basis by the fund nominators based on financial hardship. All patients who fill out the requisite financial assistance application will automatically be considered for restricted bed funds.

D. **Other Hospital-Specific Financial Assistance programs**.

(i) **Yale New Haven Hospital Me & My Baby Program**. This program is available to Yale New Haven Hospital patients. It provides prenatal, labor and delivery services, and some post-partum care free of charge. You may be eligible if you live in New Haven County, do not have any type of health insurance and your family earns less than 2 ½ times the Federal Poverty Level. For more information or to request an application see our representatives at the Yale New Haven Hospital Women's Center or call 203-688-5470.

(ii) **Greenwich Hospital Outpatient Clinic** serves patients insured by Medicare, Medicaid, or insurances offered through Access Health CT and whose family income is less than 4 times the Federal Poverty Level. Further, the clinic provides discounted care to individuals who are not eligible for insurance and who reside in Greenwich and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call 203-863-3334.

III. Limitation on Charges - Amounts Billed to FAP-Eligible Patients

Where there is an award of financial assistance that does not cover 100% of YNHHS charges for the service, the amounts charged to patients eligible for financial assistance under this Policy will not be more than the amount a Hospital generally bills patients who have insurance coverage for such care ("AGB"). YNHHS calculates AGB annually by Hospital using the "look back method" and based on Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts and all private health insurers that pay claims to each Hospital facility for the prior fiscal year. YNHHS may apply the percentage discount by Hospital, or may elect to use the percentage discount most favorable to YNHHS patients. AGB is set forth on Attachment 1 hereto.

As used herein, the "amount generally billed" and "look back method" have the meanings set forth in Internal Revenue Code §501(r)(5) and1.501(r)-5.

IV. Method of Applying for Assistance

To be eligible for financial assistance, the patient must complete the requisite application for financial assistance ("Application"). The Application sets forth (i) FAP available programs and eligibility requirements, (ii) the documentation requirements for determinations of eligibility, and (iii) the contact information for FAP assistance. The Application also specifies that (i) the Hospital will respond to each Application in writing, (ii) patients may re-apply for financial assistance under the FAP at any time, and (iii) additional free bed funds become available every year. Hospitals may not

deny financial assistance under the FAP based on failure to provide information or documents that the FAP or the Application do not require as part of the Application.

YNHHS Hospitals will make reasonable efforts to determine eligibility and document any determinations of financial assistance eligibility in the applicable patient accounts. Once Hospital identifies a patient is FAP-eligible, Hospital shall:

(i) Provide a billing statement indicating amount the individual owes as a FAP-eligible patient, including how the amount was determined and states, or describes, how the individual can get information regarding the AGB for the care;

(ii) Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5, or such other amount set by the IRS; and

(iii) Take reasonable measures to reverse any extraordinary collection actions.

V. Non-Payment – Legal Action

A Hospital (and any collection agency or other party to which it has referred debt) shall not engage in any extraordinary collection action ("ECA") before making reasonable efforts to determine if a patient or any other individual having financial responsibility for a self-pay account (Responsible Individual(s)) eligible for financial assistance under this FAP. Any ECA must be approved by the Vice President of Corporate Business Services or his designee(s), prior to the initiation of any ECA.

The Hospital will follow its A/R billing cycle in accordance with internal operational processes and practices. As part of such processes and practices, the Hospital will, at a minimum, notify patients about its FAP from the date care is provided and throughout the A/R billing cycle (or during such period as is required by law, whichever is longer) by:

1. All patients will be offered a plain language summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a Hospital.

2. At least three separate statements for collection of self-pay accounts will be mailed or emailed to the last known address of the patient and any other Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All single patient account statements of self-pay accounts will include but not limited to:

    a. An accurate summary of the hospital services covered by the statement;

    b. The charges for such services;

c. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and

d. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of financial assistance under the FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

3. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the billing deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A plain language summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

4. Prior to initiation of any ECA, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial assistance that may be available under the FAP.

5. Subject to compliance with the provisions of this policy, a YNHHS Hospital may take the ECA listed on Attachment 2 of this Policy to obtain payment for medical services provided.

VI. Policy Availability

Copies of the FAP, a plain language summary of the FAP and FAP application are available at https://www.ynhhs.org/billing-insurance.aspx.

Each Hospital makes available copies of the FAP, a plain language summary of the FAP and FAP application on request, free of charge, by mail or in the Hospital Emergency Department and at all points of registration in paper form in English and the primary language of any population with limited English proficiency that constitutes 5% or more of the population the Hospital serves. See Attachment 3 for a list of languages.

Contact Corporate Business Services toll free at (855) 547-4584 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, plain language summary of the FAP, FAP application form, or Billing and Collection Policy to be mailed to you, or if you need a copy of the FAP, plain language summary, or FAP application form translated to a language other than English. Further, patients may ask Patient Registration, Patient Financial Services and Social Work/Case Management about initiating the FAP application process.

Further efforts to widely publicize the FAP include publishing notices in newspapers of general circulation; providing written notice of FAP in billing statements; providing notice of FAP in oral communications with patients regarding the amount due; and holding open houses and other informational sessions.

VII. Management Oversight Committee

The FAP will be overseen by a management oversight committee chaired by a Senior Vice President, YNHHS and comprised of representatives from Corporate Business Services, patient financial services, patient relations, finance, and the medical staff, as necessary. This committee will meet on a monthly basis.

VIII. Compliance with State Law

Each Hospital shall comply with relevant State laws, including, without limitation, Connecticut General Statutes governing Collections by Hospitals from Uninsured Patients and Rhode Island *Statewide Standard for the Provision of Charity Care* set forth in Section 11.3 of the Rhode Island Department of Health Rules and Regulations Pertaining to Hospital Conversions (the "RI Regulations") and the *Statewide Standard for the Provision of Uncompensated Care* set forth in Section 11.4 of the RI Regulations.

REFERENCES
Internal Revenue Code 501(c)(3)
Internal Revenue Code 501(r)
Conn. Gen. Stat. § 19a-673 et seq.
RI Regulations 11.3 and 11.4

RELATED POLICIES
YNHHS Billing and Collections Policy
Yale-New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2

Attachment 1

250% of the Federal Poverty Guidelines (FPG)

Family size:	Maximum Income:
1	$30,150
2	$40,600
3	$51,050
4	$61,500
5	$71,950
6	$82,400

Add* **$10,450 *for each additional family member*

Amounts Generally Billed (AGB)

Patients eligible for financial assistance under this Policy will receive assistance according to the following:

All YNHHS Hospitals:

Annual Family Income	Amount of Discount % of Charges	Patient Pays % of Charges
< or = 250% FPG	100%	0
> 250% FPG	69%	31%

**For calendar year 2017, AGB (% of charges): BH 32%, GH 32%, LMH 55%, YNHH 31% and WH 31%*

Attachment 2

EXTRAORDINARY COLLECTION ACTIONS

Property Liens

Liens on personal residences are permitted only if:

a) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;

b) The patient has not applied or qualified for other financial assistance under the Hospital's Financial Assistance Policy, to assist in the payment of his/her debt, or has qualified, in part, but has not paid his/her responsible part;

c) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;

d) The aggregate of account balances is over $10,000 and the property(ies) to be made subject to the lien are at least $300,000 in assessed value; and

e) The lien will not result in a foreclosure on a personal residence.

Attachment 3

Limited English Proficiency Languages

Albanian
Arabic
Simplified Chinese
French
French Creole (Haitian Creole)
German
Greek
Hindi
Italian
Japanese
Korean
Pashto
Persian Dari
Persian Farsi
Polish
Portuguese
Portuguese Creole (Cape Verdean)
Russian
Spanish
Swahili
Tagalog
Tigrinya
Turkish
Vietnamese

YaleNewHavenHealth

Yale New Haven Health System (YNHHS)
Financial Assistance Policy - Provider List

All physicians and providers employed by Bridgeport Hospital (BH), Greenwich Hospital (GH), Lawrence and Memorial Hospital (LMH), Westerly Hospital (WH), and Yale New Haven Hospital (YNHH) are covered under the YNHHS Financial Assistance Policy (FAP).

The following is a list of providers rendering care in YNHHS hospitals that are **not** covered under the YNHHS FAP. If the provider is not covered under the YNHHS FAP, patients should contact the provider's office to determine if the provider offers financial assistance and if so, how to become eligible, and for what services the provider's financial assistance policy covers.

While the YNHHS FAP does not apply to Northeast Medical Group (NEMG), NEMG providers that practice in the Hospital subdivision will honor the charity care, including but not limit to Free Care and Discounted Care, granted by YNHHS Hospital's Corporate Business Services.

This listing is effective as of 01/03/17, and is updated quarterly. If you do not see a physician or provider listed here and want to verify whether that person is currently covered under the YNHHS FAP, please call Patient Financial and Admitting Services at 855-547-4584.

Facility	Name	Title	Department	Practice
BH	Abdel-Razeq, Sonya	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Abder, Roxanne	MD	Obstetrics & Gynecology	Womens Healthcare of Trumbull
BH	Abi-Raad, Rita	MD	Pathology	YUSM Department of Pathology
BH	Abraham, Jossie	DPM	Surgery	Orthopedic Specialty Group
BH	Abrahams, James	MD	Radiology	Yale-New Haven Hospital - Temple Radiology
BH	Abramowitz, Nicole	MD	Pediatrics	Optimus Healthcare
BH	Acquarulo, Ariana	PA	Pediatrics	Pedi Care
BH	Adams-Quow, Sonja	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc.
BH	Adelstein, Judith	APRN	Pediatrics	Yale-New Haven Hospital NICU
BH	Adeniran, Adebowale	MD	Pathology	YUSM Department of Pathology
BH	Adjepong, Yaw	MD	Internal Medicine	Northeast Medical Group
BH	Afrin, Syeda	DO	Internal Medicine	Milford Hospital
BH	Agag, Richard	MD	Surgery	S. Jandali Plastic Surgery, LLC
BH	Ahmadian, Fereshteh(Faye)	MD	Internal Medicine	Fairfield Primary Health Care, LLC
BH	Ahuja, Moha	DO	Internal Medicine	Orthopaedic Specialty Group
BH	Aiello, Paul	MD	Radiology	Robert D. Russo, MD & Assoc.
BH	Albini, Glorianna	APRN	Internal Medicine	Northeast Medical Group
BH	Alcedo, Francis	MD	Internal Medicine	PriMed
BH	Aldaas, Fadi	MD	Internal Medicine	Bridgeport Hospital
BH	Ali, S. M. Yousuf	MD	Internal Medicine	Nirmala L Monteiro MD LLC
BH	Ali, Shazi	APRN	Internal Medicine	Milford Hospital
BH	Altbaum, Robert	MD	Internal Medicine	Internal Med Assoc of Westport
BH	Amberson, Nancy	MD	Pediatrics	Pediatric Healthcare Associates
BH	Amir, Doron	MD	Internal Medicine	Advanced Cardiovascular Specialists
BH	Amoo, Francis	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
BH	Anand, Rahul	MD	Anesthesiology	Connecticut Pain and Wellness Center
BH	Andrejeva, Liva	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Andres, Pietro	MD	Internal Medicine	Gastroenterology Associates, P.C.
BH	Anson, Andrew	MD	Psychiatry	Northeast Medical Group
BH	Antignani, David	PA	Surgery	Bridgeport Hospital
BH	Antonico, Joseph	MD	Internal Medicine	Immediate Medical Care of Monroe
BH	Anyoha, Anselm	MD	Pediatrics	Modern Era Pediatric Practice
BH	Apiado, Frederick	MD	Internal Medicine	Bridgeport Hospital
BH	Argento, Vivian	MD	Internal Medicine	Northeast Medical Group
BH	Armel, Harvey	MD	Surgery	
BH	Armm, Milton	MD	Surgery	Milton Armm, M.D., P.C.

BH	Arslan, Anthony	DO	Internal Medicine	Northeast Medical Group
BH	Asare, Michael	PA	Internal Medicine	Northeast Medical Group
BH	Atkins, Susanne	PA	Emergency Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
BH	Atweh, Nabil	MD	Surgery	Bridgeport Hospital
BH	Awad, John	MD	Surgery	Orthopaedic Specialty Group
BH	Ayala, John-Paul	MD	Internal Medicine	Pulmonary & Int Med Assoc.
BH	Ayyagari, Rajasekhara	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Azodi, Masoud	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
BH	Backe, Henry	MD	Surgery	Orthopaedic Specialty Group
BH	Backman, Kenneth	MD	Internal Medicine	Allergy & Asthma Care Flfd Cty
BH	Bahtiyar, Mert	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Bailey, Allison	PA	Pediatrics	Yale-New Haven Children's Hospital at Bridgeport Hospital
BH	Bajda, Katherine	APRN	Psychiatry	Bridgeport Hospital REACH
BH	Baker, Kathryn	DO	Pediatrics	Baker Pediatrics, LLC
BH	Balasingham, Shivashanker	MD	Internal Medicine	Bridgeport Hospital
BH	Baldassarri, Rebecca	MD	Pathology	YUSM Department of Pathology
BH	Barasch, Philip	MD	Internal Medicine	Neurological Specialists, P.C.
BH	Barbieri, Andrea	MD	Pathology	YUSM Department of Pathology
BH	Bard, Adam	MD	Internal Medicine	
BH	Barnaby, Dina	DO	Obstetrics & Gynecology	Women's Obstetrics and Gynecology, P.C.
BH	Barr, Matthew	PA	Radiology	Advanced Radiology Consultants
BH	Barrett, Mary	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Basta, Yong-Son	MD	Pediatrics	
BH	Bauer, Stephen	MD	Surgery	Southern Connecticut Vascular Center
BH	Baum, David	MD	Internal Medicine	Internal Med Assoc of Westport
BH	Beauboeuf, Anne-Lise	MD	Internal Medicine	Southwest Community Health Center
BH	Beck, Lawrence	MD	Internal Medicine	Neurological Specialists, P.C.
BH	Becker, Heather	MD	Emergency Medicine	Bridgeport Hospital Emergency Medicine
BH	Bedford, Andrew	MD	Internal Medicine	Gastroenterology Associates, P.C.
BH	Belkin, Barton	MD	Internal Medicine	Weicholz & Belkin, M.D.
BH	Belmont, Samantha	APRN	Internal Medicine	Northeast Medical Group
BH	Belmont, Steven	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Benaderet, Steven	MD	Internal Medicine	Northeast Medical Group
BH	Benaviv-Meskin, Danielle	MD	Internal Medicine	PriMed
BH	Bennett, David	MD	Internal Medicine	Nephrology Associates, PC

BH	Berard, Paul	MD	Internal Medicine	Medical Specialist Fairfield
BH	Bercik, Richard	MD	Obstetrics & Gynecology	YUSM Section of Urogynecology
BH	Beres, Sarah	PA	Pediatrics	YUSM Section of Pediatric Neonatology
BH	Berkwits, Kieve	MD	Pediatrics	Northeast Medical Group Pediatric Specialists
BH	Bertini, Nicholas	MD	Internal Medicine	PriMed
BH	Bianchi, Mark	MD	Surgery	Yale Medical Group-Stratford Otolaryngology
BH	Bindelglass, David	MD	Surgery	Orthopaedic Specialty Group
BH	Bindra, Ranjit	MD, PhD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Bishop, Matthew	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Blagodatny, Marina	MD	Internal Medicine	Northeast Medical Group
BH	Blair, Emily	DO	Obstetrics & Gynecology	OB/GYN of Fairfield County
BH	Blattman, Seth	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
BH	Block, Kalvin	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Blondin, Nicholas	MD	Internal Medicine	Assoc. Neuro. of Southern CT
BH	Bloom, Gregory	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Bloom, Katherine	MD	Internal Medicine	Allergy & Asthma Care Flfd Cty
BH	Bluestein, Harvey	MD	Surgery	Harvey J. Bluestein M.D., L.L.C.
BH	Blumenfeld-Jaffe, Fern	CNM	Obstetrics & Gynecology	
BH	Boateng, Freda	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
BH	Boatright, Renu	MD	Pediatrics	Trumbull Pediatrics
BH	Bogen, David	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Bonaventura, Kathleen	APRN	Internal Medicine	Cardiac Specialists, PC
BH	Bonde, Pramod	MD	Surgery	YUSM Section of Cardiac Surgery
BH	Bonheim, David	MD	Pediatrics	Trumbull Pediatrics
BH	Boolbol, Robert	MD	Anesthesiology	
BH	Boone, Peter	MD	Surgery	Orthopaedic & Sports Med Ctr.
BH	Bordea, Doru	MD	Internal Medicine	Northeast Medical Group
BH	Bossuyt, Veerle	MD	Pathology	YUSM Department of Pathology
BH	Botta, Marivic	MD	Pediatrics	Pediatric Healthcare Associates
BH	Bottone, Kimberly	APRN	Pediatrics	Yale-New Haven Hospital NICU
BH	Bowman, Jonathan	MD	Surgery	Southern Connecticut Vascular Center
BH	Braddock, Demetrios	MD	Pathology	YUSM Department of Pathology
BH	Brennan, Michael	MD	Internal Medicine	Michael J. Brennan, MD, LLC
BH	Breunig, Joanna	PA	Internal Medicine	Pulmonary & Internal Medicine Associates
BH	Brittis, Dante	MD	Surgery	Orthopaedic Specialty Group

BH	Brockett, Renee	APRN	Pediatrics	Yale-New Haven Children's Hospital at Bridgeport Hospital
BH	Broedlin, Kristen	APRN	Internal Medicine	PriMed
BH	Bronen, Richard	MD	Radiology	Yale-New Haven Hospital - Temple Radiology
BH	Brown, Angela	PA	Surgery	Northeast Medical Group
BH	Brown, David	MD	Surgery	OrthoCare Specialists, L.L.C.
BH	Brown, James	MD	Radiology	YUSM Department of Radiology and Biomedical Imaging
BH	Browning, Nicholas	MD	Emergency Medicine	Y-NHH, St. Raphael Campus - Occupational Health Plus
BH	Brueggestrat, Carly	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Brunelli, Vincent	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Buller, Gregory	MD	Internal Medicine	Northeast Medical Group, Inc.
BH	Buonafede, Dennis	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Burns, Bryan	MD	Internal Medicine	PriMed
BH	Burrows, Stephen	DPM	Surgery	
BH	Buscher, Michael	DO	Emergency Medicine	Bridgeport Hospital Emergency Medicine
BH	Bushell, David	MD	Internal Medicine	Associates in Pulmonary and Sleep Medicine
BH	Butler, Christine	MD	Pediatrics	Pediatric and Adolescent Medicine, Sydney Z. Spiesel, Ph.D., M.D., LLC
BH	Butler, James	MD	Internal Medicine	Neurological Specialists, P.C.
BH	Butler, Reni	MD	Radiology	YUSM Department of Radiology
BH	Butler, Sabrina	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Butler, William	MD	Surgery	The Center for Wound Healing & Hyperbaric Medicine
BH	Cadan, Alex	PA	Surgery	Orthopaedic Specialty Group
BH	Cadan, Rachel	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Cadariu, Arina	MD	Internal Medicine	Bridgeport Hospital
BH	Cafaro, Michael	MD	Internal Medicine	PriMed
BH	Cahill, Justin	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Cai, Guoping	MD	Pathology	YUSM Department of Pathology
BH	Callahan, Carol	DPM	Surgery	Advanced Medical Footcare
BH	Camilleri, Joseph	MD	Surgery	Griffin Faculty Physicians
BH	Campbell, Gail	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Campbell, Katherine	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Cantatore-Francis, Julie	MD	Internal Medicine	YUSM Department of Dermatology
BH	Capozzi, Katherine	PA	Internal Medicine	
BH	Caramico, Lisa	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Cardinale, Joseph	MD	Internal Medicine	Yale Medical Group

BH	Carius, Michael	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Carling, Tobias	MD, PhD	Surgery	YUSM Department of Surgical Oncology
BH	Carravone, John	PA	Surgery	
BH	Carroll, Richard	MD	Pediatrics	Pediatric Healthcare Associates
BH	Casablanca, Domenic	MD	Internal Medicine	PriMed
BH	Casale, Linda	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Casey, Renee	MD	Pediatrics	Optimus Healthcare
BH	Cassell, Steven	MD	Obstetrics & Gynecology	OB/GYN of Fairfield County
BH	Castillo, Jairo	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Castillo, Judith	MD	Internal Medicine	Endo & Diabetes Specialists
BH	Cedeno, Paul	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Cerqueira, Paula	DMD	Surgery	Commerce Park Dental Group
BH	Chacho, Karol	MD	Obstetrics & Gynecology	Robert D. Russo, MD & Assoc.
BH	Chanda, Arijit	MD	Internal Medicine	YUSM Section of Cardiology
BH	Chanda, Kaberi	MD	Internal Medicine	PriMed
BH	Chao, Nelson	MD	Internal Medicine	Allergy & Pulmonary Specialists
BH	Chapman, Jennifer	PA	Pediatrics	Yale-New Haven Hospital NICU
BH	Chen, Yaniv	MD	Internal Medicine	Neurological Specialists, P.C.
BH	Chennattu, Bindu	MD	Internal Medicine	
BH	Chervin, Bradford	MD	Surgery	ENT, Allergy & Facial Plastic Surgery Specialists, LLC
BH	Chess, David	MD	Internal Medicine	
BH	Chessin, Robert	MD	Pediatrics	Pediatric Healthcare Associates
BH	Cheuk, William	MD	Internal Medicine	Bridgeport Hospital
BH	Chianese, Claire	APRN	Psychiatry	Bridgeport Hospital
BH	Chicarilli, Damien	PA	Surgery	Bridgeport Hospital
BH	Chieco-Schwartz, Tina	DPM	Surgery	
BH	Chinniah, Anton	MD	Internal Medicine	
BH	Chiravuri, Murali	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Chiu, Rafael	MD	Surgery	Ophthalmic Associates, P.C.
BH	Choksey, Mithil	MD	Internal Medicine	Northeast Medical Group
BH	Cholewczynski, Walter	MD	Surgery	Bridgeport Hospital
BH	Chou, Lucia	MD	Internal Medicine	PriMed
BH	Choudhary, Ronika	MD	Obstetrics & Gynecology	Women's Obstetrics and Gynecology, P.C.
BH	Chowdhury, Monzurul	MD	Internal Medicine	Northeast Medical Group
BH	Chung, Joyce	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus

BH	Chung, Taesun	MD	Pediatrics	
BH	Ciancimino, David	MD	Psychiatry	
BH	Cicale, Lauren	PA	Pediatrics	Bridgeport Hospital - Dept of Neonatology
BH	Ciminiello, Frank	MD	Internal Medicine	PriMed
BH	Cimino, Peter	MD	Internal Medicine	
BH	Cimino, William	MD	Surgery	Beach Road Orthopedic Spec.
BH	Cinguina, Julita	APRN	Internal Medicine	
BH	Citarella, Jason	DO	Pediatrics	Bpt-Monroe Pediatric Group
BH	Coffey, Tom	MD	Surgery	Connecticut Ear Nose Throat Medical & Surgical Specialists, P.C.
BH	Cohen, Elin	MD	Pediatrics	Black Rock Pediatrics, PC
BH	Cohen, Paul	MD	Pathology	Bridgeport Hospital
BH	Cohen, Steven	MD	Radiology	Advanced Radiology Consultants
BH	Combest, Spiro	MD	Surgery	Robert D. Russo, MD & Assoc.
BH	Connelly, Lauren	PA	Psychiatry	Bridgeport Hospital
BH	Connolly, Katharine	PA	Surgery	Bridgeport Hospital
BH	Connolly, Michael	MD	Internal Medicine	PriMed
BH	Constantinescu, Simona	MD	Internal Medicine	Bridgeport Hospital
BH	Contessa, Joseph	MD	Internal Medicine	YUSM Dept. of Therapeutic Radiology
BH	Contini, Joseph	MD	Pediatrics	Pediatric Healthcare Assoc.
BH	Cook, Gary	PA	Surgery	Bridgeport Hospital
BH	Cook, Timothy	PA	Surgery	Yale-New Haven Hospital, Saint Raphael Campus
BH	Copel, Joshua	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Coppola, Amanda	APRN	Pediatrics	Pediatric Healthcare Associates
BH	Correia, Sara	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Costa, Jose	MD	Pathology	YUSM Department of Pathology
BH	Costin, Mihaela	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Coutu, Francois	MD	Pediatrics	Canterbury Pediatrics
BH	Crombie, Roselle	MD	Surgery	Northeast Medical Group
BH	Cronin, Harold	MD	Pediatrics	Brookside Pediatrics
BH	Cronin-Weir, Taralyn	DO	Pediatrics	Brookside Pediatrics
BH	Cronsell, Jennifer	DO	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Cross, Sarah	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Crowley, Jillian	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Cuevas, Claribel	PA	Internal Medicine	Northeast Medical Group
BH	Custis, Kyle	MD	Internal Medicine	Northeast Medical Group

BH	Cuteri, Joseph	MD	Obstetrics & Gynecology	Northeast Medical Group
BH	Cutney, Andrew	MD	Internal Medicine	Northeast Medical Group
BH	Dafcik, Adrian	MD	Internal Medicine	PriMed
BH	Dakwa, Kwasi	MB, ChB	Internal Medicine	Northeast Medical Group
BH	Dalal, Bipin	MD	Pediatrics	
BH	Dall, Chris	PA	Surgery	Connecticut Neurosurgical Specialists, P.C.
BH	Damast, Shari	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	D'Amato, Marc	PA	Surgery	Northeast Medical Group
BH	Darr, Umer	MD	Surgery	Bridgeport Hospital
BH	Das, Debasish	MD	Internal Medicine	PriMed
BH	Daunis, Kerri	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Davenport, Thomas	MD	Surgery	Long Island Plastic Surgical
BH	Davis, R. Daniel	DPM	Surgery	Family Podiatry Center
BH	Dawe, Robert	MD	Surgery	Orthopaedic Specialty Group
BH	Dawlagala, Umanga	MD	Pediatrics	Optimus Health Care
BH	Dayan, Nimrod	MD	Pediatrics	Pediatric Healthcare Associates
BH	Deal, Robert	MD	Obstetrics & Gynecology	Womens Health Care LLC
BH	Deal, Therese-Ann	PA	Pediatrics	Bridgeport Hospital
BH	Deaso, Michele	APRN	Pediatrics	Bridgeport Hospital - Dept of Neonatology
BH	DeBroff, Brian	MD	Surgery	Eye Surgery Associates, LLC
BH	Decker, Roy	MD, PhD	Internal Medicine	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
BH	DeGirolamo, Angela	MD	Internal Medicine	
BH	Della-Giustina, Karen	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	DeLucia, Kathy	PA	Surgery	Orthopedic Specialty Group
BH	Demartini, Paul	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
BH	Denowitz, Jill	MD	Internal Medicine	Internal Med Assoc of Westport
BH	Depuy, James	MD	Surgery	
BH	Despot, Katy	CNM	Obstetrics & Gynecology	Womens Health Care LLC
BH	Detterbeck, Frank	MD	Surgery	Park Avenue Surgical Associates
BH	Devir, Katherine	PA	Pediatrics	Yale-New Haven Hospital NICU
BH	Dewar, Michael	MD	Surgery	YUSM Section of Cardiac Surgery
BH	Dewera-Moczerniuk, Alicja	MD	Pediatrics	Pediatric Healthcare Associates
BH	Dhanjal, Sandhya	MD	Internal Medicine	Medical Specialists of Fairfield
BH	Diaz, Vicente	MD	Surgery	Eye Surgery Associates, LLC

BH	DiBartholomeo, Thomas	MD	Radiology	Advanced Radiology Consultants
BH	Dicks, Demetrius	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Dijeh, Sylvester	MD	Internal Medicine	Bridgeport Hospital
BH	Dillon, Brian	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Dinkes, Lawrence	DDS	Surgery	Commerce Park Dental Group
BH	Distefano, Arcangelo	MD	Internal Medicine	PriMed
BH	Doctor, Leslie	MD	Surgery	Doctor and Associates
BH	Dolan, Neil	MD	Psychiatry	Northeast Medical Group, Inc.
BH	Dombrow, Matthew	MD	Surgery	Connecticut Retina Consultants
BH	Dommu, Aaron	MD	Internal Medicine	Nephrology Associates, PC
BH	Donahue, John	MD	Radiology	Robert D. Russo, MD & Assoc.
BH	Donahue, Sarah	APRN	Pediatrics	Optimus Healthcare
BH	Donaldson-Ramos, Shireen	MD	Obstetrics & Gynecology	Optimus Health Care
BH	Donnelly, Theresa	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	DoRosario, Arnold	MD	Internal Medicine	PriMed
BH	Dortzbach, Kathryn	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Doyle, Michael	MD	Obstetrics & Gynecology	CT Fertility Associates
BH	Dragoi, Elena	MD	Pediatrics	Optimus Healthcare
BH	Drake, Gail	PA	Internal Medicine	Milford Hospital
BH	Driesman, Mitchell	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Driesman, Shelley	MD	Surgery	Ophthalmic Surgeon Greater Bpt
BH	Driggers, Allyson	MD	Pediatrics	Bridgeport Hospital
BH	Driscoll, Colleen	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	D'Souza, Anthony	MD	Internal Medicine	PriMed CHVC
BH	Duben, Michael	MD	Internal Medicine	Endocrinology of Fairfield County, LLC
BH	Duchen, Douglas	MD	Internal Medicine	PriMed
BH	Duda, E. Andrew	MD	Internal Medicine	Medical Specialists of Fairfield
BH	Duffy, Andrew	MD	Surgery	YUSM Section of Surgical Gastroenterology
BH	Dufore, Douglas	PhD	Psychiatry	Northeast Medical Group
BH	Duguay, Nicole	APRN	Pediatrics	YUSM Section of Maternal/Fetal Medicine
BH	Dumitrescu, Mirela	MD	Internal Medicine	Rheumatology & Int. Med Assoc.
BH	Dunston-Boone, Gina	MD	Obstetrics & Gynecology	Bridgeport Hospital
BH	Durand, Melissa	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Durchhalter, Ashley	PA	Internal Medicine	Northeast Medical Group
BH	Duris, Donna	APRN	Internal Medicine	PriMed

BH	Dzienis, Barbara	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Dzubaty, Tanya	PA	Surgery	Orthopedic Specialty Group
BH	Eagan, Patricia	DO	Pediatrics	Pediatric Healthcare Assoc.
BH	Eaton, Maurita	PA	Radiology	Advanced Radiology Consultants
BH	Edusa, Valentine	MD	Obstetrics & Gynecology	OB/GYN of Fairfield County
BH	Edwards, Kristin	MD	Internal Medicine	Northeast Medical Group
BH	Eladawy, Janine	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Emmens, Gregory	APRN	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Ericson, Raina	PA	Surgery	Bridgeport Hospital
BH	Espina-Lee, Elenita	MD	Obstetrics & Gynecology	Affiliates in Women's Care
BH	Esposito, Christa	CNM	Obstetrics & Gynecology	Womens HealthCare Trumbull
BH	Esposito, Claire	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Esposito, Jay	MD	Pediatrics	PriMed
BH	Estime, Pierre	DO	Internal Medicine	Southwest Comm. Health Center
BH	Eterno, Robert	DPM	Surgery	Foot Specialists of Trumbull
BH	Evangelista, Joseph	MD	Internal Medicine	Northeast Medical Group
BH	Evans, Suzanne	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Even, Michele	MD	Radiology	Advanced Radiology Consultants
BH	Exume, Betty	PA	Internal Medicine	Northeast Medical Group
BH	Fabian, Caitlin	PA	Surgery	Bridgeport Hospital
BH	Falcone, Philip	MD	Surgery	Connecticut Retina Consultants
BH	Fan, Jennifer	MD	Radiology	Advanced Radiology Consultants
BH	Fattahi, Pooia	MD	Internal Medicine	Waterbury Neurology
BH	Federman, Adam	MD	Radiology	Advanced Radiology Consultants
BH	Fei, Xiaolan	MD	Obstetrics & Gynecology	Womens Health Center, PC
BH	Feinberg, Dennis	MD	Internal Medicine	
BH	Feintzeig, Irwin	MD	Internal Medicine	Nephrology Associates, PC
BH	Feldman, Alan	DPM	Surgery	The Orthopedic & Sports Medicine Center
BH	Ferdman, Dina	MD	Pediatrics	Northeast Medical Group Pediatric Specialists
BH	Ferreira, Maria	MD	Pediatrics	Bpt-Monroe Pediatric Group
BH	Ferrigno, Rockman	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Figueroa, Eduardo	MD	Pediatrics	Stratford Pediatrics
BH	Filiberto, Cosmo	MD	Internal Medicine	PriMed
BH	Fine, Kenneth	MD	Internal Medicine	Jewish Home for the Elderly
BH	Fischbach, Neal	MD	Internal Medicine	Y-NHH Smilow Fairfield Care Center

BH	Fisher, Lawrence	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Fisher, Steven	MD	Internal Medicine	Fairfield. Co. Med. Grp, P.C.
BH	Fishman, Robert	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Fitzgerald, William	MD	Internal Medicine	
BH	FitzGibbons, James	MD	Surgery	Orthopaedic Specialty Group
BH	Fliegelman, Lawrence	MD	Surgery	Richard A. Levin, M.D., Lawrence J. Fliegelman, M.D., LLC
BH	Floch, Craig	MD	Surgery	Ffld Bariatrics & Surgical Spec
BH	Floch, Neil	MD	Surgery	Ffld Bariatrics & Surgical Spec
BH	Flores, John	MD	Internal Medicine	Trumbull Medical Practice
BH	Flynn, Janeane	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Fogel, Mitchell	MD	Internal Medicine	Nephrology Associates, PC
BH	Folman, Robert	MD	Internal Medicine	Smilow Cancer Care -Trumbull
BH	Ford, Catherine	MD	Pediatrics	Optimus Health Care
BH	Forest, Lee	DO	Internal Medicine	Ffld Family Physicians, LLC
BH	Forrest, John	MD	Internal Medicine	YUSM Section of Cardiology
BH	Forte, Kenneth	APRN	Emergency Medicine	Bridgeport Hospital
BH	Fotjadhi, Irma	MD	Internal Medicine	Advanced Cardiovascular Spec.
BH	Free, Richard	MD	Internal Medicine	Northeast Medical Group
BH	Freedman, Richard	MD	Pediatrics	Pediatric Healthcare Associates
BH	Frey, Marnie	APRN	Pediatrics	Bridgeport Hospital
BH	Friedlaender, Gary	MD	Surgery	YUSM Department of Orthopedics
BH	Friedman, Craig	MD	Surgery	
BH	Fullerton, Susan	MD	Pediatrics	Main Street Pediatrics
BH	Gada, Pritee	MD	Internal Medicine	PriMed
BH	Gaeta, Mary Lou	MD	Pediatrics	YUSM Department of Pediatrics
BH	Gagne, Paul	MD	Surgery	Southern Connecticut Vascular Center
BH	Galati, Sandi-Jo	MD	Internal Medicine	Endo & Diabetes Specialists
BH	Galerneau, France	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Gallo-VanEss, Diane	MD	Pediatrics	Pediatric Healthcare Assoc.
BH	Galvin, Jennifer	MD	Surgery	Yale Eye Center
BH	Garrido, Frank	MD	Emergency Medicine	Bridgeport Hospital
BH	Garvey, Richard	MD	Surgery	General Surgeons Greater Bridgeport
BH	Gavin, James	MD	Internal Medicine	Nephrology Associates, PC
BH	Geeti, Adiba	MD	Internal Medicine	Northeast Medical Group
BH	Gehrie, Eric	MD	Pathology	Y-NHH Smilow Cancer Hospital

BH	Geiger, Arthur	MD	Surgery	
BH	Geirsson, Arnar	MD	Surgery	YUSM Section of Cardiac Surgery
BH	Geisel, Jaime	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Gentes, Cynthia	MD	Internal Medicine	PriMed
BH	Gentry, Eric	MD	Internal Medicine	PriMed
BH	Georgalas, Melanie	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
BH	George, Sosamma	MD	Internal Medicine	Neurological Specialists
BH	Geraci, Eileen	APRN	Internal Medicine	PriMed
BH	Geter, Jaime	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Ghiassi, Saber	MD	Surgery	YUSM Section of Surgical Gastroenterology
BH	Gianninoto, Laura	APRN	Surgery	Northeast Medical Group
BH	Girasole, Gerard	MD	Surgery	The Orthopedic & Sports Medicine Center
BH	Giuran Benetato, Iulian	MD	Internal Medicine	Bridgeport Hospital
BH	Gladstein, Geoffrey	MD	Internal Medicine	Northeast Medical Group
BH	Glasgow, Kristen	MD	Surgery	Mill Hill Surgical Associates
BH	Glasser, Jack	MD	Internal Medicine	
BH	Glazer, Peter	MD, PhD	Internal Medicine	Lawrence & Memorial Hospital
BH	Glick, Kristen	PA	Emergency Medicine	
BH	Goldstein, Lee	MD	Surgery	Southern Connecticut Vascular Center
BH	Goldstone-Orly, Leslie	MD	Obstetrics & Gynecology	Womens Healthcare of Trumbull
BH	Goodstine, Shelley	MD	Radiology	Advanced Radiology Consultants
BH	Gordon, Kilbourn	MD	Emergency Medicine	Urgent Care of CT Ridgefield
BH	Gordon, Ram	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Gourineni, Venkata	MD	Internal Medicine	Northeast Medical Group
BH	Grant, Jillian	APRN	Pediatrics	Pediatric Healthcare Associates
BH	Gray, Pamela	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Greenspan, Philip	MD	Internal Medicine	PriMed
BH	Gregg, Kristin	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Gregg, Shea	MD	Surgery	Bridgeport Hospital
BH	Greiner, Richard	MD	Emergency Medicine	
BH	Grewal, Kevin	MD	Internal Medicine	Northeast Medical Group
BH	Grey, Wendy	APRN	Internal Medicine	Northeast Medical Group
BH	Grochowalska, Agnieszka	MD	Internal Medicine	Endo & Diabetes Specialists
BH	Gross, Stewart	MD	Surgery	Hand Surgery of Southern CT
BH	Grossman, Kenneth	MD	Internal Medicine	

BH	Gruskay, Jeffrey	MD	Pediatrics	Milford Pediatric Group
BH	Guadagnoli, Germano	MD	Internal Medicine	
BH	Guess, Marsha	MD	Obstetrics & Gynecology	YUSM Section of Urogynecology
BH	Gulliford, Jill	PA	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
BH	Gulrajani, Avinash	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Gunabushanam, Gowthaman	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Gunn, Jennifer	CRNA	Anesthesiology	YUSM Department of Anesthesiology
BH	Guoth, Maria	MD	Internal Medicine	Maria S. Guoth, M.D.
BH	Gupta, Bhawna	MD	Internal Medicine	Northeast Medical Group
BH	Gupta, Manisha	MD	Internal Medicine	Northeast Medical Group
BH	Gupta, Tarun	MD	Internal Medicine	
BH	Gussin, Bruce	PA	Psychiatry	Northeast Medical Group, Inc.
BH	Hagani, Andrea	MD	Pediatrics	Pediatric Healthcare Associates
BH	Haims, Andrew	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Hann, Michael	PA	Surgery	
BH	Hansen, James	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Hao, Liming	MD	Pathology	Bridgeport Hospital
BH	Harigopal, Malini	MD	Pathology	YUSM Department of Pathology
BH	Harkins-Squitieri, Kelly	MD	Radiology	Advanced Radiology Consultants
BH	Harman, Mary Beth	DO	Obstetrics & Gynecology	
BH	Harris, Darcy	DO	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Haydon-Ryan, Amy	PA	Surgery	Orthopedic Specialty Group
BH	Heiat, Asefeh	MD	Internal Medicine	Southern CT Geriatric and Preventive Medicine, L.L.C.
BH	Heineken, Christian	MD	Internal Medicine	PriMed
BH	Heller, Warren	MD	Internal Medicine	Northeast Medical Group
BH	Hemenway, Charles	MD	Pediatrics	Pediatric Healthcare Associates
BH	Hemstock, Heidi	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Hen, Jacob	MD	Pediatrics	Northeast Medical Group Pediatric Specialists
BH	Henvy, Elisabeth	APRN	Internal Medicine	Bridgeport Hospital
BH	Hermele, Herbert	MD	Surgery	Orthopaedic Specialty Group
BH	Herzlinger, Robert	MD	Pediatrics	Bridgeport Hospital
BH	Higgins, Susan	MD	Internal Medicine	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
BH	Hill, Monica	APRN	Internal Medicine	PriMed
BH	Hobbie, Robert	MD	Pediatrics	Pediatric Healthcare Associates

BH	Hochstadt, Judith	MD	Pediatrics	Pediatric Healthcare Associates
BH	Hoggatt, Tracey	APRN	Pediatrics	Bridgeport Hospital
BH	Homa, Thomas	MD	Pediatrics	Pediatric Healthcare Associates
BH	Homer, Robert	MD, PhD	Pathology	YUSM Department of Pathology
BH	Hong, Jin Ki	MD	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Honigsberg, Elizabeth	MD	Surgery	General Surgeons Greater Bridgeport
BH	Hooley, Regina	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Hoq, Sheikh	MD	Internal Medicine	Bridgeport Hospital
BH	Horn, Jay	MD	Internal Medicine	
BH	Horvath, Laura	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Hubbard, Matthew	MD, MS	Surgery	YUSM Section of Surgical Gastroenterology
BH	Huber, Steffen	MD	Radiology	YUSM Department of Radiology and Biomedical Imaging
BH	Hudnall, Stanley	MD	Pathology	YUSM Department of Pathology
BH	Hughes, Terence	MD	Radiology	Advanced Radiology Consultants
BH	Hui, Pei	MD, PhD	Pathology	YUSM Department of Pathology
BH	Humphrey, Peter	MD	Pathology	YUSM Department of Pathology
BH	Hung, Alex	DMD	Surgery	
BH	Hunt, William	MD	Internal Medicine	Nephrology Associates, PC
BH	Hur, Sik	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Huribal, Marsel	MD	Surgery	Southern CT Vascular Center, LLC
BH	Husain, Zain	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Hussain, Syed	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Hutchinson, Karen	MD	Internal Medicine	Bridgeport Hospital
BH	Huttner, Anita	MD	Pathology	YUSM Department of Pathology
BH	Iava, Pamela	APRN	Internal Medicine	Northeast Medical Group
BH	Ingraldi, Peter	MD	Surgery	
BH	Irby, Ceasar	DPM	Surgery	Mill Hill Surgical Associates
BH	Irving, Michele	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Ivy, Michael	MD	Surgery	Bridgeport Hospital
BH	Jackson, Pamela	MD	Internal Medicine	Pamela E. Jackson, MD LLC
BH	Jackson, Wilhelmina	CNM	Obstetrics & Gynecology	Northeast Medical Group
BH	Jacobs, Harris	MD	Pediatrics	Bridgeport Hospital
BH	Jacobs, Lee	MD	Obstetrics & Gynecology	Southport Women's Care
BH	Jaffe, David	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Jain, Dhanpat	MD	Pathology	YUSM Department of Pathology

BH	Jain, Monica	MD	Internal Medicine	
BH	Jain, Neil	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Jakubowski, Peter	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Jalkut, Susanna	MD	Pediatrics	Pediatric Healthcare Associates
BH	Jandali, Shareef	MD	Surgery	
BH	Jennings, Bryan	PA	Internal Medicine	Bridgeport Hospital
BH	John, Genevieve	MD	Internal Medicine	PriMed
BH	Johnson, Christa	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
BH	Johnson, Keisha	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Johnson, Michele	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Johung, Kimberly	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Jordan, B. Bryan	DO	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Ju, Jennifer	MD	Internal Medicine	Fam. Health & Wellness CTR LLC
BH	Jutkowitz, David	MD	Internal Medicine	
BH	Kallen, Amanda	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
BH	Kalu, Chinenye	APRN	Internal Medicine	Milford Hospital
BH	Kamath, Amit	MD	Pediatrics	Trumbull Pediatrics
BH	Kaplan, Jeffrey	MD	Surgery	
BH	Karkanitsa, Leonid	MD	Internal Medicine	Internal Med. Of Greater New Haven
BH	Karol, Ian	MD	Radiology	Advanced Radiology Consultants
BH	Karol, Nina	MD	Internal Medicine	
BH	Karpenos, Leonid	MD	Internal Medicine	
BH	Kashani, Shabnam	MD	Obstetrics & Gynecology	Bridgeport Hospital
BH	Kassapidis, Elizabeth	DO	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Katigbak, Guillermo	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Katz, Eric	MD	Surgery	
BH	Katz, Lee	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Katz, Samuel	MD, PhD	Pathology	YUSM Department of Pathology
BH	Kaufman, David	MD	Internal Medicine	Northeast Medical Group
BH	Kaufman, Jeremy	MD	Surgery	Urological Associates of Bridgeport, PC
BH	Kaushal, Neelima	MD	Obstetrics & Gynecology	
BH	Kayani, Sohail	MD	Pediatrics	
BH	Kaye, Alan	MD	Radiology	Advanced Radiology Consultants
BH	Kazi, Azimuddin	MD	Pediatrics	Neurological Specialists, P.C.
BH	Keane, Charis	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine

BH	Keenan, Casey	PA	Internal Medicine	Bridgeport Hospital
BH	Kejner, Alexandra	MD	Surgery	YUSM Section of Otolaryngology
BH	Keller, Jill	APRN	Internal Medicine	Bridgeport Hospital
BH	Kelly, Sean	MD	Internal Medicine	OrthoCare Specialists, L.L.C.
BH	Kemp-Prosterman, Karen	DDS	Surgery	
BH	Kenler, Andrew	MD	Surgery	Park Avenue Surgical Associates
BH	Kerner, Jeffrey	MD	Surgery	
BH	Kersten-Ulmen, Laurie	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Khalid, Haroon	MD	Internal Medicine	Southwest Community Health Center
BH	Khan, Jenifer	MD	Internal Medicine	Northeast Medical Group
BH	Khan, Sajid	MD	Surgery	Bridgeport Hospital
BH	Kier, Ruben	MD	Radiology	Advanced Radiology Consultants
BH	Kim, Jennifer	MD	Radiology	Yale Diagnostic Radiology
BH	Kim, Robert	MD	Internal Medicine	Nephrology Associates, PC
BH	Kim, Young	MD	Pathology	Bridgeport Hospital
BH	King, Brian	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
BH	King, Michael	MD	Internal Medicine	Allergy & Asthma Assoc. of CT
BH	Kingsly, Kenneth	MD	Surgery	NEMG Urology
BH	Kipperman, Harry	MD	Pediatrics	Milford Pediatric Group
BH	Kirschenbaum, Lawrence	MD	Anesthesiology	Orthopaedic Specialty Group
BH	Kishinevsky, Anya	MD	Surgery	Aesthetic Surgery Center of Connecticut
BH	Klein, Rhonda	MD	Internal Medicine	
BH	Klein, Wendy	MD	Surgery	Ophthalmic Associates, P.C.
BH	Kleinman, Gary	MD	Obstetrics & Gynecology	Northeast Medical Group
BH	Klufas, Adrian	MD	Internal Medicine	
BH	Knaus, David	DDS	Surgery	
BH	Knowlton, Christin	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus, Hamden
BH	Kochan, Charles	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
BH	Kocinsky, Daniel	MD	Internal Medicine	PriMed
BH	Kodaman, Pinar	MD, PhD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
BH	Kohari, Katherine	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Kokenos, Lara	PA	Surgery	PriMed
BH	Kolade, Christina	DO	Internal Medicine	
BH	Kolade, Ebenezer	MD	Internal Medicine	

BH	Kondor, Melanie	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Koral, Alexander	MD	Pediatrics	YUSM Department of Pediatrics
BH	Koskinas, Christina	PA	Pediatrics	Yale-New Haven Hospital NICU
BH	Kowalski, Diane	MD	Pathology	YUSM Department of Pathology
BH	Koziel, Jeannette	APRN	Emergency Medicine	YUSM Department of Emergency Medicine
BH	Kraft, Michael	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Kraus, Melanie	APRN	Pediatrics	Bridgeport Hospital
BH	Krichavsky, Marc	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Kucher, Taras	MD	Surgery	Southern Connecticut Vascular Center
BH	Kulakov, Slava	MD	Internal Medicine	PriMed
BH	Kumaradhas, Catherine	MD	Internal Medicine	Northeast Medical Group
BH	Kumaraswami, Rajesh	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Kunkes, Steven	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Kwok, Katie	PA	Obstetrics & Gynecology	
BH	Kwok, Patrick	MD	Surgery	Orthopaedic Specialty Group
BH	Kwon, Jeffrey	MD	Internal Medicine	Bridgeport Hospital
BH	Kwon, Soo Hyun	MD	Pediatrics	YUSM Section of Pediatric Neonatology
BH	Laifer, Julie	MD	Obstetrics & Gynecology	Southport Women's Care
BH	Laifer, Steven	MD	Obstetrics & Gynecology	Bridgeport Hospital
BH	Lam, Chunwang	MD	Internal Medicine	PriMed
BH	LaMastra, Philip	MD	Obstetrics & Gynecology	Bridgeport Hospital
BH	Lamba, Amarjit	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	LaMonte, Thomas	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Lancaster, Gilead	MD	Internal Medicine	
BH	Landau, Alan	MD	Internal Medicine	PriMed
BH	Landau, Charles	MD	Internal Medicine	
BH	Landis, Robert	MD	Pediatrics	Pediatric Healthcare Associates
BH	Landry, Marie	MD	Pathology	YUSM Department of Laboratory Medicine
BH	Lane, Edward	MD	Surgery	
BH	Langeland, Rolf	MD	Surgery	Orthopaedic Specialty Group
BH	Larrison, Wayne	MD	Surgery	Connecticut Retina Consultants
BH	Laser, Mark	MD	Obstetrics & Gynecology	Womens Health Care LLC
BH	Laskin, William	MD	Pathology	Bridgeport Hospital
BH	Lastomirsky, David	MD	Internal Medicine	
BH	Latham, Douglas	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine

BH	Latich, Igor	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Latzman, Gordon	MD	Internal Medicine	PriMed
BH	Laugel, Karen	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
BH	Lauren, David	DO	Internal Medicine	
BH	Lavi, Nimrod	MD	Internal Medicine	Arrhythmia Center of Connecticut
BH	Lavin, Marissa	APRN	Internal Medicine	Bridgeport Palliative Care
BH	LeCleir, Karen	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Lee, Michael	MD	Pediatrics	Pediatric Healthcare Associates
BH	Lenard, Edward	MD	Pediatrics	
BH	Lenhart, Kevin	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Leonardi, Rachel	DO	Obstetrics & Gynecology	
BH	Leonida, Sophia	MD	Pediatrics	Station House Pediatrics
BH	Lerner, Seth	MD	Internal Medicine	Adult & Pediatric Dermatology Specialists, P.C.
BH	Lettera, James	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
BH	Levesque, Paul	MD	Radiology	Yale Diagnostic Radiology - St. Raphael Campus
BH	Levi, Andrew	MD	Obstetrics & Gynecology	Park Ave Fertility&ReprodMed
BH	Levi, Angelique	MD	Pathology	YUSM Department of Pathology
BH	Levin, Flora	MD	Surgery	Y-NHH Smilow Cancer Hospital Multispecialty Care Center
BH	Levin, Richard	MD	Surgery	Richard A. Levin, M.D., Lawrence J. Fliegelman, M.D., LLC
BH	Levine, Edwin	MD	Internal Medicine	PriMed
BH	Levine, Steven	MD	Surgery	ENT and Allergy Associates, P.C.
BH	Lillo, Nicholas	MD	Internal Medicine	
BH	Lindahl, Diana	APRN	Internal Medicine	
BH	Lindstrom, Karen	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Link, Richard	MD	Internal Medicine	
BH	Lipkind, Heather Sue	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Lipow, Kenneth	MD	Surgery	Connecticut Neurosurgical Specialists, P.C.
BH	Lipton, Lawrence	DMD	Surgery	Children's Dental Assoc., P.C.
BH	Lischuk, Andrew	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Liu, Renu	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Lo, Lawrence	MD	Radiology	Advanced Radiology Consultants
BH	Lobo, David	MD	Internal Medicine	Internal Medicine & Infectious Disease Assoc
BH	Lockhart, Roberta	MD	Pediatrics	Milford Pediatric Group
BH	Loeser, Caroline	MD	Internal Medicine	

BH	Logiadis, Emmanuel	MD	Internal Medicine	PriMed
BH	Longtine, Janina	MD	Pathology	YUSM Department of Pathology
BH	Lopatin, Richard	MD	Internal Medicine	
BH	Lopez, Javier	MD	Psychiatry	Yale-New Haven Children's Hospital at Bridgeport Hospital
BH	Lopez, Rolando	PA	Surgery	
BH	Lopusny, Diana	MD	Pediatrics	Preferred Pediatrics
BH	Loss, Alexis	PA	Psychiatry	YUSM Section of Surgical Gastroenterology
BH	Lottick, Adam	MD	Internal Medicine	Northeast Medical Group Cardiology
BH	Lowell, Darcy	MD	Pediatrics	Bridgeport Hospital
BH	Lu, Esther	MD	Internal Medicine	NEMG - Bridgeport Community Health
BH	Luizzi, Megan	PA	Pediatrics	Yale-New Haven Hospital NICU
BH	Lukawski, Jolanta	MD	Internal Medicine	Northeast Medical Group Internal Medicine Fairfiel
BH	Luna-Rudin, Francesca	MD	Internal Medicine	Fairfield County Medical Group, P.C.
BH	Luu, Lemi	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Ly, David	PA	Internal Medicine	Northeast Medical Group
BH	Machledt, John	MD	Internal Medicine	
BH	Madonick, Maria	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
BH	Madri, Joseph	MD, PhD	Pathology	YUSM Department of Pathology
BH	Magriples, Urania	MD	Obstetrics & Gynecology	YUSM Section of Maternal Fetal-Medicine
BH	Mahajan, Amit	MD	Radiology	Yale Diagnostic Radiology
BH	Maiocco, John	DPM	Surgery	PriMed
BH	Maisel, Jonathan	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Majumdar, Sachin	MD	Internal Medicine	
BH	Malefatto, Jerry	MD	Internal Medicine	Smilow Cancer Care -Trumbull
BH	Malhotra, Ajay	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Malik, Awais	MD	Internal Medicine	
BH	Malin, Joel	MD	Surgery	Orthopaedic Specialty Group
BH	Mancher, Kenneth	MD	Internal Medicine	PriMed
BH	Manoni, Timothy	MD	Surgery	Southern Connecticut Vascular Center
BH	Marchetti, Daniel	PA	Surgery	Bridgeport Hospital
BH	Marrinan, Greg	MD	Radiology	Advanced Radiology Consultants
BH	Marrone, Jennifer	MD	Obstetrics & Gynecology	Norwalk Community Health Center
BH	Marsan, Ben	MD	Surgery	Southern Connecticut Vascular Center
BH	Marsillio, Olga	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Martin, David	MD	Surgery	The Orthopedic & Sports Medicine Center

BH	Martin, Joseph	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
BH	Martins, Jessica	PA	Surgery	
BH	Masone, Pasquale	MD	Internal Medicine	PriMed
BH	Masoud, Amir	MD	Internal Medicine	YUSM Section of Digestive Diseases
BH	Mathew-Rohaly, Shybi	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Mauer, Kenneth	MD	Internal Medicine	
BH	McCormick, Marie	APRN	Internal Medicine	Cardiac Specialists, PC
BH	McCullough, David	MD	Surgery	PriMed
BH	McDermott, Dermot	PA	Internal Medicine	
BH	McGibbon, Bruce	MD	Internal Medicine	Bridgeport Hospital
BH	McGuigan, Courtney	CRNA	Anesthesiology	YUSM Department of Anesthesiology
BH	McLaughlin, Coleen	PA	Internal Medicine	PriMed
BH	McLaughlin, Pamela	APRN	Internal Medicine	Cardiac Specialists, P.C.
BH	McPherson, Craig	MD	Internal Medicine	Bridgeport Hospital
BH	Mehal, Wajahat	MD	Internal Medicine	YUSM Section of Gastroenterology
BH	Mehra, Saral	MD	Surgery	YUSM Section of Otolaryngology
BH	Meizlish, Jay	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Mejia, Victor	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Mele, Frank	MD	Radiology	Advanced Radiology Consultants
BH	Melton, Barry	MD	Pediatrics	
BH	Menzies, Cheryl	MD	Pediatrics	Bridgeport Hospital
BH	Merck, Stephanie	APRN	Internal Medicine	Fairfield. Co. Med. Grp, P.C.
BH	Merithew, Katie	PA	Pediatrics	Bridgeport Hospital - Dept of Neonatology
BH	Merkle, Diane	APRN	Surgery	Northeast Medical Group, Inc.
BH	Meskin, Seth	MD	Surgery	Eye Physicians & Surgeons
BH	Messina, Robert	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Messinger, Kaitlynn	PA	Pediatrics	YUSM Section of Pediatric Neonatology
BH	Michels-Ashwood, Karin	MD	Internal Medicine	Optimus Healthcare
BH	Mikan, Paul	MD	Internal Medicine	PriMed
BH	Miljkovic, Goran	MD	Internal Medicine	Internal Medicine & Infectious Disease Assoc
BH	Miller, Leslie	DO	Internal Medicine	
BH	Miller, Stuart	MD	Internal Medicine	
BH	Miller-Rivero, Nancy	MD	Surgery	Connecticut Retina Consultants
BH	Minja, Frank	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Mintz, Abraham	MD	Surgery	Abraham Mintz, MD, PC

BH	Miranti, James	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Misra, Monique	MD	Internal Medicine	Northeast Medical Group
BH	Mitchell Richards, Kisha	MD	Pathology	Greenwich Hospital
BH	Mix, Vanessa	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Mize, Charles	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Moeckel, Gilbert	MD, PhD	Pathology	YUSM Department of Pathology
BH	Mojibian, Hamid	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Mokotoff, Greg	DMD	Surgery	KidsFirst Pediatric Dentistry
BH	Molloy, Bonnie	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Mongillo, Anthony	MD	Internal Medicine	PriMed
BH	Mongillo, Nicholas	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
BH	Monteiro, Nirmala	MD	Internal Medicine	Nirmala L Monteiro MD LLC
BH	Moran, Meena	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Morgan, Charles	MD	Psychiatry	Bridgeport Hospital
BH	Moriber, Nancy	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Morotti, Raffaella	MD	Pathology	YUSM Department of Pathology
BH	Morrow, Jon	MD, PhD	Pathology	YUSM Department of Pathology
BH	Moskowitz, Robert	MD	Internal Medicine	Cardiac Specialists, PC
BH	Mpuku, Felix	MD	Surgery	
BH	Much, Melissa	MD	Pathology	YUSM Department of Pathology
BH	Muldoon, Lawrence	MD	Surgery	NEMG Urology
BH	Muro, Gerard	MD	Radiology	Advanced Radiology Consultants
BH	Musto, Anthony	MD	Surgery	Eye Surgery Associates, LLC
BH	Myers, Clifford	PA	Surgery	Bridgeport Hospital
BH	Nadzam, Geoffrey	MD	Surgery	YUSM Section of Surgical Gastroenterology
BH	Naik, Harsha	MD	Internal Medicine	Northeast Medical Group
BH	Nallainathan, Sanatkunar	MD	Pediatrics	Neurological Specialists, P.C.
BH	Nallu, Loren	MD	Pediatrics	Yale-New Haven Children's Hospital
BH	Napolitano, Guido	MD	Internal Medicine	PriMed
BH	Napolitano, John	PA	Surgery	Abraham Mintz, MD, PC
BH	Nascimento, Joao	MD	Internal Medicine	
BH	Nash, Esther	MD	Emergency Medicine	Bridgeport Hospital
BH	Nathanson, Michael	MD	Internal Medicine	YUSM Section of Transplantation
BH	Natt, Beth	MD	Pediatrics	Northeast Medical Group, Inc.
BH	Nedelcuta, Steluta	MD	Internal Medicine	Milford Hospital

BH	Needham, Christine	APRN	Internal Medicine	Northeast Medical Group
BH	Negbenebor, Darlene	MD	Internal Medicine	Shoreline Medical, LLP
BH	Nelson, Alan	MD	Internal Medicine	
BH	Nelson, Angella	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Nessralla, Laurie-Ann	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Neuberth, Danielle	PA	Emergency Medicine	Greenwich Hospital - NEMG
BH	Noccioli, Daniel	PA	Emergency Medicine	Bridgeport Hospital Emergency Medicine
BH	Noonan, Michael	MD	Internal Medicine	Adult & Pedi Dermatology Specialists
BH	Nori, Kenneth	MD	Internal Medicine	PriMed
BH	Novik, Larry	MD	Internal Medicine	PriMed
BH	Nunez, Mario	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
BH	Nussbaum, Paul	MD	Internal Medicine	Nephrology Associates, PC
BH	Nute-Aupi, Sandra	PA	Obstetrics & Gynecology	
BH	Nuzzolo, Florabel	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc.
BH	O'Brien, Michael	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	O'Connell, Joseph	MD	Surgery	Plastic Surgery of Southern CT
BH	O'Connell, Ryan	MD	Internal Medicine	Bridgeport Hospital
BH	OConnor, Julie	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Odinak, Thomas	MD	Pediatrics	Pediatric Healthcare Associates
BH	Oesau, Michael	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Oestreicher, Mark	MD	Internal Medicine	Adult & Pediatric Dermatology Specialists, P.C.
BH	Oestrich, Charles	MD	Surgery	
BH	Ogundipe, Nnenna	MD	Internal Medicine	Milford Hospital
BH	Ohene-Adjei, Rita	MD	Emergency Medicine	YNHH Occupational Health Services
BH	Okada, Ashley	APRN	Internal Medicine	Northeast Medical Group
BH	Oliveira, Carlos	MD	Pediatrics	Trumbull Pediatrics
BH	Olsavsky, Thomas	MD	Radiology	Advanced Radiology Consultants
BH	Olsen, Adam	PA	Internal Medicine	PriMed
BH	Olson, Alan	PA	Internal Medicine	Bridgeport Hospital
BH	Opalak, Michael	MD	Surgery	Neurological Surgery
BH	Orazietti, John	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Orazietti, Kathleen	PA	Radiology	
BH	O'Reilly, Michael	MD	Obstetrics & Gynecology	
BH	Ostroff, Barry	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	O'Toole, Monika	CRNA	Anesthesiology	YUSM Department of Anesthesiology

BH	Ott Young, Anke	MD	Surgery	
BH	Ovide, Trishia	PA	Obstetrics & Gynecology	
BH	Ozerdem, Ugur	MD	Pathology	YUSM Department of Pathology
BH	Pacheco-Irby, Denorah	APRN	Anesthesiology	Bridgeport Anesthesia Associates
BH	Padilla, Linda	MD	Obstetrics & Gynecology	
BH	Pagan, Krystal	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Paidas, Michael	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Pana, Edmund Ray	MD	Internal Medicine	Milford Hospital
BH	Panzer, Kevin	MD	Internal Medicine	
BH	Paraiso, Edward	MD	Surgery	Urological Associates of Bridgeport, PC
BH	Paramanathan, Mary	MD	Pediatrics	Bpt-Monroe Pediatric Group
BH	Paramanathan, Wigneswaran	MD	Internal Medicine	
BH	Parkash, Vinita	MD	Pathology	Bridgeport Hospital
BH	Passalacqua, Jo-Anne	MD	Internal Medicine	PriMed
BH	Passaretti, David	MD	Surgery	Aesthetic Surgery Center of Connecticut
BH	Patel, Abhijit	MD, PhD	Internal Medicine	Lawrence & Memorial Hospital
BH	Patel, Hemal	PA	Psychiatry	Northeast Medical Group
BH	Patel, Suhash	DO	Internal Medicine	Advanced Cardiovascular Specialists
BH	Patil, Ranjana	MD	Pediatrics	Fairfield Pediatrics, Inc.
BH	Patrignelli, Robert	MD	Internal Medicine	
BH	Patrizio, Pasquale	MD	Obstetrics & Gynecology	Yale Fertility Center
BH	Pazienza, Anthony	PA	Anesthesiology	YUSM Department of Emergency Medicine
BH	Pearl, Adam	MD	Surgery	Connecticut Ear Nose Throat Medical & Surgical Specialists, P.C.
BH	Peluso, Anthony	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Pepin, Lauren	APRN	Internal Medicine	Bridgeport Hospital
BH	Perali, Tulasi	MD	Internal Medicine	Northeast Medical Group
BH	Peregrim, David	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Perez Lozada, Juan Carlos	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Perlman, Neil	MD	Surgery	
BH	Persico, Justin	MD	Internal Medicine	Smilow Cancer Care -Trumbull
BH	Persing, John	MD	Surgery	YUSM Section of Plastic Surgery
BH	Peterson, Arnold	MD	Internal Medicine	
BH	Petrok, Karen	APRN	Internal Medicine	Bridgeport Hospital
BH	Pettker, Christian	MD	Obstetrics & Gynecology	YUSM Section of Maternal Fetal-Medicine
BH	Pettway-Stewart, Sharon	APRN	Internal Medicine	Northeast Medical Group, Inc.

BH	Phelan, Kay	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Philpotts, Liane	MD	Radiology	YUSM Department of Diagnostic Radiology/ Smilow Cancer Hospital
BH	Pillsbury, Nicole	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Pinto, Edward	MD	Internal Medicine	Northeast Medical Group
BH	Pinto, Marguerite	MD	Pathology	Bridgeport Hospital
BH	Piscitelli, Ruth	APRN	Internal Medicine	PriMed
BH	Pitassi, Theresa	PA	Emergency Medicine	
BH	Plasencia, Veronica	MD	Internal Medicine	PriMed
BH	Pleimann, Jennifer	PA	Radiology	Advanced Radiology Consultants
BH	Polisetty, Lakshmi	MD	Internal Medicine	Northeast Medical Group
BH	Polke, Nicolle	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Pollack, Ari	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Pollack, Brian	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Pollak, Jeffrey	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Pomeraniec, Lazaro	MD	Psychiatry	
BH	Pomianowski, Pawel	MD	Internal Medicine	Northeast Medical Group
BH	Ponomarenko, Ihor	MD	Surgery	
BH	Portnay, Edward	MD	Internal Medicine	Cardiology Physicians of Fairfield, LLC
BH	Possenti, Paul	PA	Surgery	Bridgeport Hospital, Section of Trauma and Critical Care
BH	Pounds, Nicole	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Power-Lewis, Dana	APRN	Internal Medicine	Cardiac Specialists, PC
BH	Prasad, Manju	MD	Pathology	YUSM Department of Pathology
BH	Preda, Ioana	MD	Internal Medicine	PriMed
BH	Presnick, Carole	MD	Obstetrics & Gynecology	Northeast Medical Group, Inc.
BH	Prewitt, R. Scott	MD	Internal Medicine	PriMed
BH	Pronovost, Mary	MD	Surgery	Northeast Medical Group
BH	Proto, Kristiane	APRN	Internal Medicine	Northeast Medical Group
BH	Pulice, Edward	MD	Surgery	
BH	Pun, Manuel	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Pylypiv, Taras	PA	Surgery	Bridgeport Hospital
BH	Qadir, Muhammad	MD	Internal Medicine	Northeast Medical Group
BH	Quinn, Kathryn	MD	Pediatrics	Trumbull Pediatrics
BH	Rabinowitz, Stephen	MD	Surgery	Ophthalmic Surgeons of Greater Bridgeport, P.C.
BH	Raghu, Madhavi	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging

BH	Rago, Thomas	MD	Surgery	
BH	Rai, Himal Yadav	APRN	Internal Medicine	Northeast Medical Group
BH	Ralabate, James	MD	Internal Medicine	Primary Care Associates Stratford
BH	Rama, Myl	MD	Internal Medicine	
BH	Ramirez, Randolph	MD	Internal Medicine	
BH	Ramzan, Usman	MD	Internal Medicine	
BH	Rancourt, Jamille	PA	Pediatrics	Yale-New Haven Children's Hospital at Bridgeport Hospital
BH	Rankin, Katricia	CRNA	Anesthesiology	YUSM Department of Anesthesiology
BH	Rao, Balaji	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Rao, Sanjeev	MD	Internal Medicine	Northeast Medical Group
BH	Rao, Vidhya	MD	Internal Medicine	PriMed
BH	Rapko, Leon	DO	Internal Medicine	Northeast Medical Group
BH	Ray, Kerry	APRN	Pediatrics	Bridgeport Hospital - Dept of Neonatology
BH	Raymond, Ronald	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Razdan, Rishi	MD	Radiology	CT Image Guided Surgery
BH	Reddy, Vikram	MD	Surgery	YUSM Department of Surgical Gastroenterology
BH	Redler, Michael	MD	Surgery	
BH	Reese, Katherine	MD	Obstetrics & Gynecology	
BH	Reeser, Pamela	MD	Radiology	Advanced Radiology Consultants
BH	Reguero Hernandez, Jorge	MD	Surgery	YUSM Section of Gastroenterology
BH	Renzulli, Brenda	APRN	Internal Medicine	Northeast Medical Group
BH	Reyes, Jose Luis	MD	Obstetrics & Gynecology	Affiliates in Women's Care
BH	Reyes, Myrna	MD	Internal Medicine	Optimus Health Care
BH	Reznikoff, Glen	MD	Internal Medicine	
BH	Riccio, Gioia	MD	Radiology	Bridgeport Hospital Outpatient Radiology
BH	Rich, Glenn	MD	Internal Medicine	Fairfield. Co. Med. Grp, P.C.
BH	Richard, Amelita	APRN	Internal Medicine	Northeast Medical Group
BH	Richards, Dara	MD	Pediatrics	Southwest Community Health Center
BH	Richer, Ross	MD	Surgery	Orthopaedic Specialty Group
BH	Richer, Sara	MD	Surgery	NEMG - Head and Neck Surgery
BH	Rimm, David	MD, PhD	Pathology	YUSM Department of Pathology
BH	Rivelli, Michelle	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
BH	Rivera, Arnold	MD	Surgery	
BH	Robbins, Kim	MD	Surgery	Robbins Eye Center
BH	Robert, Marie	MD	Pathology	YUSM Department of Pathology

BH	Roberts, Kenneth	MD	Internal Medicine	YUSM Department of Therapeutic Radiology - Smilow Cancer Hospital
BH	Roberts, Kurt	MD	Surgery	YUSM Section of Surgical Gastroenterology
BH	Robles, Amy	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
BH	Rodriguez, Jose Alberto	CRNA	Anesthesiology	YUSM Department of Anesthesiology
BH	Rodriguez, Lealani	MD	Obstetrics & Gynecology	
BH	Rodriguez-Murphy, Amanda	MD	Pediatrics	Pediatric Healthcare Associates
BH	Rohrig, Carolyn	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Ronen, Alon	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Rosa, Joseph	MD	Internal Medicine	PriMed
BH	Rosen, Louis	APRN	Internal Medicine	Northeast Medical Group
BH	Rosenberg, Ilene	MD	Internal Medicine	Internal Medicine of Milford
BH	Rosenblatt, Melvin	MD	Radiology	CT Image Guided Surgery, P.C.
BH	Rosenfeld, Lynda	MD	Internal Medicine	YMG at the Shoreline-Cardiology
BH	Rosenthal, Jeffrey	MD	Surgery	
BH	Rosovsky, Mark	MD	Radiology	Advanced Radiology Consultants
BH	Rossie, Carrie	PA	Surgery	
BH	Rotondi, Stephen	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc.
BH	Rowe, Stephanie	DO	Internal Medicine	Northeast Medical Group
BH	Rowland, Christine	PA	Psychiatry	Northeast Medical Group, Inc.
BH	Ruchman, Mark	MD	Surgery	
BH	Rudolph, Daniel	MD	Internal Medicine	Pulmonary & Internal Medicine Associates
BH	Ruggiero, Filomena	CRNA	Anesthesiology	YUSM Department of Anesthesiology
BH	Rusadze, Eka	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Russi, Mark	MD	Emergency Medicine	YNHH Occupational Health Services
BH	Russo, Gregory	MD	Radiology	Robert D. Russo, MD & Assoc.
BH	Russo, Robert	MD	Radiology	Robert D. Russo, MD & Assoc
BH	Ruszkowski, Jaime	MD	Internal Medicine	PriMed
BH	Ryan, Kyle	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Sackstein, Robert	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	Sadinsky, Howard	DO	Pediatrics	Milford Pediatric Group
BH	Saffir, Michael	MD	Internal Medicine	Orthopaedic Specialty Group
BH	Sager, Barbara	MD	Obstetrics & Gynecology	
BH	Saintilus, Molain	MD	Internal Medicine	PriMed
BH	Salam, Adil	MD	Internal Medicine	Pulmonary & Internal Medicine Associates

BH	Salem, Ronald	MD	Surgery	YUSM Section of Surgical Oncology
BH	Sanchez, Mayra	MD	Internal Medicine	YUSM Section of Gastroenterology
BH	Sandler, Jeffrey	MD	Surgery	Eye Group of CT, LLC
BH	Santomauro, Anthony	MD	Obstetrics & Gynecology	Alliance for Women's Health
BH	Sapiente, Kathryn	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Sapire, Joshua	MD	Radiology	Advanced Radiology Consultants
BH	Sarracino, Joanna	MD	Surgery	Ophthalmic Surgeons of Greater Bridgeport, P.C.
BH	Sauer, Harold	MD	Obstetrics & Gynecology	
BH	Saul, Zane	MD	Internal Medicine	Internal Medicine & Infectious Disease Assoc
BH	Savage, Joseph	DO	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Savetamal, Alisa	MD	Surgery	Northeast Medical Group, Inc.
BH	Sceppa, Debra	PA	Internal Medicine	
BH	Schaschl, Jodi	PA	Surgery	Bridgeport Hospital
BH	Schilling, Kate	PA	Internal Medicine	Northeast Medical Group
BH	Schlachter, Todd	MD	Radiology	YUSM Department of Radiology and Biomedical Imaging - Outpatient Radiology Services
BH	Schlein, Allen	MD	Surgery	Orthopaedic Surgery Associates, P.C.
BH	Schmaling, Brittany	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Schoppmann, Ann Marie	PA	Surgery	Bridgeport Hospital
BH	Schussheim, Adam	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Schwartz, Dana	MD	Radiology	Advanced Radiology Consultants
BH	Schwartz, Robert	DPM	Surgery	
BH	Scoville, Ann	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Scuderi, Joseph	MD	Internal Medicine	Northeast Medical Group
BH	Segen, Janet	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Sena, Kanaga	MD	Internal Medicine	Neurological Specialists
BH	Sergi, Michael	MD	Surgery	Southern Connecticut Vascular Center
BH	Setkoski, Ronald	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Severo, Charles	PA	Internal Medicine	CT Heart & Vascular Center, PC
BH	Sfakianaki, Anna	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Shah, Mukeshkumar	MD	Pediatrics	
BH	Shah, Shivani	MD	Pediatrics	Southwest Community Health Center
BH	Shah, Subhash	MD	Surgery	General Surgeons Greater Bridgeport
BH	Shah, Vinnie	MD	Surgery	Ophthalmic Surgeons of Greater Bridgeport, P.C.
BH	Shanley, Ana	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc

BH	Sharfuddin, Muhammad	MD	Internal Medicine	Northeast Medical Group
BH	Sharma, Prabin	MD	Internal Medicine	Bridgeport Hospital
BH	Shear, Perry	MD	Surgery	Orthopaedic Specialty Group
BH	Sheehan, Diane	APRN	Internal Medicine	Northeast Medical Group
BH	Sheehan, Jeffrey	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Sheikh, Kiran	MD	Radiology	Advanced Radiology Consultants
BH	Sheiman, Laura	MD	Radiology	Yale-New Haven Hospital, Saint Raphael Campus
BH	Sheiman, Rachel	MD	Pediatrics	Willow Pediatric Group
BH	Sherlip, Bernard	MD	Internal Medicine	
BH	Sheynberg, Boris	MD	Internal Medicine	
BH	Shimkin, Peter	MD	Radiology	Advanced Radiology Consultants
BH	Shin, Chung	MD	Surgery	
BH	Shipkowitz, Sandra	APRN	Pediatrics	Bridgeport Hospital
BH	Shostak, Lakin	PA	Obstetrics & Gynecology	
BH	Sica, Daniel	MD	Internal Medicine	PriMed
BH	Sierra, Cesar	MD	Surgery	
BH	Sikorski, Kristan	MD	Internal Medicine	Bridgeport Hospital
BH	Sikorski, Linsley	MD	Internal Medicine	
BH	Silasi, Dan-Arin	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
BH	Silasi, Michelle	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
BH	Siljamaki, Karie	APRN	Internal Medicine	PriMed
BH	Simkovitz, Philip	MD	Internal Medicine	
BH	Simo, Sheran	APRN	Internal Medicine	Bridgeport Palliative Care
BH	Simpson, Christine	APRN	Psychiatry	Bridgeport Hospital
BH	Simses, John	MD	Surgery	
BH	Sinard, John	MD, PhD	Pathology	YUSM Department of Pathology
BH	Sklar, Jeffrey	MD	Pathology	YUSM Department of Pathology
BH	Small, Jeffrey	MD	Surgery	
BH	Small, Martha	MD	Pediatrics	Pediatric Healthcare Associates
BH	Small, Peter	MD	Surgery	Peter A. Small. M.D.
BH	Smerling, Neil	MD	Internal Medicine	
BH	Smillie, Christina	MD	Pediatrics	Breastfeeding Resources
BH	Smith, Brian	MD	Pathology	YUSM Department of Laboratory Medicine
BH	Smith, Jason	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Smith, Marilyn	MD	Pediatrics	Canterbury Pediatrics

BH	Smith, Marissa	MD	Internal Medicine	The Orthopedic & Sports Medicine Center
BH	Smith, Michael	MD	Internal Medicine	Northeast Medical Group
BH	Smith, Scott	MD	Radiology	Advanced Radiology Consultants
BH	Snowden, Lenore	MD	Internal Medicine	PriMed
BH	Snyder, Christopher	MD	Internal Medicine	Internal Medicine of Milford
BH	Sokol, Joseph	MD	Surgery	Connecticut Eye Specialists
BH	Solomon, Daniel	MD	Surgery	YUSM Section of Pediatric Surgery - YNHH Children's Hospital
BH	Soloway, Gregory	MD	Internal Medicine	Gastroenterology Associates, P.C.
BH	Sood, Pardeep	MD	Anesthesiology	
BH	Soto, Leland	MD	Surgery	
BH	Soviero, Fiore	PA	Surgery	
BH	Spadinger, Andrew	DDS	Surgery	Commerce Park Dental Group
BH	Spak, James	MD	Surgery	The Orthopedic & Sports Medicine Center
BH	Spano, Frank	MD	Internal Medicine	Fairfield. Co. Med. Grp, P.C.
BH	Spanolios, Paris	MD	Internal Medicine	Internal Medicine of Milford
BH	Spector, Gary	MD	Internal Medicine	Internal Medicine of Milford
BH	Spector, Kenneth	MD	Internal Medicine	Cardiology Associates of Derby
BH	Spinner, Gary	PA	Internal Medicine	Southwest Community Health Center
BH	Spinner, Janet	CNM	Obstetrics & Gynecology	Southwest Community Health Center
BH	Spivack, Julie	MD	Internal Medicine	
BH	Squicciarini, Helena	DO	Obstetrics & Gynecology	Womens Healthcare of Trumbull
BH	Stahl Hartley, Lynne	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Stanton, Robert	MD	Surgery	Orthopaedic Specialty Group
BH	Stanwood, Nancy	MD	Obstetrics & Gynecology	Women's Center
BH	Staub, Edward	MD	Surgery	
BH	Steckel, Mark	MD	Surgery	Pediatric & Adult Ophthalmology
BH	Steenbergen, Peter	MD	Radiology	Advanced Radiology Consultants
BH	Steeves, Corrie	MD	Pediatrics	Pediatric Healthcare Associates
BH	Stein, Stephen	MD	Radiology	Advanced Radiology Consultants
BH	Stelman, Milla	MD	Internal Medicine	PriMed
BH	Stetter, Kevin	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Stevenson, David	APRN	Internal Medicine	
BH	Stewart, Raymond	MD	Internal Medicine	Optimus Health Care
BH	Stiller, Robert	MD	Obstetrics & Gynecology	Mill Hill Medical Consultants
BH	Stone, Kenneth	MD	Anesthesiology	Bridgeport Anesthesia Associates

BH	Storck, Susan	APRN	Internal Medicine	
BH	Stramaglia, Lynn	PA	Surgery	Orthopedic Specialty Group
BH	Stratford, Kevin	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Stupak, Daniel	MD	Internal Medicine	
BH	Sumpio, Bauer	MD, PhD	Surgery	YUSM Section of Vascular Surgery
BH	Sze, Gordon	MD	Radiology	Yale-New Haven Hospital - Temple Radiology
BH	Taikowski, Richard	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Tandon, Sapna	DO	Obstetrics & Gynecology	
BH	Taubin, Howard	MD	Internal Medicine	Gastroenterology Associates, P.C.
BH	Taylor, Amy Rose	APRN	Internal Medicine	Northeast Medical Group
BH	Taylor, Lauren	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Thomas, Kenneth	MD	Obstetrics & Gynecology	
BH	Thomas, Listy	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Thomson, James	MD	Surgery	YUSM Section of Plastic Surgery
BH	Thornquist, Steven	MD	Surgery	Solo Practice
BH	Thornton, Scott	MD	Surgery	Northeast Medical Group
BH	Tiano, Joseph	MD	Internal Medicine	Cardiology Physicians of Fairfield
BH	Tilley, Evan	MD	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Tola-Shelby, Vicky	MD	Internal Medicine	Optimus Health Care
BH	Torbey, Marina	MD	Obstetrics & Gynecology	Womens Healthcare of Trumbull
BH	Tornatore, Jean	MD	Obstetrics & Gynecology	Northeast Medical Group
BH	Torres, Richard	MD	Internal Medicine	Southwest Community Health Center
BH	Tortora, Louise	DPM	Surgery	
BH	Tortora, Peter	MD	Internal Medicine	
BH	Tortorello, Joseph	MD	Internal Medicine	PriMed
BH	Toumanian, Karine	MD	Internal Medicine	PriMed
BH	Tracy, Lindsey	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Tracy, Todd	MD	Internal Medicine	Internal Medicine of Milford
BH	Tsalapatanis, John	MD	Pediatrics	Canterbury Pediatrics
BH	Tsang, Benjamin	MD	Pediatrics	Greenwich Hospital
BH	Tuohy, Edward	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Turetsky, Arthur	MD	Internal Medicine	Pulmonary & Internal Medicine Associates
BH	Turetsky, Rochelle	MD	Internal Medicine	Northeast Medical Group
BH	Tyler, Chrystal	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Tzakas, Nicholas	MD	Pediatrics	Bpt-Monroe Pediatric Group

BH	Urciuoli, Stephen	MD	Internal Medicine	PriMed
BH	Uysal, Alisa	CRNA	Anesthesiology	
BH	Vaidya, Kirit	MD	Anesthesiology	Bridgeport Anesthesia Assoc.
BH	Vallabhaneni, Vasudha	MD	Internal Medicine	PriMed
BH	VanDell, Peter	MD	Obstetrics & Gynecology	OB/GYN of Fairfield County
BH	Vander Vennet, Scott	MD	Obstetrics & Gynecology	
BH	Varga-Eaton, Brittany	PA	Surgery	Park Avenue Surgical Associates
BH	Varkey, Prathibha	MD	Internal Medicine	Northeast Medical Group
BH	Vash-Margita, Alla	MD	Obstetrics & Gynecology	The Center for Women's Health and Midwifery
BH	Vasquez, Romulo	MD	Internal Medicine	
BH	Vasquez, Tito	MD	Surgery	CT Plastic Surgery Group
BH	Vayneris, Lindsey	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Veksler-Offengenden, Irena	MD	Internal Medicine	Allergy & Asthma Care Flfd Cty
BH	Velasco, Noel	MD	Radiology	Advanced Radiology Consultants
BH	Vilarinho, Silvia	MD, PhD	Internal Medicine	YUSM Section of Gastroenterology
BH	Vindheim, Sonja	DO	Pediatrics	Pediatric Healthcare Associates
BH	Viner, Nicholas	MD	Surgery	Urological Associates of Bridgeport, PC
BH	Wainer, Bruce	MD	Internal Medicine	
BH	Wallick, Nancy	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Walsh, Brooks	MD	Emergency Medicine	Bridgeport Hospital
BH	Walsh, Keelin	PA	Pediatrics	PediCare
BH	Waltzman, Michael	MD	Surgery	Primed
BH	Wang, Annie	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Wang, Jeff	MD	Obstetrics & Gynecology	Sher Fertility Institute
BH	Ward, Douglas	PA	Surgery	Bridgeport Hospital
BH	Watkins-Colwell, Kellie	MD	Internal Medicine	PriMed
BH	Watson, Charles	MD	Anesthesiology	Bridgeport Anesthesia Associates
BH	Waynik, Mark	MD	Psychiatry	Waynik & Waynik
BH	Webb, Lisa	MD	Internal Medicine	Neurological Specialists, P.C.
BH	Weber-Chess, Barbara	MD	Pediatrics	Northeast Medical Group
BH	Weed, Maia	APRN	Internal Medicine	Northeast Medical Group
BH	Weiland, Daniel	MD	Surgery	The Orthopedic & Sports Medicine Center
BH	Weinrib, Amy	MD	Pediatrics	Pediatric Healthcare Associates
BH	Weinstein, Robert	MD	Surgery	Urological Associates of Bridgeport, PC
BH	Weiss, Scott	MD	Internal Medicine	PriMed

BH	Weisz, James	MD	Surgery	Connecticut Retina Consultants
BH	Weitzman, Marc	MD	Surgery	Ophthalmic Surgeons of Greater Bridgeport, P.C.
BH	Welte, Rebecca	APRN	Pediatrics	Yale-New Haven Hospital NICU
BH	Werdmann, Michael	MD	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Werner, Craig	MD	Internal Medicine	CT Heart & Vascular Center, PC
BH	West, Alexander	MD	Pathology	YUSM Department of Pathology
BH	Wieber, Stasia	MD	Internal Medicine	PriMed
BH	Wilchinsky, Mark	MD	Surgery	
BH	Wilder, Jason	DO	Internal Medicine	Adult & Pedi Dermatology Specialists
BH	Wilkinson, Joseph	MD	Emergency Medicine	
BH	Williams, Cheryl	PA	Obstetrics & Gynecology	
BH	Williams, Dennis	MD	Internal Medicine	Bridgeport Family Health
BH	Williams, Jody	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
BH	Williams, Scott	MD	Radiology	Advanced Radiology Consultants
BH	Williams, Shaun	MD	Obstetrics & Gynecology	
BH	Wilson, Lynn	MD	Internal Medicine	YUSM Department of Therapeutic Radiology
BH	Winslow, Robert	MD	Internal Medicine	Cardiac Specialists, P.C.
BH	Winter, Sarah	PA	Obstetrics & Gynecology	
BH	Witt, David	MD	Internal Medicine	Smilow Cancer Care -Trumbull
BH	Wolf, Carrie	CNM	Obstetrics & Gynecology	
BH	Wolff, Armand	MD	Internal Medicine	Northeast Medical Group, Inc.
BH	Wong, Serena	MD	Pathology	YUSM Department of Pathology
BH	Wood, Kevin	PA	Internal Medicine	Northeast Medical Group
BH	Woods, John	PA	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Woodworth, Stephen	MD	Internal Medicine	
BH	Wozmak, Stefanie	PA	Emergency Medicine	
BH	Woznica, David	MD	Internal Medicine	Yale-New Haven Hospital Spine Center
BH	Wray, Shantell	PA	Internal Medicine	Northeast Medical Group
BH	Wright, Catherine	APRN	Internal Medicine	Northeast Medical Group
BH	Wright, Monica	APRN	Emergency Medicine	Bpt. Hosp. Emergency Medicine
BH	Xie, Minhui	MD	Internal Medicine	Northeast Medical Group
BH	Xu, Mina	MD	Pathology	YUSM Department of Pathology
BH	Yagan, Neda	MD	Radiology	Advanced Radiology Consultants
BH	Yale, Abraham	DPM	Surgery	Assoc Podiatrists of Fairfield
BH	Yannopoulos, Panayotes	DO	Internal Medicine	

BH	Yarbrough, Wendell	MD	Surgery	YUSM Section of Otolaryngology
BH	Yasick, Donna	APRN	Internal Medicine	
BH	Yavari, Reza	MD	Internal Medicine	Northeast Medical Group
BH	Yildiz, Isil	MD	Pathology	Greenwich Hospital
BH	Young, Amy	PA	Radiology	
BH	Young, Robert	PA	Surgery	Advanced Radiology Consultants
BH	Yu, James	MD	Internal Medicine	Lawrence & Memorial Hospital
BH	Yuh, David	MD	Surgery	YUSM Section of Cardiac Surgery
BH	Zachmann, Dorothy	MD	Psychiatry	
BH	Zack, Michelle	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc
BH	Zangrillo, Richard	MD	Internal Medicine	Immediate Medical Care of Monroe
BH	Zarcu-Power, Flora	MD	Internal Medicine	NEMG - PriMed
BH	Zarich, Stuart	MD	Internal Medicine	Northeast Medical Group
BH	Zimmerman, Gary	MD	Surgery	Connecticut Neurosurgical Specialists, P.C.
BH	Zinn, Kenneth	MD	Radiology	Advanced Radiology Consultants
BH	Zohrabian, Vahe	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
BH	Zolkowski-Wynne, Joanna	MD	Pediatrics	Northeast Medical Group, Inc.
BH	Zou, Lei	MD	Psychiatry	YUSM Department of Child Psychiatry
BH	Zucconi, William	DO	Radiology	Yale-New Haven Hospital, Saint Raphael Campus
BH	Zuckerman, Howard	MD	Surgery	Urological Associates of Bridgeport, PC
BH	Zuckman, Arnold	DPM	Surgery	Northeast Medical Group
BH	Zylick, Anne	APRN	Internal Medicine	
GH	Abbed, Khalid	MD	Surgery	Yale-New Haven Hospital Spine Center
GH	Abernathie, Brenon	MD	Surgery	WESTMED Medical Group
GH	Abrahams, Hanief	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Accorsini, Elaine	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Acker, Peter	MD	Pediatrics	WESTMED Medical Group (Pediatrics)
GH	Adams, Diana	MD	Obstetrics & Gynecology	Greenwich Perinatology Services
GH	Addeo, Daniela	MD	Radiology	Greenwich Hospital- Radiation Oncology
GH	Agrawal, Anjali	MD	Radiology	Teleradiology Solutions
GH	Alleva, Anthony	MD	Internal Medicine	Stamford Health Medical Group
GH	Alonzo, Catherine	MD	Surgery	Greenwich Urological Associates, PC
GH	Altmeyer, Vicki	MD	Pathology	Greenwich Hospital
GH	Amstel, David	MD	Internal Medicine	WESTMED Medical Group
GH	Anderson, Erin	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists

GH	Anegundi, Vidya Margaret	MD	Pediatrics	Next Generation Pediatrics, LLC
GH	Ang, Sandra	MD	Internal Medicine	Rye Walk In Medical Center
GH	Ankrah, Yvonne	MD	Obstetrics & Gynecology	OB/GYN Specialists of Westchester - NEMG
GH	Anschel, David	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Apostolides, Paul	MD	Surgery	Orthopaedic & Neurosurgery Specialists
GH	Archer, Herbert	MD, PhD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Arevalo, Diana	MD	Internal Medicine	WESTMED Medical Group
GH	Aribandi, Manohar	MD	Radiology	Teleradiology Solutions
GH	Aronow, Rachel	MD	Pediatrics	WESTMED Medical Group
GH	Aschkenasi, Carl	MD	Radiology	
GH	Aslanian, Robert	DDS	Surgery	Infinity Oral Surgery
GH	Attaran, Robert	MD	Internal Medicine	YUSM Section of Cardiology
GH	Attkiss, Keith	MD	Surgery	Keith Attkiss, M.D.
GH	Auerbach, Marc	MD	Emergency Medicine	YUSM Section of Pediatric Emergency Medicine
GH	Badaru, Angela	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
GH	Bader, Eric	MD	Internal Medicine	YUSM Section of Cardiovascular Medicine
GH	Band, Matthew	PA	Internal Medicine	YUSM Section of Trauma & Critical Care
GH	Baranin, Renee	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Barowsky, Jeremy	MD	Psychiatry	Greenwich Hospital
GH	Barro, Jennifer	MD	Internal Medicine	Center for GI Medicine of Fairfield & Westchester
GH	Basile, Kimberly	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Baskin, Steven	PhD	Psychiatry	Steven Baskin, Ph.D.
GH	Basulto, Dean	MD	Internal Medicine	WESTMED Medical Group
GH	Bauer, Stephen	MD	Surgery	Southern Connecticut Vascular Center
GH	Beckman, Karen	MD	Pediatrics	Riverside Pediatrics, LLC
GH	Bell, Ryan	MD	Internal Medicine	NEMG Internal Medicine Cos Cob
GH	Bellapianta, Joseph	MD	Orthopedics	Bellapianta Orthopaedics & Sports Medicine
GH	Bellapianta, Karen	MD	Surgery	Associates of Otolaryngology, P.C.
GH	Benn, Britt	PA	Obstetrics & Gynecology	WESTMED Medical Group
GH	Bennett, Steven	DO	Internal Medicine	Greenwich Pain Consulting Services - Northeast Medical Group
GH	Benton, Patrick	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Bergen, Michele	DMD	Surgery	Infinity Oral Surgery
GH	Berkun, David	MD	Pediatrics	High Ridge Family Practice
GH	Berna, Gioiamaria	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Bernstein, Lana	MD	Internal Medicine	

GH	Berran, Mary	APRN	Pediatrics	Greenwich Hospital
GH	Berzolla, Catherine	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Besser, Gary	MD	Obstetrics & Gynecology	Obstetrics & Gynecology Associates
GH	Beucher, Meghan	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
GH	Bhojwani, Shaan	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Bilenkin, Leonid	PA	Surgery	Greenwich Hospital
GH	Blaine, Theodore	MD	Orthopedics	YUSM Department of Orthopedics
GH	Blair, Bryan	MD	Surgery	WESTMED Medical Group
GH	Blake, Kimberly	APRN	Internal Medicine	Greenwich Hospital- Morgan Stanley Occupational Me
GH	Blanco, Christina	MD	Pediatrics	WESTMED Medical Group
GH	Blum, Susan	MD	Internal Medicine	Blum Center for Health
GH	Boczko, Judd	MD	Surgery	WESTMED Medical Group
GH	Bond, Annette	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Bonheim, Nelson	MD	Internal Medicine	Center for GI Medicine of Fairfield & Westchester
GH	Bonheur, James	MD	Surgery	The Advanced Minimally Invasive Surgery, LLC
GH	Bonoan, Elaine	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Bouchard, Nicole	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists, P.C.
GH	Bowman, Jonathan	MD	Surgery	Southern Connecticut Vascular Center
GH	Boyd, D. Barry	MD	Internal Medicine	Greenwich Hospital Smilow Physicians Specialty Program
GH	Bragg, Jennifer	MD	Pediatrics	Greenwich Hospital
GH	Bramwit, Steven	MD	Surgery	Greenwich Ear, Nose & Throat - Head & Neck Surgery
GH	Brauer, Anate	MD	Obstetrics & Gynecology	Greenwich Fertility
GH	Brauer, Richard	MD	Surgery	Associates of Otolaryngology, P.C.
GH	Braun, Devra	MD	Psychiatry	IMAP of Greenwich, LLC
GH	Braunworth, Jacqueline	PA	Surgery	Elsa M. Raskin, MD, PC
GH	Brea, Francisco	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Brennan, Joseph	MD	Internal Medicine	Yale-New Haven Cardiac Rehabilitation Center
GH	Briccetti, Grace	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Brito, Monica	MD	Obstetrics & Gynecology	OB/GYN Specialists of Westchester - NEMG
GH	Britto Leon, Clemente	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Britvan, J. Allen	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Brodlie, Jerome	PhD	Psychiatry	Jerome Brodlie, Ph.D.
GH	Brodsky, Adam	MD	Orthopedics	Orthopaedic Surgery & Sports Medicine
GH	Brody, Steven	DDS	Surgery	Greenwich Oral & Maxillofacial Surgery, P.C.
GH	Bronin, Andrew	MD	Internal Medicine	

GH	Brown, William	MD	Surgery	The Urology Clinic of Greenwich
GH	Browning, Nicholas	MD	Internal Medicine	Y-NHH, St. Raphael Campus - Occupational Health Plus
GH	Brunetti, James	DO	Internal Medicine	James A. Brunetti, II, D.O.
GH	Cabin, Henry	MD	Internal Medicine	YUSM Section of Cardiology
GH	Calayag, Patricia	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Camel, Mark	MD	Surgery	Orthopaedic & Neurosurgery Specialists, P.C.
GH	Canter, Michael	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Cantlon, Matthew	MD	Orthopedics	Orthopaedic & Neurosurgery Specialists, PC
GH	Carolan, Stephen	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Carroll, Dzwinka	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Carter, Cordelia	MD	Orthopedics	YUSM Department of Orthopedics
GH	Carton, Lauren	MD	Pediatrics	WESTMED Medical Group (Pediatrics)
GH	Casasanta, Kristin	MD	Pediatrics	Pediatric Associates - Northeast Medical Group
GH	Cass, Alison	MD	Pediatrics	Greenwich Pediatric Associates
GH	Caty, Michael	MD	Surgery	YUSM Section of Pediatric Surgery
GH	Cavallo, Russell	MD	Orthopedics	Russell Cavallo, M.D.
GH	Ceccarelli, Silvio	MD	Internal Medicine	WESTMED Medical Group
GH	Cerabona, Thomas	MD	Surgery	Surgical Intensivists
GH	Chang, Andrew	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Chang, Robert	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Chapar, George	PhD	Psychiatry	
GH	Charny, Caleb	MD	Surgery	WESTMED Medical Group
GH	Charron, Mariane	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Chinitz, Noah	MD	Orthopedics	WESTMED Medical Group
GH	Chinn, Lauren	PA	Surgery	WESTMED Medical Group
GH	Chodock, Allen	MD	Internal Medicine	
GH	Christison-Lagay, Emily	MD	Surgery	YUSM Section of Pediatric Surgery
GH	Chrostowski, Mark	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Clain, Michael	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Clarke, Adelina	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Clarke-Leconte, Tracy-Ann	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Cleare, Wendy	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Cleman, Michael	MD	Internal Medicine	YUSM Section of Cardiology
GH	Close, Patricia	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Cochran, Terry	MD	Anesthesiology	Greenwich Anesthesiology Associates

GH	Cody, Loretta	MD	Pediatrics	Children's Medical Group of Greenwich P.C.
GH	Cohen, Erik	MD	Pediatrics	Next Generation Pediatrics, LLC
GH	Coleman, Christine	APRN	Pediatrics	Greenwich Hospital
GH	Coletti, Donna	MD	Internal Medicine	Greenwich Hospital
GH	Colker, Carlon	MD	Internal Medicine	Peak Wellness
GH	Conboy, Kevin	MD	Internal Medicine	
GH	Connors, Geoffrey	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Connors, Richard	MD	Internal Medicine	Richard C. Connors, M.D., P.C.
GH	Conway, Joseph	MD	Surgery	Greenwich Ophthalmology Associates
GH	Cooper, Louis	DDS	Surgery	Louis Cooper, DDS
GH	Cooperman, Daniel	MD	Orthopedics	YUSM Department of Orthopedics
GH	Cottrol, Cheryl	MD	Psychiatry	Affiliates of Neurology and Psychiatry
GH	Cousin, Jeffrey	MD	Surgery	ENT AND ALLERGY ASSOCIATES, LLP
GH	Coven, Barbara	MD	Pediatrics	WESTMED Medical Group
GH	Cowles, Robert	MD	Surgery	YUSM Section of Pediatric Surgery
GH	Cram, Amy	MD	Pediatrics	Pediatric Associates - Northeast Medical Group
GH	Cunningham, James	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Curtis, Jeptha	MD	Internal Medicine	Cardiovascular Services of Greenwich - NEMG
GH	Cziner, David	MD	Internal Medicine	WESTMED Medical Group
GH	Dadasovich, Ryan	MD	Internal Medicine	Northeast Medical Group Internal Medicine
GH	Damast, Shari	MD	Radiology	YUSM Department of Therapeutic Radiology
GH	D'Amico, Joseph	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Danehower, Richard	MD	Internal Medicine	NEMG Greenwich Rheumatology
GH	Dasgupta, Ranjan	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Date, Pravin	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Datta, Manpreet	PA	Surgery	Greenwich Hospital - Operating Room
GH	Davis, Gerald	MD	Internal Medicine	Gerald Davis, M.D.
GH	Davison, Christopher	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	de Cholnoky, Corinne	MD	Obstetrics & Gynecology	Ob/Gyn Professional Associates
GH	De La Morena, Maria	MD	Pediatrics	Harrison Pediatrics
GH	De Lotbiniere, Alain	MD	Surgery	Brain & Spine Surgeons of New York, P.C.
GH	De Oliveira, Paulo	APRN	Pediatrics	Greenwich Hospital
GH	Decker, Roy	MD, PhD	Radiology	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
GH	Del Vecchio, John	MD	Internal Medicine	John Del Vecchio, M.D.

GH	Delos, Demetris	MD	Orthopedics	Orthopaedic Neurosurgery Specialists
GH	Delosangeles, Servando	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	DelVecchio, Alexander	MD	Internal Medicine	Cardiovascular Services of Greenwich - NEMG
GH	Dempsey, Tania	MD	Internal Medicine	Armonk Integrative Medicine
GH	Denepitiya-Balicki, Tiffany	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Denkin, Jennifer	PhD	Psychiatry	Greenwich Hospital-Diabetes & Weight Management
GH	Densel, Donna	MD	Surgery	Greenwich Ophthalmology Associates, PC
GH	Desai, Kapil	MD	Radiology	Greenwich Hospital
GH	Devaraj, Chander	MD	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
GH	Devgan, Lara	MD	Surgery	
GH	Di Fazio, Frank	MD	Orthopedics	Yale Orthopaedics - Stamford
GH	Diamond, Eric	MD	Pathology	Greenwich Hospital
GH	DiCosmo, Bruno	MD	Internal Medicine	WESTMED Medical Group
GH	Dicostanzo, Damian	MD	Pathology	AmeriPath NY, LLC
GH	DiMarco, Rosaria	MD	Pediatrics	WESTMED Medical Group
GH	Dipietro, Jessica	APRN	Internal Medicine	
GH	Diwan, Adnan	MD	Internal Medicine	WESTMED Medical Group
GH	Dodington, James	MD	Emergency Medicine	YUSM Section of Pediatric Emergency Medicine
GH	Doft, Melissa	MD	Surgery	
GH	Donegan, Stacey	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Donohue, Kenneth	MD	Orthopedics	YUSM Department of Orthopedics
GH	Donovan, Leslie	MD	Obstetrics & Gynecology	Brookside Gynecology
GH	Douglas, Andrea	MD	Surgery	Stamford Health Medical Group, Neurosurgery
GH	Doyle, Casey	APRN	Internal Medicine	Cardiovascular Services of Greenwich - NEMG
GH	Doyle, James	MD	Internal Medicine	WESTMED Medical Group
GH	Drucker, Beverly	MD	Internal Medicine	Hematology & Oncology Associates of Greenwich, PC
GH	Du, Tao	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Dyer, Lori	MD	Surgery	Pediatric Urology Associates, P.C.
GH	Earle, Bridget	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Edelmann, Christopher	MD	Internal Medicine	Christopher Edelmann, MD, PC
GH	Eigles, Stephen	MD	Radiology	Teleradiology Solutions
GH	Eisenberg, Amy	MD	Pediatrics	Scarsdale Medical Group
GH	Ekong, Udeme	MD	Pediatrics	Greenwich Hospital
GH	Elias, Sara	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Ennis, Francis	MD	Orthopedics	Orthopaedic & Neurosurgery Specialists, PC

GH	Erhard, Heather	MD	Surgery	
GH	Erlich, Elyse	MD	Internal Medicine	NEMG - Internal Medicine
GH	Eschricht, Emma	APRN	Pediatrics	Greenwich Hospital
GH	Evans, David	MD	Radiology	Greenwich Hospital
GH	Ewell, Ricky	CRNA	Anesthesiology	
GH	Fajardo, Elaine	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Fazzinga, Nancy	MD	Pediatrics	Valley Pediatrics of Greenwich
GH	Federici, Vito	DMD	Surgery	Vito Federici, D.M.D., P.C.
GH	Feldman, Jarett	MD	Internal Medicine	WESTMED Medical Group
GH	Feldman, Steven	MD	Surgery	WESTMED Medical Group (Otolaryngology)
GH	Feldman, Stuart	MD	Internal Medicine	WESTMED Medical Group
GH	Fennell, Gail	MD	Internal Medicine	Stamford Health Medical Group
GH	Fern, Steven	MD	Surgery	Greenwich Plastic Surgery, LLC
GH	Feuer, Barry	MD	Internal Medicine	WESTMED Medical Group
GH	Feuerstein, Joseph	MD	Internal Medicine	Center for Integrative Health and Wellness
GH	Fey, Christopher	MD	Radiology	Greenwich Hospital
GH	Fierman, Jessica	DDS	Surgery	Louis Cooper, DDS
GH	Filippelli, Vanessa	APRN	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
GH	Filor, Caroline	MD	Obstetrics & Gynecology	Brookside Gynecology
GH	Fine, Ronnie	MD	Surgery	Pediatric Urology Associates, P.C.
GH	Finerman, Wilmore	MD	Internal Medicine	WESTMED Medical Group
GH	Finkelstein, Michael	MD	Internal Medicine	Scarsdale Medical Group
GH	Finlay, Alexis	MD	Surgery	Ridgefield Eye Physicians
GH	Fiore, Amory	MD	Surgery	Orthopaedic & Neurosurgery Specialists, P.C.
GH	Fishman, Eric	MD	Surgery	WESTMED Medical Group
GH	Flynn, Joseph	MD	Psychiatry	Greenwich Hospital
GH	Flynn, Lucy	MD	Psychiatry	
GH	Forni, Arthur	MD	Internal Medicine	WESTMED Medical Group
GH	Forrest, John	MD	Internal Medicine	YUSM Section of Cardiology
GH	Fou, Adora	MD	Surgery	WESTMED Medical Group
GH	Fox, Mark	MD	Surgery	ENT and Allergy Associates, LLP
GH	Fox, Matthew	MD	Radiology	Teleradiology Solutions
GH	Fraga, Mary	MD	Pediatrics	WESTMED Medical Group
GH	Francella, Andrew	MD	Internal Medicine	WESTMED Medical Group
GH	Francis, Gaetane	MD	Obstetrics & Gynecology	Brookside Gynecology

GH	Franco, Michael	MD	Internal Medicine	Greenwich Hospital
GH	Freedland, Susan	PhD	Psychiatry	
GH	Freedman, Janet	MD	Internal Medicine	Greenwich Hospital
GH	Friend, Todd	DO	Internal Medicine	WESTMED Medical Group
GH	Frohwirth, Richard	PhD	Psychiatry	
GH	Fusco, Michael	MD	Internal Medicine	Michael S. Fusco, M.D.
GH	Fuss, Kathryn	PA	Surgery	Greenwich Hospital
GH	Gagne, Paul	MD	Surgery	Southern Connecticut Vascular Center
GH	Gamble, Sarah	DO	Internal Medicine	Greenwich Pure Medical
GH	Gandelman, Glenn	MD	Internal Medicine	Greenwich Cardiology Associates, LLC
GH	Gandhi, Amy	MD	Emergency Medicine	Stamford Hospital
GH	Ganem, Amanda	MD	Internal Medicine	WESTMED Medical Group
GH	Gannot, Sharon	MD	Internal Medicine	WESTMED Medical Group (Internal Medicine)
GH	Gardner, Peter	MD	Internal Medicine	
GH	Garrett, Leila	MD	Obstetrics & Gynecology	Greenwich Gynecology & Obstetrics, P.C.
GH	Garrido, Frank	MD	Emergency Medicine	Bridgeport Hospital
GH	Gasiorowski, Henry	MD	Internal Medicine	Greenwich Dermatology
GH	Gazzola-Kraenzlin, Elena	MD	Pediatrics	In Town Pediatrics, PLLC
GH	Gennarelli, Louis	MD	Obstetrics & Gynecology	Greenwich Hospital
GH	George, Sandy	MD	Internal Medicine	WESTMED Medical Group
GH	Gewirtz, Harold	MD	Surgery	
GH	Gharekhan, Mandira	MD	Internal Medicine	WESTMED Medical Group
GH	Giannone, Jonathan	MD	Surgery	Surgical Intensivists
GH	Giordano, Frank	MD	Internal Medicine	YUSM Section of Cardiology
GH	Giovani, Micheline	MD	Internal Medicine	Rye Brook Cardiology & Vascular Medicine, P.C.
GH	Gitelman, Alex	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Gittelman, Paul	MD	Surgery	ENT & Allergy Associates, LLP
GH	Gladstein, Gina	MD	Surgery	Greenwich Ophthalmology Associates, LLC
GH	Glasser, Steven	MD	Internal Medicine	
GH	Glassman, Mark	MD	Pediatrics	Children's Physicians of Westchester, LLP
GH	Gleason, Bethany	APRN	Internal Medicine	YUSM Section of Trauma & Critical Care
GH	Gleason, Paul	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Glenday, Betsy	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists, PC
GH	Goldberg-Berman, Judith	MD	Internal Medicine	Judith Goldberg-Berman, M.D., Ph.D.
GH	Goldman, Kenneth	MD	Internal Medicine	

GH	Goldstein, Lee	MD	Surgery	Southern Connecticut Vascular Center
GH	Gomez Villalobos, Jose	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Goodman, Caren	MD	Pediatrics	Pediatric Associates - Northeast Medical Group
GH	Goyal, Ameet	MD	Surgery	Ameet K. Goyal, MD, PC
GH	Graham, Scott	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Grano, Vanessa	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Grant, Linda	MD	Internal Medicine	Greenwich Hospital
GH	Green, Ileana	MD	Pathology	Greenwich Hospital
GH	Greenberg-Lee, Alissa	MD	Internal Medicine	Northeast Medical Group Pulmonary Medicine
GH	Greene, Ronald	MD	Orthopedics	Orthopaedic & Neurosurgery Specialists PC
GH	Greenspun, David	MD	Surgery	
GH	Gretz, Herbert	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Gupta, Shruti	MD	Pediatrics	Greenwich Hospital
GH	Gyambibi, Kakra	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Haas, Andrew	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Habib, Taimur	MD	Internal Medicine	NEMG - Internal Medicine
GH	Haffner, Gregory	MD	Surgery	New England Retina Associates
GH	Hagberg, Donna	MD	Obstetrics & Gynecology	Donna J. Hagberg, M.D., LLC
GH	Halim, Andrea	MD	Orthopedics	YUSM Department of Orthopedics
GH	Halleran, Kerry	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Hansen, James	MD	Radiology	YUSM Department of Therapeutic Radiology
GH	Hansley, Margaret	APRN	Internal Medicine	Greenwich Hospital
GH	Harkin, Kristin	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Hart, Alyson	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Hashem, Hashem	MD	Internal Medicine	WESTMED Medical Group
GH	Hashim, Sabet	MD	Internal Medicine	Heart and Vascular Institute Hartford Healthcare
GH	Haven, Lynne	MD	Internal Medicine	
GH	Heavner, Jason	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Hedrick, David	MD	Pediatrics	Children's Medical Group
GH	Heftler, Jeffrey	MD	Internal Medicine	Orthopaedic & Neurosurgery Specialists, P.C.
GH	Heiman, Mark	MD	Internal Medicine	Cardiology Physicians of Fairfield County. LLC
GH	Heinegg, Philip	MD	Internal Medicine	Larchmont Family Medicine
GH	Henderson, Lisa	APRN	Pediatrics	Greenwich Hospital
GH	Herazo-Maya, Jose	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Herzog, David	MD	Internal Medicine	WESTMED Medical Group

GH	Hillman, Caroline	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists PC
GH	Hindman, Steven	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Hines, Brian	MD	Obstetrics & Gynecology	Stamford Health Medical Group, Urogynecology
GH	Hines, William	MD	Internal Medicine	Stamford Health Medical Group, Nephrology
GH	Hirsch, Jordan	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Hodges, Laura	MD	Radiology	Greenwich Hospital
GH	Hollister, Dickerman	MD	Internal Medicine	Hematology & Oncology Associates of Greenwich, PC
GH	Howes, Christopher	MD	Internal Medicine	YUSM Section of Cardiology
GH	Hrabosky, Joshua	PsyD	Psychiatry	Greenwich Hospital-Diabetes & Weight Management
GH	Huang-Lionnet, Julie	MD, MBA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Hughes, Peter	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Hung, Elizabeth	MD	Obstetrics & Gynecology	Scarsdale Medical Group
GH	Hurd, Karen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
GH	Hurwitz, Joshua	MD	Obstetrics & Gynecology	Reproductive Medicine Associates of Connecticut
GH	Imundo, Lisa	MD	Pediatrics	Herbert Irving Pavilion
GH	Iommazzo, Silvestro	DDS	Surgery	Children's Dentistry and Orthodontics of Greenwich
GH	Jablon, Jeffrey	MD	Surgery	ENT and Allergy Associates, LLC
GH	Jackman, Alexis	MD	Surgery	ENT and Allergy Associates
GH	Jacobson, Edward	MD	Obstetrics & Gynecology	Greenwich Gynecology, L.L.C.
GH	Jaffe, Alan	MD	Internal Medicine	WESTMED Medical Group
GH	Jaggessarsingh, Dana	MD	Pathology	Greenwich Hospital
GH	Jaglal, Reynold	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Jamal, Habib	MD	Surgery	
GH	Jang, Joon Ho	MD	Internal Medicine	NEMG Internal Medicine Cos Cob
GH	Jayasuriya, Sasanka	MD	Internal Medicine	YUSM Section of Cardiology
GH	Jen, James	MD	Surgery	WESTMED Medical Group
GH	Jeyanandarajan, Dhiraj	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Johanna, Janet	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Johnson, Aaron	MD	Internal Medicine	North Pacific Neuromonitoring Associates
GH	Johnson, Jenifer	MD	Internal Medicine	WESTMED Medical Group
GH	Johung, Kimberly	MD	Radiology	YUSM Department of Therapeutic Radiology
GH	Jones, Stephen	MD	Internal Medicine	Greenwich Hospital-Outpatient Services
GH	Juan, Paul	MD	Pediatrics	Valley Pediatrics of Greenwich
GH	Kalan, Gary	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Kalayjian, Tro	DO	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group

GH	Kalyanpur, Arjun	MD	Radiology	Teleradiology Solutions
GH	Kamath, Sanjay	MD	Radiology	Teleradiology Solutions
GH	Kanayama, Masahide	MD	Obstetrics & Gynecology	Masahide Kanayama, M.D.
GH	Kane-Brock, Mary	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Kanner, Barry	MD	Radiology	Greenwich Radiological Group
GH	Kappelman, Amy	MD	Pediatrics	Greenwich Pediatric Associates
GH	Karlis, Vasiliki	DMD, MD	Surgery	Maxillofacial Surgery of Greenwich, LLC
GH	Kasinskas, Kaitlyn	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Kates, Matthew	MD	Surgery	ENT and Allergy Associates, LLC
GH	Katsigiannis, Antonios	MD	Internal Medicine	
GH	Kaul, Ashutosh	MD	Surgery	Surgical Intensivists
GH	Kavanagh, Brian	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Keizerweerd, Michelle	CRNA	Anesthesiology	YUSM Department of Anesthesiology
GH	Kelton, Melanie	MD	Internal Medicine	Old Greenwich Medical Group
GH	Keltz, Martin	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Kenney, Patrick	MD	Surgery	YUSM Department of Urology
GH	Kesh, Sandra	MD	Internal Medicine	WESTMED Medical Group
GH	Kessel, Tamar	MD	Internal Medicine	Orthopaedic & Neurosurgery Specialists
GH	Khadjehturian, Rachele	APRN	Surgery	WESTMED Medical Group
GH	Khaghan, Neda	MD	Internal Medicine	Center for GI Medicine of Fairfield & Westchester
GH	Khairkhah, Nazanine	MD	Internal Medicine	True Care Medical Inc.
GH	Khosla, Natasha	MD	Pediatrics	WESTMED Medical Group (Pediatrics)
GH	Khoury, F Frederic	MD	Surgery	F. Frederic Khoury, M.D., F.A.C.S.
GH	Kim, Chang	MD	Surgery	Gold Coast Plastic Surgery & Laser Center
GH	Kirwan, Laurence	MD	Surgery	Dr. K. Services PC
GH	Kishinevsky, Anya	MD	Surgery	Aesthetic Surgery Center of Connecticut
GH	Klegar, Eunjie	MD	Psychiatry	Greenwich Hospital
GH	Kolbovsky, Iosif	MD	Internal Medicine	WESTMED Medical Group
GH	Koral, Alexander	MD	Internal Medicine	YUSM Department of Pediatrics
GH	Kornel, Ezriel	MD	Surgery	Brain & Spine Surgeons of New York, P.C.
GH	Korosi, Anthony	MD	Internal Medicine	WESTMED Medical Group
GH	Korval, Arnold	MD	Pediatrics	Greenwich Pediatric Associates
GH	Kotula, Jason	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists
GH	Kovacevic, David	MD	Orthopedics	YUSM Department of Orthopedics
GH	Kowalsky, Marc	MD	Orthopedics	Orthopaedic Neurosurgery Specialitsts, PC

GH	Krakovitz, Evan	MD	Surgery	WESTMED Medical Group
GH	Kramer, Scott	MD	Internal Medicine	Center for GI Medicine of Fairfield & Westchester
GH	Krowitz, Elizabeth	MD	Pediatrics	Greenwich Pediatric Associates
GH	Kucher, Taras	MD	Surgery	Southern Connecticut Vascular Center
GH	Kulp, Jennifer	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Kumar, Angelish	MD	Surgery	WESTMED Medical Group
GH	Kurian, Lisa	MD	Internal Medicine	Stamford Health Medical Group
GH	Laifer, Steven	MD	Obstetrics & Gynecology	Bridgeport Hospital
GH	Landesman, Barbara	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Langhan, Melissa	MD	Emergency Medicine	YUSM Section of Pediatric Emergency Medicine
GH	Lataillade, Max	DO	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Latich, Igor	MD	Radiology	YUSM Department of Radiology & Biomedical Imaging
GH	LaTrenta, Gregory	MD	Surgery	Peau
GH	Latrenta, Linda	MD	Radiology	Greenwich Radiological Group
GH	Lebowitz, Alan	MD	Internal Medicine	Alan Lebowitz, M.D., P.C.
GH	Lee, Andrea	PA	Internal Medicine	YUSM Section of Trauma & Critical Care
GH	Lee, M.Sung	MD	Internal Medicine	Hematology & Oncology Associates of Greenwich, PC
GH	Lee, Modestus	MD	Pediatrics	Greenwich Hospital
GH	Lee, Myung-Ho	MD	Internal Medicine	Rye Brook Cardiology & Vascular Medicine, P.C.
GH	Legatt, Elizabeth	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Leibert, Eric	MD	Internal Medicine	Northeast Medical Group Pulmonary Medicine
GH	Leistner, Hedi	MD	Pediatrics	Hedi L. Leistner, MD, PLLC
GH	Leondires, Mark	MD	Obstetrics & Gynecology	Reproductive Medicine Associates of Connecticut
GH	Lescale, Keith	MD	Obstetrics & Gynecology	Hudson Valley Perinatal Consulting
GH	Lester, Mitchell	MD	Internal Medicine	Ffld County Allergy, Asthma & Immunology Assoc
GH	Letts, Gary	MD	Pathology	
GH	Levat, Jay	MD	Internal Medicine	WESTMED Medical Group
GH	Levey, Allison	MD	Pediatrics	Darien Medical Center
GH	Levin, Michael	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Levine, Dorothy	MD	Pediatrics	Greenwich Pediatric Associates
GH	Levine, Joshua	MD	Surgery	Joshua Levine, M.D.
GH	Levine, Ronald	MD	Internal Medicine	Ronald Levine, M.D.
GH	Levine, Sara	MD	Pediatrics	Greenwich Adolescent Medicine, LLC
GH	Liebert, Peter	MD	Surgery	Children's & Women's Physicians of Westchester LLP
GH	Lief, Amy	MD	Pediatrics	Scarsdale Medical Group

GH	Lindenmuth, Danielle	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Lipschutz, Marvin	MD	Internal Medicine	Greenwich Hospital
GH	Litchman, Charisse	MD	Internal Medicine	
GH	Litchman, Mark	MD	Internal Medicine	Fairfield County Allergy, Asthma & Immunology
GH	Lithgow, Sandra	MD	Internal Medicine	Greenwich Medical Partners
GH	Littzi, Jacqueline	MD	Surgery	
GH	Liu, Michael	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Lleva, Ranee	MD	Internal Medicine	Endocrinology Associates of Greenwich
GH	Lo, Tammy	APRN	Surgery	Stamford Health Medical Group, Neurosurgery
GH	Lodato, Caroline	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Lopez Gonzalez, Felipe	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
GH	Lorch, Daniel	MD	Internal Medicine	WESTMED Medical Group
GH	Loria, Franklin	MD	Internal Medicine	Northeast Medical Group Internal Medicine
GH	LoTempio, Maria	MD	Surgery	LoTempio Plastic Surgery for Women
GH	Louit, Aymeric	MD	Internal Medicine	Fairfield Allergy & Immunology Associates
GH	Lubin, Matthew	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Lukawski, Jolanta	MD	Internal Medicine	Northeast Medical Group Internal Medicine Fairfiel
GH	Luna-Rudin, Francesca	MD	Internal Medicine	Fairfield County Medical Group, P.C.
GH	Lundin, Carol	MD	Surgery	
GH	Luongo, Albert	PA	Surgery	AMI Surgery (Tully Center)
GH	Lurie, Preston	MD	Internal Medicine	WESTMED Medical Group
GH	Macbeth, Laura	MD	Pediatrics	WESTMED Medical Group
GH	Madris, Roger	MD	Internal Medicine	Roger S. Madris, M.D., P.C.
GH	Madsen, Eileen	APRN	Internal Medicine	Greenwich Hospital - Outpatient Center
GH	Maffei, Anthony	MD	Surgery	Surgical Intensivists
GH	Maffei, David	PA	Internal Medicine	Greenwich Hospital Occupational Health
GH	Magnan, John	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Malhotra, Samit	MD	Internal Medicine	Sleep and Neuroscience Associates
GH	Maloney, Romelle	MD	Obstetrics & Gynecology	OB/GYN Specialists of Westchester - NEMG
GH	Mandava, Suresh	MD	Surgery	Greenwich Ophthalmology
GH	Manoni, Timothy	MD	Surgery	Southern Connecticut Vascular Center
GH	Marcus, Judith	MD	Pediatrics	Judith R. Marcus, M.D.
GH	Mardh, Ellika	MD	Internal Medicine	Greenwich Hospital - Medical Residency Program
GH	Margoles, Sandra	MD	Surgery	
GH	Mariani, Tania	MD	Emergency Medicine	Greenwich Hospital - NEMG

GH	Marion, Chad	DO	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Mark, Alissa	MD	Internal Medicine	WESTMED Medical Group
GH	Marousek, Jillian	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Marrinan, Michelle	MD	Surgery	Greenwich Ear, Nose & Throat - Head & Neck Surgery
GH	Marsan, Ben	MD	Surgery	Southern Connecticut Vascular Center
GH	Marsh, Elizabeth	MD	Internal Medicine	Dermatology Center of Stamford
GH	Marshall, Peter	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Martimucci, William	MD	Internal Medicine	WESTMED Medical Group
GH	Martin, Jolene	APRN	Internal Medicine	Cardiovascular Services of Greenwich-NEMG
GH	Martone, Cari	APRN	Pediatrics	Neurological & Spine Surgical Associates
GH	Masia, Shawn	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Matczuk, Agnieszka	MD	Internal Medicine	Fairfield Cty Allergy, Asthma & Immunology
GH	Mattern, Christopher	MD	Orthopedics	WESTMED Medical Group
GH	Matut, Jay	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Mayus, Marcus	MD	Internal Medicine	The Doctors Office
GH	McCarty Conner, Stephanie	MD	Internal Medicine	Greenwich Hospital - Medical Residency Program
GH	McEvoy, Daniel	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	McGibbon, Bruce	MD	Radiology	Bridgeport Hospital
GH	Mcguire-Wreschner, Bonnie	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Mcleod, Gavin	MD	Internal Medicine	Infectious Disease Consultants of Greenwich, P.C.
GH	McVicar, Kathryn	MD	Pediatrics	Greenwich Hospital - Outpatient Pediatric Dept.
GH	McWhorter, Peter	MD	Surgery	Northeast Medical Group Surgical Specialists
GH	McWhorter, Philip	MD	Surgery	Northeast Medical Group Surgical Specialists
GH	Mehra, Sona	MD	Pediatrics	Children's Medical Group
GH	Meis, Alexandra	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Melendez, Mark	MD	Surgery	Cosmetic and Reconstructive Surgery Associates of CT, PC
GH	Mena-Hurtado, Carlos	MD	Internal Medicine	YUSM Section of Cardiology
GH	Mendelsohn-Elzam, Cerrah	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Messenger, Adam	MD	Internal Medicine	Adam Messenger, M.D.
GH	Metzen, Amy	PA	Surgery	Greenwich Hospital
GH	Meyer, Janice	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Meyer, Laura	MD	Obstetrics & Gynecology	Greenwich Fertility
GH	Mickley, Steven	MD	Internal Medicine	Glenville Medical Concierge Care
GH	Migotsky, John	MD	Obstetrics & Gynecology	
GH	Miller, Michael	MD	Pathology	AmeriPath NY, LLC

GH	Miller, Nora	MD	Obstetrics & Gynecology	Greenwich Fertility
GH	Miller, Seth	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Mini, Katherine	MD	Pediatrics	Children's Medical Group of Greenwich, PC
GH	Mir, Tansar	MD	Surgery	
GH	Mitchell Richards, Kisha	MD	Pathology	Greenwich Hospital
GH	Mobiglia, Jaime	PA	Surgery	Greenwich Hospital - Operating Room
GH	Molinelli, Elizabeth	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Molloy, Marcelyn	MD	Internal Medicine	AmeriCares
GH	Monaco, Michael	MD	Pediatrics	
GH	Monahan, Marianne	MD	Internal Medicine	WESTMED Medical Group
GH	Mones, Alejandro	MD	Pediatrics	Riverside Pediatrics, LLC
GH	Monroe, Julie	MD	Internal Medicine	WESTMED Medical Group
GH	Moore, Caleb	MD	Internal Medicine	Greenwich Medical Partners
GH	Morrissey, Mary	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Muftah, Loay	MD	Radiology	Teleradiology Solutions
GH	Mullen, David	MD	Radiology	Greenwich Hospital
GH	Murdock, Cynthia	MD	Obstetrics & Gynecology	Reproductive Medicine Associates of CT
GH	Murphy, Stephen	PA	Surgery	USA Surgical Services CT, PC
GH	Murphy, Steven	MD	Internal Medicine	Diagnostic & Medical Specialists of Greenwich
GH	Mutic, Mario	MD	Internal Medicine	WESTMED Medical Group
GH	Nachtygal, Joanne	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists
GH	Nagle, Claire	APRN	Pediatrics	Greenwich Hospital
GH	Nahm, Frederick	MD	Internal Medicine	NeuroCare Health PC
GH	Naparst, Thomas	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Narayana, Ashwatha	MD	Radiology	
GH	Nash, Esther	MD	Internal Medicine	Bridgeport Hospital
GH	Nasir, Irem	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Neeson, Francis	MD	Internal Medicine	Stamford Health Medical Group
GH	Negrin, Anne	MD	Surgery	Rye Eye Associates
GH	Nero, Thomas	MD	Internal Medicine	Cardiology Associates of Fairfield County, P.C.
GH	Ness, Tehila	APRN	Pediatrics	Greenwich Hospital
GH	Neuberth, Danielle	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Newman, Fredric	MD	Surgery	Aesthetic Surgery Center of Connecticut
GH	Nishida, Karen	MD	Obstetrics & Gynecology	Gynecologic Cancer Care, LLC
GH	Noble, Katherine	MD	Pediatrics	Sound Beach Pediatrics

GH	Nocek, David	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Novakova, Elena	PA	Surgery	Greenwich Hospital - Operating Room
GH	Nurzia, Michael	MD	Surgery	Michael Nurzia, MD
GH	Ober-Adams, Colleen	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	O'brien, Elisa	APRN	Surgery	Breast Care Services of Greenwich - NEMG
GH	O'Brien, Jessica	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Odierna, Elizabeth	MD	Internal Medicine	WESTMED Medical Group
GH	Oh, Young-Don	MD	Orthopedics	WESTMED Medical Group
GH	Onorato, Catherine	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Ostrager, Jill	MD	Internal Medicine	WESTMED Medical Group
GH	Ostroff, Allison	MD	Internal Medicine	Stamford Health Medical Group
GH	Overby, Philip	MD	Pediatrics	Philip Overby, M.D.
GH	Ozgediz, Doruk	MD	Surgery	YUSM Section of Pediatric Surgery
GH	Pabani, Qaayam	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Pacelli, Philip	DMD	Surgery	New Canaan Oral & Maxillofacial Surgery, P. C.
GH	Paek, Hyung	MD	Internal Medicine	Greenwich Hospital
GH	Palac, Susan	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Palmer, Debbie	DO	Internal Medicine	Dermatology Associates of New York
GH	Palos, Patricia	MD	Obstetrics & Gynecology	Caterina Violi, M.D., OB/GYN
GH	Palvinskaya, Tatsiana	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
GH	Park, Eunjin	PA	Internal Medicine	Greenwich Hospital
GH	Partridge, Langley	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Pashankar, Dinesh	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
GH	Passaretti, David	MD	Surgery	Aesthetic Surgery Center of Connecticut
GH	Pavlis, Maria	MD	Internal Medicine	Cardiology Associates of Fairfield County, P.C.
GH	Peden, Sean	MD	Orthopedics	Orthopaedics Neurosurgery Specialists, LLC
GH	Pellechi, Thomas	MD	Internal Medicine	
GH	Pere, Joyce	MD	Psychiatry	Joyce Pere, M.D.
GH	Perley Kwauk, Rosemary	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Petranker, Oren	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Petrotos, Athanassios	MD	Surgery	Northeast Medical Group Surgical Specialists
GH	Petrucci, Debra	MD	Surgery	Yale-New Haven Hospital Spine Center
GH	Petrylak, Daniel	MD	Internal Medicine	YUSM Section of Oncology
GH	Pfau, Steven	MD	Internal Medicine	VAMC
GH	Phanumas, Donna	MD	Internal Medicine	Greenwich Hospital

GH	Phatak, Uma	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
GH	Piccorelli, George	MD	Surgery	WESTMED Medical Group
GH	Pinar, Aydin	MD	Internal Medicine	
GH	Pincus, Jayne	MD	Internal Medicine	Old Greenwich Medical Group
GH	Plummer, Catherine	MD	Orthopedics	WESTMED Medical Group
GH	Pollack, Joshua	MD	Psychiatry	Greenwich Hospital - Center for Healthy Aging
GH	Porco, Jaclyn	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Portnay, Edward	MD	Internal Medicine	Cardiology Physicians of Fairfield, LLC
GH	Porto, Anthony	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
GH	Potack, Jonathan	MD	Internal Medicine	WESTMED Medical Group
GH	Potter, William	MD	Surgery	Greenwich Ophthalmology Associates, LLC
GH	Proskin, Wendy	MD	Pediatrics	WESTMED Medical Group
GH	Provataris, Jennifer	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Puglisi, Jeffrey	MD	Internal Medicine	Glenville Medical Concierge Care
GH	Raab, Carolyn	APRN	Pediatrics	Greenwich Hospital
GH	Rana, Sunil	MD	Internal Medicine	Sunil Rana MD, PC
GH	Ranauro, Tina	APRN	Emergency Medicine	WESTMED Medical Group
GH	Ranta, Jeffrey	MD	Surgery	Greenwich Urological Associates, PC
GH	Rascoff, Henry	MD	Pediatrics	Sound Beach Pediatrics
GH	Raskin, Elsa	MD	Surgery	Elsa M. Raskin, MD, PC
GH	Rawlins, Patricia	APRN	Pediatrics	Greenwich Hospital
GH	Razdan, Rishi	MD	Radiology	CT Image Guided Surgery
GH	Reardon, Michelle	APRN	Internal Medicine	Greenwich Hospital-Outpatient Services
GH	Reid, Linda	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Rein, Joel	MD	Surgery	Joel Rein, M.D.
GH	Reiss, Ronald	MD	Obstetrics & Gynecology	Scarsdale Medical Group
GH	Remakus, Christopher	MD	Internal Medicine	Northeast Medical Group, Inc.
GH	Remetz, Michael	MD	Internal Medicine	YUSM Section of Cardiology
GH	Resnick, Donald	PhD	Psychiatry	
GH	Rieger, Alicia	MD	Pediatrics	WESTMED Medical Group
GH	Riera, Antonio	MD	Emergency Medicine	YUSM Section of Pediatric Emergency Medicine
GH	Roberts, Kenneth	MD	Radiology	YUSM Department of Therapeutic Radiology - Smilow Cancer Hospital
GH	Robles, Amy	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Rodgers, I. Rand	MD	Surgery	

GH	Rohr, Michele	MD	Obstetrics & Gynecology	Brookside Gynecology
GH	Romanek, Adam	PA	Surgery	Greenwich Hospital
GH	Rosen, Danya	MD	Pediatrics	Yale Pediatric Specialty Center
GH	Rosenstein, C.Cory	MD	Surgery	Stamford Health Medical Group
GH	Rosoff, James	MD	Surgery	YUSM Department of Urology
GH	Rossi, Kerri	APRN	Internal Medicine	Greenwich Cardiology Associates, LLC
GH	Rothbart, Gary	MD	Internal Medicine	WESTMED Medical Group
GH	Rothenberg, Saul	PhD	Psychiatry	Greenwich Hospital
GH	Rubin, Burton	MD	Internal Medicine	Old Greenwich Medical Group
GH	Rummel, Karen	DO	Emergency Medicine	Greenwich Hospital - NEMG
GH	Rusk, Alice	MD	Internal Medicine	Greenwich Neurology
GH	Russi, Mark	MD	Internal Medicine	YNHH Occupational Health Services
GH	Ryan, Elizabeth	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Ryan, Meghan	APRN	Pediatrics	Greenwich Hospital
GH	Sabetta, James	MD	Internal Medicine	Infectious Disease Consultants of Greenwich, P.C.
GH	Sabetta, Julia	MD	Internal Medicine	
GH	Sacharski, Eileen	MD	Internal Medicine	WESTMED Medical Group
GH	Sadeghi, Hossein	MD	Pediatrics	Pediatric Pulmonology, LLC
GH	Sahler, Christopher	MD	Internal Medicine	Orthopaedics Neurosurgery Specialists, PC
GH	Salik, Erez	MD	Radiology	Greenwich Hospital
GH	Salomon, Jason	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists, P.C.
GH	Salvatore, Toni	MD	Pediatrics	Greenwich Hospital
GH	Salzer, Stephen	MD	Surgery	Greenwich Ear, Nose & Throat - Head & Neck Surgery
GH	Sandhu, Katherine	MD	Obstetrics & Gynecology	Stamford Health Medical Group, Urogynecology
GH	Santarosa, Richard	MD	Surgery	Richard P. Santarosa M.D., LLC
GH	Santiago, Jesus	PA	Surgery	YUSM Department of Neurosurgery
GH	Santos, Rolando	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Santucci, Karen	MD	Emergency Medicine	YUSM Section of Pediatric Emergency Medicine
GH	Sapanaro, Kristin	APRN	Pediatrics	Pediatric Associates - Northeast Medical Group
GH	Sauler, Maor	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Sayeed, Syed	MD	Surgery	
GH	Schamberg, Neal	MD	Internal Medicine	Center for GI Medicine of Fairfield & Westchester
GH	Schechter, Michael	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Scheinthal, Deborah	DO	Pediatrics	WESTMED Medical Group
GH	Schilsky, Michael	MD	Internal Medicine	YUSM Section of Digestive Diseases

GH	Schiz, Steven	MD	Pediatrics	Children's Medical Group of Greenwich, PC
GH	Schmidt, William	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Schneider, Marcie	MD	Pediatrics	Greenwich Adolescent Medicine, LLC
GH	Schoeneman, Sandra	PhD	Psychiatry	
GH	Schoenfeld, Mark	MD	Internal Medicine	Arrhythmia Center of Connecticut
GH	Schrager, Alan	MD	Surgery	
GH	Schwartz, Kenneth	MD	Surgery	WESTMED Medical Group
GH	Seelig, Charles	MD	Internal Medicine	Greenwich Hospital-Medical Residency Program
GH	Seidenstein, Harvey	MD	Internal Medicine	Cardiovascular Services of Greenwich - NEMG
GH	Selkin, Alan	MD	Internal Medicine	The Center for Gastrointestinal Medicine
GH	Sessa, Vito	MD	Pediatrics	WESTMED Medical Group
GH	Setaro, John	MD	Internal Medicine	YUSM Section of Cardiology
GH	Sethi, Paul	MD	Orthopedics	Orthopaedic & Neurosurgery Specialists, PC
GH	Shahid, Kameron	MD	Radiology	Greenwich Radiological Group
GH	Shajan, Joshan	MD	Internal Medicine	Joshan K. Shajan, M.D.
GH	Sharma, Nitya	MD	Internal Medicine	WESTMED Medical Group
GH	Sharma, Seema	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Shea, Judith	MD	Internal Medicine	Glenville Medical Concierge Care
GH	Sheehy, Jessica	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Shender, Anna	MD	Internal Medicine	
GH	Sherling, Bruce	MD	Internal Medicine	WESTMED Medical Group
GH	Sherman, John	MD	Surgery	John E. Sherman, MD, PC
GH	Sherwyn, Jonathan	MD	Surgery	Jonathan Hilton Sherwyn, MD, FACS
GH	Shestak, William	DO	Emergency Medicine	Greenwich Hospital - NEMG
GH	Shirazy-Majd, Nahid	MD	Pediatrics	Harrison Pediatrics LLP
GH	Silberstein, Linda	MD	Internal Medicine	Linda R. Silberstein, M.D.
GH	Silver, Marc	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Silver, Michael	MD	Internal Medicine	WESTMED Medical Group
GH	Silverman, Jill	PhD	Psychiatry	
GH	Simon, Beth	MD	Obstetrics & Gynecology	Scarsdale Medical Group
GH	Simon, Scott	MD	Surgery	Orthopaedic & Neurosurgery Specialists, PC
GH	Siner, Jonathan	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Slate, Emily	MD	Orthopedics	Orthopedic Associates of Stamford, LLC
GH	Sloan, Bart	MD	Psychiatry	Shoreline Psychiatry of Western CT, LLC
GH	Smith, Howard	PA	Emergency Medicine	Greenwich Hospital - NEMG

GH	Smith, Izabela	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
GH	Smullin, Steven	DMD, MD	Surgery	Steven Smullin, DMD
GH	Snelwar, Yekaterina	APRN	Pediatrics	Greenwich Hospital
GH	Snowball, Halina	MD	Internal Medicine	Pain Management, LLC
GH	Snyder, Michael	MD	Pediatrics	
GH	Sohrab, Mahsa	MD	Surgery	Rye Eye Associates
GH	Solad, Yauheni	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Solomon, Daniel	MD	Surgery	YUSM Section of Pediatric Surgery - YNHH Children's Hospital
GH	Song, Christopher	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Soni, Dhara	PA	Surgery	Greenwich Hospital
GH	Souza, Fabiola	MD	Pathology	Greenwich Hospital
GH	Sproviero, Joseph	MD	Internal Medicine	Fairfield County Allergy, Asthma & Immunology
GH	Stark, Robert	MD	Internal Medicine	Robert M. Stark, M.D.,P.C.
GH	Steckler, Lois	APRN	Pediatrics	Greenwich Hospital
GH	Steele, Maureen	MD	Internal Medicine	Maureen K. Steele, MD, PC
GH	Steinbacher, Derek	MD, DMD	Surgery	Yale Pediatric Specialty Center
GH	Stella, Caroline	MD	Obstetrics & Gynecology	Greenwich Hospital
GH	Stevens, Mitchell	MD	Pediatrics	WESTMED Medical Group
GH	Stewart, Sarah	MD	Radiology	Greenwich Radiological Group
GH	Stitelman, David	MD	Surgery	YUSM Department of Pediatrics
GH	Stroumbakis, Nicholas	MD	Surgery	Greenwich Urological Associates, PC
GH	Sullivan, Scott	MD	Radiology	Greenwich Hospital
GH	Sultan, Heena	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Sutton, Karen	MD	Orthopedics	YUSM Department of Orthopedics
GH	Suzman, Michael	MD	Surgery	WESTMED Medical Group
GH	Syed, Muhammad	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Sygall, Paul	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Tagliavia, Alfonso	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Tartaglia, Joseph	MD	Internal Medicine	Joseph Tartaglia, MD, PC
GH	Tedesco, Janine	PA	Surgery	Southern Connecticut Vascular Center
GH	Teslya, Pavel	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Thakur, Mrudangi	MD	Surgery	
GH	Theofanidis, Stylianos	MD	Pediatrics	Greenwich Hospital
GH	Tifford, Craig	MD	Orthopedics	Yale Orthopaedics - Stamford
GH	Tinger, Alfred	MD	Radiology	

GH	Tom, David	MD	Surgery	New England Retina Associates
GH	Tom, Michael	MD	Surgery	ENT AND ALLERGY ASSOCIATES, LLP
GH	Tomchik, Heather	PA	Surgery	WESTMED Medical Group
GH	Tomita, Kiyoko	MD	Internal Medicine	NEMG - Internal Medicine Greenwich
GH	Torina, Georgeann	PA	Orthopedics	Orthopaedic & Neurosurgery Specialists
GH	Torres, Jill	CRNA	Anesthesiology	Greenwich Anesthesiology Associates
GH	Tribble, Cassandra	MD	Anesthesiology	Greenwich Anesthesiology Associates
GH	Tsang, Benjamin	MD	Pediatrics	Greenwich Hospital
GH	Tsong, Jerry	MD	Surgery	Greenwich Ophthalmology Associates, LLC
GH	Tuttle, Lisa	PhD	Psychiatry	Greenwich Fertility
GH	Tuyama, Ana	MD	Internal Medicine	WESTMED Medical Group
GH	Tyson, Jeremiah	MD	Internal Medicine	Greenwich IM Hospitalist Service - Northeast Medical Group
GH	Vadasdi, Katherine	MD	Orthopedics	Orthopaedic and Neurosurgery Specialists, P.C.
GH	Vaid, Chetan	MD	Internal Medicine	Greenwich Private Medicine
GH	Valentino, Pamela	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
GH	Varghese, Geena	DO	Internal Medicine	WESTMED Medical Group
GH	Varghese, Mary	PhD	Psychiatry	Greenwich Hospital - Weight Loss and Diabetes Cent
GH	Vasile, Julie	MD	Surgery	Julie Vasile, M.D.
GH	Vega-Bermudez, Francisco	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Velagapudi, Venu	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Verga, Marco	MD	Radiology	Diagnostic Radiology Associates
GH	Versfelt, Mary	MD	Pediatrics	Pediatric Associates - Northeast Medical Group
GH	Violi, Caterina	MD	Obstetrics & Gynecology	Caterina Violi, M.D., OB/GYN
GH	Violi, Lisa	PA	Obstetrics & Gynecology	Caterina Violi, MD OB/GYN
GH	Vitale, Mark	MD	Orthopedics	Orthopaedic & Neurosurgery Specialists, P.C.
GH	Vora, Chaula	MD	Internal Medicine	NEMG - Internal Medicine Greenwich
GH	Vundavalli, Shravani	MD	Pediatrics	Greenwich Pediatric Associates
GH	Waddell, Robin	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
GH	Wagner, Anja	MD	Internal Medicine	Cardiology Associates of Fairfield County, P.C.
GH	Wainwright, Sandra	MD	Internal Medicine	Center for Hyperbaric Medicine & Wound Healing
GH	Waldman, Joshua	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Wallace, Joseph	DDS	Surgery	Greenwich Oral & Maxillofacial Surgery, P.C.
GH	Wallenstein, Michelle	MD	Obstetrics & Gynecology	WESTMED Medical Group
GH	Walsh, Francis	MD	Internal Medicine	The Doctors Office
GH	Walsh, Jessica	APRN	Internal Medicine	Cardiovascular Services of Greenwich-NEMG

GH	Wandel, Erika	MD	Surgery	Rye Eye Associates
GH	Ward, Barbara	MD	Surgery	Breast Care Services of Greenwich, LLC
GH	Warkol, Rebecca	MD	Internal Medicine	Old Greenwich Medical Group
GH	Warmouth, Grant	MD	Internal Medicine	American Neuromonitoring Associates, PC
GH	Waters, Paul	MD	Surgery	Paul Waters, M.D.
GH	Waxler, Diana	PA	Emergency Medicine	WESTMED Medical Group
GH	Weber, Litchia	MD	Internal Medicine	Diagnostic & Medical Specialists of Greenwich
GH	Weeks, Randall	PhD	Psychiatry	Randall Weeks, Ph.D.
GH	Wei, David	MD	Orthopedics	Orthopaedic & Neurosurgery Specialists PC
GH	Weinberger, Jeffrey	MD	Internal Medicine	Jeffrey Weinberger, M.D.
GH	Weiner, Gail	MD	Pediatrics	Greenwich Pediatric Associates
GH	Weinschenk, Barbara	PA	Emergency Medicine	Greenwich Hospital - NEMG
GH	Weinstein, David	MD	Obstetrics & Gynecology	Obstetrics & Gynecology Associates
GH	Weintraub, Jeffrey	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Weiss, Pnina	MD	Pediatrics	YUSM Section of Pedi Respiratory Medicine
GH	Weissler, Matthew	MD	Internal Medicine	WESTMED Medical Group
GH	Welch, Susan	APRN	Pediatrics	Greenwich Hospital - Outpatient Pediatric Dept.
GH	Werner, Michael	MD	Surgery	Michael A. Werner, MD, PC
GH	Whitney, Christian	DO	Anesthesiology	Greenwich Anesthesiology Associates
GH	Wiechmann, Lisa	MD	Surgery	Breast Care Services of Greenwich - NEMG
GH	Williams, Carla	MD	Obstetrics & Gynecology	Brookside Gynecology
GH	Wilson, Lynn	MD	Radiology	YUSM Department of Therapeutic Radiology
GH	Wilson, Thomas	MD	Surgery	Greenwich Oral & Maxillofacial Surgery, P.C.
GH	Winter, Patricia	APRN	Internal Medicine	Greenwich Hospital
GH	Winterbottom, Christopher	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
GH	Witt, Barry	MD	Obstetrics & Gynecology	Greenwich Fertility
GH	Wong, Anthony	PA	Surgery	Stamford Health Medical Group, Neurosurgery
GH	Woodard, Kristen	MD	Pediatrics	Pediatric Associates - Northeast Medical Group
GH	Woodbury, Robert	MD	Internal Medicine	Robert Woodbury, M.D.
GH	Woolf, Seth	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
GH	Wosnitzer, Matthew	MD	Surgery	NEMG Urology
GH	Wurm, Emanuel	DO	Internal Medicine	WESTMED Medical Group
GH	Wynn, Jonathan	MD	Internal Medicine	WESTMED Medical Group
GH	Xu, Thomas	MD	Internal Medicine	WESTMED Medical Group (Internal Medicine)
GH	Youkeles, Lisa	MD	Internal Medicine	WESTMED Medical Group

GH	Yu, Irene	MD	Surgery	ENT & Allergy Associates, LLP
GH	Yu, Yi-Hao	MD	Internal Medicine	Endocrinology Associates of Greenwich
GH	Yudin, Howard	MD	Internal Medicine	Howard S. Yudin, MD
GH	Yuh, David	MD	Internal Medicine	YUSM Section of Cardiac Surgery
GH	Yunkovic, Kathryn	PA	Surgery	Greenwich Hospital
GH	Zarakiotis, Stacy	DDS	Surgery	Greenwich Pediatric Dental Group, LLC
GH	Zelkovic, Paul	MD	Surgery	Pediatric Urology Associates P.C.
GH	Zemon, Harry	MD	Surgery	WESTMED Medical Group
GH	Zislis, Jan	MD	Emergency Medicine	Greenwich Hospital - NEMG
GH	Zitsman, Jeffrey	MD	Surgery	
GH	Zuckman, Brett	DMD	Surgery	Oral Surgery Associates
GH	Zwas, Felice	MD	Internal Medicine	Center for GI Medicine of Fairfield & Westchester
LMH	Abdelhafiz, Gada	MD	Medicine	IPC Hospitalists of NE
LMH	Abdel-Razeq, Sonya	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Adams, Theresa	MD	Emergency Medicine	EMP of New London County
LMH	Adekanye, Oluwaseun	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Agrawal, Anjali	MD	Radiology	Teleradiology Solutions
LMH	Alessi, Anthony	MD	Medicine	IPC Hospitalists of NE
LMH	Allard, Elizabeth	MD	Medicine	New London Family Practice
LMH	Allard, Elizabeth	MD	Pediatrics	New London Family Practice
LMH	Allen, John	DMD	Surgery	
LMH	Allyn, David	PA-C	Emergency Medicine	EMP of New London County
LMH	Altin, Sophia	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Amdur, Henry	MD	OB-GYN	L+MMG OB-GYN NL
LMH	Amin, Hardik	MD	Medicine	Yale New Haven Telestroke
LMH	Ancona, John	MD	Pediatrics	GF Pediatric Group
LMH	Andrias, Charles	MD	Medicine	L+MMG Cardiology Waterford
LMH	Antic, Anica	MD	Pathology	Pathology Consultants of NL
LMH	Antonelli, Vincent	DDS	Surgery	Bridgeworks Family Dental Ctr
LMH	Applegate, Brenda	MD	Medicine	L+MMG Primary Care Stonington
LMH	Archer, Steven	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Aribandi, Manohar	MD	Radiology	Teleradiology Solutions
LMH	Armstrong, Benjamin	MD	Emergency Medicine	EMP of New London County
LMH	Aschkenasi, Carl	MD	Radiology	Teleradiology Solutions
LMH	Attaran, Robert	MD	Medicine	Yale Univ Cardiovascular Med

LMH	Auerbach, Peter	MD	OB-GYN	Thameside OB/GYN Ctr
LMH	Augusto, Donna	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Azia, Gregory	MD	Surgery	
LMH	Badal, Romina	DMD	Surgery	Childrens Dental Assoc of NL
LMH	Bagheri, Roshanak	MD	Medicine	L+MMG Cardiology New London
LMH	Bahtiyar, Mert	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Balch, Eric	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Baleswaren, Anandhi	MD	Medicine	Community Health Ctr
LMH	Bangs, Katherine	PA-C	Surgery	Orthopedic Partners
LMH	Barczak, Timothy	MD	OB-GYN	L+MMG OB-GYN NL
LMH	Barri, Anthony	MD	Surgery	Barri Eye Care Ctr
LMH	Bassett, Ann	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Basu, Arun	MD	Radiology	Ocean Radiology Assoc
LMH	Bedard, Lisa	APRN	Medicine	L+M Stroke Ctr
LMH	Bellas, David	PHD	Rehab Medicine	L+MMG Rehab Medicine
LMH	Bender, Katherine	APRN	Medicine	IPC Hospitalists of NE
LMH	Benedict, Joseph	MD	Pathology	Pathology Consultants of NL
LMH	Benoit, Evangeline	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Bentz, Mary Ann	MD	Medicine	Dermatology Assoc of SE CT
LMH	Ber, Doron	MD	Medicine	Shoreline Allergy & Asthma
LMH	Ber, Doron	MD	Pediatrics	Shoreline Allergy & Asthma
LMH	Bertman, Gary	MD	Pediatrics	GP Family Care LLC
LMH	Bertolozzi, Peter	DO	Emergency Medicine	EMP of New London County
LMH	Bindra, Ranjit	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Bizzarro, Matthew	MD	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Blackman-Cochran, Judith	APRN	Pediatrics	Gold Star Pediatrics
LMH	Blefeld, Michael	MD	Pediatrics	Gold Star Pediatrics
LMH	Blue, Todd	MD	Radiology	Ocean Radiology Assoc
LMH	Blum, Thomas	MD	Medicine	Drs Blum & Bontempi
LMH	Boie, Christine	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Boisoneau, David	MD	Surgery	ENT Assoc of SE CT
LMH	Bontempi, Rosemary	MD	Medicine	Drs Blum & Bontempi
LMH	Boonvisudhi, Kitima	MD	Surgery	L+M Wound Care Clinic
LMH	Borden, Roberta	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Bortan, Alin	MD	Medicine	L+M Infectious Disease & Travel Med

LMH	Bourganos, George	MD	Medicine	RI Cardiovascular Assoc
LMH	Bourguignon, Paul	MD	Surgery	L+MMG Surgery Westerly
LMH	Bowen, Heather	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Brennan, Garrett	DDS	Surgery	Childrens Dental Assoc of NL
LMH	Brennan, Joseph	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Brennan, Paige	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Brill, David	MD	Surgery	L+MMG Cardiology Waterford
LMH	Brown, Shereene	MD	OB-GYN	L+MMG OB-GYN NL
LMH	Bryant, Craig	MD	Emergency Medicine	EMP of New London County
LMH	Buggeln, Craig	MD	Medicine	
LMH	Cabin, Henry	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Cambi, Brian	MD	Medicine	L+MMG Cardiology New London
LMH	Cambi, Kathryn	MD	Pediatrics	Flanders Pediatrics LLC
LMH	Cameron, Alison	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Campbell, Elaine	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Campbell, Katherine	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Campbell, Mical	MD	Medicine	Coastal Digestive Diseases
LMH	Capalbo, Anna	DMD	Surgery	Childrens Dentistry/Westerly
LMH	Cardella, Jonathan	MD	Medicine	Yale Medical Group
LMH	Carlow, Steven	MD	Surgery	Seacoast Ortho/Sports Med
LMH	Carroll, John	DPM	Surgery	
LMH	Carter, H Anthony	MD	Medicine	L+MMG Primary Care New London
LMH	Casey, Elizabeth	APRN	Medicine	IPC Hospitalists of NE
LMH	Cecere, Joseph	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Cervera, Patricia	APRN	Medicine	IPC Hospitalists of NE
LMH	Chaar, Cassius	MD	Surgery	L+MMG General Surgery NL
LMH	Chemacki, Kimberly	PA-C	Medicine	L+MMG Cardiology Waterford
LMH	Cherry, Thomas	MD	Surgery	Backus Physician Services
LMH	Chittamooru, Subha	PA-C	Surgery	L+MMG General Surgery
LMH	Chokshi, Swati	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Christian, Jeffrey	MD	Surgery	L+MMG General Surgery Westerly
LMH	Chua-Chiaco, John	MD	Medicine	Norwich Cardiac Medicine
LMH	Ciccone, Lori	PA-C	Medicine	IPC Hospitalists of NE
LMH	Cicero, Mark	MD	Emergency Medicine	EMP of New London County
LMH	Ciotola, Robert	MD	Medicine	L+MMG Primary Care Mystic

LMH	Cirillo, Louis	MD	Emergency Medicine	EMP of New London County
LMH	Citarella, Brett	MD	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Clancy, Jude	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Clark, Christopher	DMD	Surgery	Childrens Dental Assoc of NL
LMH	Cleman, Michael	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Cloutier, Josee	MD	Medicine	Cloutier Family Practice LLC
LMH	Cloutier, Josee	MD	Pediatrics	Cloutier Family Practice LLC
LMH	Coffey, Margo	PA-C	Surgery	L+MMG General Surgery
LMH	Coiculescu, Olivia	MD	Medicine	L+MMG Neurology
LMH	Colby, Jay	MD	Radiology	Ocean Radiology Assoc
LMH	Coletti, David	MD	Surgery	Chelsea Surgical Care
LMH	Collemer, Susan	MD	Emergency Medicine	EMP of New London County
LMH	Colom, William	MD	Medicine	SE CT Med Assoc
LMH	Connor, Kathryn	PA-C	Medicine	L+M Occupational Health @ PHC
LMH	Cooper, Bruce	MD	Medicine	IPC Hospitalists of NE
LMH	Copel, Joshua	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Corpuz, Danielle	MD	Pediatrics	Flanders Pediatrics
LMH	Coss, Edward	MD	Psychiatry	
LMH	Courtright, Darren	DPM	Surgery	Shoreline Foot & Ankle Ctr
LMH	Craft, Angela	NNP	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Crawford, William	MD	Surgery	IPC Hospitalists of NE
LMH	Crawley, David	MD	Surgery	Thames Urology Ctr
LMH	Credit, Scott	APRN	Medicine	L+MMG Primary Care Mystic
LMH	Crispino, Carmine	MD	Medicine	IPC Hospitalists of NE
LMH	Cronin Vorih, Deirdre	MD	Emergency Medicine	EMP of New London County
LMH	Cross, Robert	MD	Radiology	Ocean Radiology Assoc
LMH	Cross, Sarah	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Curioso-Uy, Cynthia	MD	Medicine	Gold Coast Pulmonary & Sleep
LMH	Curtis, Jeptha	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Dahlquist, Heather	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Daley, Kristin	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Darout, Rachelle	MD	Medicine	LMMG Primary Care Waterford
LMH	Daulaire, Siri	MD	Emergency Medicine	EMP of New London County
LMH	Davey, Jennifer	PA-C	Medicine	L+M Occupational Health @ PHC
LMH	Dearborn, Jennifer	MD	Medicine	Yale-New Haven Telestroke

LMH	DeBaets, Myriam	MD	Medicine	IPC Hospitalists of NE
LMH	Decker, Roy	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Dellacono, Frank	MD	Surgery	ENT Assoc of SE CT
LMH	Deloge, Jo-Ann	APRN	Medicine	Coastal Digestive Diseases
LMH	DelPrado, Juan	PA-C	Surgery	L+MMG General Surgery
LMH	Deptulski, Nancy	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Deren, Michael	MD	Surgery	Backus Wound Care/Hyperbaric Oxygen Therapy
LMH	D'Errico, Teresa	APRN	Medicine	Coastal Digestive Diseases
LMH	DeSantis, Christopher	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Detterbeck, Frank	MD	Surgery	Yale Univ Thoracic Surgery
LMH	Deutsch, Paul	MD	Medicine	
LMH	Diffin, Daniel	MD	Radiology	Ocean Radiology Assoc
LMH	DiFrancesca, Joseph	DPM	Surgery	Kierstein & DiFrancesca DPM PC
LMH	DiLullo, Anthony	MD	OB-GYN	Thameside OB/GYN Ctr
LMH	DiSilvestro, Paul	MD	OB-GYN	Women & Infants Hospital
LMH	D'Mello, Suresh	MD	Medicine	L+MMG Primary Care Old Lyme
LMH	Dodington, James	MD	Emergency Medicine	EMP of New London County
LMH	Doerwaldt, Hartmut	MD	Pediatrics	Community Health Ctr
LMH	Doherty, Lauren	MD	Medicine	IPC Hospitalists of NE
LMH	Doherty, Patrick	MD	Surgery	Yale Neurosurgery
LMH	Doherty, Terrence	MD	Medicine	SE CT Med Assoc
LMH	Donahue, Jennifer	MD	Medicine	ProHealth Physicians Wmns Care
LMH	Donka, Abel	MD	Medicine	Thompson Goldberg & Donka
LMH	Donnel, Joann	NMW	OB-GYN	L+MMG OB-GYN NL
LMH	Donovan, Kenneth	MD	Medicine	IPC Hospitalists of NE
LMH	Dubin, Seth	PA-C	Emergency Medicine	EMP of New London County
LMH	Duby, Walterine	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Ducey, Stephen	MD	Medicine	SE CT Med Assoc
LMH	Duhig, Niall	MD	Medicine	Shoreline Pulmonary Assoc LLC
LMH	Duke, Daniella	MD	Medicine	Coastal Dermatology PC
LMH	Ecker, Robert	MD	Medicine	Integrated Dermatology of Groton LLC
LMH	Ehrlich, Brian	MD	Medicine	L+MMG Cardiology Waterford
LMH	Ehrlich, Owen	MD	Pediatrics	ProHealth Ped Assoc of NL
LMH	Eigles, Stephen	MD	Radiology	Teleradiology Solutions
LMH	Ejaz, Asim	MD	Pathology	Pathology Consultants of NL

LMH	Ejzak, Alexander	PA-C	Emergency Medicine	EMP of New London County
LMH	Ejzak, Kelsey	PA-C	Emergency Medicine	EMP of New London County
LMH	Elder, Robert	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Elsamra, Shady	MD	Psychiatry	L+MMG Behavioral Health
LMH	Enquist, Erik	MD	Surgery	Champion Urology Ltd
LMH	Esposito, Charles	MD	Pediatrics	GF Pediatric Group
LMH	Evans, Suzanne	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Fabian, Taryn	PA-C	Surgery	L+MMG General Surgery
LMH	Fahey, John	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Falck, Francis	MD	Surgery	Falck Eye Ctr LLC
LMH	Famiglietti, Peter	MD	Surgery	Famiglietti Eye Assoc
LMH	Fantl, Eugene	MD	Pediatrics	East Lyme Pediatrics
LMH	Faulise, Ellen	MD	Surgery	L+MMG General Surgery
LMH	Feder, Ingrid	MD	Medicine	IPC Hospitalists of NE
LMH	Feldman, Barry	MD	Medicine	Shoreline Family Practice
LMH	Feldman, Barry	MD	Pediatrics	Shoreline Family Practice
LMH	Felitto, Donald	MD	Medicine	IPC Hospitalists of NE
LMH	Felter, Kate	PA-C	OB-GYN	Shoreline OB/GYN PC
LMH	Feltes, Michael	MD	Medicine	IPC Hospitalists of NE
LMH	Feng, Honghui	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Ferdman, Dina	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Ferguson, Bernard	MD	Emergency Medicine	EMP of New London County
LMH	Ferrero, Vittorio	MD	Psychiatry	L+MMG Behavioral Health
LMH	Fields, Warren	MD	Medicine	Mystic Med Group
LMH	Fiengo, Mark	DO	Medicine	Hartford Healthcare Cardiology Assoc
LMH	Fiftal, Carol	MD	Pediatrics	Gold Star Pediatrics
LMH	Finiguerra, Roseann	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Fink, Lindsay	PA-C	Emergency Medicine	EMP of New London County
LMH	Firman, Russell	MD	Emergency Medicine	EMP of New London County
LMH	Fisher, Eric	DO	Medicine	New London Family Practice
LMH	Fisher, Eric	DO	Pediatrics	New London Family Practice
LMH	Flynn, Daniel	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Force, Farid	MD	Psychiatry	L+MMG Behavioral Health
LMH	Forrest, John	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Forstein, Steven	MD	Pediatrics	GF Pediatric Group

LMH	Forsyth, Allyson	PA-C	Surgery	Crossroads Orthopaedics
LMH	Fox, Matthew	MD	Radiology	Teleradiology Solutions
LMH	Fracchia, Elizabeth	APRN	Medicine	IPC Hospitalists of NE
LMH	Fraser, Richard	MD	Surgery	Thames Urology Ctr
LMH	Frederiks, David	MD	Medicine	IPC Hospitalists of NE
LMH	Frese, John	MD	Medicine	Coastal Digestive Diseases
LMH	Friedman, Alan	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Friedman, Franklin	MD	Surgery	Eastern CT Urology
LMH	Fucci, Michael	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Gaccione, Daniel	MD	Surgery	Soundview Orthopaedic Assoc
LMH	Gadbaw, Joseph	MD	Medicine	L+M Infectious Disease & Travel Med
LMH	Gaetano, John	DPM	Surgery	Allegheny Foot & Ankle Ctr
LMH	Gaffar, Majida	MD	Surgery	Childrens Eye Care PC
LMH	Gaito, Raymond	MD	Surgery	ENT Assoc of SE CT
LMH	Galerneau, France	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Gaona, Rosalinda	MD	Medicine	SE CT Primary Care LLC
LMH	Garber, Suzanne	MD	Emergency Medicine	EMP of New London County
LMH	Gates, Peter	MD	Medicine	GP Family Care LLC
LMH	Gaudio, Jon	MD	Medicine	L+MMG Cardiology New London
LMH	Gautam, Vibha	MD	Medicine	Endocrin & Osteoporosis Ctr
LMH	Gelfand, Robert	MD	Medicine	IPC Hosptialists of NE
LMH	Geronimo, Mark Dennis	MD	Medicine	IPC Hospitalists of NE
LMH	Gesino, Jenine	PA-C	Surgery	L+MMG General Surgery
LMH	Ghoneim, Nada	MD	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Gianfrocco, Robert	DO	Emergency Medicine	EMP of New London County
LMH	Giffault, George	DO	Medicine	IPC Hospitalists of NE
LMH	Ginsberg, Jay	MD	Medicine	SE CT Neph Assoc
LMH	Giordano, Frank	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Giordano, Joan	MD	Medicine	
LMH	Girard, Elisa	MD	OB-GYN	Thameside OB/GYN Ctr
LMH	Giserman, Bernard	MD	Pediatrics	ProHealth Ped Assoc of NL
LMH	Glazer, Peter	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Glenn, Mary	MD	Pediatrics	Gold Star Pediatrics
LMH	Goldberg, Robert	MD	Medicine	Thompson Goldberg & Donka
LMH	Golden, David	MD	Medicine	Shoreline Family Practice

LMH	Golden, David	MD	Pediatrics	Shoreline Family Practice
LMH	Gonzalez, Rita	MD	Medicine	IPC Hospitalists of NE
LMH	Goodman, Margaret	MD	Radiology	Teleradiology Solutions
LMH	Gordon, Jeffrey	MD	Medicine	New London Cancer Ctr
LMH	Govil, Mithlesh	MD	Medicine	New London Cancer Ctr
LMH	Graham, Garth	MD	Medicine	IPC Hospitalists of NE
LMH	Gramlich, Curt	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Granai, Cornelius	MD	OB-GYN	Women & Infants Hospital
LMH	Grann, Karin	APRN	Medicine	IPC Hospitalists of NE
LMH	Graves, Jay	MD	Medicine	L+MMG Primary Care Old Lyme
LMH	Graves, Kathryn	APRN	Medicine	IPC Hospitalists of NE
LMH	Green, Kevin	MD	Pathology	Pathology Consultants of NL
LMH	Green, Shay	APRN	Medicine	IPC Hospitalists of NE
LMH	Greenhouse, Sanford	MD	Medicine	GF Med Group
LMH	Greenwald, Alan	MD	Medicine	Digestive Disease Assoc PC
LMH	Greer, David	MD	Medicine	Yale-New Haven Telestroke
LMH	Grillo, Susan	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Grossman, Katheryn	PA-C	Emergency Medicine	EMP of New London County
LMH	Hahn, Peter	MD	Medicine	Circulatry Centers of CT
LMH	Hahn-Schubert, Lora	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Haim, Lior	MD	Surgery	Shoreline Eye Group PC
LMH	Haldas, Jason	MD	Medicine	L+M Cancer Center
LMH	Hall, E Kevin	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Halperin, Michael	MD	Surgery	Orthopedic Partners
LMH	Hansen, James	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Hardy, Jennifer	APRN	Medicine	Mystic Med Group
LMH	Haronian, Howard	MD	Medicine	Cardiology Specialists Ltd
LMH	Harris, Randall	DDS	Surgery	
LMH	Hartman, Daniel	MD	Emergency Medicine	EMP of New London County
LMH	Hatfield, Jennifer	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Haus, Mihkel	MD	Medicine	SE CT Neph Assoc
LMH	Headley, Annette	MD	Medicine	
LMH	Healy, James	MD	Medicine	Cardiology Assoc of Norwich
LMH	Hebert, Ryan	MD	Surgery	Yale Neurosurgery
LMH	Hellman, Richard	MD	Medicine	L+M Cancer Center

LMH	Henderson, Brooke	PA-C	Medicine	Coastal Digestive Diseases
LMH	Hennessey, John	MD	Medicine	GF Med Group
LMH	Henry, Glen	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Hespeler, Luanne	PA-C	Medicine	L+M Cancer Center
LMH	Hesse, Katherine	MD	Emergency Medicine	EMP of New London County
LMH	Higgins, Susan	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Hobbie, Christopher	MD	Radiology	Teleradiology Solutions
LMH	Hochreiter, Daniela	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Hodgson, Eric	MD	OB-GYN	SE CT Maternal Fetal Med Assoc
LMH	Holtzman, Phyllis	MD	Pediatrics	GF Pediatric Group
LMH	Hornby, John	MD	Surgery	Eye MD LLC
LMH	Hotsky-Cikatz, Patricia	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Hovagim, Lisa	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Husain, Zain	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Huta, Tara	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Hutchins, Christopher	MD	Surgery	Soundview Orthopaedic Assoc
LMH	Hwang, Anita	MD	Surgery	Cataract & Cornea Eye Spec
LMH	Hwang, David	MD	Medicine	Yale New Haven Telestroke
LMH	Hyppolite, Jenny	MD	Medicine	L+MMG Primary Care Groton
LMH	James, Edward	MD	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Johnson, Steven	MD	Medicine	New London Family Practice
LMH	Johnson, Steven	MD	Pediatrics	New London Family Practice
LMH	Johnson, Vanessa	MD	Medicine	Eastern CT Hematology & Oncology Assoc
LMH	Johung, Kimberly	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Kadian, Sudhir	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Kahle, Kristopher	MD	Surgery	Yale Medical Group
LMH	Kaiser, Raymond	PA-C	Medicine	IPC Hospitalists of NE
LMH	Kalyanpur, Arjun	MD	Radiology	Teleradiology Solutions
LMH	Kamath, Sanjay	MD	Radiology	Teleradiology Solutions
LMH	Kanowitz, Jane	MD	Medicine	L+M Cancer Center
LMH	Karinski, Debra	FNP	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Karwiel, Adam	PA-C	Emergency Medicine	EMP of New London County
LMH	Kawa, John	PA-C	Emergency Medicine	EMP of New London County
LMH	Keiser, Amaris	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Kelly, Barbara	MD	Pediatrics	L+M Hospital/Neonatology Dept

LMH	Kelly, Brian	MD	Surgery	Southern CT Vascular Ctr
LMH	Kelly, Christopher	MD	Surgery	Childrens Eye Care PC
LMH	Keltner, Robert	MD	Medicine	SE Pulmonary Assoc
LMH	Kemal, Mustapha	MD	Rehab Medicine	L+MMG Rehabilitation Medicine
LMH	Kereshi, Tibor	MD	Radiology	Ocean Radiology Assoc
LMH	Khalid, Saima	MD	Medicine	L+MMG Stonington
LMH	Khan, Amzad	MD	Medicine	Coastal Digestive Diseases
LMH	Khanna, Amit	MD	Medicine	L+MMG Sleep Medicine
LMH	Khanna, Ekta	MD	Pediatrics	ProHealth Ped Assoc of NL
LMH	Kierstein, Jeffrey	DPM	Surgery	Kierstein & DiFrancesca DPM PC
LMH	Kington, Randi	APRN	Medicine	L+MMG Joslin Diabetes Center
LMH	Klekotka, Suzanne	MD	Medicine	SE Pulmonary Assoc
LMH	Knowlton, Christin	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Kober, William	MD	Medicine	L+MMG Primary Care Stonington
LMH	Koelle, Kenneth	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Kohari, Katherine	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Krasner, Alan	MD	Medicine	L+MMG Joslin Diabetes Center NL
LMH	Krejci, Elise	MD	Pathology	Pathology Consultants of NL
LMH	Kronisch, Louis	PA-C	Surgery	L+MMG General Surgery
LMH	Kurey, Kimberly	APRN	Rehab Medicine	L+MMG Physiatry
LMH	Kwon, Soo Hyun	MD	Pediatrics	L+M Hospital/Neonatology Dept
LMH	LaChance, Jennifer	PA-C	Surgery	L+MMG General Surgery
LMH	Lake, AeuMuro	MD	OB-GYN	Shoreline OB/GYN PC
LMH	Lamberton, R	MD	Medicine	L+MMG Joslin Diabetes Center NL
LMH	Langer, Victoria	NNP	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Lattanzi, Stephen	MD	Medicine	New London Cancer Ctr
LMH	Laurans, Maxwell	MD	Surgery	Yale Medical Group
LMH	Lavallee, Michael	DO	OB-GYN	Shoreline OB/GYN PC
LMH	Lawrence, David	DPM	Surgery	David & Debra Lawrence DPM
LMH	Lawrence, Debra	DPM	Surgery	David & Debra Lawrence DPM
LMH	Leach, Maureen	APRN	Rehab Medicine	L+MMG Physiatry
LMH	Lebovitz, Ruth	MD	Pediatrics	ProHealth Ped Assoc of NL
LMH	Lee, John	MD	Surgery	New England Plastic Surgery
LMH	Lehrach, Christopher	MD	Emergency Medicine	EMP of New London County
LMH	Levin, Robert	MD	Medicine	

LMH	Levine, Jonathan	MD	OB-GYN	Shoreline OB/GYN PC
LMH	Levy, Susan	MD	Pediatrics	Child Neurology Assoc LLP
LMH	Li, Ting	MD	Medicine	Yale Cardiovascular Assoc of Norwich
LMH	Licare, Lisa	DO	OB-GYN	L+MMG Obstetrics & Gynecology
LMH	Licata, Paul	DO	Medicine	Gold Coast Pulmonary & Sleep
LMH	Lin Monte, Melissa	DO	Emergency Medicine	EMP of New London County
LMH	Lin, Foong-Yi	MD	Pediatrics	GF Pediatric Group
LMH	Lincer, Robert	MD	Surgery	L+MMG General Surgery NL
LMH	Lipkind, Heather	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Lodato, Nicholas	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Lombo-Lievano, Bernardo	MD	Medicine	L+MMG Cardiology Waterford
LMH	Long, T Scott	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Loomis, Caitlin	MD	Medicine	Yale-New Haven Telestroke
LMH	Lopez, Maria	MD	Pediatrics	Flanders Pediatrics LLC
LMH	Loranger Cashman, Marcelle	PA-C	Surgery	L+MMG General Surgery
LMH	Lovin, Jennifer	MD	Pediatrics	GF Pediatric Group
LMH	Lozano, Alan	PA-C	Emergency Medicine	EMP of New London County
LMH	Lu, Steven	MD	Medicine	IPC Hospitalists of NE
LMH	Lunn, James	PA-C	Surgery	L+MMG General Surgery
LMH	Luther, Katherine	APRN	Medicine	IPC Hospitalists of NE
LMH	Ma, Harry	MD	Surgery	Southern CT Vascular Ctr
LMH	Ma, Shuaike	MD	Medicine	SE CT Neph Assoc
LMH	Mackenzie, Bonnie	MD	Emergency Medicine	EMP of New London County
LMH	Magnuson, Katherine	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Magriples, Urania	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Maheshwari, Ashok	MD	Emergency Medicine	EMP of New London County
LMH	Main, Roy	MD	Medicine	IPC Hospitalists of NE
LMH	Maletz, Frank	MD	Surgery	Crossroads Orthopaedics
LMH	Malik, Sajda	MD	Pediatrics	East Lyme Pediatric Clinic
LMH	Manning, Thomas	MD	Radiology	Ocean Radiology Assoc
LMH	Manthous, Constantine	MD	Medicine	Thompson Goldberg & Donka
LMH	Marshall, Sonya	DPM	Surgery	Shoreline Foot & Ankle Ctr
LMH	Martin, Victor	MD	Medicine	IPC Hospitalists of NE
LMH	Mathews, Cara	MD	OB-GYN	Women & Infants Hospital
LMH	Matouk, Charles	MD	Surgery	Yale Medical Group

LMH	Mattke, Angela	MD	Emergency Medicine	EMP of New London County
LMH	Mayeda, Francis	MD	OB-GYN	Shoreline OB/GYN PC
LMH	Mayorga, Oliver	MD	Emergency Medicine	EMP of New London County
LMH	Mazzarelli, Louis	MD	Radiology	Ocean Radiology Assoc
LMH	McAteer, Allison	MD	Surgery	L+MMG Surgery Westerly
LMH	McCalla, Carlo	MD	Medicine	L+M Infectious Disease & Travel Med
LMH	McCarthy, Madeline	MD	Emergency Medicine	EMP of New London County
LMH	McCormick, Rachel	MD	Medicine	IPC Hospitalists of NE
LMH	McCullough, T Casey	DO	Surgery	Backus Physician Services
LMH	McDermott, Catherine	DO	Pediatrics	L+M Hospital/Neonatology Dept
LMH	McDermott, Edward	MD	Medicine	
LMH	McKnight, Craig	MD	OB-GYN	Craig McKnight MD PhD LLC
LMH	McLean, Christina	MD	Medicine	Primary Care for Women
LMH	McManus, Jessie	APRN	Medicine	S Kris Verma MD
LMH	McPherson, Toby	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Mejza, Bridget	APRN	Rehab Medicine	L+M Wound Care Clinic
LMH	Melchreit, Anna-Marie	MD	Pediatrics	Gold Star Pediatrics
LMH	Mena-Hurtado, Carlos	MD	Medicine	L+MMG Cardiology New London
LMH	Mendelovicz, Naomi	MD	Psychiatry	L+MMG Behavioral Health
LMH	Mercurio, Mark	MD	Pediatrics	L+M Hospital/Neonatology Dept
LMH	Miano, Alexander	MD	Psychiatry	L+MMG Behavioral Health
LMH	Miett, Thomas	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Miller, Debra	MD	Medicine	
LMH	Miller, Jeffrey	DO	Surgery	Shaws Cove Orthopaedics LLC
LMH	Milstein, Peter	MD	Medicine	L+MMG Cardiology New London
LMH	Mirecki, Francis	MD	Medicine	L+MMG Cardiology Waterford
LMH	Mitchell, Paul	MD	Surgery	Childrens Eye Care PC
LMH	Mlynarski, F	MD	Surgery	ENT Assoc of SE CT
LMH	Moalli, Daniel	MD	Medicine	L+M Neurodiagnostic Lab
LMH	Monroe, John	MD	Medicine	Community Health Ctr
LMH	Moran, Meena	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Morgan, Peter	MD	Psychiatry	L+MMG Behavioral Health
LMH	Moro-de-Casillas, Maria	MD	Medicine	L+MMG Neurology
LMH	Muftah, Loay	MD	Radiology	Teleradiology Solutions
LMH	Muhs, Bart	MD	Surgery	Southern CT Vascular Ctr

LMH	Murphy-Fiengo, Mary	DO	Medicine	GF Med Group
LMH	Murray, Lynette	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Muscato, Nicole	MD	Pathology	Pathology Consultants of NL
LMH	Nath, Sameer	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Navaratnam, Dhasakumar	MD	Medicine	Yale-New Haven Telestroke
LMH	Negulescu, Mihaela	MD	Medicine	SE CT Neph Assoc
LMH	Nelligan, Elizabeth	MD	Medicine	L+MMG Primary Care Old Lyme
LMH	Nelson, John	MD	Medicine	IPC Hospitalists of NE
LMH	Netravali, Mahesh	MD	Medicine	Shoreline Allergy & Asthma
LMH	Netravali, Mahesh	MD	Pediatrics	Shoreline Allergy & Asthma
LMH	Neuman, Saul	MD	Medicine	SE CT Med Assoc
LMH	Newton, Benjamin	MD	Medicine	L+M Cancer Center
LMH	Nichols, Katherine	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Nickerson, Heather	PA-C	Surgery	L+MMG General Surgery
LMH	Nicolosi, Paul	PA-C	Emergency Medicine	EMP of New London County
LMH	Niedelman, Adam	MD	Medicine	Cardiology Assoc of Norwich
LMH	Niles, Michael	MD	Radiology	Ocean Radiology Assoc
LMH	Nipper, Karen	MD	Surgery	Shoreline Eye Group PC
LMH	Noonan, Joseph	MD	Surgery	Crossroads Orthopaedics
LMH	Nordness, Robert	MD	Emergency Medicine	EMP of New London County
LMH	Nordness, Robert	MD	Medicine	L+M Occupational Health @ PHC
LMH	Nordness, Robert	MD	Rehab Medicine	L+M Wound Care Clinic
LMH	O'Connell, Sarah	MD	Radiology	Ocean Radiology Assoc
LMH	O'Donnell, Sophia	MD	Emergency Medicine	EMP of New London County
LMH	O'Keefe, Joseph	MD	Rehab Medicine	L+MMG Physiatry
LMH	Olivier, Stephanie	PA-C	OB-GYN	Thameside OB/GYN Ctr
LMH	Olszewski, Mariusz	MD	Radiology	Teleradiology Solutions
LMH	Ouellette, George	MD	Medicine	Coastal Digestive Diseases
LMH	Paidas, Michael	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Palazzo, Regina	MD	Pediatrics	Nutmeg Pediatric Pulmonary Svs
LMH	Palker, Neil	MD	Medicine	L+MMG Niantic
LMH	Pandit, Meenakshi	MD	Radiology	Teleradiology Solutions
LMH	Paonessa, Kenneth	MD	Surgery	Orthopedic Partners
LMH	Parad, Adrienne	MD	Medicine	L+MMG Primary Care Mystic
LMH	Parad, Andrew	MD	Medicine	Shoreline Family Practice

LMH	Parad, Andrew	MD	Pediatrics	Shoreline Family Practice
LMH	Parekh, Anisha	MD	Medicine	Primary Care for Women
LMH	Parico, Lia	DDS	Surgery	Childrens Dental Assoc of NL
LMH	Parker, Prior	MD	Surgery	Thames Eye Group
LMH	Patel, Abhijit	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Patel, Nimesh	DO	Medicine	L+MMG Primary Care Groton
LMH	Pathy, Vinod	MD	Surgery	Northeast Plastic Surgery
LMH	Patterson, Bruce	DMD	Surgery	Waterford Dental Health
LMH	Pennington, Norman	MD	Radiology	Teleradiology Solutions
LMH	Peraino, Robert	MD	Medicine	IPC Hospitalists of NE
LMH	Perry, Robert	MD	Medicine	L+MMG Primary Care New London
LMH	Perry, Warren	MD	Emergency Medicine	EMP of New London County
LMH	Peter, Thomas	MD	Medicine	SE CT Neph Assoc
LMH	Peterec, Steven	MD	Pediatrics	Yale School of Medicine/ Dept of Pediatrics
LMH	Peters, Joseph	MD	Rehab Medicine	L+MMG Physiatry
LMH	Petersen, Nils	MD	Medicine	Yale-New Haven Telestroke
LMH	Pettker, Christian	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Pfau, Steven	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Phillips, Harold	MD	Medicine	IPC Hospitalists of NE
LMH	Phillips, Kimberly	MD	Medicine	Phillips Integrative Health
LMH	Pierce, Richard	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Piposar, Jonathan	MD	Surgery	Orthopedic Partners
LMH	Pollock, Dennis	MD	Medicine	L+M Occupational Health @ PHC
LMH	Popkin, Valerie	MD	Medicine	L+MMG Cardiology Waterford
LMH	Posner, Melissa	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Powers, Evelyn	PA-C	Emergency Medicine	EMP of New London County
LMH	Provoncha, Danielle	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Puttagunta, Sailaja	MD	Medicine	L+M Infectious Disease & Travel Med
LMH	Pyle, Alaina	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists
LMH	Quevedo, Stephen	MD	Medicine	L+MMG Joslin Diabetes Center NL
LMH	Quinn, Anthony	MD	Surgery	Thames Urology Ctr
LMH	Racek, Christina	MD	OB-GYN	Thameside OB/GYN Ctr
LMH	Radin, Laurence	MD	Medicine	Neurological Group PC
LMH	Rajkumar, Michael	MD	Medicine	L+M Infectious Disease Dept
LMH	Rajput, Kanishka	MD	Anesthesia	Anesthesia Assoc of NL

LMH	Ramos, Valmarie	MD	Medicine	New London Cancer Ctr
LMH	Rana, Mohammad	MD	Medicine	IPC Hospitalists of NE
LMH	Rasool, Altaf	MD	Medicine	SE CT Neph Assoc
LMH	Rau, Laura	MD	Emergency Medicine	EMP of New London County
LMH	Reardon, Claire	MD	Medicine	IPC Hospitalists of NE
LMH	Reed, Jeanne	PA-C	Medicine	L+M Occupational Health @ PHC
LMH	Regan, Christopher	MD	Medicine	Yale Univ Cardiolvascular Med
LMH	Reisfeld, David	MD	Surgery	L+MMG General Surgery NL
LMH	Remetz, Michael	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Reyes, Karen	APRN	Medicine	IPC Hospitalists of NE
LMH	Reyes, Victoria	MD	Pathology	Pathology Consultants of NL
LMH	Reznik, Heather	PA-C	Surgery	L+MMG Surgery Westerly
LMH	Robbins, Sheldon	MD	Radiology	Ocean Radiology Assoc
LMH	Roberts, Kenneth	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Romania, Anthony	MD	Surgery	Romania Eye Center
LMH	Roque, Dario	MD	OB-GYN	Women & Infants Hospital
LMH	Rosenthal, Mark	MD	Pediatrics	GF Pediatric Group
LMH	Roy, Karen	APRN	Medicine	IPC Hospitalists of NE
LMH	Ruffa, Geraldine	MD	Medicine	L+M Occupational Health @ PHC
LMH	Rufo, Janet	NMW	OB-GYN	L+MMG Obstetrics & Gynecology
LMH	Ryan, John	MD	Surgery	Famiglietti Eye Assoc
LMH	Rydell, Margret	MD	Medicine	New London Family Practice
LMH	Rydell, Margret	MD	Pediatrics	New London Family Practice
LMH	Saccoccio, Dustin	PA-C	Emergency Medicine	EMP of New London County
LMH	Sajjad, Sepehr	MD	Surgery	Connecticut Hand Center
LMH	Sala, Christopher	MD	Emergency Medicine	EMP of New London County
LMH	Salek, Allyson	MD	Pediatrics	ProHealth Ped Assoc of NL
LMH	Salkin, Jeffrey	MD	Surgery	Crossroads Orthopaedics
LMH	Sanfilippo, Ross	DMD	Surgery	Soundview Oral & Maxillofacial
LMH	Sansing, Lauren	MD	Medicine	Yale-New Haven Telestroke
LMH	Santoro, Fred	MD	Pediatrics	
LMH	Sapozhnikov, Eugene	MD	Medicine	Coastal Digestive Diseases
LMH	Scarles, James	MD	Medicine	Mystic Med Group
LMH	Schell, Elizabeth	PA-C	Emergency Medicine	EMP of New London County
LMH	Schindler, Joseph	MD	Medicine	Yale-New Haven Telestroke

LMH	Schneider, Kathryn	APRN	Medicine	L+M Infectious Disease & Travel Med
LMH	Schnepp, Brittany	PA-C	Surgery	L+MMG General Surgery
LMH	Schoenberger, Steven	MD	Surgery	Thames Urology Ctr
LMH	Schrempf, Michael	MD	OB-GYN	Thameside OB/GYN Ctr
LMH	Scoggins, Misty	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Scoppetta, Daniel	MD	Surgery	L+MMG General Surgery NL
LMH	Sedore, Stanley	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Seidell, Dianne	APRN	Medicine	IPC Hospitalists of NE
LMH	Seltzer, Jeffrey	MD	Medicine	Cardiology Assoc of Norwich
LMH	Sena, Thomas	MD	Surgery	
LMH	Setaro, John	MD	Medicine	Yale Univ Cardiovascular Med
LMH	Sfakianaki, Anna	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Shaver, Randy	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Sheth, Kevin	MD	Medicine	Yale New-Haven Telestroke
LMH	Shichman, Steven	MD	Surgery	Hartford HealthCare Urology
LMH	Shute, Marlene	MD	Medicine	L+MMG Primary Care New London
LMH	Siew, Lawrence	MD	Emergency Medicine	EMP of New London County
LMH	Sikand, Vijay	MD	Medicine	
LMH	Silasi, Michelle	MD	OB-GYN	Yale Univ Maternal Fetal Med
LMH	Simpson, Jeffrey	MD	OB-GYN	
LMH	Singh, Deepika	MD	Emergency Medicine	EMP of New London County
LMH	Sitko, Ira	MD	Radiology	Ocean Radiology Assoc
LMH	Slater, Alexander	MD	Anesthesia	Anesthesia Assoc of NL
LMH	Sloan, Stephanie	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Solitare, Gilbert	MD	Pathology	St Barnabas Med Ctr
LMH	Somers, Mark	MD	Medicine	L+MMG Cardiology Waterford
LMH	Sorrentino, John	MD	Radiology	Ocean Radiology Assoc
LMH	Spitz, Robert	MD	OB-GYN	Montauk GYN
LMH	Sprecace, George	MD	Medicine	Allergy Assoc of NL
LMH	Stallard, John	MD	Emergency Medicine	EMP of New London County
LMH	Stanat, Christy	MD	Surgery	L+MMG General Surgery NL
LMH	Stebbins, Stefanie	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Steiner, Brian	MD	Emergency Medicine	EMP of New London County
LMH	Steiner, Laura	PA-C	Emergency Medicine	EMP of New London County
LMH	Stevens, Anna	MD	Emergency Medicine	EMP of New London County

LMH	Stuckey, Ashley	MD	OB-GYN	Women & Infants Hospital
LMH	Sullivan, James	MD	Medicine	Mystic Med Group
LMH	Sumpio, Bauer	MD	Surgery	Yale Medical Group
LMH	Sun, Wenting	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Sutherland, Jennifer	MD	Medicine	L+MMG Primary Care Old Lyme
LMH	Szutowska, Magdalena	MD	OB-GYN	Shoreline OB-GYN PC
LMH	Talavera-Briggs, Amarilis	MD	Psychiatry	L+MMG Behavioral Health
LMH	Terranova, George	MD	Emergency Medicine	EMP of New London County
LMH	Thompson, Christopher	PA-C	Surgery	Orthopedic Partners
LMH	Thompson, David	MD	Medicine	Thompson Goldberg & Donka
LMH	Thoms, R Justin	MD	Surgery	Orthopedic Partners
LMH	Tinklepaugh, David	MD	Medicine	Neurology Associates
LMH	Toole, Wendy	MD	Emergency Medicine	EMP of New London County
LMH	Toplosky, Agnes Maria	APRN	Medicine	IPC Hospitalists of NE
LMH	Torres, Kevin	DO	Emergency Medicine	L+MMG Primary Care Waterford
LMH	Tschetter, Kimberly	PA-C	Anesthesia	Anesthesia Assoc of NL
LMH	Tucker, Cynthia	MD	Emergency Medicine	EMP of New London County
LMH	Ucanda, Martin	MD	Medicine	L+MMG Infectious Disease & Travel Med
LMH	Uguccioni, Krystin	APRN	Medicine	IPC Hospitalists of NE
LMH	Urbanetti, John	MD	Medicine	SE Pulmonary Assoc
LMH	Ureles, Steven	DMD	Surgery	Childrens Dental Assoc of NL
LMH	Vachhani, Jitesh	MD	Medicine	L+MMG Primary Care Niantic
LMH	Velankar, Pradnya	MD	Medicine	L+MMG Cardiology Waterford
LMH	Ventulett, Robert	PA-C	Medicine	IPC Hospitalists of NE
LMH	Verma, Shri	MD	Medicine	
LMH	Vitello, Sarah	DO	Emergency Medicine	EMP of New London County
LMH	Wable, Sumathi	MD	Radiology	Teleradiology Solutions
LMH	Waggoner, Daniel	MD	Medicine	Shoreline Allergy & Asthma
LMH	Waggoner, Daniel	MD	Pediatrics	Shoreline Allergy & Asthma
LMH	Wagner, Joseph	MD	Surgery	Hartford HealthCare Urology
LMH	Walcott, Charles	DO	Rehab Medicine	L+M Wound Care Clinic
LMH	Walcott, Charles	DO	Medicine	L+MMG Niantic
LMH	Walden, Peter	MD	Surgery	Childrens Eye Care PC
LMH	Walker, David	MD	Medicine	Middlesex Hosp Primary Care Westbrook
LMH	Walsh, Christina	MD	Pediatrics	L+M Hospital/Pediatric Hospitalists

LMH	Watson, Edward	MD	OB-GYN	L+MMG OB-GYN NL
LMH	Watson, Michelle	MD	Pediatrics	GF Pediatric Group
LMH	Watts-St Germain, Megan	APRN	Psychiatry	L+MMG Behavioral Health
LMH	Webster, Benjamin	CRNA	Anesthesia	Anesthesia Assoc of NL
LMH	Weeks, Bevin	MD	Pediatrics	Yale Pediatric Cardiology
LMH	Wei, Steven	MD	Surgery	Orthopedic Partners
LMH	Weiss, Mark	MD	Radiology	Teleradiology Solutions
LMH	Welch, Arthur	PA-C	Surgery	L+MMG Neurosurgery
LMH	Wesolek, John	MD	Surgery	Chelsea Surgical Care
LMH	West, John	MD	Medicine	Seaport Dermatology
LMH	Whelan, Mae	MD	Medicine	L+MMG Joslin Diabetes Center
LMH	Whitney, Rachel	MD	Emergency Medicine	EMP of New London County
LMH	Williams, Brian	MD	Medicine	L+MMG Primary Care Mystic
LMH	Williams, Gina	MD	Medicine	L+MMG Primary Care Mystic
LMH	Willis, Dean	MD	Surgery	L+MMG General Surgery NL
LMH	Wilner, Andrew	MD	Medicine	IPC Hospitalists of NE
LMH	Wilson, Lynn	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Witt, Wendy	MD	Emergency Medicine	L+M Emergency Dept
LMH	Wolf, Eric	MD	Medicine	
LMH	Wolff, Mirela	MD	Medicine	IPC Hospitalists of NE
LMH	Wu, Chadwick	MD	Surgery	Connecticut Hand Center
LMH	Yoselevsky, Melvin	MD	Medicine	
LMH	Young, Melissa	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Younger, Angela	APRN	Medicine	L+MMG Joslin Diabetes Center Stonington
LMH	Yu, James	MD	Medicine	Yale Univ Therapeutic Rad Dept
LMH	Zeevi, Neer	MD	Medicine	IPC Hospitalists of NE
LMH	Zito, Julie	MD	Medicine	New London Cancer Ctr
WH	A Rita, Peter Faherty	MD	Medicine	Rhode Island Cardiovascular
WH	Adam, Karwiel	PA-C	Emergency Services	EMP
WH	Adam, Niedelman	MD	Medicine	IPC Hospitalists of New England
WH	Adrian, Hamburger	MD	Anesthesia	L+MMG
WH	Adriene, Miller	DO	Medicine	IPC Hospitalists
WH	Andrew, Neuhauser	MD	Surgery	
WH	Angela, Mattke	MD	Emergency Services	EMP
WH	Anica, Antic	MD	Pathology	Pathology Consultants of New London

WH	Anjali, Agrawal	MD	Radiology	Teleradiology Solutions
WH	Anne, Garvey	MD	Medicine	Westerly Pediatrics
WH	Annette, Headley	MD	Medicine	
WH	Anthony, Quinn	MD	Surgery	Hartford Healthcare Urology Group
WH	Arjun, Kalyanpur	MD	Radiology	Teleradiology Solutions
WH	Ashley, Stuckey	MD	Surgery	Women and Infants Hospital of RI
WH	Asim, Ejaz	MD	Pathology	Pathology Consultants of New London
WH	Barbara, Muir	PA-C	Surgery	L+M Medical Group Westerly
WH	Bartel, Crisafi	MD	Medicine	Ocean State Urgent Care of Westerly
WH	Bernard , Marzilli	DO	Medicine	
WH	Bradford, Lavigne	MD	Medicine	Gastroenterology Specialists Inc
WH	Brandi, Iovino	DO	Medicine	L+M Medical Group Stonington
WH	Brandon, Luk	MD	Medicine	Lawrence and Memorial Medical Group - Westerly
WH	Bridget, Mejza	RNP	Surgery	Wound Clinic/L+M Westerly Hospital
WH	Carl, Aschkenasi	MD	Radiology	Teleradiology Solutions
WH	Carlos, Mena Hurtado	MD	Medicine	Yale New Haven Health System
WH	Catherine, Benoit	RNP	Medicine	Gastroenterology and Digestive Wellness
WH	Christopher, Campagnari	MD	Medicine	Wood River Health Services
WH	Christopher, D Arcy	MD	Medicine	Coastal Rheumatology
WH	Christopher, DeSantis	MD	Anesthesia	Anesthesia Associates
WH	Christopher, Hutchins	MD	Surgery	Soundview Orthopaedic Assoc LLP
WH	Christopher, Jalbert	MD	Medicine	IPC Hospitalists of Westerly
WH	Christopher, Lehrach	MD	Emergency Services	EMP
WH	Colleen, Planchon	RNP	Medicine	IPC Hospitalists of New England
WH	Cornelius, Granai	MD	Surgery	Womens Oncology
WH	Curt, Gramlich	MD	Anesthesia	Anesthesia Associates
WH	Daniel, Diffin	MD	Radiology	Westerly Radiology Assoc Inc
WH	Daniel, Gaccione	MD	Surgery	Soundview Orthopaedic Assoc. LLP
WH	Dante, Gulino	MD DDS	Surgery	
WH	Darlene, Gabeau	MD	Radiology	South County Radiation Therapy
WH	David , Rivera	MD	Surgery	Vision Care Associates
WH	David, Barrall	MD	Surgery	Hand Surgery Specialists
WH	David, Burchenal	MD	Medicine	
WH	David, Cameron	MD	Surgery	ENT Associates Of Westerly Ltd
WH	David, Donaldson	MD	Medicine	Rhode Island Cardiovascular

WH	David, Lawrence	DPM	Surgery	David & Debra Lawrence DPM
WH	David, Schwindt	MD	Medicine	
WH	David, Shlaes	MD	Medicine	
WH	David, Wright	MD	Emergency Services	EMP
WH	Debra, Lawrence	DPM	Surgery	David & Debra Lawrence DPM
WH	Deepika, Singh	MD	Emergency Services	EMP
WH	Diandra, Fallone	PA-C	Emergency Services	EMP of Washington County
WH	Diane, Paggioli	DO	Medicine	South County Medical Group - Hematology/Oncology
WH	Donald, Felitto	MD	Medicine	IPC Hospitalists of New England
WH	Doron, Ber	MD	Medicine	Shoreline AllergY Asthma Assocs
WH	Elise, Krejci	MD	Pathology	Pathology Consultants of New London
WH	Elsburgh, Clarke	MD	Emergency Services	EMP
WH	Emilio, S Belaval	MD	Emergency Services	EMP
WH	Erik, Enquist	MD	Surgery	Champion Urology
WH	Evelyn, Powers	PA-C	Emergency Services	EMP
WH	Francis, Mayeda	MD	Surgery	Shoreline Obstetrics Gynecology
WH	Frank, Toole III	PA-C	Surgery	Ninigret Orthopedics Inc
WH	Franklin, Leddy	MD	Surgery	Champion Urology
WH	Frederick, Jaccarino	MD	Emergency Services	EMP
WH	George, Bourganos	MD	Medicine	Rhode Island Cardiovascular
WH	George, Giffault	DO	Medicine	IPC Hospitalists of New England
WH	Geraldine, Ruffa	MD	Medicine	Department of Employee Health
WH	H Anthony, Carter	MD	Medicine	L+MMG
WH	Harold, Phillips	MD	Medicine	IPC Hospitalists of New England
WH	Heather, Reznik	PA-C	Surgery	L+MMG
WH	Henry, Amdur	MD	Surgery	Womens Health of Westerly
WH	Howard, Haronian	MD	Medicine	Cardiology Specialists Ltd
WH	Ingrid, Feder	MD	Medicine	IPC Hospitalists of New England
WH	Insu, Kong	MD	Surgery	
WH	James , Smythe	MD	Medicine	South County Medical Group Hematology/Oncology
WH	James , Stuart	DO	Medicine	James G. Stuart, DO LLC
WH	James, Sullivan	MD	Medicine	IPC Hospitalists of New England
WH	Janet, Fetherston	CRNA	Anesthesia	Anesthesia Associates
WH	Jay, Colby	MD	Radiology	Westerly Radiology Assoc Inc.
WH	Jeanne, Ansel	PA-C	Emergency Services	EMP

WH	Jeffrey, Christian	MD	Surgery	L+M Medical Group Westerly
WH	Jeffrey, Feldman	MD	Surgery	ENT Associates of Westerly Ltd
WH	Jenine, Gesino	PA-C	Surgery	
WH	Jennifer, Davey	PA-C	Medicine	Department of Employee Health
WH	Joanna, Lannie	PA-C	Medicine	IPC Hospitalists of New England
WH	Job, Sandoval	MD	Medicine	
WH	John, Beauchamp	MD	Medicine	Seaside Internal Medicine
WH	John, Bergeron	MD	Medicine	Wood River Health Services
WH	John, West	MD	Medicine	Seaport Dermatology
WH	Jon, Scheiber	MD	Medicine	Cardiology Specialists Ltd
WH	Jon, Solis	MD	Medicine	Westerly Dermatology Center
WH	Joseph, Benedict	MD	Pathology	Pathology Consultants of New London
WH	Joseph, Dotolo	MD	Medicine	
WH	Joseph, Giancaspro	MD	Medicine	Ocean State Urgent Care of Westerly
WH	Joseph, Romanello	MD	Medicine	Shoreline Nephrology Associates
WH	Juan, DelPrado	PA-C	Surgery	L+MMG
WH	Kacia, Yazbak Toussaint	PA-C	Emergency Services	EMP
WH	Karen, Castaldo	DO	Anesthesia	Anesthesia Associates
WH	Keith, Hilliker	MD	Emergency Services	EMP
WH	Kelly, Burns	PA-C	Emergency Services	EMP
WH	Kenneth, Donovan	MD	Medicine	IPC Hospitalists of Westerly
WH	Kevin, Green	MD	Pathology	Pathology Consultants of New London
WH	Kevin, Torres	DO	Emergency Services	EMP
WH	L Anthony, Cirillo	MD	Emergency Services	EMP
WH	Laryl, Riley	RNP	Medicine	LMMG
WH	Laura, Rau	MD	Emergency Services	EMP
WH	Leon, Goldstein	MD	Surgery	Coastal Plastic Surgery Center
WH	Lisa, Licare	DO	Surgery	Lawrence and Memorial Medical Group - OB/GYN
WH	Lisa, Menard Manlove	MD	Medicine	Wood River Health Services
WH	Louis, Iovino	DO	Medicine	L+M Medical Group Stonington
WH	M Daniella, Duke	MD	Medicine	Coastal Dermatology
WH	Manohar, Aribandi	MD	Radiology	Teleradiology Solutions
WH	Marcelle, Loranger Cashman	PA-C	Surgery	L+MMG
WH	Margaret, Goodman	MD	Radiology	Teleradiology Solutions
WH	Margaret, Mueller	MD	Emergency Services	EMP

WH	Mark, Geronimo	MD	Medicine	IPC Hospitalists of New England
WH	Mark, Mancini	MD	Medicine	Shoreline Nephrology Associates
WH	Marshall, Carpenter	MD	Surgery	New Beginnings
WH	Matthew, Fox	MD	Radiology	Teleradiology Solutions
WH	Meenakshi, Pandit	MD	Radiology	Teleradiology Solutions
WH	Melissa, Lin Monte	DO	Emergency Services	EMP
WH	Michael, Betler	DO	Surgery	L+M Medical Group Westerly
WH	Michael, Deren	MD	Surgery	Backus Wound Care
WH	Michael, Harwood	MD	Medicine	L+MMG
WH	Michael, Niles	MD	Radiology	Westerly Radiology Assoc Inc
WH	Molly, Fox	PA-C	Emergency Services	EMP
WH	Myriam, DeBaets	MD	Medicine	IPC Hospitalists
WH	N Christopher, Kelley	MD	Medicine	Rhode Island Cardiovascular
WH	Nabila, Mazumder	MD	Medicine	IPC Hospitalists of Westerly
WH	Naomi, Mendelovicz	MD	Medicine	
WH	Niall, Duhig	MD	Medicine	
WH	Nicole, Muscato	MD	Pathology	Pathology Consultants of New London
WH	Norman, Pennington	MD	Radiology	Teleradiology Solutions
WH	Oliver, Mayorga	MD	Emergency Services	EMP
WH	Pamela, Connors	MD	Medicine	Gastroenterology and Digestive Wellness
WH	Patricia, Cervera	RNP	Medicine	IPC Hospitalists of New England
WH	Patricia, Krause	RNP	Medicine	Department of Employee Health
WH	Paul, Bourguignon	MD	Surgery	L+M Medical Group Westerly
WH	Paul, Casinelli	MD	Anesthesia	Anesthesia Associates of Westerly
WH	Paul, Licata	DO	Medicine	IPC Hospitalists of New England
WH	Peter, Bolton	MD	Medicine	Ocean State Urgent Care of Westerly
WH	Peter, Shorter	MD	Medicine	Shoreline Nephrology Associates
WH	Philo, Willetts	MD	Surgery	
WH	Prabhakar, Tipirneni	MD	Surgery	Prabhakar R. Tipirneni, MD, Inc
WH	Rachel, Ketter	PA-C	Emergency Services	EMP
WH	Rachel, McCormick	MD	Medicine	IPC Hospitalists of New England
WH	Rebecca, Vanasse	MD	Medicine	Oncology Hematology Associates
WH	Rita, Gonzalez	MD	Medicine	IPC Hospitalists of Westerly
WH	Robert, Fox	MD	Medicine	
WH	Robert, Harrison	MD	Surgery	

WH	Robert, Legare	MD	Medicine	Oncology Hematology Associates
WH	Robert, Nordness	MD	Emergency Services	EMP
WH	Robert, Peraino	MD	Medicine	IPC Hospitalists of New England
WH	Robert, Ventulett	PA-C	Medicine	IPC Hospitalists of New England
WH	Rocco, Andreozzi	DO	Medicine	Ocean State Urgent Care of Westerly
WH	Roy, Main	MD	Medicine	IPC Hospitalists of New England
WH	Russell, Lenihan	PA	Surgery	L+M Medical Group Westerly
WH	Russell, Stokes	MD	Medicine	We Luv Kids
WH	Samuel, Montalto	OD	Surgery	Coastal Eye Associates
WH	Sanjay, Kamath	MD	Radiology	Teleradiology Solutions
WH	Sepehr, Sajjad	MD	Surgery	Connecticut Hand Center
WH	Shereene, Brown	MD	Surgery	L+M Medical Group Westerly
WH	Simon, Knopf	MD JD	Emergency Services	EMP
WH	Sophia, O Donnell	MD	Emergency Services	EMP
WH	Stefana, Pecher	MD	Medicine	
WH	Stephen, Eigles	MD	Radiology	Teleradiology Solutions
WH	Stephen, Gross	MD	Surgery	
WH	Stephen, Kutz	MD	Medicine	Cardiology Specialists, Ltd
WH	Stephen, Phelan	MD	Medicine	L+M Medical Group Westerly
WH	Steven, Wetzner	MD	Radiology	
WH	Steven, Yolen	MD	Medicine	Gastroenterology Specialists Inc
WH	Susan, Collemer	MD	Emergency Services	EMP
WH	Susan, Stuart	DO	Medicine	The Westerly Medical Center
WH	Tara, Whelan	DO	Medicine	L+MMG
WH	Taryn, Fabian	PA-C	Surgery	L+MMG
WH	Thomas, Lanna	MD	Medicine	Rhode Island Cardiovascular
WH	Timothy, Olson	MD	Anesthesia	
WH	Timothy, Shafman	MD	Radiology	South County Radiation Therapy
WH	Victoria, Reyes	MD	Pathology	Pathology Consultants of New London
WH	Vincent, MacAndrew	MD	Surgery	L+MMG
WH	Vincent, Montemarano	MD	Surgery	
WH	Wendy, Silversmith	MD	Medicine	
WH	Wendy, Witt	MD	Emergency Services	EMP
WH	William , Conlin	MD	Emergency Services	
WH	William, Ware	MD	Surgery	Mystic Medical Center

YNHH	Abbed, Khalid	MD	Neurosurgery	Yale-New Haven Hospital Spine Center
YNHH	Abdallah, Chadi	MD	Psychiatry	VAMC
YNHH	Abdel-Razeq, Sonya	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Abder, Roxanne	MD	Obstetrics & Gynecology	Womens Healthcare of Trumbull
YNHH	Abedin, Sakena	MD	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Abi-Raad, Rita	MD	Pathology	YUSM Department of Pathology
YNHH	Ablow, Karen	DMD	Dentistry	
YNHH	Abraham, Clara	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Abraham, Gineesha	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital
YNHH	Abrahams, James	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Abramowitz, Nicole	MD	Pediatrics	Optimus Healthcare
YNHH	Accomando, Angelo	MD	Internal Medicine	FPIM of New Haven County
YNHH	Acharya, Ami	MD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Ackerman, Adam	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Adekanye, Oluwaseun	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Adekolu, Evelyn	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Adekolu, Olurotimi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Adelman, Ron	MD	Ophthalmology	Yale Eye Center
YNHH	Adelsberg, Bernard	MD	Internal Medicine	Northeast Medical Group
YNHH	Adelson, Kerin	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital Breast Center
YNHH	Adelstein, Judith	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Adeniran, Adebowale	MD	Pathology	YUSM Department of Pathology
YNHH	Adetola, Adedayo	MD	Internal Medicine	West Haven Medical Group
YNHH	Adimando, Andrea	APRN	Psychiatry	Andrea Adimando, A.P.R.N.
YNHH	Adriani, Melissa	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Adsuar, Natalie	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Advani, Anisha	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Affenito, James	DMD	Surgery	OMS Associates, PC
YNHH	Afolalu, Abisola	MD	Internal Medicine	Broadway Medical Group, L.L.C.
YNHH	Afolalu, Bayode	MD	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Afridi, Waffiyah	MD	Internal Medicine	Arthritis & Osteoporosis Center, P.C.
YNHH	Afrin, Syeda	DO	Internal Medicine	Milford Hospital
YNHH	Aftassi, Cynthia	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Aggarwal, Sanjay	MD	Internal Medicine	Sanjay Aggarwal, M.D., LLC
YNHH	Agin, Elliot	MD	Internal Medicine	Cardiovascular Physicians & Consultants

YNHH	Agli, Jeffrey	APRN	Pediatrics	YUSM Department of Anesthesiology
YNHH	Agnoli, Alicia	MD	Internal Medicine	YNHH Adult PCC
YNHH	Agrawal, Pooja	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Aguayo, Patricia	MD	Child Psychiatry	
YNHH	Aguilar-Zanatta, Jorge	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Ahasic, Amy	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Ahmad, Tariq	MD	Internal Medicine	
YNHH	Ahmed, Elizabeth	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Ahn, Kyung-Heup	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Akande, Olukemi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Akar, Joseph	MD, PhD	Internal Medicine	YUSM Section of Cardiology
YNHH	Akeyson, Edward	MD, PhD	Neurosurgery	
YNHH	Akgun, Kathleen	MD	Internal Medicine	VAMC
YNHH	Akhtar, Shamsuddin	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Akinbo, Oluwaseun	MD	Orthopedics	Center for Orthopaedics
YNHH	Al Haddadin, Caroline	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Alaparthi, Latha	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Alberti, Paul	MD	Surgery	Ear, Nose & Throat Medical and Surgical
YNHH	Albright, Melanie	CNM	Obstetrics & Gynecology	The Center for Women's Health and Midwifery
YNHH	Aldrich, Jennifer	PA	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Alexiades-Armenakas, Macrene	MD	Dermatology	YUSM Department of Dermatology
YNHH	Alfirii, Alina	MD	Internal Medicine	Alina Alfirii, MD, LLC
YNHH	Ali, Shazi	APRN	Internal Medicine	Milford Hospital
YNHH	Alian, Aymen	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Alkawadri, Mhd Rafeed	MD	Neurology	YUSM Department of Neurology
YNHH	Allison, Joel	PhD	Psychiatry	
YNHH	Almeida, Samantha	PA	Surgery	Southern New England ENT
YNHH	Alonso, Luis	MD	Pediatrics	Pediatric & Adolescent Medicine, P.C.
YNHH	Alper, Arik	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Alpern, Robert	MD	Internal Medicine	YUSM Department of Internal Medicine
YNHH	Alperovich, Michael	MD	Surgery	YUSM Section of Plastic Surgery
YNHH	Al-Qadi, Mazen	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Alsaid Alkhreisat, Mustafa	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Altalib, Hamada	DO	Neurology	YUSM Department of Neurology
YNHH	Altan, Mehmet	MD	Internal Medicine	Yale-New Haven Hospital-Multispecialty Clinic/GU Oncology

YNHH	Alter, Jeffrey	MD	Dermatology	Jeffrey Alter, M.D.
YNHH	Altice, Frederick	MD	Internal Medicine	YUSM Section of Infectious Disease, AIDS Program
YNHH	Altin, Sophia	MD	Internal Medicine	
YNHH	Altman, Mark	MD	Orthopedics	Center for Orthopaedics
YNHH	Altshul, Victor	MD	Psychiatry	
YNHH	Altwerger, Gary	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Alvino, Patrick	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Amah, Linda	MD	Internal Medicine	Northeast Medical Group
YNHH	Amato, Peter	MD	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
YNHH	Amberson, Nancy	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Ambrogio, Lisa	PA	Neurosurgery	Northeast Medical Group, Inc.
YNHH	Ambrosino, Jodie	PhD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Ameen, Nadia	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Amell, Nicola	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Ameti, Lirim	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Amico, Carol	PA	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Amin, Hardik	MD	Neurology	YUSM Department of Neurology
YNHH	Amodeo, John	MD	Surgery	New Haven Surgical Associates
YNHH	Amon-Perpetua, Vicky	APRN	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Amoo, Francis	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Anand, Rahul	MD	Anesthesiology	Connecticut Pain and Wellness Center
YNHH	Ancona, John	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Ancuta, Michael	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Anderson, Cheryl	MD	Pediatrics	Pediatrics Plus, P.C.
YNHH	Anderson, Rachel	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Anderson, Robert	MD	Pediatrics	Whitney Pediatrics & Adolescent Medicine/NEMG
YNHH	Anderson, Tara	PA	Internal Medicine	YUSM Section of Hematology
YNHH	Anderson-Peterkin, Nycaine	MD	Orthopedics	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Andrejeva, Liva	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Andreozzi, Christopher	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Andres, Pietro	MD	Internal Medicine	Gastroenterology Associates, P.C.
YNHH	Andrus, Jason	PA	Orthopedics	Bridgeport Hospital
YNHH	Anekondadha Revakala, Latha	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Angarita Africano, Gustavo	MD	Psychiatry	YUSM Department of Psychiatry

YNHH	Angelo, Steven	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Angoff, Nancy	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Angoff, Ronald	MD	Pediatrics	Pediatric & Medical Associates
YNHH	Angulo Diaz, Veronica	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Annamalai, Aniyizhai	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Ansari, Ehsan	MD	Internal Medicine	Cardiology Associates of Greater Waterbury
YNHH	Anschel, David	MD	Neurology	American Neuromonitoring Associates, PC
YNHH	Antaya, Richard	MD	Dermatology	Yale Dermatology Associates
YNHH	Antignani, David	PA	Surgery	Bridgeport Hospital
YNHH	Antin-Ozerkis, Danielle	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Antonetti, David	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Aouad, Rima	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Apiado, Frederick	MD	Internal Medicine	Bridgeport Hospital
YNHH	Ardeshirpour, Laleh	MD	Pediatrics	Children's Medical Group, LLC dba Pediatric Endocrine
YNHH	Ardesia, Robert	MD	Internal Medicine	Take Heart Cardiovascular Health Center
YNHH	Argento, Vivian	MD	Internal Medicine	Northeast Medical Group
YNHH	Argo, Michele	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Arici, Aydin	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Arici, Melih	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Ariyan, Stephan	MD	Surgery	YUSM Section of Plastic Surgery
YNHH	Arlis-Mayor, Stephanie	MD	Internal Medicine	Center for Orthopaedics
YNHH	Armel, Harvey	MD	Urology	
YNHH	Armm, Milton	MD	Urology	Milton Armm, M.D., P.C.
YNHH	Arnold, Catharine	MD	Internal Medicine	Guilford Internal Medicine Group
YNHH	Arnold, Linda	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Arons, Jeffrey	MD	Surgery	Jeffrey A. Arons, M.D., P.C.
YNHH	Aronson, Paul	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Aronson, Peter	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Arora, Anita	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Arsenault, Ronald	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Artigliere, Ryan	PA	Urology	YUSM Department of Urology
YNHH	Aruny, John	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Asare, Vivian	MD	Internal Medicine	YNHH Sleep Medicine Center
YNHH	Asch, William	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Asefaw, Senai	MD	Internal Medicine	NEMG - Y-NHH Hospitalists

YNHH	Asiedu, Patrick	MD	Internal Medicine	Northeast Medical Group
YNHH	Asiedu, Rosemary	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Asis, Maria	MD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Aslanian, Harry	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital - Ambulatory Procedure Center
YNHH	Asmus, Mary	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Asnes, Andrea	MD	Pediatrics	YUSM Department of General Pediatrics
YNHH	Asnes, Jeremy	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Assis, David	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Astrachan, David	MD	Surgery	Ear, Nose and Throat Specialists of Conn
YNHH	Atandeyi, Kolawole	MD	Internal Medicine	Milford Hospital
YNHH	Atkins, Stephen	MD	Psychiatry	Solo Practice
YNHH	Atkins, Susanne	PA	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
YNHH	Atlas, Stephen	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Attaran, Robert	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Atton, Andrew	MD	Dermatology	Dermatology Associates of Glastonbury
YNHH	Atweh, Nabil	MD	Surgery	Bridgeport Hospital
YNHH	Auerbach, Claudia	APRN	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Auerbach, Marc	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Austen, Burton	MD	Psychiatry	Burton G. Austen, M.D.
YNHH	Avanecean, Donna	APRN	Neurosurgery	YUSM Department of Neurology
YNHH	Aversa, David	MD	Child Psychiatry	Connecticut Psychiatric & Wellness Center, LLC
YNHH	Aversa, John	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Aversa, Kristen	MD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Avni-Singer, Abraham	MD	Pediatrics	Child-Adolescent Healthcare
YNHH	Awad, John	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Axelrod, Seth	PhD	Psychiatry	YNHH Partial Hospital
YNHH	Aydin, Ani	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Ayepah, Michael	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Ayepah, Rina	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Ayyagari, Rajasekhara	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Azodi, Masoud	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Bacal, Darron	MD	Ophthalmology	Eye Physicians & Surgeons
YNHH	Backe, Henry	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Backiel, Joanna	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Backman, Kenneth	MD	Pediatrics	Allergy & Asthma Care Flfd Cty

YNHH	Badaru, Angela	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Bader, Eric	MD	Internal Medicine	YUSM Section of Cardiovascular Medicine
YNHH	Badescu, Gina	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Baehring, Erikka	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Baehring, Joachim	MD	Neurology	YUSM Section of Neuro-Oncology
YNHH	Bahtiyar, Mert	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Baidwan, Sanjeet	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bailey, Allison	PA	Pediatrics	Yale-New Haven Children's Hospital at Bridgeport Hospital
YNHH	Bailey, Meredith	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Bains, Ranbir	APRN	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Baker, Julie	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Baker, Kathryn	DO	Pediatrics	Baker Pediatrics, LLC
YNHH	Baker, Kirsten	MD	Pediatrics	Children's Medical Group, LLC
YNHH	Baker, Kristen	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bakhtiari, Nojan	DDS	Dentistry	YNHH Department of Dentistry
YNHH	Bakkali, Leen	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Balas, Horatiu	MD	Internal Medicine	West Haven Medical Group
YNHH	Balasingham, Shivashanker	MD	Internal Medicine	Bridgeport Hospital
YNHH	Balcacer De la Cruz, Patricia	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Balcezak, Thomas	MD	Internal Medicine	Yale-New Haven Hospital
YNHH	Baldassarre, Lauren	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Baldassarri, Rebecca	MD	Pathology	YUSM Department of Pathology
YNHH	Baldeo, Sashani	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Baldieri, Jennifer	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Bale, Allen	MD	Internal Medicine	Smilow Cancer Center Genetics & Prevention Program
YNHH	Balga, Thomas	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Balica, Elena	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Balisciano, Deborah	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ball, Bruce	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Balsamo, Joseph	MD	Internal Medicine	West Haven Medical Group
YNHH	Balsamo, Lyn	PhD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Balter, Andrew	MD	Psychiatry	Solo Practice
YNHH	Baltimore, Robert	MD	Pediatrics	YUSM Section of Pediatric Infectious Diseases
YNHH	Bamford, Nigel	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Banack, Trevor	MD	Anesthesiology	YUSM Department of Anesthesiology

YNHH	Banasiak, Nancy	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Banatoski, Jill	MD	Internal Medicine	Internal Medicine of Clinton, L.L.C.
YNHH	Band, Matthew	PA	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Bandaranayake, Thilinie	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Bang, Daisy	MD	Internal Medicine	Arthritis & Osteoporosis Center, P.C.
YNHH	Bangiyev, Simon	DDS,MD	Dentistry	Kings Highway Oral and Maxillofacial Surgery
YNHH	Bar, Noffar	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Barajas, Denise	MD	Surgery	The Hewitt Center for Breast Wellness
YNHH	Barakat, Lydia	MD	Internal Medicine	YUSM Section of Infectious Disease Nathan Smith Clinic
YNHH	Baranowski, Erika	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Barasch, Philip	MD	Neurology	Neurological Specialists, P.C.
YNHH	Barba, Susan	APRN	Psychiatry	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Barbieri, Andrea	MD	Pathology	YUSM Department of Pathology
YNHH	Barcewicz, Paul	MD	Surgery	Surgical Associates of New Haven
YNHH	Bardia, Amit	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Barnaby, Dina	DO	Obstetrics & Gynecology	Women's Obstetrics and Gynecology, P.C.
YNHH	Barrett, Mary	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Barrett, Sharon	MD	Dermatology	Integrated Dermatology of Clinton
YNHH	Bartels, Andrea	APRN	Neurology	Yale Mutliple Sclerosis Center
YNHH	Bartels, Christopher	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Baum, Carl	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Baum, Eric	MD	Surgery	CT Pediatric Otolaryngology
YNHH	Bauman, Joel	MD	Neurosurgery	
YNHH	Baumbusch, Margaret	MD	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Baumgaertner, Michael	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Bayer, Katrina	PA	Urology	YNH Urology Center
YNHH	Bayer, Robert	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Bazaz-Kapoor, Renu	DO	Internal Medicine	CareMedica
YNHH	Bazzy-Asaad, Alia	MD	Pediatrics	YUSM Section of Pedi Respiratory Med
YNHH	Beaudoin, Eric	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Becher, Robert	MD	Surgery	YUSM Section of Trauma and Critical Care
YNHH	Bechtel, Kirsten	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Beck, Lawrence	MD	Pediatrics	Neurological Specialists, P.C.
YNHH	Becker, Bonnie	PhD	Psychiatry	Solo Practice
YNHH	Becker, Kevin	MD, PhD	Neurology	YUSM Department of Neurology

YNHH	Becker, Richard	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Becker-Talwalkar, Kristen	CNM	Obstetrics & Gynecology	Women's Health Associates, LLC
YNHH	Beckman, Charles	MD	Surgery	Connecticut Heart Group, P.C.
YNHH	Bedarida, Gabriella	MD, PhD	Internal Medicine	Pfizer, New Haven Clinical Research Unit
YNHH	Bedford, Andrew	MD	Internal Medicine	Gastroenterology Associates, P.C.
YNHH	Beech, Robert	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Beiner, John	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C. (outpatient surgery)
YNHH	Beitel, Allison	MD	Pediatrics	Pediatric Medicine of Wallingford
YNHH	Bekui, Amenuve	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Bekui, Elizabeth	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Belcher, Justin	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Belfort De Aguiar, Renata	MD	Internal Medicine	Yale Diabetes Center
YNHH	Belitsky, Richard	MD	Psychiatry	YUSM Office of Education
YNHH	Bellumkonda, Lavanya	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Belmont, Steven	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Belsky, Justin	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bemis, Claudia	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Bender, Jeffrey	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Bendor, Daniel	MD	Psychiatry	Daniel E. Bendor, M.D., LLC
YNHH	Ben-Dov, Issahar	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Benfari, Renee	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Benjamin, Christopher	PhD	Neurology	YUSM Department of Neurology
YNHH	Bennett, David	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Bennick, Jennifer	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Bennick, Michael	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Bercik, Richard	MD	Obstetrics & Gynecology	YUSM Section of Urogynecology
YNHH	Berenberg, Thomas	MD	Ophthalmology	The Eye Care Group
YNHH	Beres, Sarah	PA	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Berger, Eric	MD	Psychiatry	
YNHH	Bergeron, Rachel	PhD	Psychiatry	
YNHH	Bergman, Eric	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bergman, Michael	MD	Internal Medicine	Michael D. Bergman, M.D.
YNHH	Bergwitz, Clemens	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Berkley, Jeffrey	DDS	Dentistry	CT Oral & Maxillofacial Surgery Centers
YNHH	Berkwits, Kieve	MD	Pediatrics	Northeast Medical Group Pediatric Specialists

YNHH	Berkwitt, Adam	MD	Pediatrics	Yale-New Haven Children's Hospital
YNHH	Berland, Gretchen	MD	Internal Medicine	YNHH Adult PCC
YNHH	Berna, Gioiamaria	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bernardi, Gary	APRN	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bernardo, Raffaele	DO	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Bernasko, Nana	APRN	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Bernstein, Douglas	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Bernstein, Frederic	DO	Pediatrics	Connecticut Children's Medical Center
YNHH	Bernstein, Richard	MD	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	Bernstein, Steven	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bers, Susan	PhD	Psychiatry	
YNHH	Bersenev, Alexey	PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Berv, Douglas	MD	Psychiatry	Atlantic Health Services, P.C.
YNHH	Besse, Whitney	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Beucher, Meghan	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Bevilacqua, Paula	MD	Dermatology	Paula M. Bevilacqua, M.D., LLC
YNHH	Bhatia, Aarti	MD	Internal Medicine	Y-NHH Smilow Head and Neck Program
YNHH	Bhatt, Paras	MD	Internal Medicine	YMG at the Shoreline-Cardiology
YNHH	Bhattacharya, Bishwajit	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Bhutta, Abdul	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bhutta, Adil	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bhuvanesh, Urmila	MD	Obstetrics & Gynecology	Solo Practice
YNHH	Bia, Margaret	MD	Internal Medicine	YUSM Organ Transplantation Center
YNHH	Bialecki, Jennifer	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Bianchi, Mark	MD	Surgery	Yale Medical Group-Stratford Otolaryngology
YNHH	Bilinski, Douglas	MD	Dermatology	Solo Practice
YNHH	Bindelglass, David	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Binder, Henry	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Bindra, Ranjit	MD, PhD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Binelli, Daniel	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Bird, Elizabeth	MD	Pediatrics	Whitney Pediatrics & Adolescent Medicine/NEMG
YNHH	Bishop, Matthew	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Bisson, Emily	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Bizzarro, Matthew	MD	Pediatrics	Yale-New Haven Hospital NICU

YNHH	Black, Jonathan	MD	Obstetrics & Gynecology	YUSM Section of Oncology
YNHH	Blaine, Theodore	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Blair, Emily	DO	Obstetrics & Gynecology	OB/GYN of Fairfield County
YNHH	Blanchette, Scott	RA	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Blander, Steven	MD	Internal Medicine	Steven Blander, M.D., LLC
YNHH	Blasberg, Justin	MD	Surgery	Y-NHH Smilow Cancer Hospital
YNHH	Blatt, Leslie	APRN	Internal Medicine	Adult Palliative Care
YNHH	Blattman, Seth	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
YNHH	Blazevich, Beth	APRN	Pediatrics	YUSM Section of Neonatology
YNHH	Blessing, Marcelle	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Blitzer, Mark	MD	Internal Medicine	Arrhythmia Center of Connecticut
YNHH	Bloch, Michael	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Bluestein, Harvey	MD	Surgery	Harvey J. Bluestein M.D., L.L.C.
YNHH	Blumberg, Hilary	MD	Psychiatry	Mood Disorder Research Program
YNHH	Blume, Peter	DPM	Podiatry	Affiliated Foot Surgeons
YNHH	Blumenfeld, Hal	MD, PhD	Neurology	YUSM Department of Neurology
YNHH	Boatright, Dowin	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Boatright, Renu	MD	Pediatrics	Trumbull Pediatrics
YNHH	Bober-Sorcinelli, Kathleen	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Bockenstedt, Linda	MD	Internal Medicine	Yale Interventional Immunology Center
YNHH	Bod, Jessica	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Boeras, Crina	MD	Obstetrics & Gynecology	Primary Care Center at Bridgeport Hospital
YNHH	Boey, Howard	MD	Surgery	Southern New England ENT
YNHH	Boffa, Daniel	MD	Surgery	YUSM Section of Thoracic Surgery
YNHH	Bogan, Courtney	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bogan, Jonathan	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Bogardus, Sidney	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Bogen, David	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Bogucki, Mary	MD, PhD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bogue, Clifford	MD	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	Bokhari, Syed	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Bolognia, Jean	MD	Dermatology	Yale Dermatology Associates
YNHH	Boltas, Debra	PhD	Psychiatry	
YNHH	Boltax-Stern, Sandra	MD	Child Psychiatry	Sandra Boltax, M.D., P.C.
YNHH	Bona, Robert	MD	Internal Medicine	YUSM Section of Hematology

YNHH	Bonadies, John	MD	Surgery	PACT Surgical Specialists
YNHH	Bond, Debra	PhD	Psychiatry	
YNHH	Bonde, Pramod	MD	Surgery	YUSM Section of Cardiac Surgery
YNHH	Bonoan, Elaine	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bonura, Kyle	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bonz, James	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Book, Samuel	MD	Dermatology	Yale Dermatologic Surgery
YNHH	Booth, Rachel	APRN	Surgery	Shoreline Foot and Ankle Center, P.C.
YNHH	Borad, Anoli	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Boras, John	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Bornstein, Harold	MD	Pediatrics	YUSM Section of Pulmonology/Critical Care
YNHH	Boron, Margaret	MD	Pediatrics	Cornell Scott - Hill Health Center
YNHH	Borrelli, Patricia	APRN	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Borsuk, Elyse	APRN	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Bosenberg, Marcus	MD, PhD	Dermatology	YUSM Department of Dermatology
YNHH	Bossuyt, Veerle	MD	Pathology	YUSM Department of Pathology
YNHH	Botta, Marivic	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Bottone, Kimberly	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Boubert, Francoise	MD	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Boudreau, Amy	APRN	Internal Medicine	YNHH Heart and Vascular Center
YNHH	Boulware, Susan	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Bourassa, Joseph	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Boustani, Anne Marie	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Boutilier, Cindy	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bowen, Erin	MD	Pediatrics	Childrens Medical Associates
YNHH	Bowker, Brennan	PA	Surgery	Orchard Surgical Specialists
YNHH	Boyarsky, Rachel	MD	Pediatrics	Hamden Pediatrics, P.C.
YNHH	Boyer, James	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Bracale, Laura	APRN	Psychiatry	YNHH Psychiatric Hospital
YNHH	Brackett, Jennifer	APRN	Internal Medicine	Yale Health Plan
YNHH	Bradburn, Hubert	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Bradbury, Anderson	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Braddock, Demetrios	MD	Pathology	YUSM Department of Pathology
YNHH	Brady, Hannah	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Bragg, Jennifer	MD	Pediatrics	Greenwich Hospital

YNHH	Bramley, Kyle	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Brand, Myron	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Branden, Peter	MD	Ophthalmology	The Eye Care Group
YNHH	Brandon, Laurel	APRN	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Brandt, Debra	DO	Internal Medicine	Y-NHH Smilow Cancer Hospital Torrington Care Center
YNHH	Branson, Brittany	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Brask, Michael	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Brasseaux, Jessika	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Braveman, Ferne	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Braverman, Irwin	MD	Dermatology	Yale Dermatology Associates
YNHH	Braverman, Tamar	MD	Internal Medicine	Prohealth Physicians of Hamden
YNHH	Breen, Jeanne	MD	Internal Medicine	Fair Haven Community Health Center
YNHH	Brei, Michelle	APRN	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Breier, Richard	MD	Internal Medicine	Street, Melchinger, Breier, Rosenthal
YNHH	Brekus-Watson, Carol	CNM	Obstetrics & Gynecology	County OB/GYN
YNHH	Brennan, Andrea	PA	Obstetrics & Gynecology	Y-NHH Smilow Gynecologic Oncology
YNHH	Brennan, Joseph	MD	Internal Medicine	Yale-New Haven Cardiac Rehabilitation Center
YNHH	Brennan, Paige	MD	Internal Medicine	Cardiology Associates of Norwich
YNHH	Brenner, Stephen	MD	Internal Medicine	Northeast Medical Group
YNHH	Brewster, Ursula	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Bria, Jessica	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Bridger, Laurie	MD	Internal Medicine	Yale Health Plan
YNHH	Brier, Jonathan	MD	Internal Medicine	The Cardiology Group
YNHH	Briggs, Caroline	APRN	Neurology	YUSM Department of Neurology
YNHH	Brines, Patricia	MD	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Brinkman, Ingrid	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Brissette, David	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Brittis, Dante	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Britto Leon, Clemente	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Brockett, Renee	APRN	Pediatrics	Yale-New Haven Children's Hospital at Bridgeport Hospital
YNHH	Bronen, Richard	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Bronin, Andrew	MD	Dermatology	
YNHH	Brook, Jennifer	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Brooks, Christin	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Brown, Camille	MD	Pediatrics	YNHH Primary Care Center

YNHH	Brown, Carly	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Brown, Carmen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Brown, David	MD	Orthopedics	OrthoCare Specialists, L.L.C.
YNHH	Brown, Deborah	APRN	Surgery	Orchard Surgical Specialists
YNHH	Brown, Franklin	PhD	Neurology	YUSM Department of Neurology
YNHH	Brown, James	MD	Radiology & Biomedical Ima	YUSM Department of Radiology and Biomedical Imaging
YNHH	Brown, Karen	MD	Internal Medicine	NEMG - Whitney Internal Medicine
YNHH	Brown, Kyle	PA	Orthopedics	YNHH Department of Orthopedic Surgery
YNHH	Brown, Nancy	MD	Pediatrics	Pediatric & Medical Associates
YNHH	Brown, Tanilla	MD, MPH	Pediatrics	Cornell Scott - Hill Health Center
YNHH	Brown, Thomas	PhD	Psychiatry	YUSM Department of Psychiatry
YNHH	Browning, Nicholas	MD	Internal Medicine	Y-NHH, St. Raphael Campus - Occupational Health Plus
YNHH	Bruce, Robert	MD	Internal Medicine	Cornell Scott - Hill Health Center
YNHH	Brueckner, Martina	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Brueggestrat, Carly	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Brunet, Cristina	MD	Internal Medicine	Yale Interventional Immunology Center
YNHH	Brunetti, Ronald	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Bruno, Christie	DO	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Bucala, Richard	MD	Internal Medicine	Yale Interventional Immunology Center
YNHH	Buck, Alyson	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Buckley, Lenore	MD	Internal Medicine	Yale Interventional Immunology Center
YNHH	Buckley, Thomas	MD	Urology	YNH Urology Center
YNHH	Bukanova, Elena	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Bulsara, Ketan	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Bunick, Christopher	MD, PhD	Dermatology	YUSM Department of Dermatology
YNHH	Bunn, Teresa	DDS	Dentistry	YNHH Department of Dentistry
YNHH	Buonafede, Dennis	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Burger, Joanne	MD	Pediatrics	Yale Health Plan
YNHH	Burke, Kenneth	MD	Pediatrics	Wildwood Pediatrics & Adolescent Medicine
YNHH	Burke, Leah	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Burns, Adrienne	PA	Internal Medicine	YUSM Section of Hematology
YNHH	Burns, Kevin	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Burr, Alicia	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Burrell, Morton	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Burtness, Barbara	MD	Internal Medicine	Y-NHH Smilow Head and Neck Program

YNHH	Bussen, Patricia	APRN	Surgery	YUSM Section of Plastic Surgery
YNHH	Butler, Christine	MD	Pediatrics	Pediatric and Adolescent Medicine, Sydney Z. Spiesel, Ph.D., M.D., LLC
YNHH	Butler, James	MD	Pediatrics	Neurological Specialists, P.C.
YNHH	Butler, Reni	MD	Radiology & Biomedical Ima	YUSM Department of Radiology
YNHH	Buza, Natalia	MD	Pathology	YUSM Department of Pathology
YNHH	Byrne, Maria	MD	Surgery	
YNHH	Cabin, Henry	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Cable, Allison	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cabrera Martinez, Maribel	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cadan, Rachel	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Cadariu, Arina	MD	Internal Medicine	Bridgeport Hospital
YNHH	Cai, Guoping	MD	Pathology	YUSM Department of Pathology
YNHH	Cain, Hilary	MD	Internal Medicine	YUSM Section of Pulmonary and Critical Care Medicine
YNHH	Cain, Peter	DDS	Dentistry	YNHH Pediatric Specialty Clinic
YNHH	Calandro, Courtney	PA	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Caldwell, Cary	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Calia, Kerstin	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Califano, Claudia	MD	Child Psychiatry	Shoreline Psychiatry, L.L.C.
YNHH	Calix, Roberto	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Callahan, Carol	DPM	Podiatry	Advanced Medical Footcare
YNHH	Callender, Glenda	MD	Surgery	YUSM Section of Surgical Oncology/Endocrine
YNHH	Calo, Leonard	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cambi, Brian	MD	Internal Medicine	LMPA Cardiology at Waterford
YNHH	Camenga, Deepa	MD	Pediatrics	YUSM Section of General Pediatrics
YNHH	Cameron, Annette	MD	Pediatrics	Chapel Pediatric Group
YNHH	Cameron, Kelsey	PA	Internal Medicine	Thoracic Interventional Program
YNHH	Camilleri, Joseph	MD	Urology	Griffin Faculty Physicians
YNHH	Caminear, David	DPM	Podiatry	Connecticut Orthopaedic Specialists, P.C
YNHH	Camizzi, Kathryn	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Camp, Anne	MD	Internal Medicine	Fair Haven Community Health Center
YNHH	Campbell, Bryce	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Campbell, Charlene	APRN	Orthopedics	YNHH Saint Raphael Campus, Center for Musculoskeletal Care
YNHH	Campbell, Katherine	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Campbell, Sheldon	MD, PhD	Laboratory Medicine	VAMC

YNHH	Canapari, Craig	MD	Pediatrics	YUSM Section of Pedi Respiratory Med
YNHH	Canarie, Michael	MD	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	Canchi, Deepti	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Caneira, Laura	APRN	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Canny, Christopher	MD	Pediatrics	Hamden Pediatrics, P.C.
YNHH	Cantatore-Francis, Julie	MD	Dermatology	YUSM Department of Dermatology
YNHH	Canterino, Joseph	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Cantey, Lisa	PA	Internal Medicine	Metabolism Associates
YNHH	Cantley, Lloyd	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Capobianco, Anthony	PA	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Cappello, Michael	MD	Pediatrics	YUSM Section of Pediatric Infectious Disease
YNHH	Caprio, Sonia	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Caramico, Lisa	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Carbonella, Judith	APRN	Pediatrics	Lead Program
YNHH	Cardella, Jonathan	MD	Surgery	YUSM Section of Vascular Surgery
YNHH	Cardinale, Joseph	MD	Therapeutic Radiology	Yale Medical Group
YNHH	Cardona-Wolenski, Laurie	PsyD	Child Psychiatry	YUSM Department of Child Psychiatry
YNHH	Cardone, Lauren	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital
YNHH	Carey, Hugh	MD	Internal Medicine	Metabolism Associates
YNHH	Carling, Tobias	MD, PhD	Surgery	YUSM Department of Surgical Oncology
YNHH	Carlson, Andrew	MD	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Carlson, David	MD	Psychiatry	
YNHH	Carlson, Elise	MD	Internal Medicine	New Haven Rheumatology, P.C.
YNHH	Carlson, Erik	MD	Orthopedics	Active Orthopaedics, P.C.
YNHH	Carlson, Kacie	PA	Dermatology	YUSM Department of Dermatology
YNHH	Carlson, Liliana	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Carlson, Sarah	PA	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Carney, Heather	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Carpenter, Thomas	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Carroll, Carolyn	MD	Dermatology	Dermatology Physicians of Connecticut
YNHH	Carroll, Richard	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Carroll, Tamara	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Carter, Cordelia	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Carter, Ryan	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Carusillo, Nina	PA	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology

YNHH	Caruso, Wendy	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Casale, Linda	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Casemyr, Natalie	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Caserta, Michelle	MD	Pediatrics	Complete Pediatrics, P.C.
YNHH	Casper, Scott	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Cassa, Richard	PA	Neurology	YUSM Department of Neurosurgery
YNHH	Cassell, Steven	MD	Obstetrics & Gynecology	OB/GYN of Fairfield County
YNHH	Cassese, Todd	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Castiblanco, Claudia	MD	Ophthalmology	Doctor and Associates
YNHH	Castiglione, Frank	MD	Dermatology	Solo Practice
YNHH	Castilho Godinho e Silva, Giovan	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Castillo, Jairo	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Castillo, Ronald	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Castracane, Stephen	MD	Ophthalmology	Solo Practice
YNHH	Castro, Angel	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Caty, Michael	MD	Surgery	YUSM Section of Pediatric Surgery
YNHH	Cavallo, Dana	PhD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Cedarbaum, Harvey	DDS	Dentistry	New Haven Dental Group
YNHH	Cedeno, Paul	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Cengiz, Eda	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Cerrito, Stephanie	PA	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Cha, Bruce	DMD	Dentistry	Endodontics
YNHH	Cha, Charles	MD	Surgery	YNHH Smilow Cancer Hospital Multi-Specialty Clinic
YNHH	Chabria, Shiven	MD	Internal Medicine	NEMG/Y-NHH Saint Raphael Campus
YNHH	Chacho, Karol	MD	Obstetrics & Gynecology	Robert D. Russo, MD & Assoc.
YNHH	Chacko, Elizabeth	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Chadwick, Sandra	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Chagpar, Anees	MD	Surgery	YNHH Smilow Cancer Hospital Breast Center
YNHH	Chai, Toby	MD	Urology	YNHH Urology
YNHH	Chan, Belinda	MD	Internal Medicine	Northeast Medical Group
YNHH	Chan, Florence	MD	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Chan, Francis	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Chandler, John	MD	Internal Medicine	Connecticut Heart Group, P.C.
YNHH	Chandler, Patricia	MD	Internal Medicine	YSM/Office of Education

YNHH	Chang, Dean	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Chang, Sandy	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Chang, Sue	MD	Internal Medicine	Metabolism Associates
YNHH	Chang, Victor	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital - Waterbury
YNHH	Chang, William	MD, PhD	Internal Medicine	YUSM Section of Nephrology
YNHH	Chang, Ya-Ching	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Chao, Hanna	MD, PhD	Internal Medicine	West Haven Walk-In Clinic
YNHH	Chapman, Jennifer	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Chappell, Phillip	MD	Child Psychiatry	Pfizer, Inc.
YNHH	Chaptini, Louis	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Charchaflieh, Jean	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Charron, Kate	PA	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Charron, Mariane	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Chatterjee, Sharmila	MD	Internal Medicine	West Haven Walk-In Clinic
YNHH	Chaudhary, Jessica	MD	Psychiatry	CPC Associates
YNHH	Chaudhry, Nauman	MD	Ophthalmology	Retina Group of New England
YNHH	Chaudhry, Sarwat	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Chauhan, Zeeshan	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Chavel, Severine	MD	Dermatology	Dermatology Center of Stamford
YNHH	Chawarska, Katarzyna	PhD	Child Psychiatry	Child Study Center
YNHH	Chawla, Nikhil	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Check, Joseph	MD	Psychiatry	Yale-New Haven Hospital
YNHH	Chekijian, Sharon	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Chelouche, Adina	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Chen, Christine	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Chen, Eaton	MD	Surgery	Southern New England ENT
YNHH	Chen, Fred	DMD	Dentistry	Vaughn Family Dentistry
YNHH	Chen, Jara	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Chen, Lei	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Chen, Michael	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Chen, Ming-Kai	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Chen, Richard	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Chen, Ruo Zhu	PA	Surgery	YUSM Section of Surgical Oncology
YNHH	Chen, Yaniv	MD	Pediatrics	Neurological Specialists, P.C.

YNHH	Chen, Zhe	PhD	Therapeutic Radiology	Smilow Cancer Hospital - YUSM Department of Therapeutic Radiology
YNHH	Cheng, Joseph	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Cheng, Shi-Jen	MD	Pediatrics	East Haven Pediatrics, PC
YNHH	Chepenik, Lara	MD, PhD	Psychiatry	Yale-New Haven Hospital
YNHH	Cheron, Rebecca	APRN	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Chervin, Bradford	MD	Surgery	ENT, Allergy & Facial Plastic Surgery Specialists, LLC
YNHH	Chessin, Robert	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Cheuk, William	MD	Internal Medicine	Bridgeport Hospital
YNHH	Chhabra, Sunita	MD	Internal Medicine	Village Medical Associates
YNHH	Chhabra, Vijay	MD	Internal Medicine	Oncology/Hematology Care of Connecticut
YNHH	Chiang, Anne	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Chiang, Veronica	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Chicarilli, Damien	PA	Surgery	Bridgeport Hospital
YNHH	Chicarilli, Zeno	MD	Surgery	Zeno Chicarilli, M.D., D.M.D.
YNHH	Childs, Amber	PhD	Psychiatry	Adolescent Day Hospital - Yale New Haven Hospital
YNHH	Chin, Hsiao-Ying	MD	Internal Medicine	Northeast Medical Group- SRC Geriatrics
YNHH	Chinchilla, Jeannette	MD	Pediatrics	Pediatric & Adol. Medicine of Cheshire
YNHH	Chinni, Santhi	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Chiravuri, Murali	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Chirnomas, S.	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Chmael, Susan	APRN	Internal Medicine	Smilow Cancer Center Genetics & Prevention Program
YNHH	Chmielowicz, Helena	APRN	Psychiatry	YNHH Psychiatric Hospital
YNHH	Cho, Joan	MD	Internal Medicine	Yale Health Plan
YNHH	Choate, Keith	MD, PhD	Dermatology	Yale Dermatology Associates
YNHH	Choksey, Mithil	MD	Internal Medicine	Northeast Medical Group
YNHH	Chokshi, Swati	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Cholewczynski, Walter	MD	Surgery	Bridgeport Hospital
YNHH	Choma, Michael	MD	Pediatrics	YNHH Pediatric PCC
YNHH	Chosak, Roslyn	MD	Obstetrics & Gynecology	Solo Practice
YNHH	Choudhary, Ronika	MD	Obstetrics & Gynecology	Women's Obstetrics and Gynecology, P.C.
YNHH	Chow, Andrew	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Chow, Jessica	MD	Ophthalmology	Yale Eye Center
YNHH	Christensen, Sean	MD, PhD	Dermatology	Yale Dermatologic Surgery
YNHH	Christison-Lagay, Emily	MD	Surgery	YUSM Section of Pediatric Surgery

YNHH	Chu, Yvonne	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Chuang, Peter	MD	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Chun, Hyung	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Chung, Chuhan	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Chung, Gina	MD	Internal Medicine	Smilow Cancer Hospital, Orange Care Center
YNHH	Chung, Joyce	MD	Therapeutic Radiology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Chung, Keun	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Chuong, Jack	MD	Internal Medicine	Digestive Disease Associates
YNHH	Chupp, Geoffrey	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Churchwell, Keith	MD	Internal Medicine	
YNHH	Chustecka, Margaret	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Chyfetz, Michael	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Chyun, Yong-Sung	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Ciancimino, David	MD	Psychiatry	
YNHH	Ciarleglio, Justine	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Cibelli, Deborah	CNM	Obstetrics & Gynecology	Women's Health Associates, LLC
YNHH	Cicale, Lauren	PA	Pediatrics	Bridgeport Hospital - Dept of Neonatology
YNHH	Cicero, Mark	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Cimino, William	MD	Orthopedics	Beach Road Orthopedic Spec.
YNHH	Citarella, Brett	MD	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Ciuci, Paul	DMD, MD	Dentistry	Milford & Derby Oral & Maxillofacial Surgeons
YNHH	Clancy, Jude	MD	Internal Medicine	YMG at the Shoreline-Cardiology
YNHH	Clauss, Jennifer	PA	Internal Medicine	YUSM Section of Oncology
YNHH	Cleman, Michael	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Cleves-Bayon, Juan Carlos	MD	Psychiatry	Juan Carlos Cleves-Bayon, MD - Adult & Geriatric Psychiatry
YNHH	Clune, James	MD	Surgery	YUSM Section of Plastic Surgery
YNHH	Coady, Patrick	MD	Ophthalmology	New England Retina Associates
YNHH	Cochran, Lynn	APRN	Internal Medicine	Y-NHH Smilow Head and Neck Program
YNHH	Coffey, Tom	MD	Surgery	Connecticut Ear Nose Throat Medical & Surgical Specialists, P.C.
YNHH	Coffin, Kathleen	PA	Internal Medicine	YUSM Section of Oncology
YNHH	Cohen, Allison	MD	Pediatrics	Pediatrics Plus, P.C.
YNHH	Cohen, Andrew	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cohen, Brian	DO	Internal Medicine	Connecticut Medical Group
YNHH	Cohen, David	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Cohen, Lawrence	MD	Internal Medicine	YUSM Section of Cardiology

YNHH	Cohen, Miriam	MD	Pediatrics	Pediatric Medicine of Wallingford
YNHH	Cohen, Paul	MD	Pathology	Bridgeport Hospital
YNHH	Cohen, Steven	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Cohen, Theresa	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Cohn, Lauren	MD	Internal Medicine	Yale Medical Group
YNHH	Coiro, Kimberly	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Colabelli, Lara	DO	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Colberg, John	MD	Urology	YUSM Section of Urology
YNHH	Cole, Joanna	APRN	Internal Medicine	Adult Sickle Cell Program
YNHH	Cole, Kelsey	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Colegio, Oscar	MD	Dermatology	Yale Dermatology Associates
YNHH	Colella, Stephanie	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Coleman, Letitia	APRN	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Colina-Biscotto, Juner	MD	Ophthalmology	New England Retina Associates
YNHH	Collins, Beth	MD	Surgery	Beth A. Collins, M.D.
YNHH	Collins, Stephen	MD, PhD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Colon, Vanessa	APRN	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Colson, Eve	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Colton, Christine	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Combest, Spiro	MD	Ophthalmology	Robert D. Russo, MD & Assoc.
YNHH	Condulis, Nicholas	MD	Pediatrics	Wildwood Pediatrics & Adolescent Medicine
YNHH	Cone, David	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Conforti, Philip	DDS	Dentistry	Hamden Shoreline Oral & Maxillofacial Surgery
YNHH	Conley, Thomas	MD	Neurology	American Neuromonitoring Associates, PC
YNHH	Connair, Michael	MD	Orthopedics	Solo Practice
YNHH	Connell, Kevin	RA	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Connery, Neil	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Connolly, Katharine	PA	Surgery	Bridgeport Hospital
YNHH	Connors, Geoffrey	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Constantinescu, Simona	MD	Internal Medicine	Bridgeport Hospital
YNHH	Contessa, Joseph	MD	Therapeutic Radiology	YUSM Dept. of Therapeutic Radiology
YNHH	Cook, Gary	PA	Surgery	Bridgeport Hospital
YNHH	Cook, Timothy	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Cooke, Thomas	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Cookson, Caryn	MD	Obstetrics & Gynecology	OB/GYN & Infertility Group

YNHH	Cooney, Emily	PhD	Psychiatry	YUSM Department of Psychiatry
YNHH	Cooney, Leo	MD	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Cooperman, Daniel	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Copel, Joshua	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Coppola, Anthony	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Coppola, Paul	MD	Obstetrics & Gynecology	Solo Practice
YNHH	Corbin, Elizabeth	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Corbin, Kathleen Jo	MD	Pediatrics	Greenwich Hospital - Outpatient Pediatric Dept.
YNHH	Corcoran, Amanda	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Cord, Sheila	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cordido, Ricardo	MD	Internal Medicine	Heart Care Associates of Connecticut, L.L.C.
YNHH	Corjulo, Michael	APRN	Pediatrics	Children's Medical Group, LLC
YNHH	Correa, Paulo	MD	Psychiatry	Northeast Medical Group, Inc.
YNHH	Correale, Dana	MD	Dermatology	Paula M. Bevilacqua, M.D., LLC
YNHH	Correia, Sara	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Corsi, John	PA	Surgery	Y-NHH Smilow Cancer Hospital, Multispecialty Care Center
YNHH	Corso, Michelle	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Cortes, Milaurise	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Corwin, John	MD	Psychiatry	Solo Practice
YNHH	Coscina, Kimberly	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Cosentino, Marianne	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Cosgrove, Ann	APRN	Radiology & Biomedical Imaging	
YNHH	Cosgrove, Marianne	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Costa, Jose	MD	Pathology	YUSM Department of Pathology
YNHH	Costin, Mihaela	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Cottrol, Cheryl	MD	Psychiatry	Affiliates of Neurology and Psychiatry
YNHH	Coughlin, Alanna	MD	Pediatrics	Branford / North Branford Pediatrics, P.C.
YNHH	Coughlin, Ryan	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Coulis, Natalie	PA	Internal Medicine	YUSM Section of Cardiology
YNHH	Couloures, Kevin	DO	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	Couloures, Olivera	MD	Pediatrics	YUSM Section of Pediatric Nephrology
YNHH	Courtney, Maria	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Courtright, Darren	DPM	Podiatry	Shoreline Foot and Ankle Center, P.C.
YNHH	Covey, Cinthia	MD	Ophthalmology	The Eye Care Group
YNHH	Coviello, Jessica	APRN	Internal Medicine	YUSM Section of Cardiology

YNHH	Cowles, Robert	MD	Surgery	YUSM Section of Pediatric Surgery
YNHH	Cowper, Shawn	MD	Dermatology	YUSM Department of Dermatology
YNHH	Cowperthwait, Meridith	APRN	Pediatrics	Pediatric & Medical Associates
YNHH	Cox, Alyse	APRN	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Coyle, Brian	MD	Surgery	Connecticut Vascular Center, P.C.
YNHH	Coyle, Debra	APRN	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Cozza, Elizabeth	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Craft, Angela	APRN	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Craft, Joseph	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Craig, Elizabeth	MD	Surgery	Stefano Fusi, M.D.
YNHH	Craig, Holly	MD	Internal Medicine	NEMG - Whitney Internal Medicine
YNHH	Craiglow, Brittany	MD	Dermatology	Yale Dermatology Associates
YNHH	Crede, William	MD	Internal Medicine	Fair Haven Medical Group at Bella Vista
YNHH	Crescenzi, Zina	APRN	Internal Medicine	Grimes Center
YNHH	Cretella, Lori	MD	Neurology	NEMG Neurology Associates
YNHH	Criscenzo, Donna	MD	Internal Medicine	Donna R. Criscenzo, M.D., LLC
YNHH	Criscuolo, Gregory	MD	Neurosurgery	Eastern CT Neurosurgery, P.C.
YNHH	Cristofalo, Elizabeth	MD, MPH	Pediatrics	Waterbury Hospital
YNHH	Croce, Kathleen	PhD	Psychiatry	
YNHH	Crombie, Roselle	MD	Surgery	Northeast Medical Group
YNHH	Cromwell, Polly	APRN	Pediatrics	Bridgeport Hospital
YNHH	Cron, Julia	MD	Obstetrics & Gynecology	YUSM Department of OB/GYN and Reproductive Sciences
YNHH	Cronin, Kelly	APRN	Internal Medicine	Regional Hospice and Home Care of Western Ct, Inc
YNHH	Cronin, Tara	MD	Ophthalmology	The Eye Care Group
YNHH	Crosby, Jill	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Cross, Sarah	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Crowley, Kristen	APRN	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Crowther, Lisa	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Cullam, Neil	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Cunningham, Kayla	MD	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Cunningham, Patricia	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Cuoco, Elisabeth	PA	Pediatrics	Y-NHH Smilow Cancer Hospital
YNHH	Cuomo, Carrie	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Curtis, Anne	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Curtis, Jeptha	MD	Internal Medicine	Cardiovascular Services of Greenwich - NEMG

YNHH	Curtiss, Douglas	MD	Pediatrics	Pediatric & Adolescent Healthcare, P.C.
YNHH	Curto, Cynthia	APRN	Urology	YNH Urology Center
YNHH	Cusano, Elizabeth	APRN	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus - Haelen Center
YNHH	Cushing, Kristen	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cushing, William	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Cuteri, Joseph	MD	Obstetrics & Gynecology	Northeast Medical Group
YNHH	Cwik, Ronald	MD	Obstetrics & Gynecology	Obstetrics & Gynecology Associates
YNHH	Czajkowski, Melissa	APRN	Surgery	YUSM Section of Cardiac Surgery
YNHH	Czarkowski, Nancy	MD	Pediatrics	Guilford Pediatrics
YNHH	Czibulka, Agnes	MD	Surgery	Ear, Nose & Throat Medical and Surgical
YNHH	Dabu-Bondoc, Susan	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	DaCosta, Sabrina	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	D'Addario, Johanna	PA	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Daddio, Mark	DPM	Podiatry	Connecticut Podiatry Group, P.C.
YNHH	D'Agostino, Mark	MD	Surgery	Southern New England ENT
YNHH	Dahl, Neera	MD	Internal Medicine	Yale Neurology
YNHH	Dahlquist, Heather	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Daigneault, John	MD	Orthopedics	Center for Orthopaedics
YNHH	Daley, Jessica	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Dalipi, Resul	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Dall, Chris	PA	Neurosurgery	Connecticut Neurosurgical Specialists, P.C.
YNHH	Damast, Shari	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Damlakhi, Rahaf	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Dana, Maureen	MD	Internal Medicine	The Connecticut Hospice
YNHH	D'Andrea, Maura	APRN	Psychiatry	Smoking Cessation Service
YNHH	Danis, Lauren	APRN	Internal Medicine	YNHH Adult PCC
YNHH	Dann, Sarah	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Danve, Abhijeet	MD	Internal Medicine	YNHH Old Saybrook Medical Center
YNHH	D'Aria, Antonio	DO	Internal Medicine	Livella Care
YNHH	Darr, Umer	MD	Surgery	Bridgeport Hospital
YNHH	Dashevsky, Meir	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Datunashvili, Ann	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Daunis, Kerri	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Davey, Janice	APRN	Internal Medicine	YUSM Section of Endocrinology

YNHH	Davies, Angela	MD	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Davies, Marianne	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Davila, Javier	MD	Surgery	Javier Davila, M.D., L.L.C.
YNHH	Davis, Janine	APRN	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Davis, John	MD	Internal Medicine	YUSM Section of Pulmonology
YNHH	Davis, Kimberly	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Davis, Krystal	APRN	Anesthesiology	Yale-New Haven Hospital CTICU
YNHH	Davis, Melissa	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Davis, Paul	MD	Radiology & Biomedical Ima	Diagnostic Imaging of Milford
YNHH	Dawe, Robert	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Day, Denise	SA	Ophthalmology	Connecticut Retina Consultants
YNHH	Dayan, Nimrod	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	De Cruz, Suzzunne	PA	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	de Figueiredo, John	MD	Psychiatry	John M. de Figueiredo, M.D.
YNHH	Deal, Robert	MD	Obstetrics & Gynecology	Womens Health Care LLC
YNHH	Deal, Therese-Ann	PA	Pediatrics	Bridgeport Hospital
YNHH	DeAngelo, Anita	APRN	Internal Medicine	Arthritis & Osteoporosis Center, P.C.
YNHH	Dearborn, Jennifer	MD	Neurology	YUSM Department of Neurology
YNHH	Deaso, Michele	APRN	Pediatrics	Bridgeport Hospital - Dept of Neonatology
YNHH	DeBroff, Brian	MD	Ophthalmology	Eye Surgery Associates, LLC
YNHH	Decho, Janice	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Decker, Roy	MD, PhD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
YNHH	DeFrank, Janine	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	DeFusco, Dianne	MD	Internal Medicine	Broadway Medical Group, L.L.C.
YNHH	DeGennaro, Nancy	CNM	Obstetrics & Gynecology	The Center for Women's Health and Midwifery
YNHH	Del Prato, Katherine	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Del Priore, Luciano	MD, PhD	Ophthalmology	YUSM Department of Ophthalmology
YNHH	Del Rossi, Erin	PA	Surgery	YUSM Section of Thoracic Surgery
YNHH	Dela Cruz, Charles	MD, PhD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Delerme, Pamela	CNM	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Delfini, Ronald	DDS	Dentistry	Ronald Delfini, D.D.S., P.C.
YNHH	DeLisle, Angela	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Della-Giustina, David	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	DeLott, Jeffrey	DPM	Podiatry	Connecticut Orthopaedic Specialists, P.C

YNHH	DeLuca, Peter	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	DeLucia, Anna	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Delucia, Maria	DO	Pediatrics	Children's Medical Group, LLC
YNHH	DelVecchio, Alexander	MD	Internal Medicine	Cardiovascular Services of Greenwich - NEMG
YNHH	DeMaio, Christine	PhD	Psychiatry	YUSM Department of Psychiatry
YNHH	DeMartini, Kelly	PhD	Psychiatry	YUSM Department of Psychiatry
YNHH	Demartini, Paul	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
YNHH	Demers, Gwendeline	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Demsky, Carolyn	APRN	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	DeNatale, Ralph	MD	Surgery	Connecticut Vascular Center, P.C.
YNHH	Deng, Jie	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Deniz, Engin	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Depathy, Jocelyn	PA	Surgery	YUSM Section of Plastic Surgery
YNHH	DePino, Linda	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Desai, Andrea	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Desai, Nihar	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Desai, Shivani	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Desai, Vrunda	MD	Obstetrics & Gynecology	YUSM Department of OB/GYN
YNHH	Desan, Paul	MD, PhD	Psychiatry	YUSM Department of Psychiatry
YNHH	Deshpande, Hari	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Deshpande, Ohm	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Deshpande, Ranjit	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Desiato, Paolo	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	DeSilva, Garumuni	MD	Internal Medicine	Patient Choice Medical Care
YNHH	Desir, Deborah	MD	Internal Medicine	Arthritis & Osteoporosis Center, P.C.
YNHH	Desir, Gary	MD	Internal Medicine	VAMC
YNHH	Desmond, Christine	MD	Psychiatry	
YNHH	DeSouza, Richard	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Dest, Vanna	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital
YNHH	DeStefano, Katherine	MD	Neurology	Yale Mutliple Sclerosis Center
YNHH	Detroy, Ezra	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Detterbeck, Frank	MD	Surgery	Park Avenue Surgical Associates
YNHH	Detyniecki, Kamil	MD	Neurology	YUSM Department of Neurology
YNHH	Devaraj, Chander	MD	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
YNHH	Devir, Katherine	PA	Pediatrics	Yale-New Haven Hospital NICU

YNHH	DeVita, Vincent	MD	Internal Medicine	YUSM Section of Oncology
YNHH	DeVito, Ralph	MD	Urology	YNH Urology Center
YNHH	DeVries, Brett	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Dewar, Michael	MD	Surgery	YUSM Section of Cardiac Surgery
YNHH	Dewera-Moczerniuk, Alicja	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Dharmarajan, Kumar	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Dhodapkar, Kavita	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Dhodapkar, Madhav	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Dhond, Abhay	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Diana, Richard	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Diaz, Esperanza	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Diaz, Martha	PA	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	DiBartholomeo, Thomas	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Dibble, Jacqueline	APRN	Surgery	YUSM Section of Otolaryngology
YNHH	DiBenedetto, Lauren	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	DiCapua, Daniel	MD	Neurology	YUSM Department of Neurology
YNHH	DiCello, Donna	PsyD	Psychiatry	
YNHH	Dickenson, Susan	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Dickey, Phillip	MD	Neurosurgery	New Haven Neurosurgical Associates
YNHH	Dicks, Demetrius	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	DiCola, Vincent	MD	Internal Medicine	Yale Cardiology
YNHH	Dieckman, Elizabeth	MD	Pediatrics	Whitney Pediatrics & Adolescent Medicine/NEMG
YNHH	Digby, Kerry	PA	Surgery	YUSM Section of Plastic Surgery
YNHH	DiGiovanna, Michael	MD, PhD	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Dijeh, Sylvester	MD	Internal Medicine	Bridgeport Hospital
YNHH	Dill, Christopher	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Dill, Edward	MD	Internal Medicine	Edward J. Dill, Jr., M.D./Shoreline Internal Medicine
YNHH	Dillaway, Marguerite	MD	Pediatrics	Whitney Pediatrics & Adolescent Medicine/NEMG
YNHH	Dillon, Brian	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	DiLorenzo, Michelle	DO	Pediatrics	Wildwood Pediatrics & Adolescent Medicine
YNHH	DiLuna, Michael	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	DiMaira, Francesca	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Dinauer, Catherine	MD	Pediatrics	Yale Pediatric Specialty Center
YNHH	DiNoia, Barbara	APRN	Psychiatry	YNHH Partial Hospital
YNHH	Dioguardi, Anthony	DMD	Dentistry	YNHH Department of Dentistry

YNHH	DiSabatino, Charles	MD	Internal Medicine	New Haven Rheumatology, P.C.
YNHH	Distefano, Alberto	MD	Ophthalmology	Yale Eye Center
YNHH	Distelman, Howard	MD	Ophthalmology	Shoreline Eye Associates, P.C.
YNHH	Dobbins, John	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Doctor, Leslie	MD	Ophthalmology	Doctor and Associates
YNHH	Dodd, Matthew	PA	Neurology	YUSM Department of Neurology
YNHH	Dodge, Jennifer	PA	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Dodington, James	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Dogbey, Pia	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Dogbey, Rupert	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Doherty, Patrick	MD	Neurosurgery	Lawrence & Memorial Medical Group Neurosurgery
YNHH	Dohr, Kay	MD	Obstetrics & Gynecology	Ob/Gyn Physicians, P.C.
YNHH	Dolan, Neil	MD	Psychiatry	Northeast Medical Group, Inc.
YNHH	Domakonda, Kunal	MD	Internal Medicine	Heart Care Associates of Connecticut, L.L.C.
YNHH	Dombrow, Matthew	MD	Ophthalmology	Connecticut Retina Consultants
YNHH	Dombrowski, Michael	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Dommu, Aaron	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Donnelly, Theresa	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Dono, Heather	PA	Surgery	Northeast Medical Group, Inc.
YNHH	D'Onofrio, Gail	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Donofrio, Lisa	MD	Dermatology	The Savin Center, PC
YNHH	Donohue, Kenneth	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Donohue, Thomas	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Donovan, Ryan	PA	Internal Medicine	YUSM Section of Cardiology
YNHH	Donroe, Evelyn	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Donroe, Joseph	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Doolittle, Benjamin	MD	Internal Medicine	St. Mary's Hospital
YNHH	Dorfman, Carol	MD	Pediatrics	Child-Adolescent Healthcare
YNHH	Dorfman, Michael	MD	Internal Medicine	Digestive Disease Associates
YNHH	Doron, Sivan	CNM	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Dorr, Robert	MD	Pediatrics	Pediatric Associates of Branford
YNHH	Dorsey, Karen	MD	Pediatrics	
YNHH	Dortzbach, Kathryn	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Douglas, Audrey	PA	Pediatrics	YUSM Section of Neonatology
YNHH	Douglas-Churchwell, Leslie	MD	Internal Medicine	Yale Internal Medicine Associates

YNHH	Dover, Jeffrey	MD	Dermatology	SkinCare Physicians
YNHH	Doyle, Elizabeth	APRN	Internal Medicine	Yale Diabetes Center
YNHH	Drabinski, Ann	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Drabinski, Mark	MD	Internal Medicine	West Haven Medical Group
YNHH	Draper, Joan	MD	Ophthalmology	The Eye Care Group
YNHH	Drewniak, Christine	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Dreyfus, David	MD, PhD	Pediatrics	Gesher Allergy, Asthma, Clinical Immunology
YNHH	Dreznick, Jeffrey	MD	Internal Medicine	Gastroenterology Specialists, PC
YNHH	Driesman, Mitchell	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Driggers, Allyson	MD	Pediatrics	Bridgeport Hospital
YNHH	Drozd, Kristine	APRN	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Drumm, Hillary	APRN	Internal Medicine	YUSM Section of Gastroenterology
YNHH	D'Souza, Anthony	MD	Internal Medicine	PriMed CHVC
YNHH	Duckrow, Robert	MD	Neurology	YUSM Department of Neurology
YNHH	Dudley, Mary	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Duffield, Emily	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Duffy, Andrew	MD	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Dufour, Karen	MD	Internal Medicine	Connecticut Medical Group - NEMG
YNHH	Dugdale, Lydia	MD	Internal Medicine	Yale Internal Medicine Associates
YNHH	Duguay, Nicole	APRN	Pediatrics	YUSM Section of Maternal/Fetal Medicine
YNHH	Duke, Cindy	MD, PhD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Dukes, Anzea	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Dukes, Jason	MD, MBA	Internal Medicine	YNHH Adult PCC
YNHH	Dun, Erica	MD	Obstetrics & Gynecology	Women's Center
YNHH	Duncan, Charles	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Dunlop, John	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Dunn, Anita	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Dunn, Clarvdia	MD	Pediatrics	Pediatric & Adolescent Healthcare, P.C.
YNHH	Dunn, Julie	APRN	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Dunne, Dana	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Dunston-Boone, Gina	MD	Obstetrics & Gynecology	Bridgeport Hospital
YNHH	Duplinsky, Thomas	DDS	Dentistry	
YNHH	Durand, Maria	APRN	Psychiatry	YNHH Psychiatric Hospital
YNHH	Durand, Melissa	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Durante, Dennis	MD	Pediatrics	Long Wharf Pediatrics & Adol. Medicine

YNHH	Durazzo, Tyler	MD	Dermatology	Dermatology Physicians of CT
YNHH	Durocher, Richard	DPM	Podiatry	Advanced Footcare Specialists, Inc
YNHH	Dwyer, Mary Ellen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Dziedzic, Melissa	APRN	Surgery	CT Pediatric Otolaryngology
YNHH	Earley, Elizabeth	PA	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
YNHH	Ecker, Alan	MD	Ophthalmology	Ecker & Ecker
YNHH	Ecker, Patricia	MD	Ophthalmology	Ecker & Ecker
YNHH	Edelglass, John	MD	Dermatology	Solo Practice
YNHH	Edelman, Eva	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Edelson, Richard	MD	Dermatology	Yale Dermatology Associates
YNHH	Eder, Joseph	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Edibam, Naushad	DMD	Dentistry	Stamford Oral and Maxillofacial Surgical Arts
YNHH	Edusa, Asia	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Edwards, Shernett	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Effraim, Philip	MD, PhD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Egan, Marie	MD	Pediatrics	YUSM Section of Pedi Respiratory Med
YNHH	Eggers, Carol	APRN	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Ehrenkranz, Richard	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Ehrenwerth, Jan	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ehrlich, Lauren	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Ehrlich, Michael	MD	Ophthalmology	Yale Eye Center
YNHH	Eid, Tore	MD, PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Eilbott, David	MD	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Einarsdottir, Hulda	MD	Surgery	YUSM Department of Surgical Gastroenterology
YNHH	Einbinder, Roslyn	MD	Neurology	
YNHH	Einbinder, Stanley	DMD	Dentistry	
YNHH	Eisen, Thomas	MD	Internal Medicine	Metabolism Associates
YNHH	Eisenbarth, Stephanie	MD, PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Ekeke, Emmanuel	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ekong, Udeme	MD	Pediatrics	Greenwich Hospital
YNHH	Elder, Joshua	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Elder, Robert	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Eldred, Douglas	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Elefteriades, John	MD	Surgery	YUSM Section of Cardiac Surgery
YNHH	El-Khoury, Joe	PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine

YNHH	Ellis, Matthew	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ellis, Peter	MD	Internal Medicine	Yale Internal Medicine Associates
YNHH	Ellison, Marybeth	MD	Pediatrics	ProHealth Physicians, P.C.
YNHH	Ellman, Matthew	MD	Internal Medicine	Yale Internal Medicine Associates
YNHH	Elman, Joseph	MD	Ophthalmology	Joseph S. Elman, M.D., P.C.
YNHH	Emerick, Karan	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Emerson, Beth	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Emre, Sukru	MD	Surgery	YUSM Section of Transplantation
YNHH	Emu, Brinda	MD	Internal Medicine	Nathan Smith Clinic
YNHH	Enriquez, Alan	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Epelbaum, Daniel	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Epstein, Serle	MD	Internal Medicine	Serle M. Epstein, M.D.
YNHH	Erb, Christopher	MD, PhD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Erben, Young	MD	Surgery	YUSM Section of Vascular Surgery
YNHH	Erdman, Trisha	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Ericson, Raina	PA	Surgery	Bridgeport Hospital
YNHH	Errico, Vito	MD	Radiology & Biomedical Ima	Diagnostic Imaging of Milford
YNHH	Escalera, Sandra	MD	Pediatrics	ProHealth Physician
YNHH	Esposito, Charles	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Esposito, Claire	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Esquibies, Americo	MD	Pediatrics	YUSM Section of Pedi Respiratory Med
YNHH	Eswarathasan, Sathiya	DPM	Podiatry	East Haven Branford Foot Care
YNHH	Etesami, Maryam	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Eum, Regina	MD	Orthopedics	West Haven Medical Group
YNHH	Evans, Daphne	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Evans, Janine	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Evans, Leigh	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Evans, Suzanne	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Evans-Benard, Sharon	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Even, Michele	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Eyma, Tara	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Fabian, Caitlin	PA	Orthopedics	Bridgeport Hospital
YNHH	Fabian, Lauren	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Fabregas, Geraldine	MD	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Fadli, Nadia	APRN	Neurosurgery	YUSM Department of Neurosurgery

YNHH	Faherty, Geraldine	APRN	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Fahey, John	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Fahmi, Nasiha	MD	Internal Medicine	Orange Internal Medicine, L.L.C.
YNHH	Fair, Susan	PA	Internal Medicine	
YNHH	Fajardo, Elaine	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Falcone, Guido	MD	Neurology	YUSM Department of Neurology
YNHH	Falcone, Philip	MD	Ophthalmology	Connecticut Retina Consultants
YNHH	Fan, Eric	MD	Internal Medicine	Solo Practice
YNHH	Fan, Linda	MD	Obstetrics & Gynecology	Women's Center
YNHH	Fankhanel, Courtney	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Fantarella, Eliza	DPM	Podiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Farber, Steven	PA	Internal Medicine	VAMC
YNHH	Fares, Wassim	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Faridi, Omar	MD	Ophthalmology	Eye Physicians & Surgeons
YNHH	Farkas, Judit	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Farmer, James	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Farmer, William	MD	Internal Medicine	Internal Medicine and Family Practice, LLC
YNHH	Farooque, Pue	DO	Neurology	YUSM Department of Neurology
YNHH	Farrell, James	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Faulkner, Judith	MD	Obstetrics & Gynecology	Ob/Gyn Physicians, P.C.
YNHH	Faustino, Edward	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Fazzone, Hilary	MD	Ophthalmology	YUSM Department of Ophthalmology
YNHH	Federici, Carolyn	APRN	Pediatrics	Primary Care Center
YNHH	Federman, Adam	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Fehon, Dwain	PsyD	Psychiatry	YUSM Department of Psychiatry
YNHH	Feinberg, Dennis	MD	Dermatology	
YNHH	Feingold, David	MD	Orthopedics	Physical Medicine & Rehab Of Hartford LLC
YNHH	Feintzeig, Irwin	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Feirick, Merry	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Feld, Tatiana	MD	Internal Medicine	Pro Health Physicians
YNHH	Feldman, Alan	DPM	Podiatry	The Orthopedic & Sports Medicine Center
YNHH	Feldman, Richard	DPM	Podiatry	Richard B. Feldman, D.P.M, FACFAS, L.L.C.
YNHH	Fenick, Ada	MD	Pediatrics	YNHH Pediatric PCC
YNHH	Ferdman, Dina	MD	Pediatrics	Northeast Medical Group Pediatric Specialists
YNHH	Ferguson, Ian	MD	Pediatrics	YUSM Section of Pediatric Rheumatology

YNHH	Ferholt, Judith	MD	Pediatrics	YUSM Office of Education
YNHH	Ferholt, Julian	MD	Child Psychiatry	Julian Ferholt, M.D.
YNHH	Fernandez Robles, Claudia	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Fernandez, Susan	DO	Pathology	YUSM Department of Pathology
YNHH	Fernandez, Thomas	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Fernando, Benedict	MD	Internal Medicine	West Haven Medical Group
YNHH	Fernando, Surani	MD	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Ferneini, Antoine	MD	Surgery	Connecticut Vascular Center, P.C.
YNHH	Ferrante, Lauren	MD	Internal Medicine	Yale Medical Group
YNHH	Ferrante, Marc	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Ferraro, Patricia	APRN	Dermatology	Kalman L. Watsky, M.D.
YNHH	Ferrentino, Jerry	MD	Obstetrics & Gynecology	Women's Health Care of Milford, PC
YNHH	Ferro, Linda	APRN	Internal Medicine	Yale Diabetes Center
YNHH	Ferrucci, Allen	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Ferrucci, Christina	APRN	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Feuerstadt, Paul	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Fickes, Joseph	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Fiellin, David	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Fiellin, Lynn	MD	Internal Medicine	YNHH Adult PCC
YNHH	Figueroa, Eduardo	MD	Pediatrics	Stratford Pediatrics
YNHH	Fikrig, Erol	MD	Internal Medicine	YUSM Section of Infectious Disease
YNHH	Fikrig, Margaret	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Finan, Mary	PA	Surgery	YUSM Section of Thoracic Surgery
YNHH	Finberg, Karin	MD	Pathology	YUSM Department of Pathology
YNHH	Fine, Emily	MD	Obstetrics & Gynecology	Fine & Gillette
YNHH	Fineberg, Sarah	MD, PhD	Psychiatry	Connecticut Mental Health Center
YNHH	Fineti, Aikaterini	MD	Psychiatry	Northeast Medical Group, Inc.
YNHH	Finkelstein, Fredric	MD	Internal Medicine	Metabolism Associates
YNHH	Fisayo, Adeniyi	MD	Neurology	YUSM Department of Neurology
YNHH	Fischbach, Neal	MD	Internal Medicine	Y-NHH Smilow Fairfield Care Center
YNHH	Fischer, David	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Fischer, Paul	MD	Surgery	Paul D. Fischer, M.D., PC
YNHH	Fisher, Rosemarie	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Fishman, Felicity	MD	Orthopedics	

YNHH	Fishman, Mindy	MD	Obstetrics & Gynecology	Yale New Haven Hospital-Saint Raphael Campus Women's Services
YNHH	Fishman, Robert	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	FitzGibbons, James	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Flaherty, Katherine	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Flaherty, Michael	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Flaherty, Sean	MD, PhD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Flaherty-Hewitt, Maryellen	MD	Pediatrics	Chapel Pediatric Group
YNHH	Flanagan, Dia	MD	Pediatrics	Guilford Pediatrics
YNHH	Flannery, Clare	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Fleischman, Steven	MD	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Fletcher, Kim	MD	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Fleysher, Larisa	APRN	Internal Medicine	Smilow Cancer Care -Trumbull
YNHH	Fliegelman, Lawrence	MD	Surgery	Richard A. Levin, M.D., Lawrence J. Fliegelman, M.D., LLC
YNHH	Flis, Gregory	APRN	Anesthesiology	Yale-New Haven Hospital Spine Center
YNHH	Flores, Valerie	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Florio, Salvatore	DDS,MD	Dentistry	The Facial Surgery Center
YNHH	Fogerty, Robert	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Folman, Robert	MD	Internal Medicine	Smilow Cancer Care -Trumbull
YNHH	Fontana, Christine	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Fontes, Manuel	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Foodim, Joanne	MD	Internal Medicine	Solo Practice
YNHH	Fopeano, Larissa	PA	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Forlano, Dana	APRN	Surgery	YUSM Department of Surgery
YNHH	Forman, Gerald	DMD	Dentistry	YNHH Department of Dentistry
YNHH	Forman, Howard	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Formica, Richard	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Forray, Ariadna	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Forrest, John	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Forstein, Steven	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Forster, Susan	MD	Ophthalmology	Yale Health Plan
YNHH	Forsyth, Brian	MD	Pediatrics	YUSM Section of General Pediatrics
YNHH	Fortgang, Paul	MD	Surgery	Southern New England ENT
YNHH	Fortin VI, Auguste	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Fortunati, Frank	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus

YNHH	Foss, Francine	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Foster, Harris	MD	Urology	YUSM Section of Urology
YNHH	Fotjadhi, Skerdi	MD	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Fox, David	MD, PhD	Obstetrics & Gynecology	UHSC OB/GYN
YNHH	Fox, Lisa	APRN	Surgery	YUSM Section of Transplantation
YNHH	Foxman, Ellen	MD, PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Fraenkel, Liana	MD	Internal Medicine	West Haven VA Hospital
YNHH	Franco Vega, Maria	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Franco, Israel	MD	Urology	YUSM Department of Urology
YNHH	Frank, Steve	MD	Pediatrics	Pediatric Medicine of Wallingford
YNHH	Franson-Hopper, Jennifer	AuD	Surgery	Yale Hearing and Balance Center
YNHH	Frascatore, Julie	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Freed, Lisa	MD	Internal Medicine	Yale Cardiology
YNHH	Freeman, Bruce	MD	Pediatrics	Shoreline Pediatric & Adoles. Medicine (ProHealth Physicians)
YNHH	Freeman, James	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	French, Alyssa	MD, MPH	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	French, Cynthia	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Freudzon, Leon	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Freund, Joshua	PA	Internal Medicine	Internal Medicine of Clinton, L.L.C.
YNHH	Frey, Marnie	APRN	Pediatrics	Bridgeport Hospital
YNHH	Fried, Deborah	MD	Psychiatry	Solo Practice
YNHH	Fried, Terri	MD	Internal Medicine	VAMC
YNHH	Friedlaender, Gary	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Friedland, Gerald	MD	Internal Medicine	YUSM Section of Infectious Disease Nathan Smith Clinic
YNHH	Friedler, Alan	DMD	Dentistry	Alan P. Friedler, DMD, P.C.
YNHH	Friedman, Alan	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Friedman, Lloyd	MD	Internal Medicine	Milford Hospital
YNHH	Friedman, William	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Fucci, Michael	DO	Internal Medicine	YUSM Section of Cardiology
YNHH	Fucito, Lisa	PhD	Psychiatry	Smoking Cessation Service
YNHH	Fulbright, Robert	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Furman, Magda	PA	Surgery	NEMG - Y-NHH Hospitalists
YNHH	Fusi, Stefano	MD	Surgery	Stefano Fusi, M.D.
YNHH	Fynan, Thomas	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Gaal, Dorothy	MD	Anesthesiology	YUSM Department of Anesthesiology

YNHH	Gad, Martin	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Gaeta, Mary Lou	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Gage, Jonathan	MD	Internal Medicine	Cardiovascular Health
YNHH	Gager, Fred	MD	Internal Medicine	
YNHH	Gagne Henderson, Rebecca	APRN	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Gagnon, Lisa	APRN	Surgery	CT Pediatric Otolaryngology
YNHH	Gal, Emese	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Galal, Magdy	MD	Pediatrics	St. Mary's Hospital
YNHH	Galan, Anjela	MD	Dermatology	YUSM Department of Dermatology
YNHH	Galante, Lorenzo	MD	Internal Medicine	Broadway Medical Group, L.L.C.
YNHH	Galerneau, France	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Gallagher, Patrick	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Gallalee, John	MD	Child Psychiatry	Solo Practice
YNHH	Galvin, Jennifer	MD	Ophthalmology	Yale Eye Center
YNHH	Galvin, Mary Jane	APRN	Pediatrics	Pediatric Hematology/Oncology Associates
YNHH	Gambaccini, Melissa	APRN	Internal Medicine	YUSM Section of Medical Oncology
YNHH	Gambardella, Gabriel	DPM	Podiatry	Affiliated Foot Surgeons
YNHH	Gambardella, Paul	DPM	Podiatry	
YNHH	Gambardella, Tracy	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Ganatra, Monica	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gandhi, Urvi	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Gannon, Alyson	MHS, PA	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Garay, Angelique	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Garceau, Casandra	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Garcia, Christina	APRN	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Garcia-Tsao, Guadalupe	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Gardner, Elizabeth	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Garg, Kabul	MD	Internal Medicine	Kabul S. Garg M.D., L.L.C.
YNHH	Gargano, Melissa	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Gariepy, Aileen	MD	Obstetrics & Gynecology	YUSM Department of Obstetrics & Gynecology
YNHH	Garino, Alexandria	PA	Internal Medicine	Oncology/Hematology
YNHH	Garland, Darcy	APRN	Therapeutic Radiology	Shoreline Radiation Oncology
YNHH	Garofalo, Pamela	APRN	Surgery	YUSM Section of Vascular Surgery
YNHH	Garvey, Richard	MD	Surgery	General Surgeons Greater Bridgeport
YNHH	Garwood, Susan	MD	Anesthesiology	YUSM Department of Anesthesiology

YNHH	Gatcomb, Patricia	APRN	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Gaudio, Paul	MD	Ophthalmology	Eye Disease Consultants
YNHH	Gavin, James	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Geffin, Joel	MD	Ophthalmology	The Eye Care Group
YNHH	Geha, Paul	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Geiger, Arthur	MD	Orthopedics	
YNHH	Geirsson, Arnar	MD	Surgery	YUSM Section of Cardiac Surgery
YNHH	Geisel, Jaime	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Geismar, Odeed	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Geisser, Daniel	MD	Internal Medicine	Yale Health Plan
YNHH	Gelfand, Samantha	MD	Internal Medicine	YNHH Adult PCC
YNHH	Geller, Samuel	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Genao, Inginia	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Genecin, Paul	MD	Internal Medicine	Yale Health Plan
YNHH	Gensicki, Edward	DPM	Podiatry	
YNHH	Georgalas, Melanie	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
YNHH	George, Geeta	MD	Internal Medicine	Regional Hospice and Home Care of Western Ct, Inc
YNHH	Gerber, Jaime	MD	Internal Medicine	Yale Cardiology
YNHH	Gerdon, Vickie	PA	Internal Medicine	YNHH Sleep Medicine Center
YNHH	Germain, Gregory	MD	Pediatrics	Pediatric & Medical Associates
YNHH	Germano, Gerald	MD	Pediatrics	Childrens Medical Associates
YNHH	Gerrard, Jason	MD, PhD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Gerritz, Sarah	MD	Internal Medicine	NEMG - Family Practice Associates
YNHH	Gerstenhaber, Brett	MD	Internal Medicine	Brett Gerstenhaber, M.D., L.L.C.
YNHH	Geschwind, Jean-Francois	MD	Radiology & Biomedical Ima	YUSM Department of Radiology and Biomedical Imaging
YNHH	Geter, Jaime	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Gettinger, Scott	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Ghantous, Andre	MD	Internal Medicine	Take Heart Cardiovascular Health Center
YNHH	Ghiassi, Saber	MD	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Ghoneim, Nada	MD	Pediatrics	YUSM Section of Neonatology
YNHH	Giannelli, Patricia	APRN	Neurology	YUSM Department of Neurology, Yale-New Haven Stroke Center
YNHH	Giannettino, Jennifer	APRN	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Gibbs, Christie	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gibbs, Ian	DMD	Surgery	Aspen Dental
YNHH	Gibson, Courtney	MD	Surgery	YUSM Section of Surgical Oncology/Endocrine

YNHH	Gibson, David	MD	Orthopedics	Center for Orthopaedics
YNHH	Gibson, Joanna	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Gielissen, Katherine	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Gil, Roberto	MD	Psychiatry	YUSM Department of Radiology & Biomedical Imaging
YNHH	Giles, Mark	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gill, Thomas	MD	Internal Medicine	YUSM Section of Geriatrics
YNHH	Gillette, Mary	MD	Obstetrics & Gynecology	Fine & Gillette
YNHH	Gilliam, Walter	PhD	Child Psychiatry	Yale University Child Study Center
YNHH	Gillis-Toffolo, Janet	APRN	Psychiatry	
YNHH	Gilmore, Emily	MD	Neurology	YUSM Department of Neurology
YNHH	Gimbel, Jeffrey	MD	Internal Medicine	Solo Practice
YNHH	Ginsberg, Evan	MD	Internal Medicine	North Haven Walk-in Clinic
YNHH	Ginsburg, Philip	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Gioioso-Datta, Cristina	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Giordano, Catherine	MD	Internal Medicine	Guilford Internal Medicine Group
YNHH	Giordano, Frank	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Giorgi, Ashley		Ophthalmology	New England Retina Associates
YNHH	Giovanniello, Dominick	DO	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Girardi, Michael	MD	Dermatology	Yale Dermatology Associates
YNHH	Giuliano, John	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Giuran Benetato, Iulian	MD	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Glasgow, Kristen	MD	Surgery	Mill Hill Surgical Associates
YNHH	Glassman, Laurie	MD	Pediatrics	Children's Medical Group, LLC
YNHH	Glazer, Peter	MD, PhD	Therapeutic Radiology	Lawrence & Memorial Hospital
YNHH	Gleason, Bethany	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Gleason, Jordan	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Glick, Amy	APRN	Internal Medicine	YUSM Department of Emergency Medicine
YNHH	Glinberg, Tsilia	MD	Psychiatry	
YNHH	Glinskii, Vladimir	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Glusac, Earl	MD	Pathology	YUSM Department of Dermatology
YNHH	Gnanapandithan, Karthik	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Gneco Wilamo, Cynthia	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Gobin, Jaya	MD	Internal Medicine	Physicians Alliance of CT Hospitalists
YNHH	Goff, Christopher	MD	Pediatrics	Wildwood Pediatrics & Adolescent Medicine
YNHH	Gohara, Mona	MD	Dermatology	Advanced DermCare

YNHH	Gokhale, Amit	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Gold, Jeffrey	MD	Ophthalmology	Eye Care LLC/Liberty Vision
YNHH	Gold, Rhonda	MD	Internal Medicine	Y-NHH, St. Raphael Campus - Occupational Health Plus
YNHH	Goldberg, Karen	MD	Pediatrics	Shoreline Pediatric & Adoles. Medicine (ProHealth Physicians)
YNHH	Goldberg, Philip	MD	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Goldberg, Sarah	MD	Internal Medicine	Yale-New Haven Hospital Thoracic Oncology Program
YNHH	Goldberg-Gell, Rachel	APRN	Pediatrics	Trumbull Pediatric Specialty Center
YNHH	Goldblatt, Phillip	MD	Psychiatry	
YNHH	Golden, Amy	APRN	Pediatrics	Shoreline Pediatric & Adoles. Medicine (ProHealth Physicians)
YNHH	Golden, Marjorie	MD	Internal Medicine	Y-NHH, St. Raphael Campus
YNHH	Goldenberg, Gidon	MD	Internal Medicine	Medical Associates of North Haven
YNHH	Goldenberg, Matthew	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Goldflam, Katja	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Goldstein, Leon	MD	Surgery	Coastal Plastic Surgery Center
YNHH	Goldstein, Mark	MD	Dermatology	Dermatology Associates, P.C.
YNHH	Goldstone-Orly, Leslie	MD	Obstetrics & Gynecology	Womens Healthcare of Trumbull
YNHH	Golembeski, Thomas	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Golia, Robert	DDS	Dentistry	One Hamden Center
YNHH	Golioto, Annmarie	MD	Pediatrics	Yale-New Haven Children's Hospital
YNHH	Gomez Villalobos, Jose	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Gomez, Christina	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital Torrington Care Center
YNHH	Goncalves, Octavio	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gong, Zhaodi	MD, PhD	Anesthesiology	Advanced Diagnostic Pain Treatment Center
YNHH	Gonzalez, Kimberly	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gonzalez, Laura	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Gonzalez, Ramon	MD	Radiology & Biomedical Ima	Quinnipiac University
YNHH	Good, Susan	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Goodkind, David	MD	Surgery	David Goodkind, M.D., P.C.
YNHH	Goodman, Thomas	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Goodstine, Shelley	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Goodwin, Julie	MD	Pediatrics	YUSM Section of Pediatric Nephrology
YNHH	Gordon, Ram	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Gordon-Dole, Sonia	MD	Internal Medicine	Arthritis & Osteoporosis Center, P.C.
YNHH	Gore, Steven	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Gorecki, Gerald	DPM	Podiatry	VAMC

YNHH	Gorelick, Judith	MD	Neurosurgery	Neurosurgery, Orthopedics and Spine Specialists, PC
YNHH	Gork, Ahmet	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Gote, Ceilia	APRN	Psychiatry	YNHH Saint Raphael Campus Department of Psychiatry
YNHH	Gotlin, Andrew	MD	Internal Medicine	Yale Health Plan
YNHH	Gottiparthy, Sreedhar	MD	Internal Medicine	Internal Medicine of West Haven, LLC
YNHH	Gottschalk, P. Christopher	MD	Neurology	YUSM Department of Neurology
YNHH	Gould, Liesel	MD	Pediatrics	Complete Pediatrics, P.C.
YNHH	Gould, Michael	PA	Surgery	YUSM Department of Surgery
YNHH	Gouveia, Brooke	APRN	Neurosurgery	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Govindaswamy, Radhika	MD	Anesthesiology	Bridgeport Anesthesia Assoc
YNHH	Gowda, Madhu	MD	Internal Medicine	Madhu S. Gowda, MD
YNHH	Gozzo, Yeisid	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Graeber, Brendon	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Graham, Allyssa	APRN	Surgery	YUSM Section of Cardiac Surgery
YNHH	Grammatico, Margaret	PA	Psychiatry	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Grant, Matthew	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Grant, Taneisha	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Grauer, Jonathan	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Grauer, Leonard	MD	Internal Medicine	
YNHH	Gray, Linda	MD	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Gray, Pamela	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Green, Michael	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Green, Traci	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Greenberg, Jason	MD	Pediatrics	YUSM Section of Pediatric Nephrology
YNHH	Greenberg, Jordan	DDS	Dentistry	New Haven Implant and Oral Surgery, L.L.C.
YNHH	Greenfeld, David	MD	Psychiatry	
YNHH	Greer, David	MD	Neurology	YUSM Department of Neurology
YNHH	Greger-Moser, Max	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Gregg, Shea	MD	Surgery	Bridgeport Hospital
YNHH	Gregorio, Melissa	CNM	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Greif, Daniel	MD	Internal Medicine	Yale-New Haven Cardiac Rehabilitation Center
YNHH	Griffin, Dyan	MD	Pediatrics	Pediatric & Medical Associates
YNHH	Grippo, Gary	DPM	Podiatry	Advanced Footcare Center, P.C.
YNHH	Grodberg, David	MD	Child Psychiatry	Yale University Child Study Center

YNHH	Gross, Cary	MD	Internal Medicine	YNHH Adult PCC
YNHH	Grossman, Matthew	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Grosso, Joseph	MD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Grubman, Eric	MD	Internal Medicine	Yale Cardiology
YNHH	Gruen, Jeffrey	MD	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Gruenbaum, Shaun	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gruskay, Jeffrey	MD	Pediatrics	Milford Pediatric Group
YNHH	Grutzendler, Jaime	MD	Neurology	YUSM Department of Neurology
YNHH	Grzybinski, Jennifer	APRN	Surgery	Yale-New Haven Hospital CTICU
YNHH	Guandalini, Cindy	APRN	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Guarnaccia, Joseph	MD	Neurology	Griffin Hospital
YNHH	Guay, Nancy	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Guess, Marsha	MD	Obstetrics & Gynecology	YUSM Section of Urogynecology
YNHH	Guglin, Charles	MD	Surgery	Surgical Associates of Milford
YNHH	Guida, Paul	MD	Ophthalmology	New Haven Ophthalmology Associates
YNHH	Guidone, Alicia	DPM	Podiatry	Alicia R. Guidone, D.P.M., L.L.C.
YNHH	Gulanski, Barbara	MD	Internal Medicine	VA Medical Center
YNHH	Gulati, Mridu	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Gulliford, Jill	PA	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
YNHH	Gunabushanam, Gowthaman	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Gundel, Janine	APRN	Internal Medicine	Regional Hospice and Home Care of Western Ct, Inc
YNHH	Gundluru, Harish	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Gunel, Murat	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Gunn, Jennifer	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Gupta, Abha	MD, PhD	Pediatrics	YUSM Department of Pediatrics, Development/Behavioral
YNHH	Gupta, Arvind	MD	Surgery	Arvind K, Gupta, MD, LLC
YNHH	Gupta, Manisha	MD	Internal Medicine	Northeast Medical Group
YNHH	Gupta, Neil	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Gussin, Bruce	PA	Psychiatry	Northeast Medical Group, Inc.
YNHH	Habboosh, May	MD	Internal Medicine	MHS Primary Care
YNHH	Haberland, Christel	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Haedicke, Kay	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Hafez, Navid	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Haffner, Gregory	MD	Ophthalmology	New England Retina Associates
YNHH	Hafler, David	MD	Neurology	YUSM Department of Neurology

YNHH	Hagani, Andrea	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Hahn, Il Song	MD	Pathology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Hahn, Kelly	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Hahn, Samuel	MD	Internal Medicine	Take Heart Cardiovascular Health Center
YNHH	Haight, Irene	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Haims, Andrew	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Halaszynski, Thomas	DMD, MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Halene, Stephanie	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Haley, Christine	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Halim, Andrea	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Hall, E.	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Hallinan, Erin	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Hally, Susan	CNM	Obstetrics & Gynecology	Women's Center
YNHH	Halperin, Richard	MD, MPH	Pediatrics	Long Wharf Pediatrics & Adol. Medicine
YNHH	Hamilton, Bradley	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hammond, Karen	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital - Waterbury
YNHH	Hammoud, Fadi	MD	Pediatrics	Pediatric & Adolescent Healthcare, P.C.
YNHH	Han, Dale	MD	Surgery	YUSM Section of Surgical Oncology
YNHH	Hanbury, Nicole	PA	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Hang, Robert	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Hannon, Brittany	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Hansen, Caitlin	MD	Pediatrics	Yale New Haven Children's Hospital
YNHH	Hansen, James	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Hansen, Timothy	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Hanson, Thomas	MD	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Hansson, Joni	MD	Internal Medicine	Metabolism Associates
YNHH	Hao, Liming	MD	Pathology	Bridgeport Hospital
YNHH	Hao, Ritche	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Harb, Roa	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Harigopal, Malini	MD	Pathology	YUSM Department of Pathology
YNHH	Haronian, Howard	MD	Internal Medicine	Cardiology Specialists, Ltd.
YNHH	Harriman, David	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Harrison, Raquel	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Harvey, Katherine	MD, MPH	Internal Medicine	Y-NHH Smilow Cancer Hospital Torrington Care Center
YNHH	Harwin, Jonathan	MD	Pediatrics	Branford / North Branford Pediatrics, P.C.

YNHH	Hasbani, Mayer	MD, PhD	Neurology	M. Hasbani, M.D. and M.J. Hasbani, M.D., Ph.D., L.L.C.
YNHH	Hasbani, Moshe	MD	Neurology	M. Hasbani, M.D. and M.J. Hasbani, M.D., Ph.D., L.L.C.
YNHH	Hashim, Sabet	MD	Surgery	Heart and Vascular Institute Hartford Healthcare
YNHH	Haskins, Kristen	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Hass, David	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Hatcher, Timothy	PA	Internal Medicine	Yale New Haven Nathan Smith Outpatient Clinic
YNHH	Hatfield, Jennifer	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hatta, Caroline	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Hattangadi, Shilpa	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Haversat, Heather	AuD	Surgery	Yale Hearing and Balance Center
YNHH	Hawk, Kathryn	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Hawkins, Alexandra	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Hawkins, Keith	PsyD	Psychiatry	Connecticut Mental Health Center
YNHH	Hayden, Alexander	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Haynes, Meagan	MD, MPH	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Hayward, Alison	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Hazel, Kathleen	CNM	Obstetrics & Gynecology	Fair Haven Community Health Center
YNHH	Heacock, Daniel	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Healy, James	MD	Internal Medicine	Cardiology Associates of Norwich
YNHH	Heard, Kathy	APRN	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Heath, Janet	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Heavner, Jason	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Hebbar, Ramnath	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Hebert, Ryan	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Hebrink, Mary	APRN	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Hecht, Craig	MD	Surgery	Ear, Nose and Throat Specialists of Conn
YNHH	Hedges, Melinda	PA	Urology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Heenan, Eva	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Heerdt, Paul	MD, MPH	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Heffernan, Jody	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Hegarty, James	DO	Psychiatry	YUSM Department of Psychiatry
YNHH	Hegde, Sonia	DO	Internal Medicine	Northeast Medical Group
YNHH	Heiat, Asefeh	MD	Internal Medicine	Southern CT Geriatric and Preventive Medicine, L.L.C.
YNHH	Heim, Kathleen	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Helburn, Daniel	MD	Internal Medicine	Connecticut Medical Group - NEMG

YNHH	Helgeson, Lars	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hellenbrand, William	MD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Hemenway, Charles	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Hemstock, Heidi	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Hen, Jacob	MD	Pediatrics	Northeast Medical Group Pediatric Specialists
YNHH	Henchel, Jacqueline	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Henderson, Raven	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Hendrickson, Jeanne	MD	Laboratory Medicine	YUSM Department of Pathology/Laboratory Med
YNHH	Hendry, Christina	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Henrich, Janet	MD	Internal Medicine	YNHH Adult PCC
YNHH	Henry, Glen	MD	Internal Medicine	Yale Cardiology
YNHH	Henry, Jean	MD	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Henry, Robert	MD	Internal Medicine	Northeast Medical Group, LLC
YNHH	Hepburn, Gillian	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Herazo-Maya, Jose	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Herbert, Peter	MD	Internal Medicine	Yale-New Haven Saint Raphael Campus/Physician Referral Services
YNHH	Herbert, Tara	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Herbst, Joy	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Herbst, Roy	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Herens, Stacey	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Hermes, Gretchen	MD, PhD	Psychiatry	Yale Stress Center
YNHH	Hernandez Rodriguez, Alejandro	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hernandez, Diadette	APRN	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Hernandez, Keith	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hernandez, Rene	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Herold, Kevan	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Herrera, Adriana	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Herrin, Bradley	MD	Pediatrics	Yale Health Plan
YNHH	Hersh, David	MD, PhD	Pediatrics	Yale-New Haven Children's Hospital
YNHH	Hersh, Stanley	MD	Ophthalmology	The Eye Care Group
YNHH	Herz, Elizabeth	MD	Pediatrics	Pediatric Associates of Cheshire, P.C.
YNHH	Herzlinger, Robert	MD	Pediatrics	Bridgeport Hospital
YNHH	Herzog, Erica	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Herzog, Keri	MD	Internal Medicine	Digestive Disease Associates

YNHH	Herzog, Raimund	MD	Internal Medicine	Yale Diabetes Center
YNHH	Hesse, David	MD	Urology	YNH Urology Center
YNHH	Hesse, Katherine	MD	Pediatrics	Lawrence & Memorial Hospital
YNHH	Hetherington, Pamela	MD	Child Psychiatry	Cornell Scott - Hill Health Center
YNHH	Hiatt, Bonnie	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Hickey, John	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Higgins, Susan	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
YNHH	Highman, Henry	PA	Internal Medicine	Yale Cardiology
YNHH	Hilbert, Janet	MD	Internal Medicine	YNHH Sleep Medicine Center
YNHH	Hill, Robert	APRN	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Hiller, Lauren	PA	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Hillis, Lynne	MD	Internal Medicine	West Haven Medical Group
YNHH	Hillman, Bernadette	MD	Pediatrics	YUSM Section of Neonatology
YNHH	Hills, Oscar	MD	Psychiatry	
YNHH	Hills, Susannah	MD	Surgery	CT Pediatric Otolaryngology
YNHH	Hillsman, Regina	MD	Orthopedics	
YNHH	Hilton, Lisa	MD	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Hinchey, Chelsea	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Hinchey, Jenna	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Hindinger, Kasey	APRN	Surgery	Y-NHH Smilow Cancer Hospital, Multispecialty Care Center
YNHH	Hines, Roberta	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hipona, Rene	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Hirokawa, Ronald	MD	Surgery	Southern New England ENT
YNHH	Hirsch, Lawrence	MD	Neurology	YUSM Department of Neurology
YNHH	Hirschman, Allison	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Hittelman, Adam	MD, PhD	Urology	YNHH Pediatric Specialty Clinic
YNHH	Hobbie, Robert	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Hochreiter, Daniela	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Hochstadt, Judith	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Hochster, Howard	MD	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Hoefer, Ann	MD	Pediatrics	Guilford Pediatrics
YNHH	Hoffer, Lisa	APRN	Therapeutic Radiology	Yale-New Haven Smilow Cancer Hospital
YNHH	Hoffman, Ellen	MD, PhD	Child Psychiatry	Yale Child Study Center
YNHH	Hoffman, Pamela	MD	Psychiatry	YNHH Saint Raphael Campus Department of Psychiatry

YNHH	Hofstatter, Erin	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Hogan, Mary Jane	MD	Pediatrics	Trumbull Pediatric Specialty Center
YNHH	Hoggatt, Tracey	APRN	Pediatrics	Bridgeport Hospital
YNHH	Holdsworth, Sarah	APRN	Surgery	Ear, Nose & Throat Medical and Surgical
YNHH	Holland, Eliza	CNM	Obstetrics & Gynecology	Women's Health Associates, LLC
YNHH	Hollingsworth, Bevan	DPM	Podiatry	New Haven Podiatry Associates, L.L.P.
YNHH	Holmes, Brittany	APRN	Pediatrics	YUSM Section of Genetics
YNHH	Holmes, Katherine	APRN	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Holt, Christina	APRN	Internal Medicine	YUSM Section of General Medicine
YNHH	Holt, Elizabeth	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Holt, Stephen	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Holtz, Stacy	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Holtz-Eakin, Eleanor	PA	Pediatrics	YUSM Section of Neonatology
YNHH	Holtzman, Phyllis	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Homa, Thomas	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Homer, Robert	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Hommel, Mark	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Hong, Jin Ki	MD	Anesthesiology	Bridgeport Anesthesia Assoc
YNHH	Hong, Xiaoming	MD	Internal Medicine	Village Medical Associates
YNHH	Hong-Curtis, JoAnn	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Honiden, Shyoko	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Honig, Stanton	MD	Urology	YNH Urology Center
YNHH	Honigsberg, Elizabeth	MD	Surgery	General Surgeons Greater Bridgeport
YNHH	Hood, Douglas	PA	Neurology	Neurological Associates of New Haven
YNHH	Hooley, Regina	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Hoq, Sheikh	MD	Internal Medicine	Bridgeport Hospital
YNHH	Hoque, Rafaz	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Horblitt, Gary	DDS	Dentistry	Gary E. Horblitt, D.D.S.
YNHH	Horowitz, Nina	MD	Surgery	Y-NHH Smilow Cancer Hospital
YNHH	Horvath, Laura	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Hossin, Tania	APRN	Urology	YUSM Department of Urology
YNHH	Hotchkiss, Mark	MD	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Hovagim, Lisa	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Howard, Martha	MD	Ophthalmology	Pediatric Eye Care

YNHH	Howe, John	PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Howell, Benjamin	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Howes, Christopher	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Hoxie, Kristen	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Hricz-Borges, Linda	PA	Internal Medicine	Yale-New Haven Transplant Center
YNHH	Hrycelak, Michael	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hsia, Henry	MD	Surgery	YUSM Section of Plastic Surgery
YNHH	Hsiao, Allen	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Hsu, Bruce	MD	Orthopedics	Gaylord Hospital
YNHH	Hsu, Florence	MD	Internal Medicine	YUSM Section of Allergy and Immunology
YNHH	Huang, John	MD	Ophthalmology	Eye Disease Consultants
YNHH	Hubbard, Matthew	MD, MS	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Huber, Steffen	MD	Radiology & Biomedical Ima	YUSM Department of Radiology and Biomedical Imaging
YNHH	Hudnall, Stanley	MD	Pathology	YUSM Department of Pathology
YNHH	Hudoba, Christine	APRN	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Huen, Sarah	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Hughes, Terence	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Hui, Pei	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Hull, Sarah	MD	Internal Medicine	Take Heart Cardiovascular Health Center
YNHH	Humbles, Payal	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Humphrey, Peter	MD	Pathology	YUSM Department of Pathology
YNHH	Hunt, William	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Huntington, Scott	MD, PhD	Internal Medicine	YUSM Section of Oncology
YNHH	Huot, Stephen	MD	Internal Medicine	YNHH Adult PCC
YNHH	Hurd, Karen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Hurney, Lee	DPM	Podiatry	Branford Podiatry Center
YNHH	Hurwitz, Michael	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Husain, Zain	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Hussain, Isma	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Huszar, Gabor	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Hutchinson, Gordon	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Hutchinson, Karen	MD	Internal Medicine	Bridgeport Hospital
YNHH	Hutchinson, Natasha	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Huttler, Craig	MD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Huttner, Anita	MD	Pathology	YUSM Department of Pathology

YNHH	Huvelle, Peter	MD	Internal Medicine	Solo Practice
YNHH	Hwang, David	MD	Neurology	YUSM Department of Neurology
YNHH	Hyde, Anne	APRN	Pediatrics	Bridgeport Hospital
YNHH	Hymel, Nicole	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Iacomacci, Aimee	SA	Ophthalmology	New England Retina Associates
YNHH	Idelson, Douglas	MD	Pediatrics	Yale Health Plan
YNHH	Iftikhar, Asma	MD	Internal Medicine	Milford Hospital
YNHH	Igboeli, Chinyere	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ikeda, Margaret	MD	Pediatrics	Park Street Pediatrics
YNHH	Ikediobi, Uchenna	MD, MPH	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Ikekpeazu, Ngozi	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Ikekpeazu, Nkemakonam	MD	Surgery	Nkem Ikekpeazu, M.D., LLC
YNHH	Ikuta, Kevin	MD	Internal Medicine	YNHH Adult PCC
YNHH	Illick, Christopher	MD	Internal Medicine	Digestive Disease Associates
YNHH	Illuzzi, Jessica	MD	Obstetrics & Gynecology	YUSM Department of OB/GYN and Reproductive Sciences
YNHH	Imaeda, Avlin	MD, PhD	Internal Medicine	VA Connecticut
YNHH	Imaeda, Suguru	MD	Dermatology	Yale Dermatology Associates
YNHH	Imevbore, Michael	MD	Internal Medicine	Connecticut Pulmonary Specialists, P.C.
YNHH	Imevbore, Olutayo	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Indes, Jodi	MD	Internal Medicine	Shoreline Internal Medicine
YNHH	Insogna, Karl	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Inzucchi, Silvio	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Ionescu, Costin	MD, PhD	Internal Medicine	Yale Cardiology
YNHH	Ionescu, Simina	MD	Internal Medicine	West Haven Medical Group
YNHH	Ionita, Cristian	MD	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Ip, Bik-Yin	MD, MS	Pediatrics	Child-Adolescent Healthcare
YNHH	Ippolito, Carmen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ippolito, Raymond	MD	Surgery	Solo Practice
YNHH	Irani, Roxanna	MD, PhD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Irby, Ceasar	DPM	Podiatry	Mill Hill Surgical Associates
YNHH	Irving, John	MD	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	Ishibe, Shuta	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Israel, Gary	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Isufi, Iris	MD	Internal Medicine	YUSM Section of Hematology

YNHH	Ivy, Michael	MD	Surgery	Bridgeport Hospital
YNHH	Jabuonski, Thiago	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Jacko, Marissa	PA	Urology	YUSM Section of Trauma & Critical Care
YNHH	Jackson, Tamiko	MD	Pediatrics	NH Pedi & Adolescent Medical Services
YNHH	Jacob, Jobey	MD	Pediatrics	West Haven Pediatrics
YNHH	Jacob, Seby	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Jacobs, Harris	MD	Pediatrics	Bridgeport Hospital
YNHH	Jacobson, Linda	APRN	Pediatrics	Complete Pediatrics, P.C.
YNHH	Jacoby, Daniel	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Jacoby, Steven	MD	Internal Medicine	Yale Cardiology
YNHH	Jacoby, Wendy	MD	Dermatology	Associates in Medical & Cosmetic Dermato
YNHH	Jacques, Ismaele	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Jadbabaie, Farid	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Jaffe, David	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Jain, Dhanpat	MD	Pathology	YUSM Department of Pathology
YNHH	Jakab, Sofia	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Jalkut, Susanna	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	James, Edward	MD	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Jamidar, Priya	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Jastreboff, Ania	MD, PhD	Internal Medicine	YUSM Section of Pediatric Endocrinology
YNHH	Jauk, Mae Ann	APRN	Internal Medicine	Yale Cancer Center
YNHH	Jayanetti, Cindy	APRN	Pediatrics	East Haven Pediatrics, PC
YNHH	Jayasuriya, Sasanka	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Jean, Chrisnel	DO	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Jean, Sandie	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Jean-Baptiste, Michel	MD	Psychiatry	Michel Jean-Baptiste, M.D., L.L.C.
YNHH	Jencks, Priscilla	CNM	Obstetrics & Gynecology	Fair Haven Community Health Center
YNHH	Jenei, Peter	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Jennings, Jeffrey	MD	Pediatrics	Pediatric Medicine of Wallingford
YNHH	Jennings, Richard	CNM	Obstetrics & Gynecology	Women's Center
YNHH	Jensen, Peter	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Jevitt, Cecilia	CNM	Obstetrics & Gynecology	Yale School of Nursing Midwifery Practice
YNHH	Jockel, Kristen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Johnson, Christa	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
YNHH	Johnson, Dirk	MD	Surgery	YUSM Section of Trauma & Critical Care

YNHH	Johnson, Jennifer	APRN	Internal Medicine	YNHH Medical Critical Care
YNHH	Johnson, Keisha	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Johnson, Kevin	MD	Radiology & Biomedical Ima	Yale Health Plan
YNHH	Johnson, Michael	DMD	Dentistry	Hamden Shoreline Oral & Maxillofacial Surgery
YNHH	Johnson, Michele	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Johnson, Philip	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Johnson, Randall	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Johnson, Raymond	MD, PhD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus - Haelen Center
YNHH	Johnson, Stefanie	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Johnson, Tameco	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Johnston, Lindsay	MD	Pediatrics	YUSM Section of Neonatology
YNHH	Johung, Kimberly	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Jokl, Peter	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Jolicoeur, Heather	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Jonas, Elizabeth	MD	Internal Medicine	YUSM Department of Endocrinology
YNHH	Jones, Maureen	APRN	Psychiatry	YNHH Saint Raphael Campus Department of Psychiatry
YNHH	Jorge Cabrera, Valerie	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Jou, Roger	MD, PhD	Child Psychiatry	Yale Child Study Center
YNHH	Joy, Sonia	MD	Psychiatry	Yale University Child Study Center
YNHH	Jubanyik-Barber, Karen	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Judson, Benjamin	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Juergensen, Peter	PA	Internal Medicine	Metabolism Associates
YNHH	Julian, AnnMarie	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Julien, Natasha	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Jung, Lee	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Juthani-Mehta, Manisha	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Kacik, Stephanie	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Kadan-Lottick, Nina	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Kahle, Kristopher	MD, PhD	Neurosurgery	YUSM Department of Neurosurgery - Smilow Pediatric Clinic
YNHH	Kalam, Sharmin	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Kaliannan, Krithica	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Kalinchak, Jillian	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Kallen, Amanda	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Kamal, Arshad	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Kaminer, Michael	MD	Dermatology	SkinCare Physicians

YNHH	Kaminsky, David	MD	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Kaml, Gary	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Kanade, Sandhya	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Kanade, Vasudev	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Kanaparthy, Naga Sasidhar	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Kandil, Sarah	MD	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	Kaner, Angelica	PhD	Psychiatry	
YNHH	Kang, Insoo	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Kaplan, Jerrold	MD	Orthopedics	
YNHH	Kaplan, Michael	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Kaplan, Norman	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Kapo, Jennifer	MD	Internal Medicine	YUSM Palliative Care
YNHH	Kapoor, Ajoy	MD	Internal Medicine	Connecticut Heart Group, P.C.
YNHH	Karas, David	MD	Surgery	CT Pediatric Otolaryngology
YNHH	Kardos, Steven	MD	Urology	Northeast Medical Group
YNHH	Karimi, Mohsen	MD	Surgery	YUSM Section of Pediatric Surgery - YNHH Children's Hospital
YNHH	Karkanitsa, Leonid	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Karne, Anita	MD	Internal Medicine	Yale Health Plan
YNHH	Karnolt, Alan	SA	Ophthalmology	Connecticut Retina Consultants
YNHH	Karol, Ian	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Karsif, Brian	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Women's Center
YNHH	Kashani, Shabnam	MD	Obstetrics & Gynecology	Bridgeport Hospital
YNHH	Kashgarian, Michael	MD	Pathology	YUSM Department of Pathology
YNHH	Kashyap, Nitu	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Kaslow, Jessica	APRN	Internal Medicine	Yale Internal Medicine Associates
YNHH	Kasper, Mark	MD	Internal Medicine	Internal Medicine of East Haven
YNHH	Katoch, Anamika	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital - Waterbury
YNHH	Katz, David	MD	Internal Medicine	Griffin Hospital
YNHH	Katz, Lee	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Katz, Martin	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Katz, Samuel	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Kauffman, Tanya	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Kaufman Scher, Jonathan	APRN	Radiology & Biomedical Ima	YUSM Department of Radiology and Biomedical Imaging
YNHH	Kaufman, David	MD	Internal Medicine	Northeast Medical Group
YNHH	Kaufman, Jeremy	MD	Urology	Urological Associates of Bridgeport, PC

YNHH	Kaufman, Richard	MD	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Kaump, Randall	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Kaushal, Neelima	MD	Obstetrics & Gynecology	
YNHH	Kayani, Sohail	MD	Pediatrics	
YNHH	Kaye, Adam	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Kaye, Alan	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Kayne, Richard	MD	Internal Medicine	Cheshire Endocrinology and Internal Medicine
YNHH	Kaza, Ravi	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Women's Center
YNHH	Kazi, Azimuddin	MD	Pediatrics	Neurological Specialists, P.C.
YNHH	Kazmierczak, Barbara	MD	Internal Medicine	YUSM Section of Infectious Disease
YNHH	Keane, Kimberly	PA	Orthopedics	Center for Orthopaedics
YNHH	Keanna, Craig	MD	Pediatrics	Pediatric & Adolescent Medicine, P.C.
YNHH	Kearney, Denise	MD	Internal Medicine	Advanced Allergy and Immunology and Asthma
YNHH	Keck, Douglas	DMD	Dentistry	Pediatric Dentistry Associates, LLC
YNHH	Keggi, Kristaps	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Keizerweerd, Michelle	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Kejner, Alexandra	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Kelleher, Michael	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Kelley, Georgia	MD	Internal Medicine	Medical Associates of North Haven
YNHH	Kelley, John	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Kelley, Kathleen	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Kellner, Daniel	MD	Urology	YUSM Department of Urology
YNHH	Kempton, James	MD	Ophthalmology	Yale Eye Center
YNHH	Kenkare, Zadie	MD	Internal Medicine	Internal Medicine of Clinton, L.L.C.
YNHH	Kennedy, Christine	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Kennedy, Karen	MD	Pediatrics	Franklin Medical Group, P.C.
YNHH	Kennedy, Katherine	MD	Psychiatry	
YNHH	Kenney, Patrick	MD	Urology	YUSM Department of Urology
YNHH	Kent, Michael	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Kent, Risa	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Ker, Zhong Yang Belinda	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Kerins, Gerard	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Kernan, Walter	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Kerwin, Gail	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ketchersid, Kimberlee	PA	Internal Medicine	NEMG - Y-NHH Hospitalists

YNHH	Ketner, David	MD	Ophthalmology	Yale Eye Center
YNHH	Keung, Benison	MD	Neurology	YUSM Department of Neurology
YNHH	Key, Jonathan	DPM	Podiatry	Connecticut Foot & Ankle Associates
YNHH	Khachane, Vasant	MD	Surgery	Heart Care Associates of Connecticut, L.L.C.
YNHH	Khan, Sajid	MD	Surgery	Bridgeport Hospital
YNHH	Khan, Shaukat	MD	Psychiatry	Yale Behavioral Health Services at Hamden
YNHH	Khodzinsky, Roman	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Khokha, Mustafa	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Khokhar, Babar	MD	Neurology	YUSM Department of Neurology
YNHH	Khurana, Anjali	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Kibbey, Richard	MD, PhD	Internal Medicine	Yale Health Plan
YNHH	Kidwai, Wajih Zaheer	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Kier, Ruben	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Killam, Jonathan	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Killelea, Brigid	MD	Surgery	YUSM Section of Surgical Oncology
YNHH	Kim, Hyun	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Kim, Hyun Jung	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Kim, Jennifer	MD	Radiology & Biomedical Ima	Yale Diagnostic Radiology
YNHH	Kim, Joseph	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital
YNHH	Kim, Jung	MD	Pathology	YUSM Department of Pathology
YNHH	Kim, Nancy	MD, PhD	Internal Medicine	Yale/YNHH Center for Outcomes Research and Evaluation (CORE)
YNHH	Kim, Robert	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Kim, Tae Kon	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Kim, Young	MD	Pathology	Bridgeport Hospital
YNHH	Kimberly, Thomas	APRN	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	King, Brett	MD, PhD	Dermatology	Yale Dermatology Associates
YNHH	King, Brian	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
YNHH	King, Robert	MD	Child Psychiatry	Yale University Child Study Center
YNHH	King, Yiming	DMD	Dentistry	Advanced Endodontics of New Haven
YNHH	Kingsly, Kenneth	MD	Urology	NEMG Urology
YNHH	Kinney, Daniel	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Kinsella, Karalyn	MD	Pediatrics	Pediatric Associates of Cheshire, P.C.
YNHH	Kinzler, Rachel	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Kipperman, Harry	MD	Pediatrics	Milford Pediatric Group

YNHH	Kirsch, Jonathan	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Kishinevsky, Anya	MD	Surgery	Aesthetic Surgery Center of Connecticut
YNHH	Kissane, Ryan	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Kissel, Margaret	MD	Pediatrics	Pediatric Healthcare Assoc.
YNHH	Kisson, Richard	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Klauser, Jeffrey	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Klegar, Eunjie	MD	Psychiatry	Greenwich Hospital
YNHH	Klein, Nomigly	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Klein, Wendy	MD	Ophthalmology	Ophthalmic Associates, P.C.
YNHH	Kleinstein, Judy	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Kliger, Alan	MD	Internal Medicine	Metabolism Associates
YNHH	Kliman, Harvey	MD, PhD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinolo
YNHH	Klingensmith, Katherine	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Kluger, Harriet	MD	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Klugman, Jeffrey	MD	Psychiatry	Atlantic Health Services, P.C.
YNHH	Knaggs, Shannon	APRN	Pediatrics	Y-NHH, St. Raphael Campus
YNHH	Knauert, Melissa	MD, PhD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Kneen, Jessyca	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Knight, Herbert	MD	Internal Medicine	Take Heart Pulmonary Care
YNHH	Knill-Selby, Elspeth	APRN	Surgery	Y-NHH Smilow Cancer Hospital
YNHH	Knispel, Jeffrey	MD	Dermatology	YNHH Primary Care Center
YNHH	Knobelman, Richard	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Knoll, Laurence	MD	Internal Medicine	Solo Practice
YNHH	Knowlton, Arthur	MD	Therapeutic Radiology	Radiation Oncology Specialists of Southern Connecticut
YNHH	Knowlton, Christin	MD	Therapeutic Radiology	Yale-New Haven Hospital, Saint Raphael Campus, Hamden
YNHH	Knudson, Joann	MD	Obstetrics & Gynecology	Yale Health Plan
YNHH	Ko, Christine	MD	Dermatology	Yale Dermatology Associates
YNHH	Kochan, Charles	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Kodaman, Pinar	MD, PhD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Koenig, Kathleen	APRN	Child Psychiatry	Yale University Child Study Center
YNHH	Koff, Jonathan	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Kohari, Katherine	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Kohilakis, Roxanne	AuD	Surgery	Yale Hearing and Balance Center
YNHH	Kohli-Pamnani, Anita	MD	Internal Medicine	Allergy, Asthma & Immunology Center, LLC

YNHH	Kohn, Donald	DDS	Dentistry	Pediatric Dentistry Associates, LLC
YNHH	Kokalari, Jennifer	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Kolanovic, Megan	PA	Surgery	YUSM Department of Surgery
YNHH	Kolb, Luis	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Kole, Lauren	MD	Dermatology	YUSM Department of Dermatology
YNHH	Kombo, Ninani	MD	Ophthalmology	YUSM Department of Ophthalmology
YNHH	Komosinski, Samantha-Josephin	SA	Ophthalmology	New England Retina Associates
YNHH	Kondor, Melanie	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Kong, Colin	DMD	Dentistry	Pediatric Dentistry Associates, LLC
YNHH	Konstantinova, Nina	MD	Internal Medicine	
YNHH	Koo, Brian	MD	Neurology	YUSM Department of Neurology
YNHH	Kopel, Dawn	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Kopf, Gary	MD	Surgery	YUSM Section of Cardiac Surgery
YNHH	Koral, Alexander	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Korn, Michael	PA	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Kortmansky, Jeremy	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Kosack, Andrea	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Koskinas, Christina	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Koslosky, Kourtney	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Kostina, Yanina	MD	Ophthalmology	The Eye Care Group
YNHH	Kota, Ajay	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Koumpouras, Fotios	MD	Internal Medicine	North Haven Walk-in Clinic
YNHH	Kovacevic, David	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Kovachev, Georgi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Koval, Nancy	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Kovar, Emily	MD	Pediatrics	Pediatrics Plus, P.C.
YNHH	Kovar, Jeffrey	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Kowalski, Diane	MD	Pathology	YUSM Department of Pathology
YNHH	Kowalsky, Kaitlin	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Kozal, Michael	MD	Internal Medicine	YUSM Section of Infectious Disease, AIDS Program
YNHH	Koziel, Jeannette	APRN	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Koziol-Dube, Kasia	MD	Pediatrics	Pediatric & Adolescent Medicine, P.C.
YNHH	Kra, Siegfried	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Kraft, Michael	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Kramer, Clifford	MD	Internal Medicine	Cardiovascular Physicians & Consultants

YNHH	Kramer, Kenneth	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Krantz, James	DPM	Podiatry	Milford Podiatry Associates, P.C.
YNHH	Krause, Diane	MD, PhD	Laboratory Medicine	YUSM Department of Pathology/Lab Med
YNHH	Krauss, Ronald	CNM	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Kremer, Jo	MD	Psychiatry	
YNHH	Kressley, Andrew	DMD	Dentistry	Shoreline Oral & Maxillofacial Surgeons, PC
YNHH	Kressley, Elisabeth	MD	Child Psychiatry	Elisabeth M. Kressley, M.D.
YNHH	Krichavsky, Marc	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Kriegel, Martin	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Krishna, Nikolas	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Kronstadt, Kenneth	DMD	Dentistry	YNHH Department of Dentistry
YNHH	Kruger, Nathan	MD	Internal Medicine	Yale Cardiology
YNHH	Krumholz, Harlan	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Kryger, Meir	MD	Internal Medicine	West Haven VA Medical Center
YNHH	Krystal, John	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Kuhn, Sharon	MD	Pediatrics	Children's Medical Group, LLC
YNHH	Kulkarni, Sanjay	MD	Surgery	YUSM Section of Transplantation
YNHH	Kulon, Michal	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Kumar, Babu	MD	Internal Medicine	Family and Internal Medicine of Dixwell Avenue, LLC
YNHH	Kumar, Chandrika	MD	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Kumar, McLynn	APRN	Internal Medicine	New Haven Rheumatology, P.C.
YNHH	Kumar, Prathibha	MD	Internal Medicine	Family and Internal Medicine of Dixwell Avenue, LLC
YNHH	Kumar, Yogesh	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Kumaraswami, Rajesh	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Kunkes, Steven	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Kupfer, Gary	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Kurian, Sherlet	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Kurup, Viji	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Kuruvilla, Deena	MD	Neurology	YUSM Department of Neurology
YNHH	Kveton, John	MD	Surgery	Ear, Nose & Throat Medical and Surgical
YNHH	Kwittken, Pamela	MD	Pediatrics	Allergy, Asthma & Immunology Center, LLC
YNHH	Kwok, Patrick	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Kwon, Lawrence	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital

YNHH	Kwon, Soo Hyun	MD	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Kyle, Robert	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Kyrcz, Robert	MD	Internal Medicine	Guilford Family Practice
YNHH	Labib, Kristy	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	LaCerva, Joann	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Lacka, Iwona	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Lacoske, Jennifer	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lacy, Jill	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Lagarde, Suzanne	MD	Internal Medicine	Fair Haven Community Health Center
YNHH	Lagasse, Robert	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lagliva, Marie	SA	Ophthalmology	New England Retina Associates
YNHH	Lai, James	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Laifer, Julie	MD	Obstetrics & Gynecology	Southport Women's Care
YNHH	Laifer, Steven	MD	Obstetrics & Gynecology	Bridgeport Hospital
YNHH	Lakhani, Saquib	MD	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	LaLiberte, Shelli	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Lalonde, Michael	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Lam, Si-hoi	MD	Internal Medicine	Si-hoi Lam, M.D., L.L.C.
YNHH	Lamacchia, Amy	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	LaMastra, Philip	MD	Obstetrics & Gynecology	Bridgeport Hospital
YNHH	Lamba, Amarjit	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Lambe, Elizabeth	APRN	Surgery	YNHH Heart and Vascular Center
YNHH	Lambie-Parise, Carol	APRN	Obstetrics & Gynecology	Women's Center
YNHH	Lampert, Rachel	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Landau, Jeffrey	MD	Child Psychiatry	
YNHH	Landesman, Barbara	MD	Neurology	American Neuromonitoring Associates, PC
YNHH	Landis, Robert	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Landry, Marie	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Lang, Robert	MD	Internal Medicine	Robert Lang, M.D., P.C.
YNHH	Langberg, Blaine	DMD	Dentistry	
YNHH	Langberg, Karl	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Langdon, Robert	MD	Dermatology	Shoreline Dermatology
YNHH	Langeland, Rolf	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Langer, Victoria	APRN	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Langhan, Melissa	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine

YNHH	Lannin, Donald	MD	Surgery	Y-NHH Smilow Cancer Hospital Breast Center
YNHH	Lansky, Alexandra	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	LaPorta, Anna	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Lariviere, Serena	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Larrison, Wayne	MD	Ophthalmology	Connecticut Retina Consultants
YNHH	Larsen, Christina	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Lasala, Johanna	MD	Internal Medicine	Smilow Cancer Hospital, Orange Care Center
YNHH	Laser, Mark	MD	Obstetrics & Gynecology	Womens Health Care LLC
YNHH	Laskin, William	MD	Pathology	Bridgeport Hospital
YNHH	Latich, Igor	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Laub, Dori	MD	Psychiatry	Dori Laub
YNHH	Laudano, Andrea	APRN	Neurosurgery	YUSM Department of Neurosurgery Oncology
YNHH	Laugel, Karen	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
YNHH	Laurans, Maxwell	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Laurans, Monika	PA	Neurology	Y-NHH Smilow Cancer Center Section of Neuro Oncology
YNHH	Lavallee, Robert	MD	Pediatrics	Childrens Medical Associates
YNHH	Lavi, Nimrod	MD	Internal Medicine	Arrhythmia Center of Connecticut
YNHH	Lawrence, Eileen	MD	Pediatrics	Shoreline Pediatric & Adoles. Medicine(ProHealth Physicians)
YNHH	Lawrence, Fraser	MD	Internal Medicine	Shoreline Internal Medicine
YNHH	Lawrence-Riddell, Jane	APRN	Pediatrics	Pediatric & Medical Associates
YNHH	Lazarides, Lazaros	MD	Internal Medicine	West Haven Medical Group, LLC
YNHH	Le, Karen	PhD	Surgery	YUSM Section of Otolaryngology
YNHH	Le, Maura	MD	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Leake, David	PA	Orthopedics	Center for Orthopaedics
YNHH	Leapman, Michael	MD	Urology	YUSM Department of Urology
YNHH	Lebowitz, Alan	MD	Internal Medicine	Alan Lebowitz, M.D., P.C.
YNHH	Lebson, Robert	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Leckman, James	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Lee, Alfred	MD, PhD	Internal Medicine	YUSM Section of Oncology
YNHH	Lee, Amanda	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Lee, Andrea	PA	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Lee, Eunice	DMD	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Lee, Forrester	MD	Internal Medicine	Yale Center for Advanced Heart Failure and Transplantation
YNHH	Lee, Grace	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Lee, Helen	MD	Internal Medicine	NEMG - Y-NHH Hospitalists

YNHH	Lee, Hochang	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Lee, Kay	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lee, Patty	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Lee, Vivian	PA	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Lee, Yoonjeong	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Leffell, David	MD	Dermatology	Yale Dermatologic Surgery
YNHH	Lefkowitz, Rafael	MD	Internal Medicine	YUSM Section of Occupational Medicine
YNHH	Lei, Pei Juan	MD	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Leinhardt, Kathryn	MD	Internal Medicine	Yale Health Plan
YNHH	Lemley, Mary	APRN	Pediatrics	Fair Haven Community Health Center
YNHH	Lempit, Sylvia	APRN	Surgery	YUSM Organ Transplantation Center
YNHH	Lendler, Amanda	CNM	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Lenox, Raymond	APRN	Internal Medicine	YUSM Section of Hematology
YNHH	Leonard, David	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Leonard-Pasley, Kevin	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Leonova, Maria	DO	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lerner, Seth	MD	Dermatology	Adult & Pediatric Dermatology Specialists, P.C.
YNHH	Leslie, Michael	DO	Orthopedics	YUSM Department of Orthopedics
YNHH	Lesser, Robert	MD	Ophthalmology	The Eye Care Group
YNHH	Lettera, James	MD	Surgery	Connecticut Vascular & Thoracic Surgical Associates, P.C.
YNHH	Levada, Andrew	MD	Ophthalmology	The Eye Care Group
YNHH	Leventhal, John	MD	Pediatrics	Primary Care Center
YNHH	Leventhal, Jonathan	MD	Dermatology	Yale Dermatology - Branford
YNHH	Leventhal, Seth	PA	Internal Medicine	Yale Cardiology
YNHH	Levesque, Paul	MD	Radiology & Biomedical Ima	Yale Diagnostic Radiology - St. Raphael Campus
YNHH	Levi, Angelique	MD	Pathology	YUSM Department of Pathology
YNHH	Levin, Flora	MD	Ophthalmology	Y-NHH Smilow Cancer Hospital Multispecialty Care Center
YNHH	Levin, Richard	MD	Surgery	Richard A. Levin, M.D., Lawrence J. Fliegelman, M.D., LLC
YNHH	Levine, Steven	MD	Surgery	ENT and Allergy Associates, P.C.
YNHH	Levinson, David	DO	Ophthalmology	Eye Physicians & Surgeons
YNHH	Levit, Orly	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Levy, Harold	MD	Internal Medicine	Harold D. Levy, MD. PC
YNHH	Levy, Susan	MD	Pediatrics	Child Neurology Associates, L.L.P.
YNHH	Lewis, Amy	MD	Dermatology	

YNHH	Lewis, Robert	MD	Internal Medicine	Cardiovascular Physicians & Consultants
YNHH	Lewoc, Rayna	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Li, Jinlei	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Li, Ting	MD	Internal Medicine	Cardiology Associates of Norwich
YNHH	Liapakis, AnnMarie	MD	Internal Medicine	
YNHH	Liben, Eric	MD	Internal Medicine	Medical Associates of North Haven
YNHH	Liberatore, Janine	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lichtor, J.	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Liebler, Brian	MD	Pediatrics	Pediatric Associates of Cheshire, P.C.
YNHH	Lieponis, Jonas	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C.
YNHH	Ligham, Dwight	MD	Anesthesiology	Advanced Diagnostic Pain Treatment Center
YNHH	Likier, Howard	MD	Internal Medicine	Gastroenterology Center of New England
YNHH	Lilenbaum, Rogerio	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital
YNHH	Lim, Edward	MD	Ophthalmology	Edward S. Lim M.D, LLC
YNHH	Lim, Joseph	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Lim, Su Hsien	MD	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Lima, David	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Lin, Ben	MD, PhD	Internal Medicine	YUSM Section of Cardiology
YNHH	Lin, Foong-Yi	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Linden, Robert	MD	Internal Medicine	YUSM Office of Education
YNHH	Lindskog, Dieter	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Lipcan, Michael	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Lipkind, Heather Sue	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Lipow, Kenneth	MD	Neurosurgery	Connecticut Neurosurgical Specialists, P.C.
YNHH	Lipshaw, Matthew	MD	Pediatrics	YNHH Pediatric PCC
YNHH	Lipska, Kasia	MD	Internal Medicine	Yale Diabetes Center
YNHH	Lischuk, Andrew	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Lister, George	MD	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	Litkouhi, Babak	MD	Obstetrics & Gynecology	Y-NHH Smilow Gynecologic Oncology
YNHH	Liu, Anne	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Liu, Ji	MD	Ophthalmology	Yale Eye Center
YNHH	Liu, My	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Liu, Paolin	APRN	Pediatrics	Primary Care Center
YNHH	Liu, Rachel	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Liu, Renu	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging

YNHH	Liu, Steven	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Llor, Xavier	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Lo, Lawrence	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Loarte Campos, Pablo	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Lobo, Ana	MD, MPH	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lobo, David	MD	Internal Medicine	Internal Medicine & Infectious Disease Assoc
YNHH	Lobo, Francis	MD	Internal Medicine	YUSM Department of General Pediatrics
YNHH	Lockhart, Roberta	MD	Pediatrics	Milford Pediatric Group
YNHH	Logan, Philip	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	LoGiudice, Jenna	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Lombardo, Daniel	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lombo Lievano, Bernardo	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Lombroso, Paul	MD	Child Psychiatry	YUSM Department of Child Psychiatry
YNHH	Lone, Naheed	MD	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Lonergan, Melissa	CNM	Obstetrics & Gynecology	Fair Haven Community Health Center
YNHH	Long, Kay	PhD	Psychiatry	
YNHH	Long, Leslie	PA	Therapeutic Radiology	Y-NHH Smilow Cancer Hospital
YNHH	Longbrake, Erin	MD, PhD	Neurology	Yale Mutliple Sclerosis Center
YNHH	Longo, Walter	MD	Surgery	Yale Colon and Rectal Surgery
YNHH	Longtine, Janina	MD	Pathology	YUSM Department of Pathology
YNHH	Loomis, Caitlin	MD	Neurology	YUSM Department of Neurology
YNHH	Lope de Haro, Helen	MD	Obstetrics & Gynecology	Women's Health Associates, LLC
YNHH	Lopez Gonzalez, Felipe	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Lopez, Antonio	MD	Internal Medicine	CareMedica
YNHH	Lopez, Javier	MD	Psychiatry	Yale-New Haven Children's Hospital at Bridgeport Hospital
YNHH	LoRusso, Patricia	DO	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Loscalzo, Christopher	MD	Internal Medicine	Yale Cardiology
YNHH	Loss, Alexis	PA	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Lotfalla, Maged	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Loth, Adrienne	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Lottick, Adam	MD	Internal Medicine	Northeast Medical Group Cardiology
YNHH	Louis, Elan	MD	Neurology	YUSM Department of Neurology
YNHH	Lovin, Jennifer	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Lowlicht, Roger	DDS	Dentistry	Solo Practice
YNHH	Loyal, Jaspreet	MD	Pediatrics	YUSM Department of General Pediatrics

YNHH	Lu, Johnny	MD	Pediatrics	Children's Medical Group, LLC
YNHH	Lu, Zhao	MD	Internal Medicine	Oncology/Hematology Care of Connecticut
YNHH	Luchini, Michael	MD	Orthopedics	Orthopaedic Surgeons, P.C.
YNHH	Luchini, Phillip	MD	Orthopedics	Orthopaedic Surgeons, P.C.
YNHH	Luciano, Randy	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Luck, Leon	MD	Dermatology	Dermatology Associates
YNHH	Lui, Felix	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Luizzi, Megan	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Lujic, Denisa	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Lundberg, Walter	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital
YNHH	Lupsa, Beatrice	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Lustbader, Andrew	MD	Child Psychiatry	Mid-Fairfield Child Guidance Ctr.
YNHH	Lynch, Christopher	MD	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	Lynch, Matthew	MD	Internal Medicine	Yale Health Plan
YNHH	Lynch, Sean	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Lyons, James	MD	Surgery	
YNHH	Macainag, Joyce	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	MacArthur, Kristin	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Mackenzie, Bonnie	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Mackey, Erin	PA	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Mackey, Wendy	APRN	Surgery	CT Pediatric Otolaryngology
YNHH	MacMillan, Donald	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	MacPherson, Alia	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Madden, Carolyn	PA	Surgery	Orchard Surgical Specialists
YNHH	Madigan, Janet	MD	Child Psychiatry	
YNHH	Madonick, Maria	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Madri, Joseph	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Maenza, Cheryl	APRN	Internal Medicine	Yale Cardiology Center for Advanced Heart Failure
YNHH	Maerz, Linda	MD	Surgery	YSM Section of General Surgery, Trauma and Surgical Critical Care
YNHH	Magraw, Ruth	MD	Pediatrics	Fair Haven Community Health Center
YNHH	Magriples, Urania	MD	Obstetrics & Gynecology	YUSM Section of Maternal Fetal-Medicine
YNHH	Maguire, Kristin	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Mahajan, Amit	MD	Radiology & Biomedical Ima	Yale Diagnostic Radiology
YNHH	Maher, Mary	MD	Urology	YNH Urology Center

YNHH	Maher, Peter	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Mahoney, Maurice	MD	Pediatrics	YUSM Section of Genetics
YNHH	Mak, Winifred	MD, PhD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Makhani, Naila	MD	Pediatrics	YUSM Section of Pediatric Neurology
YNHH	Makkouk, Al Hasan	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Makubika, Elisabeth	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Malefatto, Jerry	MD	Internal Medicine	Smilow Cancer Care -Trumbull
YNHH	Maletta, Nicole	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Maley, Ann	MD	Pediatrics	Branford / North Branford Pediatrics, P.C.
YNHH	Malhotra, Ajay	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Malik, Umer	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Malin, Joel	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Malinis, Maricar	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Malison, Robert	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Malm, Brian	MD	Internal Medicine	VAMC
YNHH	Malone-Scott, Laura	PA	Pediatrics	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Maloy, Beth	MD	Obstetrics & Gynecology	Generations Obstetrics and Gynecology, PC
YNHH	Manchisi, Alefteria	APRN	Surgery	YUSM Section of Pediatric Surgery
YNHH	Mancini, Peter	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Mandelkern, Marshal	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Manes, Richard	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Mangano, Thomas	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Mangi, Abeel	MD	Surgery	YUSM Section of Cardiac Surgery
YNHH	Mangi, Richard	MD	Internal Medicine	NEMG - Internal Medicine Hamden
YNHH	Mani, Arya	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Mann, Christa	APRN	Surgery	YUSM Section of Cardiac Surgery
YNHH	Mann, Cynthia	MD	Pediatrics	Whitney Pediatrics & Adolescent Medicine/NEMG
YNHH	Mann, Marc	MD	Internal Medicine	NEMG - Whitney Internal Medicine
YNHH	Mansoor, Muhammad	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Manuel, Kate	APRN	Pediatrics	YUSM Section of Maternal Fetal-Medicine
YNHH	Manzolillo, Hollie	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Manzon, Anthony	MD	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Mao, Johnny	MD	Surgery	Richard J. Restifo, M.D., P.C.
YNHH	Mapas-Dimaya, Ann Celeste	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Marando, Rocco	MD	Anesthesiology	YUSM Department of Anesthesiology

YNHH	Marcelynas, James	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Marchesi, Vincent	MD	Pathology	YUSM Department of Pathology
YNHH	Marchetti, Daniel	PA	Orthopedics	Bridgeport Hospital
YNHH	Marchi, Fernanda	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Marcolini, Evadne	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Marcus, Barbara	PhD	Psychiatry	
YNHH	Marcus, Kenneth	MD	Psychiatry	Solo Practice
YNHH	Marek, Kenneth	MD	Neurology	Institute for Neurodegenerative Disorder
YNHH	Marer, M.	MD	Internal Medicine	Solo Practice
YNHH	Margolies, Michael	DMD	Dentistry	Soundental Associates, P.C.
YNHH	Marieb, Mark	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Marin, Ethan	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Marino, John	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Marion, Chad	DO	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Markle, Cathy	PhD	Psychiatry	Cathy Markle, Ph.D.
YNHH	Markowski-Marino, Andrea	PA	Obstetrics & Gynecology	Project MotherCare
YNHH	Marks, Asher	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Marks, Peter	MD	Ophthalmology	Eye Center of Southern Connecticut, P.C.
YNHH	Markstein, Ellen	MD	Dermatology	Integrated Dermatology of Clinton
YNHH	Marlatt, Susan	MD	Radiology & Biomedical Ima	Diagnostic Imaging of Milford
YNHH	Marlett, Karen	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Marottoli, Richard	MD	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Marquis-Eydman, Traci	MD	Internal Medicine	North Haven Walk-in Clinic
YNHH	Marranca, Sheyla	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Marrinan, Greg	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Marriott, Patricia	PA	Orthopedics	YUSM Department of Orthopedics
YNHH	Marsh, James	MD	Orthopedics	Family Orthopedics, LLC
YNHH	Marshall, James	DMD	Dentistry	Family and Preventive Dentistry
YNHH	Marshall, Peter	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Marshall, Sonya	DPM	Podiatry	Shoreline Foot and Ankle Center, P.C.
YNHH	Martell, Bridget	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Martens, Kelly	PA	Internal Medicine	North Haven Walk-in Clinic
YNHH	Martin, Andres	MD	Child Psychiatry	Yale Child Study Center
YNHH	Martin, David	MD	Orthopedics	The Orthopedic & Sports Medicine Center
YNHH	Martin, Joseph	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology

YNHH	Martin, Thomas	MD	Urology	YNH Urology Center
YNHH	Martin, Victor	MD	Internal Medicine	Victor Martin, M.D., LLC
YNHH	Martinello, Richard	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Martinello, Shannon	MD	Pediatrics	Child-Adolescent Healthcare
YNHH	Martinez, Irenio	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Martino, Steve	PhD	Psychiatry	Yale Psychosocial SA Research Center
YNHH	Martone, James	MD	Ophthalmology	Eye Center of Southern Connecticut, P.C.
YNHH	Masi, Paul	MD	Ophthalmology	Eye Center of Southern Connecticut, P.C.
YNHH	Masia, Shawn	MD	Neurology	American Neuromonitoring Associates, PC
YNHH	Masiukiewicz, Urszula	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Mason, Patricia	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Masoud, Amir	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Massaro, Stephanie	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Massey, Sarah	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Mastroianni, Vivian	PA	Psychiatry	YNHH Psychiatric Hospital
YNHH	Mata-Fink, Ana	MD	Orthopedics	Orthopaedic Surgery & Sports Medicine
YNHH	Matczuk, Agnieszka	MD	Pediatrics	Fairfield Cty Allergy, Asthma & Immunology
YNHH	Matei, Veronica	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Materin, Miguel	MD	Ophthalmology	Y-NHH Smilow Cancer Hospital Multispecialty Care Center
YNHH	Mathew-Rohaly, Shybi	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Mathur, Mahan	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Matloff, Jeremy	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Matos Santana, Teofilo	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Matouk, Charles	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Matthay, Richard	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Mattson, Richard	MD	Neurology	YUSM Department of Neurology
YNHH	Matuskey, David	MD	Psychiatry	Yale PET Center
YNHH	Maung, Adrian	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Mauriello, Magdalen	MD	Internal Medicine	Milford Hospital
YNHH	Maxon, Shannon	PA	Surgery	Orchard Surgical Specialists
YNHH	May, Jeanine	APRN	Internal Medicine	Yale Center for Clinical Investigation
YNHH	Mayerson, Adam	MD	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Mayes, Linda	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Mayor, Rowland	MD	Orthopedics	Center for Orthopaedics

YNHH	Mazure, Carolyn	PhD	Psychiatry	
YNHH	Mazzone, Lindsey	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McBride-McGuigan, Pamela	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McCabe, Amanda	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McCallum, John	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	McCann, Thomas	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	McCarthy, Erin	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	McCarthy, John	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McCarthy, Madeline	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	McCarthy, Paul	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	McCarthy, Shari	SA	Ophthalmology	New England Retina Associates
YNHH	McCauley, Thomas	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	McCleary, Rita	PsyD	Psychiatry	
YNHH	McClintock, Kyle	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McCloskey, Gerard	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McCormack, Kyle	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	McCullough, David	MD	Ophthalmology	PriMed
YNHH	McDonough, Maryann	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McEwan, Natasha	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	McGibbon, Bruce	MD	Therapeutic Radiology	Bridgeport Hospital
YNHH	McGinness, Kristen	DPM	Podiatry	
YNHH	McGowan, Tonia	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McGrath, James	MD	Pediatrics	YUSM Section of Genetics
YNHH	McGuigan, Courtney	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McGuire, Ashlee	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McGuire, Brian	MD	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus
YNHH	McKay, Andrew	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McKay, Bernice	APRN	Psychiatry	YNHH Psychiatric Hospital
YNHH	McKenzie, Katherine	MD	Internal Medicine	YNHH Primary Care Center
YNHH	McKnight, Erin	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McLaughlin, Christopher	MD	Surgery	General Surgery Associates, P.C.
YNHH	McLaughlin, Joseph	MD	Internal Medicine	YUSM Section of Oncology
YNHH	McLean, Brenda	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	McLean, Robert	MD	Internal Medicine	Northeast Medical Group
YNHH	McMahon, Erin	CNM	Obstetrics & Gynecology	Yale-New Haven Hospital, Women's Center

YNHH	McNamara, Daniel	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	McNamara, Joseph	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	McNamara, Robert	MD	Internal Medicine	Cornell Scott - Hill Health Center
YNHH	McNiel, Joan	APRN	Surgery	YUSM Section of Transplantation
YNHH	McNiff, Jennifer	MD	Dermatology	YUSM Department of Dermatology
YNHH	McPartland, James	PhD	Child Psychiatry	Yale University Child Study Center
YNHH	McPhedran, Peter	MD	Internal Medicine	Gaylord Hospital
YNHH	McPherson, Craig	MD	Internal Medicine	Bridgeport Hospital
YNHH	McStay, Charlayne	MD	Pediatrics	Wildwood Pediatrics & Adolescent Medicine
YNHH	McVeety, James	MD	Neurology	NEMG Neurology Associates
YNHH	McVicar, Kathryn	MD	Pediatrics	Yale New Haven Children's Hospital
YNHH	Meadows, Judith	MD	Internal Medicine	VA CT Health Care
YNHH	Mednick, Adam	MD, PhD	Neurology	CT Comprehensive Neurologic Management
YNHH	Medoff, Erin	APRN	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Medow, Kathryn	APRN	Neurology	YUSM Department of Neurology
YNHH	Medvecky, Michael	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Meeks, Philip	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Mehal, Wajahat	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Mehlhaff, Krista	DO	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Mehra, Saral	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Mehrzad, Raman	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Meiman, Andrew	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Meizlish, Jay	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Mejias, Roberto	APRN	Surgery	YUSM Section of Cardiac Surgery
YNHH	Mejnartowicz, Slawomir	MD	Internal Medicine	Yale Health Plan
YNHH	Melchinger, David	MD	Internal Medicine	Street, Melchinger, Breier, Rosenthal
YNHH	Melendez, Mark	MD	Surgery	Cosmetic and Reconstructive Surgery Associates of CT, PC
YNHH	Melnick, Edward	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Mena-Hurtado, Carlos	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Menderes, Gulden	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Mendes, Joseph	PA	Surgery	YUSM Section of Otolaryngology
YNHH	Meng, Lingzhong	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Menon, Sunil	MD	Internal Medicine	Northeast Medical Group
YNHH	Ment, Laura	MD	Pediatrics	YUSM Section of Pediatric Neurology
YNHH	Menzies, Cheryl	MD	Pediatrics	Bridgeport Hospital

YNHH	Mercer, Lauren	MD	Psychiatry	Geriatric & Adult Psychiatric, L.L.C.
YNHH	Mercurio, Angela	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Mercurio, Mark	MD	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Meriam, Bryan	DDS	Surgery	New Haven Implant and Oral Surgery, L.L.C.
YNHH	Merithew, Katie	PA	Pediatrics	Bridgeport Hospital - Dept of Neonatology
YNHH	Merkle, Diane	APRN	Surgery	Northeast Medical Group, Inc.
YNHH	Mervil, Esther	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Meskin, Seth	MD	Ophthalmology	Eye Physicians & Surgeons
YNHH	Messina, Robert	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Messinger, Kaitlynn	PA	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Messner, Joan	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Meszaros, Michael	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Meyer, Ana-Claire	MD	Neurology	YUSM Department of Neurology
YNHH	Meyer, Jaimie	MD, MS	Internal Medicine	YUSM Section of Infectious Disease, AIDS Program
YNHH	Meyer-Lustman, Nancy	PhD	Psychiatry	Solo Practice
YNHH	Mezrich, Jonathan	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Michaelides, Elias	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Michaud, Maria	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Michels-Ashwood, Karin	MD	Internal Medicine	Optimus Healthcare
YNHH	Mieszczanski, Melissa	PA	Orthopedics	Connecticut Orthopaedic Specialists, P.C. (outpatient surgery)
YNHH	Mikhael, Hosni	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Miljkovic, Goran	MD	Internal Medicine	Internal Medicine & Infectious Disease Assoc
YNHH	Millard, Hun	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Miller, Cindy	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Miller, Debra	MD	Dermatology	Debra R. Miller, M.D., LLC
YNHH	Miller, Denis	MD	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Miller, Edward	MD, PhD	Internal Medicine	YUSM Section of Cardiology
YNHH	Miller, Eleanor	APRN	Internal Medicine	YNHH Heart and Vascular Center
YNHH	Miller, Geoffrey	MD	Pediatrics	YUSM Section of Pediatric Neurology
YNHH	Miller, Hannah	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Miller, I.	MD	Pediatrics	YUSM Section of Pediatric Infectious Disease
YNHH	Miller, Marsha	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Miller, Ronald	MD	Internal Medicine	NEMG - YNH Geriatric Services
YNHH	Miller-Rivero, Nancy	MD	Ophthalmology	Connecticut Retina Consultants
YNHH	Millman, Eric	MD	Psychiatry	

YNHH	Milner, Mark	MD	Ophthalmology	Eye Center of Southern Connecticut, P.C.
YNHH	Milstein, Robert	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Milstone, Ellen	MD	Dermatology	
YNHH	Milstone, Leonard	MD	Dermatology	Yale Dermatology Associates
YNHH	Minja, Frank	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Minkin, Mary Jane	MD	Obstetrics & Gynecology	Mary Jane Minkin, M.D., LLC
YNHH	Minotti, Philip	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Miranti, James	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Mirasol, Joynell	APRN	Surgery	YUSM Section of Transplantation
YNHH	Mishra, Vijayendra	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Mistry, Pramod	MD	Internal Medicine	YUSM Organ Transplantation Center
YNHH	Mistry, Shilpa	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Mitchell, Martha	APRN	Obstetrics & Gynecology	Y-NHH Smilow Gynecologic Oncology
YNHH	Mitcheom, Kathleen	CNM	Obstetrics & Gynecology	Fair Haven Community Health Center
YNHH	Mix, Vanessa	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Moadel, Tiffany	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Mocarsky, Stephanie	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Modi, Jignesh	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Moeckel, Gilbert	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Moeller, Jeremy	MD	Neurology	YUSM Department of Neurology
YNHH	Mohamed, Khaled	MD	Psychiatry	YNHH Psychiatric Hospital
YNHH	Mohammad, Amir	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Mohareb, Amir	MD	Internal Medicine	YNHH Adult PCC
YNHH	Mohrer, Peter	MD	Psychiatry	Solo Practice
YNHH	Mohsenin, Vahid	MD	Internal Medicine	YNHH Sleep Medicine Center
YNHH	Mojibian, Hamid	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Moledina, Dennis	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Moles, Rebecca	MD	Pediatrics	YUSM Department of General Pediatrics
YNHH	Moliterno Gunel, Jennifer	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Moller, Beth	APRN	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Molloy, Bonnie	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Monaco, Paul	MD	Internal Medicine	Mount Carmel Medical Associates, LLP
YNHH	Monda, Jill	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Monforte, Ellen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Mongillo, Frank	MD	Internal Medicine	Frank J. Mongillo, M.D.

YNHH	Mongillo, Nicholas	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
YNHH	Monico, Edward	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Monroy, Juan	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Montanari, Andrea	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Montefusco, Mary Ellen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Montesi, Donna	APRN	Internal Medicine	West Haven Medical Group
YNHH	Montgomery, Angela	MD	Pediatrics	YUSM Section of Neonatology
YNHH	Moore, Christopher	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Moore, Daniel	MD	Psychiatry	Spectrum Psychiatric Group, P.C.
YNHH	Moore, Jessie	APRN	Surgery	Yale Bariatric & Minimally Invasive Surgery
YNHH	Moore, Meagan	MD, PhD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Moran, Meena	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Moran, Thomas	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Morelli, Alan	MD	Pediatrics	New England Pediatrics, LLP
YNHH	Morelli, Erin	CNM	Obstetrics & Gynecology	The Center for Women's Health and Midwifery
YNHH	Moreno, Claudia	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Moreno, Jorge	MD	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Morey, Brett	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Morgan, Charles	MD	Psychiatry	Bridgeport Hospital
YNHH	Morgan, James	MD	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Morgan, Peter	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Moriarty, John	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Moriarty, Karen	APRN	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Moriarty-Daley, Alison	APRN	Pediatrics	YNHH Pediatric PCC
YNHH	Moriber, Nancy	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Moritz, Ernest	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Morotti, Raffaella	MD	Pathology	YUSM Department of Pathology
YNHH	Morris, David	DO	Internal Medicine	Bridgeport Hospital
YNHH	Morris, Jensa	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Morris, Thomas	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Morris, Victor	MD	Internal Medicine	Guilford Internal Medicine Group
YNHH	Morrison, Laura	MD	Internal Medicine	YUSM Palliative Care
YNHH	Morrison, Robert	MD	Internal Medicine	Connecticut Heart Group, P.C.
YNHH	Morrow, Jon	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Morrow, Victoria	MD	Psychiatry	

YNHH	Mortel, Marie Rosalette	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Moscarelli, Richard	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Moscovitz, Harry	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Mosher, Gena	APRN	Neurology	YUSM Department of Neurology
YNHH	Moss, Jeremy	MD, PhD	Dermatology	Moss and Maiocco, M.D., L.L.C.
YNHH	Motamedinia, Piruz	MD	Urology	Y-NHH Smilow Cancer Hospital
YNHH	Mougalian, Sarah	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Mowafi, Hani	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Moye, Renee	APRN	Internal Medicine	Y-NHH Smilow Fairfield Care Center
YNHH	Moyer, Kristen	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Moyer, Peter	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Mozny, Krystal	APRN	Pediatrics	Shoreline Pediatric & Adoles. Medicine(ProHealth Physicians)
YNHH	Much, Melissa	MD	Pathology	YUSM Department of Pathology
YNHH	Muddaraju, Manjunath	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Muhammad, Oni	CNM	Obstetrics & Gynecology	Fair Haven Community Health Center
YNHH	Mujtaba, Qaiyum	MD	Internal Medicine	Qaiyum Mujtaba, M.D., P.C.
YNHH	Mukherjee, Sandip	MD	Internal Medicine	Yale Cardiology
YNHH	Muldoon, Lawrence	MD	Urology	NEMG Urology
YNHH	Mulinski, Tina	APRN	Internal Medicine	The Cardiology Group
YNHH	Muller, Douglas	DDS	Dentistry	Children's Dental Associates
YNHH	Mulligan, David	MD	Surgery	YUSM Section of Transplantation
YNHH	Mulvey, Gregory	MD	Internal Medicine	Shoreline Internal Medicine
YNHH	Munday, Brian	PA	Neurology	YUSM Department of Neurology
YNHH	Mundus, Zackery	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Muniraj, Thiruvengadam	MD, PhD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Munteanu, Monica	MD	Internal Medicine	Northeast Medical Group
YNHH	Muro, Gerard	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Murphy, Janet	APRN	Pediatrics	Child Sexual Abuse Clinic/Family Advocacy Center
YNHH	Murphy, Michael	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C.
YNHH	Murphy, Pamela	DO	Internal Medicine	NEMG - Family Practice Associates
YNHH	Murphy, Timothy	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Murray, Mary	MD	Obstetrics & Gynecology	Southern CT Women's Health Care, P.C.
YNHH	Murtagh, Pamela	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Musco, Marc	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Muskin, Elizabeth	MD	Internal Medicine	Yale Health Plan

YNHH	Mustafa-Moinuddin, Shareen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Muvvala, Srinivas	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Myer, Jennifer	MD	Psychiatry	Yale-New Haven Hospital
YNHH	Myers, Clifford	PA	Orthopedics	Bridgeport Hospital
YNHH	Myslajek, Tori	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Myung, Peggy	MD, PhD	Dermatology	YUSM Department of Dermatology
YNHH	Nadelmann, Jeremy	MD	Internal Medicine	The Cardiology Group
YNHH	Nadzam, Geoffrey	MD	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Nagar, Anil	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Naidorf, Ellen	MD	Dermatology	
YNHH	Nair, Nandini	MD	Internal Medicine	YNHH Adult PCC
YNHH	Nallainathan, Sanatkunar	MD	Pediatrics	Neurological Specialists, P.C.
YNHH	Nallu, Loren	MD	Pediatrics	Yale-New Haven Children's Hospital
YNHH	Namek, Karim	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Narayan, Deepak	MD	Surgery	YUSM Section of Plastic Surgery
YNHH	Nardino, Robert	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Nash, Irwin	MD	Pathology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Nat, Harshdeep	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Nat, Rosy	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Nath, Ravinder	PhD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Nath, Sameer	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
YNHH	Nathan, Viswa	MD	Surgery	Viswa Nathan, M.D., LLC
YNHH	Nathanson, Michael	MD	Internal Medicine	YUSM Section of Transplantation
YNHH	Natividad Le, Claudelle	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Natkin, Sheldon	DDS	Dentistry	Soundental Associates, P.C.
YNHH	Natt, Beth	MD	Pediatrics	Northeast Medical Group, Inc.
YNHH	Nauriyal, Varidhi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Navaratnam, Dhasakumar	MD	Neurology	YUSM Department of Neurology
YNHH	Nawaz, Hafsa	MD	Internal Medicine	West Haven Medical Group
YNHH	Nedelcuta, Steluta	MD	Internal Medicine	Milford Hospital
YNHH	Nedell, Linda	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Negi, Masaru	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Nelson, Angella	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Nelson, Bethany	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists

YNHH	Nelson, Jennifer	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Nelson, Kelly	MD	Internal Medicine	Internal Medicine of Clinton, L.L.C.
YNHH	Neparidze, Natalia	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Nessralla, Laurie-Ann	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Newton, Manya	MD, MPH	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Ngaruiya, Christine	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Nguyen, Khanh	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital Derby Care Center
YNHH	Niedelman, Adam	MD	Internal Medicine	Cardiology Associates of Norwich
YNHH	Nields, Jenifer	MD	Psychiatry	
YNHH	Ninivaggi, Frank	MD	Child Psychiatry	Solo Practice
YNHH	Niziolek, Andrea	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Nockleby, Karla	MD	Internal Medicine	Physicians Alliance of CT Hospitalists
YNHH	Noel-Vulpe, Herralan	APRN	Internal Medicine	Alina Alfirii, MD, LLC
YNHH	Nolan, Heidi	PA	Internal Medicine	Grimes Center
YNHH	Nolfo, Emily	MD	Internal Medicine	Solo Practice
YNHH	Nolfo, Robert	MD	Pediatrics	Guilford Pediatrics
YNHH	Nori, Jennifer	PA	Orthopedics	YUSM Department of Orthopedics
YNHH	Noto, Christopher	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Novak, Dana	APRN	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Novella, Steven	MD	Neurology	YUSM Department of Neurology
YNHH	Novick, Gary	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Novick, Gina	CNM	Obstetrics & Gynecology	Women's Center
YNHH	Novicki, David	DPM	Podiatry	Milford Podiatry Associates, P.C.
YNHH	Novicki, Robert	DPM	Podiatry	Milford Podiatry Associates, P.C.
YNHH	Nowak, Kristin	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Nowak, Richard	MD	Neurology	Yale Neurology
YNHH	Nozetz, Erin	MD	Pediatrics	YUSM Section of General Pediatrics
YNHH	Nudel, Debra	PhD	Psychiatry	Debra O. Nudel, Ph.D.
YNHH	Nudel, Ron	MD	Internal Medicine	The Cardiology Group
YNHH	Nunez, Mario	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Nunez-Smith, Marcella	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Nussbaum, Paul	MD	Internal Medicine	Nephrology Associates, PC
YNHH	Nuzzolo, Florabel	CRNA	Anesthesiology	Bridgeport Anesthesia Assoc.
YNHH	Nwanyanwu, Kristen	MD	Ophthalmology	Yale Eye Center
YNHH	Nwokolo-Nwangwu, Chioma	MD	Internal Medicine	Main Street Medical Center

YNHH	Nwosu, Matthew	MD	Obstetrics & Gynecology	Northeast Medical Group, Inc.
YNHH	Nystrom, Karin	APRN	Neurology	YUSM Department of Neurology, Stroke Program
YNHH	O'Brien, Michael	MD	Surgery	Surgical Associates of New Haven
YNHH	O'Brien, Natalie	PA	Surgery	Yale-New Haven Hospital CTICU
YNHH	O'Bryan, Leigh	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ochoa Chaar, Cassius	MD	Surgery	YUSM Section of Vascular Surgery
YNHH	O'Connell, Joseph	MD	Surgery	Plastic Surgery of Southern CT
YNHH	O'Connell, Lucy	CNM	Obstetrics & Gynecology	County OB/GYN
YNHH	O'Connell, Ryan	MD	Internal Medicine	Bridgeport Hospital
YNHH	O'Connor, James	MD	Pediatrics	Pediatric Associates of Cheshire, P.C.
YNHH	O'Connor, Mary	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	O'Connor, Patrick	MD, MPH	Internal Medicine	YUSM Section of General Medicine
YNHH	O'Connor, Peggy	PA	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	O'Connor, Sherri	PA	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	O'Connor, Suzanne	APRN	Pediatrics	Bridgeport Hospital
YNHH	Odell, Christine	MD	Pediatrics	Long Wharf Pediatrics & Adol. Medicine
YNHH	Odell, Ian	MD	Dermatology	YUSM Department of Dermatology
YNHH	Odinak, Thomas	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Odukwe Enu, Chioma	DPM	Podiatry	Associated Podiatrists
YNHH	Oen-Hsiao, Joyce	MD	Internal Medicine	Take Heart Cardiovascular Health Center
YNHH	Oestreicher, Mark	MD	Dermatology	Adult & Pediatric Dermatology Specialists, P.C.
YNHH	Ofori-Mante, Elizabeth	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Ogbejesi, Victoria	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Ogbuagu, Onyema	MD	Internal Medicine	YUSM Section of Infectious Disease Nathan Smith Clinic
YNHH	Ogundipe, Nnenna	MD	Internal Medicine	Milford Hospital
YNHH	Oh, Andrew	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	O'Hara, Kevin	PA	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Ohene-Adjei, Rita	MD	Internal Medicine	YNHH Occupational Health Services
YNHH	O'Hern, Jennifer	APRN	Pediatrics	Mary T. Murphy Elementary School School Based Health Center
YNHH	Okada, Ashley	APRN	Internal Medicine	Northeast Medical Group
YNHH	Oldham, Mark	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Oleskey, Christopher	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Olezeski, Christy	PhD	Pediatrics	YUSM Section of Pediatric Endocrinology

YNHH	Oliva, Isabel	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Oliveira, Carlos	MD	Pediatrics	Trumbull Pediatrics
YNHH	Oliveira, Kristin	MD	Surgery	YUSM Section of Trauma and Critical Care
YNHH	Oliver, Garth	MD	Internal Medicine	Savin Medical Practice, LLC
YNHH	Oliver, Jodi-Ann	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Oliver, Lori Ann	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Oliver, Paul	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Olsavsky, Thomas	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Olson, Alan	PA	Internal Medicine	Bridgeport Hospital
YNHH	Olson, Douglas	MD	Internal Medicine	Fair Haven Community Health Center
YNHH	Olson, Kristine	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Olson, Nancy	MD	Psychiatry	
YNHH	O'Mara, Deneen	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Omay, Sacit	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Omondi, Luz	MD	Pediatrics	Optimus Healthcare
YNHH	O'Neill, Brian	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	O'Neill-Wilhelm, Patrice	APRN	Radiology & Biomedical Ima	Yale University School of Medicine
YNHH	Onofrio, Lucia	PA	Pediatrics	YUSM Section of Neonatology
YNHH	Onofrio, Maria	PA	Orthopedics	YUSM Section of Orthopedics-Rehab
YNHH	Opalak, Michael	MD	Neurosurgery	Neurological Surgery
YNHH	Opin, Gary	DMD	Dentistry	
YNHH	Opin, Perry	DDS	Dentistry	Gary Opin, Perry Opin, Orthodontics
YNHH	Oprea, Adriana	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Oray-Schrom, Pinar	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Orazietti, John	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Ordway, Monica	APRN	Pediatrics	Trumbull Pediatric Specialty Center
YNHH	O'Reilly, Dawn-Marie	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Orell, Jeffrey	MD	Internal Medicine	Medical Oncology & Hematology
YNHH	Oren, Brad	MD	Ophthalmology	The Eye Care Group
YNHH	Orion, Kristine	MD	Surgery	YUSM Section of Vascular Surgery
YNHH	Orozco, Luis	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Orsulak, Rebecca	PA	Surgery	YUSM Department of Surgery
YNHH	Osborn, Rachel	MD	Pediatrics	YUSM Section of General Pediatrics
YNHH	Oshlick, John	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Oshman, Robin	MD	Dermatology	Dermatology & Dermatologic Surgery

YNHH	Osseo-Asare, Aba	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Ostroff, Robert	MD	Psychiatry	Spectrum Psychiatric Group, P.C.
YNHH	Otolorin, Olubunmi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	O'Toole, Monika	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ouellette, Peter	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Ownbey, Richard	MD	Psychiatry	
YNHH	Ozerdem, Ugur	MD	Pathology	YUSM Department of Pathology
YNHH	Ozgediz, Doruk	MD	Surgery	YUSM Section of Pediatric Surgery
YNHH	Pacheco-Irby, Denorah	APRN	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Paci, Elizabeth	MD	Pediatrics	Fair Haven Community Health Center
YNHH	Pacini, Janelle	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Pae, Kathy	MD	Pediatrics	Pediatric Medicine of Wallingford
YNHH	Pahade, Jay	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Paidas, Michael	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Paintsil, Elijah	MD	Pediatrics	YUSM Section of Pediatric Infectious Diseases
YNHH	Pal, Lubna	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Palac, Susan	MD	Neurology	American Neuromonitoring Associates, PC
YNHH	Palazzo, Regina	MD	Pediatrics	Nutmeg Pediatric Pulmonary Services
YNHH	Palladino-Welburn, Francesca	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Palleschi, Sarah	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Palluotto, Eric	MD	Obstetrics & Gynecology	OB/GYN Associates
YNHH	Palmese, Bernadette	AuD	Surgery	Yale Hearing and Balance Center
YNHH	Palmisano, Philip	MD	Ophthalmology	YUSM Department of Ophthalmology
YNHH	Palvinskaya, Tatsiana	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Pan, Deborah	MD	Surgery	Deborah Pan, M.D., L.L.C.
YNHH	Pan, Jeffrey	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Pana, Edmund Ray	MD	Internal Medicine	Milford Hospital
YNHH	Panapada, Marci	APRN	Pediatrics	Pediatrics Plus, P.C.
YNHH	Panisello, Jose	MD	Pediatrics	YUSM Department of Pediatrics
YNHH	Panjwani, Muneera	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital - Waterbury
YNHH	Pannella, Dennis	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Pantalon, Michael	PhD	Psychiatry	YUSM Department of Emergency Medicine
YNHH	Panullo, Wayne	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Panzini, Lisa	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Pappas, Estell	DPM	Podiatry	New Haven Podiatry Associates, L.L.P.

YNHH	Papsun, Alice	MD	Psychiatry	Solo Practice
YNHH	Papu, Kristin	PA	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Paquette, Jeannine	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Paradiso, Amanda	PA	Surgery	Richard J. Restifo, M.D., P.C.
YNHH	Paragas, Lori	DPM	Podiatry	Podiatry Group of New Haven, P.C.
YNHH	Paraiso, Edward	MD	Urology	Urological Associates of Bridgeport, PC
YNHH	Parikh, Chirag	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Parikh, Nisha	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Parikh, Sunil	MD	Internal Medicine	YUSM Section of Infectious Diseases
YNHH	Park, Charles	PA	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Parkash, Vinita	MD	Pathology	Bridgeport Hospital
YNHH	Parke, Susan	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Parker, Michael	MD	Internal Medicine	Internal Medicine of East Haven
YNHH	Parker, Robert	DMD	Dentistry	Hamden Shoreline Oral & Maxillofacial Surgery
YNHH	Parker, Terri	MD	Internal Medicine	YUSM Department of Hematology
YNHH	Parks, Jesse	DPM	Podiatry	Stratford Podiatry Associates
YNHH	Parthasarathi, Tara	PA	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Partheepan, Kumuthini	MD	Internal Medicine	Bridgeport Hospital
YNHH	Parwani, Vivek	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Pashankar, Dinesh	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Pashankar, Farzana	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Passarelli, James	MD	Surgery	General Surgery
YNHH	Passarelli, Marianne	MD	Urology	YNH Urology Center
YNHH	Passik, Cary	MD	Surgery	Danbury Hospital
YNHH	Patchett, Matthew	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Patel, Abhijit	MD, PhD	Therapeutic Radiology	Lawrence & Memorial Hospital
YNHH	Patel, Amar	MD	Neurology	YUSM Department of Neurology
YNHH	Patel, Anisha	DO	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Patel, Mamta	MD	Internal Medicine	Milford Hospital
YNHH	Patel, Neha	DO	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Patel, Rakesh	MD	Anesthesiology	Connecticut Orthopaedic Specialists, P.C
YNHH	Patel, Sanjay	DPM	Podiatry	Family Footcare & Surgery, LLC
YNHH	Pathare, Pradip	MD	Therapeutic Radiology	Norwalk Radiology Consultants, P.C.
YNHH	Pathy, Shefali	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Women's Center
YNHH	Patil, Ranjana	MD	Pediatrics	Fairfield Pediatrics, Inc.

YNHH	Patrician, Kenneth	DMD	Dentistry	
YNHH	Patrizio, Pasquale	MD	Obstetrics & Gynecology	Yale Fertility Center
YNHH	Patterson, Christine	MD	Pediatrics	Pediatric & Medical Associates
YNHH	Patwa, Huned	MD	Neurology	YUSM Department of Neurology
YNHH	Paulin, Michael	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Pavlovic, Lisa	MD	Pediatrics	Child Sexual Abuse Clinic/Family Advocacy Center
YNHH	Pawlak, Maureen	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Paxton, Heather	MD	Psychiatry	Y-NHH Psychiatric Hospital
YNHH	Pazienza, Anthony	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Pazienza, Danielle	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Peace, Kimberly	MD	Pediatrics	Shoreline Pediatric & Adoles. Medicine (ProHealth Physicians)
YNHH	Peaper, David	MD, PhD	Laboratory Medicine	YUSM Department of Laboratory Medicine/Clinical Microbiology
YNHH	Pearl, Adam	MD	Surgery	Connecticut Ear Nose Throat Medical & Surgical Specialists, P.C.
YNHH	Pearlson, Godfrey	MD	Psychiatry	Olin Neuropsychiatry Building
YNHH	Pearson, W.	MD	Internal Medicine	Cardiovascular Specialists of Southbury, LLC
YNHH	Pechter, Nadine	MD	Internal Medicine	Guilford Internal Medicine Group
YNHH	Peckham, Earlene	APRN	Pediatrics	YUSM Department of Pediatrics
YNHH	Pei, Kevin	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Peixoto, Aldo	MD	Internal Medicine	YUSM Section of Vascular Surgery
YNHH	Pelker, Richard	MD, PhD	Orthopedics	YUSM Department of Orthopedics
YNHH	Pellegrino, Stefania	APRN	Pediatrics	Pediatrics Plus, P.C.
YNHH	Pels, Salley	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Peluso, Anthony	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Penarreta, Rafaela	PA	Urology	
YNHH	Pensak, Meredith	MD	Obstetrics & Gynecology	YUSM Department of Obstetrics and Gynecology
YNHH	Pepin, Lauren	APRN	Internal Medicine	Bridgeport Hospital
YNHH	Perazella, Mark	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Perera, Channa	MD	Internal Medicine	Campbell Medical Services, L.L.C.
YNHH	Perez Lozada, Juan Carlos	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Perez, Rogelio	MD	Internal Medicine	Connecticut Medical Group - NEMG
YNHH	Perrone, Joseph	DMD, MD	Dentistry	Milford & Derby Oral & Maxillofacial Surgeons
YNHH	Perrotti, Mark	MD	Internal Medicine	Mark A. Perrotti, M.D., LLC
YNHH	Perry, Julia	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Persico, Justin	MD	Internal Medicine	Smilow Cancer Care -Trumbull
YNHH	Persing, John	MD	Surgery	YUSM Section of Plastic Surgery

YNHH	Peter, Patricia	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Peterec, Steven	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Peterfi, Eszter	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Peters, Robert	MD	Psychiatry	Dr. Robert Peters
YNHH	Petersen, Kitt	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Petersen, Nils	MD	Neurology	YUSM Department of Neurology
YNHH	Petersen-Crair, Pamela	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Petroff, Ognen	MD	Neurology	YUSM Department of Neurology
YNHH	Petrok, Karen	APRN	Internal Medicine	Bridgeport Hospital
YNHH	Petrowsky, Ryan	PA	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Petrucci, Debra	MD	Neurosurgery	Yale-New Haven Hospital Spine Center
YNHH	Petruzziello, Fausto	MD	Internal Medicine	CareMedica
YNHH	Petrylak, Daniel	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Pettker, Christian	MD	Obstetrics & Gynecology	YUSM Section of Maternal Fetal-Medicine
YNHH	Pettway, Latisha	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Pfau, Steven	MD	Internal Medicine	VAMC
YNHH	Pham, Laura	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Phatak, Uma	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Phelan, Kay	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Philipp, Monica	APRN	Obstetrics & Gynecology	YNHH Primary Care Center
YNHH	Phillips, Ashley	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Phillips, James	MD	Psychiatry	
YNHH	Phillips, Nicole	APRN	Psychiatry	YNHH Saint Raphael Campus Department of Psychiatry
YNHH	Phillips, Robin	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Phillips, Sidney	MD	Psychiatry	
YNHH	Philpotts, Liane	MD	Radiology & Biomedical Ima	YUSM Department of Diagnostic Radiology/ Smilow Cancer Hospital
YNHH	Piepmeier, Joseph	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Pierce, Matthew	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Pierce, Richard	MD	Pediatrics	YUSM Section of Pediatric Critical Care
YNHH	Pillai, Manoj	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Pinar, Aydin	MD	Internal Medicine	
YNHH	Pine, Alexander	MD, PhD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Pinter, Emese	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Pinto, John	PA	Internal Medicine	Y-NHH, Saint Raphael Campus-Occupational Health Plus

YNHH	Pinto, Marguerite	MD	Pathology	Bridgeport Hospital
YNHH	Pisani, Margaret	MD	Internal Medicine	Yale Medical Group
YNHH	Pito, John	MD	Internal Medicine	
YNHH	Pitt, David	MD	Neurology	Yale Mutliple Sclerosis Center
YNHH	Pittard, Alicia	MD	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Pittenger, Christopher	MD, PhD	Psychiatry	Connecticut Mental Health Center
YNHH	Platner, Marissa	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Plavec, Martin	MD	Internal Medicine	The Cardiology Group
YNHH	Plisic, Ljiljana	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Plotke, Gary	MD	Psychiatry	
YNHH	Plyler, Michelle	CNM	Obstetrics & Gynecology	County OB/GYN
YNHH	Podell, David	MD, PhD	Internal Medicine	Rheumatology Associates of Greater Waterbury
YNHH	Podoltsev, Nikolai	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Polisetty, Lakshmi	MD	Internal Medicine	Northeast Medical Group
YNHH	Pollack, Ari	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Pollak, Jeffrey	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Pollard Murphy, Karen	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital Breast Center
YNHH	Pomarico, Alana	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Pomarico, Vanessa	APRN	Internal Medicine	NEMG - Internal Medicine Hamden
YNHH	Poncin, Yann	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Pope, Julie	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Popescu, Wanda	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Porto, Anthony	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Posada-Pacheco, Laura	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Possenti, Paul	PA	Surgery	Bridgeport Hospital, Section of Trauma and Critical Care
YNHH	Possick, Jennifer	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Possick, Stanley	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Possick, Stephen	MD	Internal Medicine	Yale Cardiology
YNHH	Potenza, Marc	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Pouliot, Marie	MD	Pediatrics	Pediatric & Adolescent Medicine, P.C.
YNHH	Pounds, Nicole	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Powell, Kelly	PhD	Child Psychiatry	Child Study Center
YNHH	Powell, Mary	APRN	Psychiatry	YNHH Psychiatric Hospital
YNHH	Powell, Tracy	APRN	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Powers, Emily	MD	Pediatrics	Primary Care Center

YNHH	Powsner, Seth	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Prabhu, Maya	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Pransky, Rachel	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Prasad, Manju	MD	Pathology	YUSM Department of Pathology
YNHH	Prasad, Sujata	MD	Internal Medicine	Primary Care and Walk In, LLC
YNHH	Pratt, Christina	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Prebet, Thomas	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Preo, Lindsey	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Presnick, Carole	MD	Obstetrics & Gynecology	Northeast Medical Group, Inc.
YNHH	Presnick, Diane	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Pressman, Martin	DPM	Podiatry	Milford Podiatry Associates, P.C.
YNHH	Price, Christina	MD	Internal Medicine	Yale Interventional Immunology Center
YNHH	Price, Courtney	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Price, Daniel	MD	Internal Medicine	Yale Cardiology
YNHH	Price, Gary	MD	Surgery	Gary J. Price, M.D., P.C.
YNHH	Priest, Brian	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Pringle, Rebecca	MD	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Prior, Edward	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Priyank, Kumar	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Proctor, Deborah	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Protiva, Petr	MD	Internal Medicine	VAMC
YNHH	Pryor, Sarah	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Puchalski, Jonathan	MD	Internal Medicine	YUSM Section of Pulmonary / Critical Care Medicine
YNHH	Pugliese, Amy	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Puglisi, Lisa	MD	Internal Medicine	Yale Internal Medicine Associates
YNHH	Punekar, Salman	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Punjala, Mamatha	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Purdy, Dana	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Pusuoglu, Gulcin	APRN	Surgery	YUSM Section of Transplantation
YNHH	Pusztai, Lajos	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Putnam, Andrew	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Putnam, Elizabeth	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Pylypiv, Taras	PA	Orthopedics	Bridgeport Hospital
YNHH	Qasba, Neena	MD	Obstetrics & Gynecology	YUSM Department of Obstetrics and Gynecology
YNHH	Qayyum, Zheala	MD	Psychiatry	YNHH Psychiatric Hospital

YNHH	Quadir, Muziana	MD	Internal Medicine	Shaheen Medical Center, LLC
YNHH	Quagliarello, Vincent	MD	Internal Medicine	YUSM Section of Infectious Disease
YNHH	Quaranta, Joseph	MD	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Quentzel, Howard	MD	Internal Medicine	Griffin Hospital
YNHH	Quinlan, Donald	PhD	Psychiatry	Ambulatory Psychiatric Services, YNHH
YNHH	Quintanilla, Meghan	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Quintanilla, Victor	PA	Urology	Orchard Surgical Specialists
YNHH	Quraishi, Imran	MD	Neurology	YUSM Department of Neurology
YNHH	Rabin, Tracy	MD	Internal Medicine	YUSM Section of General Medicine
YNHH	Rachler, Rachel	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Radebold, Andrea	MD	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Radoff, Alan	MD	Internal Medicine	The Cardiology Group
YNHH	Radulovic, Miroslav	MD	Internal Medicine	Milford Hospital
YNHH	Rafferty, Terence	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ragaza, Eric	MD	Radiology & Biomedical Ima	Diagnostic Imaging of Milford
YNHH	Raghu, Madhavi	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Rai, Manisha	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Rall, Kerri	PA	Internal Medicine	YUSM Section of Oncology
YNHH	Ramachandran, Sarika	MD	Dermatology	YUSM Department of Dermatology
YNHH	Rambus, Carolyn	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Ramirez, Rachel	MD	Psychiatry	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Ramos, Rey	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Rampal, Nishi	MD	Neurology	YUSM Department of Neurology
YNHH	Ramsey, Cassandra	APRN	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Rana, Harinder	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Ranani, Dana	MD	Internal Medicine	Prohealth Physicians of Hamden
YNHH	Rancourt, Jamille	PA	Pediatrics	Yale-New Haven Children's Hospital at Bridgeport Hospital
YNHH	Randolph, Christopher	MD	Pediatrics	Center for Allergy/Asthma and Immunology
YNHH	Rank, Thomas	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Rankin, Katricia	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ranz, Carey	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Rao, Anitha	MD	Pathology	YUSM Department of Pathology
YNHH	Rao, Balaji	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Rao, Shilpa	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rastegar, Asghar	MD	Internal Medicine	YUSM Department of Internal Medicine

YNHH	Rastetter, Rebecca	MD	Pediatrics	Whitney Pediatrics & Adolescent Medicine/NEMG
YNHH	Rastogi, Priya	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Rath, Kristina	MD	Obstetrics & Gynecology	Connecticut Medical Group - NEMG
YNHH	Rathbone, Richard	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Rathi, Sanjay	MD	Neurology	Neurology, Movement Disorders & Dystonia
YNHH	Ratner, Elena	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Rauktys, Aubrey	MD	Obstetrics & Gynecology	Ob/Gyn Physicians, P.C.
YNHH	Ravi, Sreedhar	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Ravski, Norman	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Ray, Kerry	APRN	Pediatrics	Bridgeport Hospital - Dept of Neonatology
YNHH	Rayaz, Hassan	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Razo-Vazquez, Andres Oswaldo	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Reach, John	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Reddy, Vikram	MD	Surgery	YUSM Department of Surgical Gastroenterology
YNHH	Redlich, Carrie	MD	Internal Medicine	YUSM Section of Occupational Medicine
YNHH	Reed, Anamika	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Reel, Michael	MD	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Reeser, Pamela	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Regan, Christopher	MD	Internal Medicine	Cardiology Associates of Norwich
YNHH	Rego, Mark	MD	Psychiatry	Mark D. Rego, M.D.
YNHH	Reguero Hernandez, Jorge	MD	Surgery	YUSM Section of Gastroenterology
YNHH	Reid, Vanessa	APRN	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Reilley, Karen	APRN	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Reilly, Drew	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Reilly, John	MD	Surgery	Orchard Medical Center
YNHH	Reiner, Eric	DO	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Reinwald, Sarah	APRN	Internal Medicine	YUSM Section of Medical Oncology
YNHH	Reiser, Lynn	MD	Psychiatry	
YNHH	Remakus, Christopher	MD	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Remetz, Michael	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Remley, Elaine	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Renaldi, Jacinta	APRN	Internal Medicine	YUSM Section of Rheumatology
YNHH	Renna, Sara	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Resch, Elise	CNM	Obstetrics & Gynecology	Women's Health Associates, LLC
YNHH	Restifo, Richard	MD	Surgery	Richard J. Restifo, M.D., P.C.

YNHH	Rethy, Charles	MD	Internal Medicine	Connecticut Medical Group - NEMG
YNHH	Revkin, James	MD	Internal Medicine	Yale Cardiology Center for Advanced Heart Failure
YNHH	Revzin, Margarita	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Reyes, Joy	MD	Psychiatry	Bridgeport Hospital
YNHH	Reynolds, Heather	CNM	Obstetrics & Gynecology	Women's Center
YNHH	Reynolds, Jeffrey	MD	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Reznik, Alan	MD	Orthopedics	The Orthopaedic Group, LLC
YNHH	Rhee, Maria	MD	Obstetrics & Gynecology	Northeast Medical Group
YNHH	Rhee, Richard	MD	Internal Medicine	Branford Internal Medicine, L.L.C.
YNHH	Ribb, Kersti	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Ricci-Collins, Nancy	PA	Surgery	YUSM Department of Surgery
YNHH	Riccio, David	MD	Internal Medicine	Connecticut Medical Group - NEMG
YNHH	Riccio, Gioia	MD	Radiology & Biomedical Ima	Bridgeport Hospital Outpatient Radiology
YNHH	Rice, Andrew	DPM	Podiatry	Fairfield County Foot Surgeons, P.C.
YNHH	Rice, Erin	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Richards, Bradley	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Richards, Dara	MD	Pediatrics	Southwest Community Health Center
YNHH	Richer, Ross	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Richer, Sara	MD	Surgery	NEMG - Head and Neck Surgery
YNHH	Richman, Susan	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Richmond, Cherrilyn	APRN	Obstetrics & Gynecology	Yale Urogynecology
YNHH	Richter, Barry	MD	Dermatology	Solo Practice
YNHH	Rickey, Leslie	MD	Urology	Yale Urogynecology
YNHH	Riegler, Nitai	MD	Internal Medicine	Nitai I. Riegler, M.D., L.L.C.
YNHH	Riera, Antonio	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Rigsby, Michael	MD	Internal Medicine	Yale Health Plan
YNHH	Rimm, David	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Rimm, Janet	APRN	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Rinder, Henry	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Ringstad, Bjorn	MD	Internal Medicine	Village Medical Associates
YNHH	Rinne, Seppo	MD, PhD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Riordan, Charles	MD	Psychiatry	BH Care, Inc.
YNHH	Rippel, Edward	MD	Internal Medicine	Quinnipiac Internal Medicine, P.C.
YNHH	Riso, Adam	PA	Neurosurgery	Yale-New Haven Hospital Spine Center

YNHH	Ritsema, Crystal	MD	Internal Medicine	YUSM Department of Internal Medicine
YNHH	Rivelli, Michelle	MD	Pediatrics	Pediatric Care Assoc. of CT, P.C.
YNHH	Rivera, John	MD	Internal Medicine	Southington Family Medical Center
YNHH	Rivera, Lisa	APRN	Internal Medicine	YUSM Section of Hematology
YNHH	Robakis, Daphne	MD	Neurology	YUSM Department of Neurology
YNHH	Robbins, Michael	DO	Anesthesiology	Advanced Diagnostic Pain Treatment Center
YNHH	Robert, Marie	MD	Pathology	YUSM Department of Pathology
YNHH	Roberts, John	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Roberts, Kenneth	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology - Smilow Cancer Hospital
YNHH	Roberts, Kurt	MD	Surgery	YUSM Section of Surgical Gastroenterology
YNHH	Robertson, Dilice	APRN	Psychiatry	YUSM Department of Psychiatry
YNHH	Robins, Holly	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Robinson, Deanne	MD	Dermatology	The Connecticut Dermatology Group, P.C.
YNHH	Robinson, Erica	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Women's Center
YNHH	Rochester, Carolyn	MD	Internal Medicine	VA Medical Center
YNHH	Rock, Ira	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rockefeller, Jeannine	APRN	Neurosurgery	YNHH Pediatric Dentistry Center
YNHH	Rocklin, Donald	MD	Internal Medicine	Yale Cardiology
YNHH	Rode, Kurt	DPM	Podiatry	West Hartford Podiatry Association
YNHH	Rodenas, Mario	MD	Internal Medicine	YUSM Section of Allergy and Immunology
YNHH	Rodonski, Anna	PA	Internal Medicine	Yale-New Haven Transplant Center
YNHH	Rodrigues, Allan	MD	Internal Medicine	Chapel Pulmonary and Critical Care, LLC
YNHH	Rodriguez, Alexis	MD	Pediatrics	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Rodriguez, Jose Alberto	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rodriguez, Misael	PA	Pediatrics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Rodriguez-Davalos, Manuel	MD	Surgery	YUSM Section of Transplantation
YNHH	Rodriguez-Murphy, Amanda	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Rogol, Peter	MD	Internal Medicine	Peter R. Rogol, M.D., L.L.C.
YNHH	Rohrbaugh, Robert	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Rohrig, Carolyn	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Rojkovskiy, Igor	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Rollinson, Nancy	APRN	Pediatrics	Pediatric Specialty Center
YNHH	Roman, Jaclyn	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Roman, Megan	PA	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology

YNHH	Romano, Elaine	APRN	Pediatrics	NICU Grad Program
YNHH	Romegialli, Alison	MD	Internal Medicine	YNHH Adult PCC
YNHH	Romero, Robby	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Roney, John	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Rosasco, Sarah	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Rose, Aron	MD	Ophthalmology	The Eye Care Group
YNHH	Rose, Margaret	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rose, Robin	PA	Surgery	YNHH Department of Surgery
YNHH	Rosen, Danya	MD	Pediatrics	Yale Pediatric Specialty Center
YNHH	Rosen, Marc	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Rosenbaum, Julie	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Rosenbaum, Stanley	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rosenberg, Ilene	MD	Internal Medicine	Internal Medicine of Milford
YNHH	Rosenblatt, William	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rosenblum, David	MD	Orthopedics	Gaylord Hospital
YNHH	Rosenfeld, Lynda	MD	Internal Medicine	YMG at the Shoreline-Cardiology
YNHH	Rosenthal, Marjorie	MD	Pediatrics	YNHH Pediatric PCC
YNHH	Rosenthal, Mark	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Rosenthal, Michael	MD	Internal Medicine	Street, Melchinger, Breier, Rosenthal
YNHH	Rosewater, Irina	MD	Internal Medicine	Endocrine Associates of Connecticut
YNHH	Rosner, William	MD	Internal Medicine	Family Physicians of West Haven, L.L.C./NEMG
YNHH	Rosoff, James	MD	Urology	YUSM Department of Urology
YNHH	Rosovsky, Mark	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Ross, Ann	MD	Obstetrics & Gynecology	UHSC OB/GYN
YNHH	Ross, Joseph	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Rostkowski, Amanda	MD, PhD	Obstetrics & Gynecology	Fine & Gillette
YNHH	Roth, David	MD	Obstetrics & Gynecology	UHSC OB/GYN
YNHH	Roux, Francoise	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Rowan, Cherise	MD	Pediatrics	Fair Haven Community Health Center
YNHH	Rowland, Christine	PA	Psychiatry	Northeast Medical Group, Inc.
YNHH	Roy, Brita	MD, MPH	Internal Medicine	YNHH Adult PCC
YNHH	Ruben, Harvey	MD	Psychiatry	Harvey L. Ruben, M.D., P.C.
YNHH	Rubenstein, Marc	MD	Psychiatry	
YNHH	Rubin, Ellen	APRN	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Rubin, Philip	MD	Anesthesiology	YUSM Department of Anesthesiology

YNHH	Rubin, Richard	MD	Psychiatry	Clinical Associates of CT
YNHH	Rubinowitz, Ami	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Rubinstein, Michael	MD	Internal Medicine	Internal Medicine of Clinton, L.L.C.
YNHH	Ruby, Jennifer	APRN	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Rudich, Danielle	MD	Ophthalmology	The Eye Care Group
YNHH	Rudich, Lynn	MD	Pediatrics	Maxim Offsite Pediaric Clinic/Community Partners in Action
YNHH	Rudolph, Michael	MD	Internal Medicine	Milford Hospital
YNHH	Rufin, Claire	MD	Orthopedics	Yale-New Haven Hospital St. Raphael Campus
YNHH	Ruggiero, Filomena	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Rusadze, Eka	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Ruskis, Alan	MD	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Russi, Mark	MD	Internal Medicine	YNHH Occupational Health Services
YNHH	Ruszkowski, Alice	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Ruwe, Patrick	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Ryan, Edward	PhD	Psychiatry	
YNHH	Ryan, Erin	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ryan, Kyle	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Ryan, Sheryl	MD	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Ryan-Krause, Patricia	APRN	Pediatrics	YNHH Pediatric PCC
YNHH	Sabbath, Kert	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital - Waterbury
YNHH	Saberski, Lloyd	MD	Internal Medicine	Advanced Diagnostic Pain Treatment Center
YNHH	Sabourin, Christiane	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sacco, Jillian	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Sachar, Hamita	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Sadinsky, Howard	DO	Pediatrics	Milford Pediatric Group
YNHH	Sadock, Robert	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Safavi, Yauss	MD	Psychiatry	YNHH Saint Raphael Campus Department of Psychiatry
YNHH	Safdar, Basmah	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Safian, Michael	DDS	Dentistry	
YNHH	Saga-Abrina, Rowena	APRN	Radiology & Biomedical Ima	YUSM Section of Cardiac Surgery
YNHH	Sagnella, Chad	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Sagnella, Lisa	APRN	Surgery	YUSM Section of Pediatric Surgery
YNHH	Sahay, Neayka	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Said, Anace	MD	Internal Medicine	Masonicare Health Center
YNHH	Sakalkale, Durgadas	MD	Orthopedics	Center for Orthopaedics

YNHH	Sakharova, Olga	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Salame, Camille	MD	Neurosurgery	Camille G. Salame, M.D., LLC
YNHH	Salamida, Christine	APRN	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Salardini, Arash	MD	Neurology	YUSM Department of Neurology
YNHH	Salem, Ronald	MD	Surgery	YUSM Section of Surgical Oncology
YNHH	Salerno, Amy	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Salomon, Jeffrey	MD	Surgery	Jeffrey C. Salomon, M.D., P.C.
YNHH	Salvana, Jose	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Salzano, Richard	MD	Surgery	
YNHH	Samma, Muneeb	MD	Internal Medicine	Medical Walk In Care of Westville, LLC
YNHH	Samoskevich, Joanna	APRN	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Samson, Leah	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Samuel, John	MD	Pediatrics	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Samuels, Elizabeth	MD, MPH	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Sanacora, Gerard	MD, PhD	Psychiatry	Connecticut Mental Health Center
YNHH	Sanchez, Donna	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Sanchez, Mayra	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Sander, Lisa	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Sanders, Graig	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Sanders, Lisa	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Sanford, Stephanie	APRN	Internal Medicine	YUSM Section of Hematology
YNHH	Sanft, Tara	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Sankey, Christopher	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sansing, Lauren	MD	Neurology	YUSM Department of Neurology
YNHH	Santacana-Laffitte, Guido	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Santiago, Jesus	PA	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Santin, Alessandro	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Santucci, Karen	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Sanyal, Margaret	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Saperstein, Lawrence	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Sapire, Joshua	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Sarac, Timur	MD	Surgery	YUSM Section of Vascular Surgery
YNHH	Saracco, Joseph	DPM	Podiatry	Connecticut Podiatry Group, P.C.
YNHH	Sarfeh, James	MD	Internal Medicine	

YNHH	Sarracino, Joanna	MD	Ophthalmology	Ophthalmic Surgeons of Greater Bridgeport, P.C.
YNHH	Sasaki, Clarence	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Sather, John	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Sather, Polly	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital Multispecialty Care Center
YNHH	Saul, Zane	MD	Pediatrics	Internal Medicine & Infectious Disease Assoc
YNHH	Sauler, Maor	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Saunders, Joy	APRN	Internal Medicine	Yale Cardiology
YNHH	Saunders, Steven	MD	Internal Medicine	Solo Practice
YNHH	Savage, Mary	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Savetamal, Alisa	MD	Surgery	Northeast Medical Group, Inc.
YNHH	Savin, Ronald	MD	Dermatology	The Savin Center, PC
YNHH	Saxena, Aneeta	MD	Neurology	YUSM Department of Neurology
YNHH	Scala, JoDonna	MD	Internal Medicine	North Haven Walk-in Clinic
YNHH	Scalley, Meaghen	APRN	Obstetrics & Gynecology	YUSM Section of Maternal Fetal-Medicine
YNHH	Scanlan, Mark	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Scartozzi, Richard	MD	Ophthalmology	Danbury Eye Physicians & Surgeons
YNHH	Scates, Zena	MD	Pediatrics	Pediatrics Plus, P.C.
YNHH	Sceppa, Debra	PA	Internal Medicine	
YNHH	Sceppa, John	PA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schaschl, Jodi	PA	Surgery	Bridgeport Hospital
YNHH	Scheimann, Mary	MD	Internal Medicine	Shoreline Internal Medicine
YNHH	Schilsky, Michael	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Schindler, Joseph	MD	Neurology	YUSM Department of Neurology
YNHH	Schiopescu, Irina	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Schlachter, Todd	MD	Radiology & Biomedical Ima	YUSM Department of Radiology and Biomedical Imaging - Outpatient Radiology Services
YNHH	Schlein, Allen	MD	Orthopedics	Orthopaedic Surgery Associates, P.C.
YNHH	Schlissel, Elise	MD	Pediatrics	YNHH Pediatric PCC
YNHH	Schmaling, Brittany	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Schmidt, John	MD	Surgery	Solo Practice
YNHH	Schmidt, Julie	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schneeberg, Lynelle	PsyD	Internal Medicine	Middlesex Hospital Primary Care - Madison
YNHH	Schneider, Jonathan	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schneider, Nicole	PA	Internal Medicine	NEMG - Y-NHH Hospitalists

YNHH	Schoen, Robert	MD	Internal Medicine	New Haven Rheumatology, P.C.
YNHH	Schoenfeld, Mark	MD	Internal Medicine	Arrhythmia Center of Connecticut
YNHH	Schonberger, Robert	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schoppmann, Ann Marie	PA	Surgery	Bridgeport Hospital
YNHH	Schottenfeld, Richard	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Schpero, Mark	DDS	Dentistry	
YNHH	Schrader, Alicia	DO	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Schreiber, William	MD	Internal Medicine	Northeast Medical Group
YNHH	Schreibman, Rochelle	MD	Psychiatry	Rochelle R. Schreibman, M.D.
YNHH	Schroter, Deborah	MD	Psychiatry	Deborah L. Schroter, M.D.
YNHH	Schulam, Peter	MD, PhD	Urology	YUSM Department of Urology
YNHH	Schulten, Christopher	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schulten, Richard	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schultz, Michael	PA	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Schumack, Priscilla	APRN	Orthopedics	YUSM Department of Orthopedics
YNHH	Schumitz, Diana	PA	Internal Medicine	YUSM Section of Cardiology
YNHH	Schussheim, Adam	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Schuster, Kevin	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Schwab, Carlton	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Schwartz, Dana	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Schwartz, Elizabeth	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Schwartz, Ian	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Schwartz, Jeffrey	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Schwartz, Jeremy	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Schwartz, Peter	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Schwartz, Ronald	MD	Internal Medicine	Masonicare Primary Care Physicians
YNHH	Scialla, Anthony	MD	Surgery	
YNHH	Scott, Angela	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Scott, James	MD	Psychiatry	
YNHH	Scoutt, Leslie	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Scoville, Ann	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Searles, Jennifer	APRN	Pediatrics	Children's Medical Group, LLC
YNHH	Sedore, Stanley	MD, PhD	Pediatrics	YUSM Section of Pediatric Cardiology
YNHH	Seely, James	MD	Internal Medicine	Fair Haven Community Health Center

YNHH	Seewald, Randy	MD	Internal Medicine	Regional Hospice and Home Care of Western Ct, Inc
YNHH	Segui, Lydia	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Seils, Elizabeth	PA	Pediatrics	YUSM Section of Neonatology
YNHH	Sekhar, Rajat	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Seli, Emre	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Seli, Meltem	MD	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Seligson, Raymond	MD	Pediatrics	Pediatric Associates of Branford
YNHH	Sella, Enzo	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Seltzer, Arthur	MD	Internal Medicine	Yale Cardiology
YNHH	Seltzer, Jeffrey	MD	Internal Medicine	Cardiology Associates of Norwich
YNHH	Selvam, Anand	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Selwyn, Peter	MD	Internal Medicine	Montefiore Medical Center/Albert Einstein College of Medicine
YNHH	Semeraro, Lucille	MD	Pediatrics	Long Wharf Pediatrics & Adol. Medicine
YNHH	Senatus, Patrick	MD	Neurosurgery	Eastern Orthopedic & Sports Medicine
YNHH	Senior, Audrey	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Serlin, Michelle	MD	Pediatrics	Yale Health Plan
YNHH	Sernyak, Michael	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Seropian, Stuart	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Setaro, John	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Seye, Astou	MD	Internal Medicine	Bridgeport Hospital
YNHH	Sfakianaki, Anna	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Shader, Laurel	MD	Pediatrics	Fair Haven Community Health Center
YNHH	Shafranov, George	MD	Ophthalmology	
YNHH	Shah, Brian	DDS,MD	Dentistry	YNHH Department of Dentistry
YNHH	Shah, Nidhi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Shah, Niketa	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Shah, Subhash	MD	Surgery	General Surgeons Greater Bridgeport
YNHH	Shah, Vinnie	MD	Ophthalmology	Ophthalmic Surgeons of Greater Bridgeport, P.C.
YNHH	Shahab, Zartashia	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Shakir, Omar	MD, MBA	Ophthalmology	Yale Eye Center
YNHH	Shapiro, Eugene	MD	Pediatrics	YUSM Section of General Pediatrics
YNHH	Shapiro, Marc	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Shapiro, Martin	MD	Ophthalmology	Eye Physicians & Surgeons
YNHH	Shapiro, Philip	MD	Dermatology	
YNHH	Sharifi, Mahnoosh	MD, MPH	Pediatrics	YNHH Pediatric PCC

YNHH	Sharkey, Melinda	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Sharma, Prabin	MD	Internal Medicine	Bridgeport Hospital
YNHH	Sharma, Shivi	MD	Internal Medicine	Physicians Alliance of CT Hospitalists
YNHH	Sharp, Emily	PhD	Neurology	YUSM Department of Neurology
YNHH	Sharp, Gloria	PA	Surgery	YUSM Section of Cardiology
YNHH	Sharpe, Timothy	MD	Obstetrics & Gynecology	Milford Ob-Gyn Physicians
YNHH	Shaw, Albert	MD	Internal Medicine	YUSM Section of Infectious Disease
YNHH	Shaw, Matthew	PhD	Psychiatry	
YNHH	Shaw, Melissa	PA	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Shaw, Richard	MD	Surgery	Yale-New Haven Cardiac Rehabilitation Center
YNHH	Shaywitz, Bennett	MD	Pediatrics	YUSM Section of Pediatric Neurology
YNHH	Shaywitz, Sally	MD	Pediatrics	Yale Center for Dyslexia & Creativity
YNHH	Shear, Perry	MD	Neurosurgery	Orthopaedic Specialty Group
YNHH	Sheehan, Juliann	MD	Pediatrics	YUSM Section of Neonatology
YNHH	Sheehan, Michael	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Sheehan, Raymond	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Sheikh, Kiran	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Sheiman, Laura	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Sheiman, Rachel	MD	Pediatrics	Willow Pediatric Group
YNHH	Shelby, Bryan	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Shelley, Kirk	MD, PhD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Shen, Meifeng	PA	Internal Medicine	YUSM Section of Oncology
YNHH	Shenoi, Sheela	MD	Internal Medicine	YUSM Section of Infectious Disease Nathan Smith Clinic
YNHH	Shenouda, Raymone	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Shepherd, James	MD, PhD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus - Haelen Center
YNHH	Shepherd-Hall, Janiline	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sheridan-Nath, Alison	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Sherline, Nadia	MD	Dermatology	Dermatology in Hamden, L.L.C.
YNHH	Sherman, Jodi	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Sherr, Jennifer	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Sherwin, Robert	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Sheth, Kevin	MD	Neurology	YUSM Department of Neurology
YNHH	Sheth, Sangini	MD	Obstetrics & Gynecology	YNHH Primary Care Center
YNHH	Shi, Julia	MD	Internal Medicine	Central Medical Unit

YNHH	Shia, Derek	MD	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	Shiffman, Richard	MD	Pediatrics	YNHH Pediatric PCC
YNHH	Shih, Julie	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Shih, Vivian	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Shimkin, Peter	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Shimono, Chantelle	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Shipkowitz, Sandra	APRN	Pediatrics	Bridgeport Hospital
YNHH	Shirali, Anushree	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Shirani, Shirin	MD	Internal Medicine	Metabolism Associates
YNHH	Shirazi, Nasser	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sholomskas, Alan	MD	Psychiatry	Optima Mental Health
YNHH	Shore, Rayme	MD	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Shuch, Brian	MD	Urology	YUSM Department of Urology
YNHH	Shulman, Gerald	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Sicklick, Alyse	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Sico, Jeanine	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sidana, Jasdeep	MD	Internal Medicine	Lung Docs of CT/Sleep Management Center
YNHH	Siddiqi, Aisha	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Siddon, Alexa	MD	Laboratory Medicine	YUSM Department of Pathology
YNHH	Siegal, Alan	MD	Psychiatry	Geriatric & Adult Psychiatry, L.L.C.
YNHH	Siegel, Mark	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Siegfried, Jonathan	MD	Internal Medicine	Connecticut Heart Group, P.C.
YNHH	Sienko, Amy	APRN	Pediatrics	Y-NHH, St. Raphael Campus
YNHH	Sierra, Cesar	MD	Ophthalmology	
YNHH	Siew, Lawrence	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Sikes, Kristin	APRN	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Silasi, Dan-Arin	MD	Obstetrics & Gynecology	YUSM Section of Gynecologic Oncology
YNHH	Silasi, Michelle	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Silber, Andrea	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Silbert, Jonathan	MD	Ophthalmology	The Eye Care Group
YNHH	Silin, Douglas	MD	Radiology & Biomedical Ima	Yale Medical Group
YNHH	Silva, Cicero	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Silverman, David	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Silverman, Nira	MD	Dermatology	Dermatology Physicians of CT

YNHH	Silverstein, Sheryl	PhD	Psychiatry	
YNHH	Silverstein, Steven	DPM	Podiatry	Podiatry Group of New Haven, P.C.
YNHH	Silverstone, David	MD	Ophthalmology	The Eye Care Group
YNHH	Silverstone, Philip	MD	Ophthalmology	Eye Physicians & Surgeons
YNHH	Silvestri, Mark	MD	Obstetrics & Gynecology	Cornell Scott - Hill Health Center
YNHH	Simmons, Evans	PA	Surgery	Y-NHH, Department of Surgery
YNHH	Simo, Sheran	APRN	Internal Medicine	Bridgeport Palliative Care
YNHH	Simon, David	MD	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Sinard, John	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Siner, Jonathan	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Singh, Dinesh	MD	Urology	YUSM Section of Urology
YNHH	Singh, Manpreet	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Singh, Vasundhara	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sinusas, Albert	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Sivaraju, Adithya	MD	Neurology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Sivkin, Miriam	MD	Obstetrics & Gynecology	Southern CT Women's Health Care, P.C.
YNHH	Skiba, Barbara	PA	Internal Medicine	Yale New Haven Hospital
YNHH	Sklar, Craig	MD	Ophthalmology	The Eye Care Group
YNHH	Sklar, Jeffrey	MD	Pathology	YUSM Department of Pathology
YNHH	Skope, Leonard	DDS	Dentistry	Oral & Max Surgery Assoc. of Greater NH
YNHH	Slane, Assunta	APRN	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Slattery, Stephanie	MD	Pediatrics	Pediatrics Plus, P.C.
YNHH	Sledge, William	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Small, Jeffrey	MD	Urology	
YNHH	Small, Martha	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Small, Peter	MD	Ophthalmology	Peter A. Small. M.D.
YNHH	Small, Valerie	MD	Internal Medicine	Middlesex Hospital Primary Care - Westbrook
YNHH	Smillie, Christina	MD	Pediatrics	Breastfeeding Resources
YNHH	Smith, Amy	APRN	Internal Medicine	Heart Care Associates of Connecticut, L.L.C.
YNHH	Smith, Brian	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Smith, David	MD	Internal Medicine	Yale Health Plan
YNHH	Smith, Dorothea	APRN	Obstetrics & Gynecology	Women's Center
YNHH	Smith, Izabela	CRNA	Anesthesiology	YUSM Department of Anesthesiology - Saint Raphael Campus
YNHH	Smith, J.	MD	Internal Medicine	
YNHH	Smith, Marilyn	MD	Pediatrics	Canterbury Pediatrics

YNHH	Smith, Marissa	MD	Pediatrics	The Orthopedic & Sports Medicine Center
YNHH	Smith, Paula	APRN	Pediatrics	Pediatrics Plus, P.C.
YNHH	Smith, Scott	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Snyder, Christopher	MD	Internal Medicine	Internal Medicine of Milford
YNHH	Snyder, Edward	MD	Laboratory Medicine	YUSM Department of Laboratory Medicine
YNHH	Soares, Sarita	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Socci, Adrienne	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Sofair, Andre	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Sokolowski, Chester	DDS	Dentistry	Kids First Pediatric Dentistry & Orthodontics
YNHH	Solomon, Daniel	MD	Surgery	YUSM Section of Pediatric Surgery - YNHH Children's Hospital
YNHH	Soloway, Gregory	MD	Internal Medicine	Gastroenterology Associates, P.C.
YNHH	Soloway, Scott	MD	Ophthalmology	Scott M. Soloway, MD
YNHH	Somlo, Stefan	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Soto, Alicia	MD	Pediatrics	Pediatrics Plus, P.C.
YNHH	Southard, Rachel	APRN	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Spagnuolo, Juliana	PA	Surgery	YUSM Section of Cardiac Surgery
YNHH	Spak, James	MD	Orthopedics	The Orthopedic & Sports Medicine Center
YNHH	Spangler, Stephanie	MD	Obstetrics & Gynecology	Yale Health Plan
YNHH	Spanolios, Paris	MD	Internal Medicine	Internal Medicine of Milford
YNHH	Spatz Turner, Erica	MD	Internal Medicine	Yale Health Plan
YNHH	Spector, Gary	MD	Internal Medicine	Internal Medicine of Milford
YNHH	Spector, Kenneth	MD	Internal Medicine	Cardiology Associates of Derby
YNHH	Spektor, Michael	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Spencer, Dennis	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Spencer, Stacy	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Spencer-Manzon, Michele	MD	Internal Medicine	Central Medical Unit
YNHH	Speranza, Musa	MD	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Spiesel, Sydney	MD	Pediatrics	Pediatric and Adolescent Medicine, Sydney Z. Spiesel, Ph.D., M.D., LLC
YNHH	Spollett, Geralyn	APRN	Internal Medicine	YUSM Section of Endocrinology
YNHH	Sprenkle, Preston	MD	Urology	YUSM Department of Urology
YNHH	Springer, Dena	MD	Pediatrics	Hamden Pediatrics, P.C.
YNHH	Springer, Sandra	MD	Internal Medicine	YUSM Section of Infectious Disease, AIDS Program

YNHH	Springhorn, Erin	MD	Pediatrics	Shoreline Pediatric & Adoles. Medicine (ProHealth Physicians)
YNHH	Spudich, Serena	MD	Neurology	YUSM Department of Neurology
YNHH	Square, Amanda	MD	Psychiatry	Yale-New Haven Hospital, Department of Psychiatry
YNHH	Squicciarini, Helena	DO	Obstetrics & Gynecology	Womens Healthcare of Trumbull
YNHH	Sramcik, Julie	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Sreshta, Neil	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Srihari, Vinod	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Sritharan, Kandiah	MD	Internal Medicine	Patient Choice Medical Care
YNHH	Srouji, Jessica	APRN	Pediatrics	YUSM Section of Genetics
YNHH	St. Jacques, Susan	PA	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Stack, Maria	MD	Internal Medicine	MT Carmel Internal Medicine and Geriatrics, L.L.C.
YNHH	Stahl, Barbara	APRN	Surgery	YUSM Section of Cardiac Surgery
YNHH	Stahl, Richard	MD	Surgery	Connecticut Center for Plastic Surgery
YNHH	Stair, David	MD	Internal Medicine	Connecticut Medical Group, LLC
YNHH	Stanek, Jessica	CNM	Obstetrics & Gynecology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Stannard, Andrea	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Stanton, Robert	MD	Orthopedics	Orthopaedic Specialty Group
YNHH	Stanwood, Nancy	MD	Obstetrics & Gynecology	Women's Center
YNHH	Starace-Colabella, Linda	MD	Obstetrics & Gynecology	UHSC OB/GYN
YNHH	Staugaard, Carol	APRN	Internal Medicine	YUSM Section of Oncology, Smilow Cancer Hospital
YNHH	Steckel, Mark	MD	Ophthalmology	Pediatric & Adult Ophthalmology
YNHH	Steenbergen, Peter	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Steeves, Corrie	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Stefanski, Aimee	APRN	Internal Medicine	Cardiology Associates of Norwich
YNHH	Stein, Jeffrey	MD	Pediatrics	YUSM Section of Pediatric Nephrology
YNHH	Stein, Jonathan	MD	Pediatrics	Guilford Pediatrics
YNHH	Stein, Stacey	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Stein, Stephen	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Steinbacher, Derek	MD, DMD	Surgery	Yale Pediatric Specialty Center
YNHH	Steiner, Jeanne	DO	Psychiatry	Connecticut Mental Health Center
YNHH	Steller, Rodney	DMD	Dentistry	
YNHH	Stemler, Karen	APRN	Internal Medicine	Quinnipiac Medical of Branford, LLC
YNHH	Stepczynski, Jadwiga	MD	Internal Medicine	YNHH Adult PCC
YNHH	Stern, Robert	MD, PhD	Psychiatry	Robert Stern, M.D., P.C.
YNHH	Sternberg, Diana	PA	Internal Medicine	NEMG - Y-NHH Hospitalists

YNHH	Stevenson, Devra	PA	Neurology	YUSM Department of Neurosurgery
YNHH	Stewart, Jill	APRN	Internal Medicine	Yale Medical Group
YNHH	Stewart, Jonathan	PA	Internal Medicine	Northeast Medical Group, Inc.
YNHH	Stewart, Shetal	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Stewart, Thomas	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Stewart, Wendy	PhD	Psychiatry	Solo Practice
YNHH	Stitelman, David	MD	Surgery	YUSM Department of Pediatrics
YNHH	Stitz, Douglas	PA	Internal Medicine	Heart Care Associates of Connecticut, L.L.C.
YNHH	Stoessel, Kathleen	MD	Ophthalmology	Yale Eye Center
YNHH	Stoll, Sharon	DO	Neurology	YUSM Department of Neurology
YNHH	Stone, Deborah	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Stone, Kenneth	MD	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Stone, Shepard	PA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Storeygard, Shari	MD	Pediatrics	Child-Adolescent Healthcare
YNHH	Stout, Robert	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Stransky, Martin	MD	Neurology	YUSM Department of Neurology
YNHH	Straun, Teo-Carlo	MD	Psychiatry	Straun Health & Wellness LLC
YNHH	Strazzabosco, Mario	MD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Streeter, Gordon	MD	Pediatrics	Yale Health Plan
YNHH	Strippoli, Kara	PA	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Strittmatter, Stephen	MD, PhD	Neurology	YUSM Department of Neurology
YNHH	Strong, Ann	MD	Obstetrics & Gynecology	Strong Women's Health, LLC
YNHH	Stroup, Ralph	MD	Urology	YUSM Department of Urology
YNHH	Strout, Matthew	MD, PhD	Internal Medicine	Yale Medical Group Administration
YNHH	Strugar, John	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Stubbe, Dorothy	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Stupak, Howard	MD	Surgery	Howard Stupak, M.D.
YNHH	Sturrock, Tracy	APRN	Surgery	Y-NHH Smilow Cancer Hospital
YNHH	Subtil-Deoliveira, Antonio	MD	Dermatology	YUSM Department of Dermatology
YNHH	Sude, Leslie	MD	Pediatrics	Chapel Pediatric Group
YNHH	Sudikoff, Stephanie	MD	Pediatrics	Synapse Center
YNHH	Suesserman, Herbert	MD	Obstetrics & Gynecology	Herbert Suesserman, MD, PC
YNHH	Sugeng, Lissa	MD	Internal Medicine	Yale Cardiology Center for Advanced Heart Failure
YNHH	Sugin, Stephanie	MD	Ophthalmology	The Eye Care Group
YNHH	Sullivan, Jill	PA	Surgery	YUSM Section of Cardiac Surgery

YNHH	Sultan, Michael	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Summers, Craig	MD	Pediatrics	Children's Medical Group, LLC
YNHH	Sumner, Jeffrey	MD	Orthopedics	Center for Orthopaedics
YNHH	Sumpio, Bauer	MD, PhD	Surgery	YUSM Section of Vascular Surgery
YNHH	Sun, Dharini	MD	Internal Medicine	Mount Carmel Medical Associates, LLP
YNHH	Sundstrom, Laura	CNM	Obstetrics & Gynecology	Women's Health Associates, LLC
YNHH	Suozzi, Kathleen	MD	Dermatology	Yale Dermatologic Surgery
YNHH	Sussman, Louis	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Suter, Lisa	MD	Internal Medicine	VA Medical Center
YNHH	Sutton, Judy	APRN	Internal Medicine	Yale Health Plan
YNHH	Sutton, Karen	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Sutton, Richard	MD, PhD	Internal Medicine	YUSM Section of Infectious Disease
YNHH	Swan, Andrew	MD	Ophthalmology	Eye Center of Southern Connecticut, P.C.
YNHH	Swan, Keith	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Swartz, Martha	APRN	Pediatrics	Primary Care Center
YNHH	Swidler, Mark	MD	Internal Medicine	Yale Cancer Center Palliative Care
YNHH	Swigart, Carrie	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Syed, Muhammad	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Sylvester, Kati	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Syombathy, Virginia	APRN	Internal Medicine	Y-NHH Smilow Cancer Care Center
YNHH	Sytek, Mary	APRN	Surgery	YUSM Section of Vascular Surgery
YNHH	Sze, Gordon	MD	Radiology & Biomedical Ima	Yale-New Haven Hospital - Temple Radiology
YNHH	Szekely, Anna	MD	Neurology	YUSM Section of Genetics
YNHH	Sznol, Mario	MD	Internal Medicine	YNHH Smilow Cancer Hospital
YNHH	Taddei, Tamar	MD	Internal Medicine	YUSM Section of Digestive Diseases
YNHH	Taheri, Paul	MD	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Tahir, Omair	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Taikowski, Richard	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Taillon, Emily	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Takacs, Victoria	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Takoudes, Thomas	MD	Surgery	Ear, Nose & Throat Medical and Surgical
YNHH	Takyar, Seyedtaghi	MD, PhD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Tal, Reshef	MD	Obstetrics & Gynecology	Yale Fertility Center
YNHH	Talsania, Ashita	MD	Internal Medicine	Y-NHH Smilow Cancer Hospital Torrington Care Center
YNHH	Talwalkar, Jaideep	MD	Internal Medicine	St. Mary's Hospital

YNHH	Tamborlane, William	MD	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Tandon, Suman	MD	Internal Medicine	Connecticut Heart Group, P.C.
YNHH	Taneja, Anshu	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Tanoue, Lynn	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Tantawy, Hossam	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Tao, Jing	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Tara, Harold	MD	Internal Medicine	Medical Oncology & Hematology
YNHH	Tarabar, Amerisa	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Tarabar, Asim	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Taubin, Howard	MD	Internal Medicine	Gastroenterology Associates, P.C.
YNHH	Tawiah, Phyllis	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Taylor, Caroline	MD	Radiology & Biomedical Ima	West Haven VA Hospital
YNHH	Taylor, Hugh	MD	Obstetrics & Gynecology	YUSM Section of Reproductive Endocrinology
YNHH	Taylor, Lane	DO	Child Psychiatry	Yale University Child Study Center
YNHH	Taylor, Mark	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Taylor, Richard	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Tek, Cenk	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Telfer, Michelle	CNM	Obstetrics & Gynecology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Tello Silva, Enrique	MD	Psychiatry	Spectrum Psychiatric Group, P.C.
YNHH	Teng, Christopher	MD	Ophthalmology	Yale Eye Center
YNHH	Teodoro, Dana	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Tepley, Robert	PhD	Psychiatry	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Testa, Francine	MD	Pediatrics	Child Neurology Associates, L.L.P.
YNHH	Testani, Jeffrey	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Tetrault, Jeanette	MD	Internal Medicine	Central Medical Unit
YNHH	Thampy, Unnikrishnan	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Thande, Njeri	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Thentu, Jyothi	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Theriault, Shahana	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Thibeault, Susan	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Thomas, Donna-Ann	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Thomas, Kenneth	MD	Obstetrics & Gynecology	
YNHH	Thomas, Nezbile	APRN	Psychiatry	Northeast Medical Group, Inc.
YNHH	Thomas, Prakash	MD	Child Psychiatry	Psychological Services of Sourthern CT

YNHH	Thomas, Sheeja	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Thomas, Susanna	MD	Internal Medicine	Family Medicine Associates
YNHH	Thomen, Sarah	APRN	Internal Medicine	Y-NHH Smilow Cancer Hospital Torrington Care Center
YNHH	Thompson, Jaclyn	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Thompson, Jennifer	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Thompson, Megan	PA	Obstetrics & Gynecology	Yale-New Haven Hospital, Women's Center
YNHH	Thomson, James	MD	Surgery	YUSM Section of Plastic Surgery
YNHH	Thornquist, Steven	MD	Ophthalmology	Solo Practice
YNHH	Tichy, Doug	PA	Internal Medicine	YUSM Section of Nuclear Cardiology
YNHH	Tichy, Eileen	PA	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Tierney, Virginia	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Tilak, Gauri	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Timbol, Heidi Mae	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Tinaz, Ayse Sule	MD	Neurology	YUSM Department of Neurology
YNHH	Tinetti, Mary	MD	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Tinnesz, Peter	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Tirado, Anna	MD	Obstetrics & Gynecology	County OB/GYN
YNHH	Titko, Yelena	MD	Internal Medicine	Waterbury Hospital
YNHH	Tiyyagura, Gunjan	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Tobias, Lauren	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Tobin, Brian	MD	Psychiatry	
YNHH	Tobin, Daniel	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Tocino, Irena	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Togawa, Cynthia	MD	Internal Medicine	NEMG - Whitney Internal Medicine
YNHH	Toksoy, John	MD	Internal Medicine	Yale Health Plan
YNHH	Tolomeo, Concettina	APRN	Pediatrics	YUSM Section of Pedi Respiratory Med
YNHH	Tom, David	MD	Ophthalmology	New England Retina Associates
YNHH	Tomak, Patrick	MD	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Tomak, Sanda	MD	Orthopedics	Connecticut Orthopaedic Specialists, P.C
YNHH	Tomassoni, Anthony	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Tomayko, Mary	MD, PhD	Dermatology	Yale Dermatology Associates
YNHH	Tong, David	PA	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Tonzola, Denise	MD	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Toosy, Kaiser	MD	Internal Medicine	Pulmonary and Critical Care, P.C.
YNHH	Topal, Jeffrey	MD	Internal Medicine	YUSM Pharmacy

YNHH	Topp, Nicole	MD	Obstetrics & Gynecology	Ob, Gyn & Menopause Physicians, PC
YNHH	Topran, Ernest	MD	Obstetrics & Gynecology	Obstetrics Midwifery & Gynecology, L.L.P
YNHH	Torbey, Marina	MD	Obstetrics & Gynecology	Womens Healthcare of Trumbull
YNHH	Tormey, Christopher	MD	Laboratory Medicine	YUSM Department of Pathology/Laboratory Med
YNHH	Torres, Dawn	MD	Pediatrics	Branford / North Branford Pediatrics, P.C.
YNHH	Torres, Marie	APRN	Surgery	YUSM Section of Pediatric Surgery
YNHH	Torres, Richard	MD	Laboratory Medicine	YUSM Department of Pathology/Laboratory Medicine
YNHH	Townshend, Pamela	CNM	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Tracy, Lindsey	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Tracy, Todd	MD	Internal Medicine	Internal Medicine of Milford
YNHH	Tray, Alison	APRN	Internal Medicine	YUSM Section of Oncology
YNHH	Treantafilos, Marianne	APRN	Internal Medicine	Regional Hospice and Home Care of Western Ct, Inc
YNHH	Trentcheva-Kennedy, Mariya	DDS	Dentistry	YNHH Pediatric Dentistry Center
YNHH	Trigo Blanco, Paula	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Troidle, Laura	PA	Internal Medicine	Metabolism Associates
YNHH	Troisi, Michele	SA	Ophthalmology	The Eye Care Group
YNHH	Troncale, Frank	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Trow, Terence	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Tsalbins, Semeon	MD	Pediatrics	Fair Haven Community Health Center
YNHH	Tsuei, Vivian	MD	Pediatrics	Pediatric & Adolescent Medicine, P.C.
YNHH	Tsyrulnik, Alina	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Tucker, Katherine	APRN	Internal Medicine	YUSM Section of Cardiology
YNHH	Tufro, Alda	MD, PhD	Pediatrics	YUSM Section of Pediatric Nephrology
YNHH	Tuktamyshov, Rasikh	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Tunstall, Corry	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Tuohy, Edward	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Tuozzoli, Alyssa	PA	Surgery	YUSM Section of Plastic Surgery
YNHH	Turczak, Andrew	PA	Orthopedics	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Turner, Jeffrey	MD	Internal Medicine	YUSM Section of Nephrology
YNHH	Tuzovic, Lea	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Twohig, Kevin	MD	Internal Medicine	Northeast Medical Group
YNHH	Tyler, Chrystal	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Udelsman, Robert	MD	Surgery	Y-NHH Smilow Cancer Hospital
YNHH	Ulisse, Gael	APRN	Internal Medicine	YUSM Section of General Medicine
YNHH	Ulrich, Andrew	MD	Emergency Medicine	YUSM Department of Emergency Medicine

YNHH	Uluski, Richard	MD	Pediatrics	Pediatric & Medical Associates
YNHH	Umashanker, Devika	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Umashanker, Renuka	MD	Internal Medicine	Gastroenterology Center of Connecticut
YNHH	Umstead, Alissa	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Urban, Andrea	APRN	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Vaca, Federico	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Vadivelu, Nalini	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Vaezy, Ali	MD	Pediatrics	St. Mary's Hospital
YNHH	Vahey, Marianne	MD	Internal Medicine	Connecticut Medical Group - NEMG
YNHH	Vaitkeviciute, Irena	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Valentine, Rebecca	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Valentino, Pamela	MD	Pediatrics	YUSM Section of Pediatric Gastroenterology
YNHH	Valin, Elmer	MD	Surgery	Elmer L. Valin, M.D., LLC
YNHH	Valletta, Gerald	MD	Internal Medicine	Milford Hospital
YNHH	Van Deusen, Timothy	MD	Psychiatry	West Haven MHC
YNHH	van Dyck, Christopher	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Van Gelder, Maria	APRN	Surgery	YUSM Section of Trauma & Critical Care
YNHH	Van Name, Michelle	MD	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Van Wattum, Pieter	MD	Child Psychiatry	
YNHH	Vante, Chantale	MD	Internal Medicine	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Varghese, Indu	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Varkey, Prathibha	MD	Internal Medicine	Northeast Medical Group
YNHH	Vashist, Ipshita	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Vash-Margita, Alla	MD	Obstetrics & Gynecology	The Center for Women's Health and Midwifery
YNHH	Vasquez, Juan	MD	Pediatrics	YUSM Section of Pediatric Hematology/Onc
YNHH	Vasquez, Tito	MD	Surgery	CT Plastic Surgery Group
YNHH	Vassell, Kerline	MD	Pediatrics	Pediatric & Adolescent Medicine, P.C.
YNHH	Vaughan, Sarah	APRN	Pediatrics	YNHH Pediatric PCC
YNHH	Vayneris, Lindsey	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Vazquez, Marietta	MD	Pediatrics	YUSM Section of Pediatric Infectious Diseases
YNHH	Vazquez-Valicek, Amelia	PA	Pediatrics	YUSM Section of Pediatric Neonatology
YNHH	Vedere, Swarupa	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Veet-Gillis, Barbara	APRN	Pediatrics	Yale-New Haven Hospital NICU

YNHH	Velagapudi, Venu	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Velasco, Noel	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Velcani, Artur	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Veltri, Nicole	APRN	Neurology	YUSM Department of Neurology
YNHH	Venancio, Lee	PA	Urology	Orchard Surgical Specialists
YNHH	Vender, Ronald	MD	Internal Medicine	Yale University School of Medicine
YNHH	Venkatesh, Arjun	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Verghese, Vinu	DO	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Verity, Sharon	PA	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Verulashvili, Mikheil	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Vilarinho, Silvia	MD, PhD	Internal Medicine	YUSM Section of Gastroenterology
YNHH	Villanueva, Merceditas	MD	Internal Medicine	YUSM Section of Infectious Disease Nathan Smith Clinic
YNHH	Vindheim, Sonja	DO	Pediatrics	Pediatric Healthcare Associates
YNHH	Viner, Nicholas	MD	Urology	Urological Associates of Bridgeport, PC
YNHH	Vining, Daniel	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Vining, Eugenia	MD	Surgery	Ear, Nose & Throat Medical and Surgical
YNHH	Virata, Michael	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Virojanapa, Justin	DO	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Virojanapa, Milea	PA	Neurosurgery	YUSM Department of Neurosurgery
YNHH	Visscher, Lisa	MD	Pediatrics	Hamden Pediatrics, P.C.
YNHH	Vitale, Glenn	DPM	Podiatry	Connecticut Podiatry Group, P.C.
YNHH	Vitale, Michelle	APRN	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Vitulano, Lawrence	PhD	Child Psychiatry	Yale Child Study Center
YNHH	Vodapally, Mohan	MD	Anesthesiology	Connecticut Regional Pain Specialists, P.C.
YNHH	Voets, Christopher	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Volkmar, Fred	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Vollmar, Michael	MD	Psychiatry	Spectrum Psychiatric Group, P.C.
YNHH	Volpe, Darren	MD	Neurology	VA CT Health Care
YNHH	Volpe, Fedele	DMD	Dentistry	
YNHH	Von Keudell, Gottfried	MD, PhD	Internal Medicine	YUSM Section of Hematology
YNHH	Vornovitsky, Gregory	MD	Internal Medicine	Northeast Medical Group
YNHH	Vosburgh, Evan	MD	Internal Medicine	Raymond and Beverly Sackler Foundation
YNHH	Vulpe, Marian	MD	Internal Medicine	Heart Care Associates of Connecticut, L.L.C.
YNHH	Vyce, Steven	DPM	Podiatry	

YNHH	Wacker, Svenja	PhD	Psychiatry	Yale-New Haven Hospital Rehabilitation and Wellness Center at Milford Hospital
YNHH	Waddell, Robin	APRN	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Wadley, Farlyn	DPM	Podiatry	Affiliated Foot Surgeons
YNHH	Wagner, Denise	APRN	Pediatrics	YNHH Primary Care Center
YNHH	Wagner, Krystn	MD	Internal Medicine	Fair Haven Community Health Center
YNHH	Walaliyadda, Anuruddha	MD	Internal Medicine	West Haven Medical Group
YNHH	Waldman, Erik	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Waldman, Linda	MD	Pediatrics	Branford / North Branford Pediatrics, P.C.
YNHH	Walke, Lisa	MD	Internal Medicine	YUSM Section of Geriatric Medicine
YNHH	Walker, Jennifer	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Wallace, Sara	PA	Internal Medicine	Connecticut Kidney Center, LLC
YNHH	Wallick, Nancy	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Wallis, Kristen	MD	Pediatrics	Children's Medical Group, LLC
YNHH	Walls, Raymond	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Walsh, Susan	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Walsh, Thomas	MD	Ophthalmology	Yale Eye Center
YNHH	Walters, Cheryl	MD	Internal Medicine	Northeast Medical Group
YNHH	Walther, Zenta	MD, PhD	Pathology	YUSM Department of Pathology
YNHH	Waltman, Adam	MD	Emergency Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Walton, Zachary	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Waltzman, Michael	MD	Surgery	Primed
YNHH	Walz, Jennifer	PA	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Wanerka, Gary	MD	Pediatrics	Branford Pediatrics & Allergy
YNHH	Wang, Annie	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Wang, Emily	MD	Internal Medicine	YNHH Adult PCC
YNHH	Wanjiku, Grace	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Ward, Douglas	PA	Orthopedics	Bridgeport Hospital
YNHH	Ward, Henry	MD	Internal Medicine	Connecticut Heart Group, P.C.
YNHH	Warmouth, Grant	MD	Neurology	American Neuromonitoring Associates, PC
YNHH	Warner, Brenda	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Warren, Wayne	MD	Internal Medicine	Northeast Medical Group
YNHH	Washington, Jason	PA	Surgery	YUSM Section of Cardiology
YNHH	Watsky, Kalman	MD	Dermatology	Kalman L. Watsky, M.D.
YNHH	Watson, Charles	MD	Anesthesiology	Bridgeport Anesthesia Associates

YNHH	Watson, Collin	MD	Internal Medicine	NEMG - Southern CT Internal Medicine
YNHH	Watson, Michelle	MD	Pediatrics	Gales Ferry Pediatrics - NEMG
YNHH	Wayne, Anthony	MD	Pediatrics	Childrens Medical Associates
YNHH	Webb, Lisa	MD	Neurology	Neurological Specialists, P.C.
YNHH	Weber, Jonathan	PA	Internal Medicine	Yale Health Plan
YNHH	Wechsler, Cindy	APRN	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Weeks, Bevin	MD	Pediatrics	Northeast Medical Group Pediatric Specialists
YNHH	Weiland, Daniel	MD	Orthopedics	The Orthopedic & Sports Medicine Center
YNHH	Weinberger, Amanda	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Weinreb, Jeffrey	MD	Radiology & Biomedical Ima	YUSM Department of Radiology and Biomedical Imaging
YNHH	Weinrib, Amy	MD	Pediatrics	Pediatric Healthcare Associates
YNHH	Weinstein, Mark	MD	Surgery	Solo Practice
YNHH	Weinstein, Robert	MD	Urology	Urological Associates of Bridgeport, PC
YNHH	Weinstock, Alan	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Weinstock, Robert	DDS	Surgery	Hamden Shoreline Oral & Maxillofacial Surgery
YNHH	Weinzimer, Stuart	MD	Pediatrics	YNHH Pediatric Specialty Clinic
YNHH	Weisinger, Philip	MD	Pediatrics	Allergy Associates, P.C.
YNHH	Weiss, Alan	MD	Internal Medicine	NEMG - Family Practice Associates
YNHH	Weiss, Robert	MD	Urology	YUSM Department of Urology
YNHH	Weiss, Sarah	MD	Internal Medicine	YUSM Section of Oncology
YNHH	Weiss-Rivera, Judith	MD	Internal Medicine	NEMG - Family Practice Associates
YNHH	Weisz, James	MD	Ophthalmology	Connecticut Retina Consultants
YNHH	Weitzman, Carol	MD	Pediatrics	YUSM Department of Pediatrics, Development/Behavioral
YNHH	Weitzman, Marc	MD	Ophthalmology	Ophthalmic Surgeons of Greater Bridgeport, P.C.
YNHH	Welsh, Regan	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Welte, Rebecca	APRN	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Werdiger, Norman	MD	Neurology	Solo Practice
YNHH	West, Alexander	MD	Pathology	YUSM Department of Pathology
YNHH	Westphal, Alexander	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Weyman, Kate	APRN	Pediatrics	YUSM Section of Pediatric Endocrinology
YNHH	Whang, Peter	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Wheeler, Sarah	CNM	Obstetrics & Gynecology	The Center for Women's Health and Midwifery
YNHH	Whelan, Mark	PA	Internal Medicine	Heart Care Associates of Connecticut, L.L.C.
YNHH	White, Jessica	PA	Neurosurgery	YUSM Department of Neurosurgery
YNHH	White, Lauren	MD	Pediatrics	YNHH Pediatric PCC

YNHH	White, Robert	MD	Psychiatry	
YNHH	Whitman, Laura	MD	Internal Medicine	YNHH Primary Care Center
YNHH	Whitney, Rachel	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Wiesner, Elizabeth	MD	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Wijesekera, Namita	MD	Pediatrics	Pediatric and Adolescent Medicine, Sydney Z. Spiesel, Ph.D., M.D., LLC
YNHH	Wijesekera, Shirvinda	MD	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	Wijesekera, Thilan	MD	Internal Medicine	Yale-New Haven Hospital Saint Raphael Campus
YNHH	Wilds, Tracey	APRN	Internal Medicine	YNHH Adult PCC
YNHH	Wildstein, Heidi	APRN	Pediatrics	YUSM Department of Pediatrics, Development/Behavioral
YNHH	Wiley, Kristin	CNM	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Wilf, Guita	MD	Child Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Wilk, Arthur	DDS	Dentistry	Arthur E. Wilk, D.D.S., P.C.
YNHH	Wilkinson, Samuel	MD	Psychiatry	Geriatric & Adult Psychiatric, L.L.C.
YNHH	Willett, J.	MD	Surgery	Southern New England ENT
YNHH	Williams, Jody	CRNA	Anesthesiology	Bridgeport Anesthesia Associates
YNHH	Williams, Meredith	MD	Pediatrics	Cornell Scott - Hill Health Center
YNHH	Williams, Scott	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Williams, Vincent	MD	Orthopedics	UCONN Health Center
YNHH	Williams, Wendol	MD	Psychiatry	Yale-New Haven Psychiatric Hospital
YNHH	Willis, Amy	MD	Obstetrics & Gynecology	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Wilson, Cynthia	MD	Psychiatry	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Wilson, Elizabeth	MD	Psychiatry	
YNHH	Wilson, Francis	MD	Internal Medicine	VA CT Health Care
YNHH	Wilson, Lynn	MD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology
YNHH	Wilson, Madeline	MD	Internal Medicine	Yale Health Plan
YNHH	Winderman, Craig	MD	Internal Medicine	Milford Hospital
YNHH	Windish, Donna	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus Department of Medicine, Primary Care Residency
YNHH	Winslow, Robert	MD	Internal Medicine	Cardiac Specialists, P.C.
YNHH	Winterbottom, Christopher	MD	Internal Medicine	YUSM Section of Pulmonology/Critical Care
YNHH	Wintman, Lauren	PA	Internal Medicine	YUSM Section of Oncology
YNHH	Wira, Charles	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Wiske, Prescott	MD	Internal Medicine	Yale Cardiology

YNHH	Withington, Margaret	CNM	Obstetrics & Gynecology	Greater New Haven OB/GYN
YNHH	Witt, David	MD	Internal Medicine	Smilow Cancer Care -Trumbull
YNHH	Wittreich, Tracy	CNM	Obstetrics & Gynecology	OB/GYN & Infertility Group
YNHH	Wiznia, Robert	MD	Ophthalmology	Solo Practice
YNHH	Wolfsohn, David	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Woll, Kate	MD	Pediatrics	Childrens Medical Associates
YNHH	Womack, Julie	APRN	Internal Medicine	Nathan Smith Clinic
YNHH	Won, Christine	MD	Internal Medicine	YNHH Sleep Medicine Center
YNHH	Wong, Ambrose	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Wong, Michael	MD	Orthopedics	Multicare Medical Center, P.C.
YNHH	Wong, Serena	MD	Pathology	YUSM Department of Pathology
YNHH	Wong, Thomas	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Woods, Scott	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Woolf, Seth	MD	Pediatrics	YUSM Section of Pediatric Emergency Medicine
YNHH	Woolston, Joseph	MD	Child Psychiatry	Yale University Child Study Center
YNHH	Wootton, Elizabeth	PA	Internal Medicine	YUSM Section of Infectious Disease
YNHH	Wormser, Andrew	MD	Internal Medicine	Northeast Medical Group
YNHH	Wormser, Ellen	CNM	Obstetrics & Gynecology	Fair Haven Community Health Center
YNHH	Worrell, Carolyn	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Wosnitzer, Matthew	MD	Urology	NEMG Urology
YNHH	Woznica, David	MD	Orthopedics	Yale-New Haven Hospital Spine Center
YNHH	Wu, Barry	MD	Internal Medicine	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Wu, Joseph	MD	Orthopedics	Center for Orthopaedics
YNHH	Wu, Lena	MD	Internal Medicine	West Haven Medical Group
YNHH	Wyner, Stacey	APRN	Pediatrics	YNHH Pediatric PCC
YNHH	Wysolmerski, John	MD	Internal Medicine	YUSM Section of Endocrinology
YNHH	Xu, Jin	MD	Internal Medicine	Yale Health Plan
YNHH	Xu, Mina	MD	Pathology	YUSM Department of Pathology
YNHH	Yagan, Neda	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Yaggi, Henry	MD	Internal Medicine	YNHH Sleep Medicine Center
YNHH	Yamahiro, Atsuko	MD, MPH	Internal Medicine	Nathan Smith Clinic
YNHH	Yamani, Ammar	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Yanagisawa, Ken	MD	Surgery	Southern New England ENT
YNHH	Yang, Irene	MD	Neurology	YUSM Department of Neurology
YNHH	Yang, Kai	MD	Internal Medicine	Endocrine Associates of Connecticut

YNHH	Yarbrough, Wendell	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Yardan, Christopher	DPM	Podiatry	The Center for Foot and Ankle Surgery, LLC
YNHH	Yavorek, George	MD	Surgery	YUSM Department of Surgery
YNHH	Yeboah, Benjamin	MD	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Yeung, Helen	MD	Ophthalmology	Yale Eye Center
YNHH	Yildiz, Isil	MD	Pathology	Greenwich Hospital
YNHH	Yoffe, Josh	CRNA	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Yonkers, Kimberly	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Yoo, Peter	MD	Surgery	YUSM Section of Transplantation
YNHH	You, Jaehee	PA	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Young, Jennifer	MD	Pediatrics	Shoreline Breastfeeding Medicine, L.L.C.
YNHH	Young, Lawrence	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Young, Melissa	MD, PhD	Therapeutic Radiology	YUSM Department of Therapeutic Radiology/Smilow Cancer Hospital
YNHH	Young, Nwanmegha	MD	Surgery	YUSM Section of Otolaryngology
YNHH	Young, Richard	MD	Pediatrics	Chapel Pediatric Group
YNHH	Yu, James	MD	Therapeutic Radiology	Lawrence & Memorial Hospital
YNHH	Yue, James	MD	Orthopedics	YUSM Department of Orthopedics
YNHH	Yun, James	MD, PhD	Surgery	YUSM Section of Cardiac Surgery
YNHH	Zafar, Jill	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Zaha, Liviu	MD	Internal Medicine	NEMG - Y-NHH Hospitalists
YNHH	Zaha, Oana	MD	Internal Medicine	YUSM Section of Rheumatology
YNHH	Zakhaleva, Julia	MD	Surgery	PACT Surgical Specialists
YNHH	Zamore, Leonard	MD	Obstetrics & Gynecology	Obstetrics Midwifery & Gynecology, L.L.P
YNHH	Zanchetti, Daniel	MD	Internal Medicine	Connecticut Gastroenterology Consultants
YNHH	Zanin, Tanja	MD	Emergency Medicine	YUSM Department of Emergency Medicine
YNHH	Zapata, Heidi	MD	Internal Medicine	YUSM Section of Infectious Disease Nathan Smith Clinic
YNHH	Zaret, Barry	MD	Internal Medicine	YUSM Section of Cardiology
YNHH	Zaret, Katelyn	PA	Pediatrics	Yale-New Haven Hospital NICU
YNHH	Zasypayko, Sergey	MD	Internal Medicine	Pulmonary Care, P.C.
YNHH	Zeidan, Amer	MD	Internal Medicine	YUSM Section of Hematology
YNHH	Zell, Richard	MD	Orthopedics	The Orthopaedic Group, division of Connecticut Orthopaedic Specialists
YNHH	Zelson, Joseph	MD	Pediatrics	Pediatrics and Adolescent Medicine, P.C.
YNHH	Zhang, Hui	MD	Pediatrics	YUSM Section of Genetics

YNHH	Zhang, Xuchen	MD	Pathology	YUSM Department of Pathology/Surgical Pathology
YNHH	Zheng, Tao	MD	Internal Medicine	YUSM Section of Allergy and Immunology
YNHH	Zhou, Gary	MD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Zhu, Qingbing	MD, PhD	Anesthesiology	YUSM Department of Anesthesiology
YNHH	Ziino, Madelyn	APRN	Internal Medicine	Internal Med. Of Greater New Haven
YNHH	Zimberg, Lisa	DMD	Dentistry	YNHH Department of Dentistry
YNHH	Zimbrean, Paula	MD	Psychiatry	YUSM Department of Psychiatry
YNHH	Zimmerman, Gary	MD	Neurosurgery	Connecticut Neurosurgical Specialists, P.C.
YNHH	Zinn, Kenneth	MD	Radiology & Biomedical Ima	Advanced Radiology Consultants
YNHH	Zohrabian, Vahe	MD	Radiology & Biomedical Ima	YUSM Department of Radiology & Biomedical Imaging
YNHH	Zolkowski-Wynne, Joanna	MD	Pediatrics	Northeast Medical Group, Inc.
YNHH	Zomback, Neal	DPM	Podiatry	Complete Foot Care
YNHH	Zonana, Howard	MD	Psychiatry	Connecticut Mental Health Center
YNHH	Zorzanello, Mary	APRN	Internal Medicine	YUSM Section of Nephrology
YNHH	Zubek, Amanda	MD, PhD	Dermatology	Yale Dermatology - Middlebury
YNHH	Zubkov, Bella	MD	Dermatology	Dermatology Associates of Glastonbury
YNHH	Zucconi, William	DO	Radiology & Biomedical Ima	Yale-New Haven Hospital, Saint Raphael Campus
YNHH	Zuckerman, Howard	MD	Urology	Urological Associates of Bridgeport, PC
YNHH	Zuckerman, Kaye	MD	Surgery	Surgical Associates of New Haven
YNHH	Zuckerwise, Lisa	MD	Obstetrics & Gynecology	YUSM Section of Maternal-Fetal Medicine
YNHH	Zumpano, James	MD	Internal Medicine	James J. Zumpano, M.D., L.L.C.
YNHH	Zurich, Holly	PA	Surgery	YUSM Section of Thoracic Surgery

Summary of Financial Assistance Policy

Yale New Haven Health understands that it can be difficult for some patients to afford paying their hospital bills. That is why we have a variety of financial assistance programs designed to help. Patients are required to complete a financial assistance application and provide requested documents to verify financial need.

To learn more, obtain a free copy of our Financial Assistance Policy and application, or for help completing an application contact Patient Financial and Admitting Services at 855-547-4584, go to ynhhs.patientsimple.com or visit us in our Admitting offices at: **Bridgeport Hospital** 267 Grant Street, Bridgeport, CT; **Greenwich Hospital**, 5 Perryridge Road, Greenwich, CT; **Lawrence + Memorial Hospital** 365 Montauk Avenue, New London, CT; **Westerly Hospital** 25 Wells Street, Westerly, RI; or **Yale New Haven Hospital** 20 York Street, New Haven, CT.

Free care

You may be eligible for free care if:

- Your family earns less than or equal to 2½ times the Federal Poverty Level (the maximum income amounts are listed on the table below)
- You apply for State Assistance (Medicaid) and receive a valid written decision from the State within the last 6 months; and
- You complete a financial assistance application

Family size:	**Maximum Income:**
1	$29,700
2	$40,050
3	$50,400
4	$60,750
5	$71,100
6	$81,450

Add **$10,400 for each additional family member*

Discounted care

You may be eligible for discounted care if you are uninsured and you complete an application for financial assistance.

Restricted bed funds

You may be eligible to receive restricted bed funds, funds that have been donated to provide free or discounted care to individuals who meet individual fund criteria, to reduce or eliminate your hospital bill if you have a demonstrated financial need as determined by a fund's nominator; and you meet all eligibility criteria to receive funds (each fund has unique criteria). There are no specific income limits for receipt of restricted bed funds. Eligibility is determined on a case-by-case basis by the fund nominators based on financial hardship. All patients who fill out the financial assistance application will automatically be considered for restricted bed funds.

Yale New Haven Hospital "Me & My Baby" Program

This program is applicable to Yale New Haven Hospital patients. It provides prenatal care, labor and delivery services, and some post-partum care free of charge to those who qualify. You may be eligible if you live in New Haven County; do not have any type of health insurance; your family earns less than 2½ times the Federal Poverty Level (see maximum income chart above); you apply for State Assistance (Medicaid) and receive a valid written decision from the State. For more information or to request an application for the Yale New Haven Hospital Me & My Baby Program, see our representatives at the Women's Center or call **203-688-5470.**

Greenwich Hospital Outpatient Clinic

The Greenwich Hospital Outpatient Clinic provides free or discounted care to individuals who apply for and are approved for clinic membership. If you do not have insurance, and are not eligible for State Assistance (Medicaid), you may be eligible if you are a Greenwich resident and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call **203-863-3334.**

A note about the programs

You must be a citizen or resident of the United States to be eligible for financial assistance. These programs cover emergency or other medically necessary care. They cover ONLY Yale New Haven Health member hospital bills. A link to the list of providers who provide such care and whether they do or do not follow the FAP can be found in the FAP. Patients eligible for financial assistance will not be charged more than the amount generally billed to patients with insurance for emergency or other medically necessary care. Yale New Haven Health will respond to each application in writing. If your application is denied, you can re-apply at any time. Additional free bed funds become available every year. Translations of our Financial Assistance Policy, Summary of Financial Assistance Policy and Application are available for certain groups with limited English proficiency.

Please call 1-855-547-4584 for help.

A note about the Free Care program

In order to be considered for Free Care, you MUST apply for Medical Assistance (Medicaid) in the state where you live and receive a valid, written decision on your application within the last 6 months. Please submit this decision with your application. If you are applying for Discounted Care, you must not presently have any type of health insurance. Discounted care applications do not require an attached state decision letter.

How do I apply for financial assistance?

To make the process easy for patients, Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital, Westerly Hospital and Yale New Haven Hospital use one application form for most financial assistance programs. If you are a Yale New Haven Hospital patient and wish to apply for the Me & My Baby Program, please contact our Women's Center representatives at 203-688-5470. If you are a Greenwich Hospital patient and wish to apply for the Outpatient clinic, please contact at 203-863-3334.

Note: You must have current hospital bills or a scheduled appointment at the hospital to qualify for our financial assistance programs.

Free Care Program: Follow steps 1, 2, 3 and 4.

Discounted Care Program: Follow steps 2, 3 and 4.

Step 1: Apply for State Medical Assistance.
To be eligible for Free Care, you MUST apply for Medical Assistance (Medicaid) in the state where you live and receive a valid, written decision on your application. A denial is not "valid" if it was issued because you did not provide information or cooperate.

You can apply for Medicaid at your local Department of Social Services (DSS) office. CT residents call 1-800-842-1508 to find the DSS office nearest to you or apply online at www.accesshealthct.com. The hospital also has staff that can help you fill out the applications. If you need assistance, call us at 1-855-547-4584.

Once you receive a written decision from DSS, you may apply for Free Care. We cannot accept decision letters that are greater than 6 months old.

Step 2: Complete the Application.
Please answer ALL questions and sign and date the application. If a question does not apply to your family, please write "N/A" (not applicable) in the space provided.

Step 3: Attach proof of income to your application. Proof of income is a document that shows how much income your family earns at the time you fill out the application. See the table on right for the types of documents that may be used.

Step 4: Mail the application. Include: 1) The decision letter from DSS about your eligibility for State Assistance; 2) The completed, signed and dated application; and 3) Proof of income to:

Yale New Haven Health
SBO, Attn: Financial Assistance
PO BOX 1403
New Haven, CT 06505

The following documents may be used as proof of income:

If your family's income is from …	You may attach copies of these documents as proof of income: (These documents must not be more than six months old, except for your most recent Federal Tax Return, which may be older.)
Wages (If you earn a salary or get paid by the hour for a job)	– Two (2) of the most recent pay stubs, **OR** – A letter from your employer on company letterhead stating how many hours you work and how much you earn per hour (before taxes)
Self-employed income (If you work for yourself)	– Most recent Federal Income Tax Return (must be signed by you)
Benefits (Social Security, Veteran's, Worker's Compensation, Unemployment, Pensions, Retirement funds, SSI, alimony)	– Most recent benefits award letter, **OR** – Benefits Statement, **OR** – Check stubs
Rental Income	– Copy of lease or written agreement showing amount of rent, **OR** – A letter written by you , indicating the amount of rent you receive per year
Interest, Dividends, or Annuity Payments	– Most recent Federal Income Tax Return, **OR** – Statement from financial institution stating the amount and the frequency of payments and the amount paid this year to date
If you have no income	– A letter from the person who supports you, **OR** – If you do not have a person who supports you, send a signed and dated letter explaining your current financial situation

Application for Financial Assistance Programs

Yale NewHaven Health

Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital, Westerly Hospital and Yale New Haven Hospital use one application form for most financial assistance programs. By completing this application you will be considered for our Free Care, Discounted Care, and Bed Fund programs. For instructions on how to apply for financial assistance, please refer to page 2. Any questions about this application, please call 1-855-547-4584.

1. Patient Information:

Last Name _____ First Name _____ Social Security Number _____

Street Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ Telephone Number _____

If you are pregnant, what is your due date? _____ Medical Record Number (if available) _____

Legal status: ☐ U.S. Citizen ☐ U.S. Resident (attach identification) ☐ Visa (student, work, visitor)
☐ Non U.S. Citizen

2. Family Information:

List your spouse and/or any dependent children living in your household. Do not include non-married partners. If more space is necessary, please attach a separate document.

Name of family member	Social Security Number	Relationship to applicant	Date of Birth

3. Income Information:

Income information for you and your spouse must be provided. Include all sources of income. Sources of income may include but are not limited to: wages/salary, alimony, social security, unemployment, rental income, worker's compensation, and child support. If you have no income, attach a letter of support to your application. (See instructions on Page 2)

Name of family member	Source of income	Amount earned before tax (circle)
		$_____ week/bi-week/month/year
		$_____ week/bi-week/month/year
		$_____ week/bi-week/month/year

4. Health Insurance:

Are you covered under any health insurance policy, including Medicare or Medicaid or coverage from a foreign country? ☐ YES ☐ NO

If **yes**, please attach a copy of the front and back of your insurance card to this application OR enter the following:

Policy Holder:	**Insurer:**	**Policy No.:**
Policy Holder:	**Insurer:**	**Policy No.:**

5. Restricted bed funds: Please select any that apply. If you have a financial hardship that you would like us to consider when reviewing your application, please attach a letter describing your situation.

- ☐ A person who lives in Shelton
- ☐ A person who lives in Hamden
- ☐ A person who lives in Southington
- ☐ A person who lives in Greenwich
- ☐ A child who lives in Guilford or North Branford
- ☐ A women in financial need
- ☐ A person of German heritage
- ☐ A child in financial need
- ☐ A person with throat or lung disease
- ☐ A veteran of World War II
- ☐ A child at the Children's Center in Hamden

6. Please read carefully before signing:

By signing below, I certify that everything I have stated on this application and any attachment is true.

- I understand that any incorrect, incomplete, or false information on this form could result in rejection of my application for financial assistance.
- I give Yale New Haven Health permission to verify any and all information.
- I give Yale New Haven Health permission to request my credit report.
- I agree to repay the full amount of my financial assistance award if I receive payment of any kind, including awards from a lawsuit, for the services covered by this application.
- I agree to inform Yale New Haven Health of any changes that could change my eligibility for financial assistance.
- I understand that in connection with my application for financial assistance, Yale New Haven Health may need to disclose Protected Health Information (as that term is defined in the HIPAA Privacy Rule, 42 CFR Parts 160 through 164) about me in order to determine my eligibility.
- I understand that any such disclosure will be for payment purposes, as defined in the HIPAA Privacy Rule.

_____ _____

Signature of person applying or legal guardian Date

_____

Printed name of the person applying or legal guardian

Please remember to attach a valid written decision of your Medicaid Assistance (Medicaid) application from the state in which you live and proof of income OR a letter of support to your application if applicable.

Mail the completed application to:

Yale New Haven Health
SBO, Attn: Financial Assistance
PO BOX 1403,
New Haven, CT 06505

LAWRENCE + MEMORIAL CORPORATION

BOARD OF TRUSTEES

RESOLUTIONS RELATING TO THE FINANCIAL ASSISTANCE POLICY

January 23, 2017

WHEREAS, Lawrence + Memorial Corporation ("***LMC***") is the sole member of Lawrence + Memorial Hospital and Westerly Hospital and is part of the nonprofit integrated delivery system known as Yale New Haven Health; and

WHEREAS, Yale New Haven Health member hospitals provide financial assistance to patients to help pay for emergency and other medically necessary hospital care as more fully described in the Yale New Haven Health Financial Assistance Programs Policy ("***FAP***"); and

WHEREAS, management has recommended and implemented certain changes to the FAP, including, without limitation, changes necessary to comply with law and, further, to include Lawrence + Memorial Hospital and Westerly Hospital, which hospitals joined Yale New Haven Health in September 2016; and

WHEREAS, the Board of Trustees has determined that the foregoing resolutions are in the best interest of LMC.

NOW, THEREFORE, BE IT RESOLVED, as follows:

Section 1. The Board of Trustees hereby ratifies, confirms and approves the FAP attached hereto as *Exhibit A*.

Section 2. The Board of Trustees hereby authorizes and directs the Yale New Haven Health Senior Vice President, Finance and the Senior Vice President and General Counsel, or their designees, to make such changes to the FAP as are required by law, or as they deem necessary or appropriate to effectuate or carry out fully the purpose and intent of the foregoing resolutions.

Section 3. Any and all actions previously taken by the officers or employees of LMC in connection with the foregoing resolutions are hereby ratified, approved and confirmed in all respects.

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CERTIFICATION

The undersigned assistant secretary of Lawrence + Memorial Corporation hereby certifies that the foregoing resolution was duly adopted by the Board of Trustees on January 23, 2017 and remains in full force and effect without amendment as of the date hereof.

Maureen J. Anderson, Assistant Secretary

2/16/17
Date

Yale
NewHaven
Health

Exhibit A

Service Area: Corporate Business Services	**YALE NEW HAVEN HEALTH SYSTEM POLICIES & PROCEDURES**
Title: Financial Assistance Programs Policy	
Date Approved: 09/20/2013	**Approved by:** Boards of Trustees Senior Vice President, Finance
Date Effective: 09/20/2013 1/1/2017 Lawrence + Memorial Hospital and Westerly Hospital	**Date Reviewed/Revised:** 01/21//2015, 09/30/2016, 12/16/2016
Distribution: MCN Policy Manager	**Policy Type (I or II):** Type I
Supersedes: Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4) Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13) Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services Lawrence + Memorial Hospital and Westerly Hospital Charity Care, Financial Assistance, Free Bed Fund Policy	

PURPOSE

Yale New Haven Health System ("YNHHS") recognizes that patients may not be able to pay for medically necessary health care without financial assistance. Consistent with its mission, YNHHS is committed to assuring that the ability to pay will be considered carefully when setting amounts due for emergency and other medically necessary hospital services.

In furtherance of its mission, YNHHS has established the Financial Assistance Programs ("FAP") to assist individuals with paying for emergency and other medically necessary care. The objectives of the FAP are to:

(i) Specify all financial assistance available under the FAP;

(ii) Provide clear information regarding eligibility criteria, application requirements and the method for applying for financial assistance;

(iii) Describe the basis for calculating amounts charged to FAP-eligible patients for emergency or other medically necessary care; and

(iv) Describe the steps YNHHS hospitals take to widely publicize this FAP within the communities served by YNHHS.

APPLICABILITY

This policy applies to each licensed hospital affiliated with YNHHS, including Bridgeport Hospital ("BH"), Greenwich Hospital ("GH"), Lawrence + Memorial Hospital ("LMH"), Yale-New Haven Hospital ("YNHH") and Westerly Hospital ("WH") (each a "Hospital").

POLICY

I. Scope and Provider List

A. **Emergency and Other Medically Necessary Care.** The FAP apply to emergency and other medically necessary care, including inpatient and outpatient services, billed by a Hospital. The FAP exclude: (a) private room or private duty nurses; (b) services that are not medically necessary, such as elective cosmetic surgery; (c) other elective convenience fees, such as television or telephone charges, and (d) other discounts or reductions in charges not expressly described in this policy.

B. **Provider List.** A list of providers who provide emergency and other medically necessary care at a Hospital can be found here: https://www.ynhhs.org/patient-care/billing-insurance/financial-assistance.aspx. The list indicates if the provider is covered under the FAP. If the provider is not covered under this FAP, patients should contact the provider's office to determine if the provider offers financial assistance and if so what the provider's financial assistance policy covers.

II. Financial Assistance Programs and Eligibility

Financial assistance is available to individuals who are residents of the United States of America, or citizens of the Unites States residing abroad, who complete the required financial assistance application and meet the additional eligibility requirements described below.

A. **Free Care.** The Free Care program provides care at no cost to Hospital patients with gross annual family income less than or equal to 250% of the Federal Poverty Guidelines (*see* Attachment 1), and who have applied and been approved or receive a valid denial for State medical assistance, within the last six months.

In addition, YNHHS on behalf of BH, GH, and YNHH uses a third party screening tool to assist in identifying individuals with self-pay balances who have not applied for financial assistance, but whose income is less than or equal to 250% of the Federal Poverty Level (*i.e.*, eligible for free care). If a patient is identified through this process outstanding hospital balances may be adjusted to charity (free) care.

B. **Discounted Care.** If a Hospital patient does not have insurance and his or her gross annual family income is more than 250% of the Federal Poverty Level the Hospital will discount care to the Hospital's AGB (as defined in Section III below and on Attachment 1 hereto).

C. **Restricted Bed Funds.** You may be eligible to receive restricted bed funds, which are funds that have been donated to the Hospital to provide free or discounted care to individuals who meet the individual fund criteria. There are no specific income limits for receipt of restricted bed funds. Eligibility is determined on a case-by-case basis by the fund nominators based on financial hardship. All patients who fill out the requisite financial assistance application will automatically be considered for restricted bed funds.

D. **Other Hospital-Specific Financial Assistance programs.**

(i) **Yale New Haven Hospital Me & My Baby Program**. This program is available to Yale New Haven Hospital patients. It provides prenatal, labor and delivery services, and some post-partum care free of charge. You may be eligible if you live in New Haven County, do not have any type of health insurance and your family earns less than 2 ½ times the Federal Poverty Level. For more information or to request an application see our representatives at the Yale New Haven Hospital Women's Center or call 203-688-5470.

(ii) **Greenwich Hospital Outpatient Clinic** serves patients insured by Medicare, Medicaid, or insurances offered through Access Health CT and whose family income is less than 4 times the Federal Poverty Level. Further, the clinic provides discounted care to individuals who are not eligible for insurance and who reside in Greenwich and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call 203-863-3334.

III. Limitation on Charges - Amounts Billed to FAP-Eligible Patients

Where there is an award of financial assistance that does not cover 100% of YNHHS charges for the service, the amounts charged to patients eligible for financial assistance under this Policy will not be more than the amount a Hospital generally bills patients who have insurance coverage for such care ("AGB"). YNHHS calculates AGB annually by Hospital using the "look back method" and based on Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts and all private health insurers that pay claims to each Hospital facility for the prior fiscal year. YNHHS may apply the percentage discount by Hospital, or may elect to use the percentage discount most favorable to YNHHS patients. AGB is set forth on Attachment 1 hereto.

As used herein, the "amount generally billed" and "look back method" have the meanings set forth in Internal Revenue Code §501(r)(5) and1.501(r)-5.

IV. Method of Applying for Assistance

To be eligible for financial assistance, the patient must complete the requisite application for financial assistance ("Application"). The Application sets forth (i) FAP available programs and eligibility requirements, (ii) the documentation requirements for determinations of eligibility, and (iii) the contact information for FAP assistance. The Application also specifies that (i) the Hospital will respond to each Application in writing, (ii) patients may re-apply for financial assistance under the FAP at any time, and (iii) additional free bed funds become available every year. Hospitals may

not deny financial assistance under the FAP based on failure to provide information or documents that the FAP or the Application do not require as part of the Application.

YNHHS Hospitals will make reasonable efforts to determine eligibility and document any determinations of financial assistance eligibility in the applicable patient accounts. Once Hospital identifies a patient is FAP-eligible, Hospital shall:

(i) Provide a billing statement indicating amount the individual owes as a FAP-eligible patient, including how the amount was determined and states, or describes, how the individual can get information regarding the AGB for the care;

(ii) Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5, or such other amount set by the IRS; and

(iii) Take reasonable measures to reverse any extraordinary collection actions.

V. Non-Payment – Legal Action

A Hospital (and any collection agency or other party to which it has referred debt) shall not engage in any extraordinary collection action ("ECA") before making reasonable efforts to determine if a patient or any other individual having financial responsibility for a self-pay account (Responsible Individual(s)) eligible for financial assistance under this FAP. Any ECA must be approved by the Vice President of Corporate Business Services or his designee(s), prior to the initiation of any ECA.

The Hospital will follow its A/R billing cycle in accordance with internal operational processes and practices. As part of such processes and practices, the Hospital will, at a minimum, notify patients about its FAP from the date care is provided and throughout the A/R billing cycle (or during such period as is required by law, whichever is longer) by:

1. All patients will be offered a plain language summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a Hospital.

2. At least three separate statements for collection of self-pay accounts will be mailed or emailed to the last known address of the patient and any other Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All single patient account statements of self-pay accounts will include but not limited to:

    a. An accurate summary of the hospital services covered by the statement;

    b. The charges for such services;

c. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and

d. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of financial assistance under the FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

3. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the billing deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A plain language summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

4. Prior to initiation of any ECA, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial assistance that may be available under the FAP.

5. Subject to compliance with the provisions of this policy, a YNHHS Hospital may take the ECA listed on Attachment 2 of this Policy to obtain payment for medical services provided.

VI. Policy Availability

Copies of the FAP, a plain language summary of the FAP and FAP application are available at https://www.ynhhs.org/billing-insurance.aspx.

Each Hospital makes available copies of the FAP, a plain language summary of the FAP and FAP application on request, free of charge, by mail or in the Hospital Emergency Department and at all points of registration in paper form in English and the primary language of any population with limited English proficiency that constitutes 5% or more of the population the Hospital serves. See Attachment 3 for a list of languages.

Contact Corporate Business Services toll free at (855) 547-4584 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, plain language summary of the FAP, FAP application form, or Billing and Collection Policy to be mailed to you, or if you need a copy of the FAP, plain language summary, or FAP application form translated to a language other than English. Further, patients may ask Patient Registration, Patient Financial Services and Social Work/Case Management about initiating the FAP application process.

Further efforts to widely publicize the FAP include publishing notices in newspapers of general circulation; providing written notice of FAP in billing statements; providing notice of FAP in oral communications with patients regarding the amount due; and holding open houses and other informational sessions.

VII. Management Oversight Committee

The FAP will be overseen by a management oversight committee chaired by a Senior Vice President, YNHHS and comprised of representatives from Corporate Business Services, patient financial services, patient relations, finance, and the medical staff, as necessary. This committee will meet on a monthly basis.

VIII. Compliance with State Law

Each Hospital shall comply with relevant State laws, including, without limitation, Connecticut General Statutes governing Collections by Hospitals from Uninsured Patients and Rhode Island *Statewide Standard for the Provision of Charity Care* set forth in Section 11.3 of the Rhode Island Department of Health Rules and Regulations Pertaining to Hospital Conversions (the "RI Regulations") and the *Statewide Standard for the Provision of Uncompensated Care* set forth in Section 11.4 of the RI Regulations.

REFERENCES
Internal Revenue Code 501(c)(3)
Internal Revenue Code 501(r)
Conn. Gen. Stat. § 19a-673 et seq.
RI Regulations 11.3 and 11.4

RELATED POLICIES
YNHHS Billing and Collections Policy
Yale-New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2

Attachment 1

250% of the Federal Poverty Guidelines (FPG)

Family size:	Maximum Income:
1	$29,700
2	$40,050
3	$50,400
4	$60,750
5	$71,100
6	$81,450

Add* **$10,400 *for each additional family member*

Amounts Generally Billed (AGB)

Patients eligible for financial assistance under this Policy will receive assistance according to the following:

All YNHHS Hospitals, except for Westerly Hospital:

Annual Family Income	Amount of Discount % of Charges	Patient Pays % of Charges
< or = 250% FPG	100%	0
> 250% FPG	69%	31%

Westerly Hospital:

Annual Family Income	Amount of Discount % of Charges	Patient Pays % of Charges
< or = 250% FPG	100%	0
> 250% FPG	72%	28%

**For calendar year 2016, AGB (% of charges): BH 68%, GH 68%, LMH 67%, YNHH 67% and WH 72%*

Attachment 2

EXTRAORDINARY COLLECTION ACTIONS

Property Liens

Liens on personal residences are permitted only if:

a) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;

b) The patient has not applied or qualified for other financial assistance under the Hospital's Financial Assistance Policy, to assist in the payment of his/her debt, or has qualified, in part, but has not paid his/her responsible part;

c) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;

d) The aggregate of account balances is over $10,000 and the property(ies) to be made subject to the lien are at least $300,000 in assessed value; and

e) The lien will not result in a foreclosure on a personal residence.

Attachment 3

Limited English Proficiency Languages

Albanian
Arabic
Simplified Chinese
French
French Creole (Haitian Creole)
German
Greek
Hindi
Italian
Japanese
Korean
Pashto
Persian Dari
Persian Farsi
Polish
Portuguese
Portuguese Creole (Cape Verdean)
Russian
Spanish
Swahili
Tagalog
Tigrinya
Turkish
Vietnamese

LAWRENCE + MEMORIAL HOSPITAL

BOARD OF TRUSTEES

RESOLUTIONS RELATING TO THE FINANCIAL ASSISTANCE POLICY

January 23, 2017

WHEREAS, Lawrence + Memorial Hospital ("***LMH***") is part of the nonprofit integrated delivery system known as Yale New Haven Health; and

WHEREAS, Yale New Haven Health member hospitals provide financial assistance to patients to help pay for emergency and other medically necessary hospital care as more fully described in the Yale New Haven Health Financial Assistance Programs Policy ("***FAP***"); and

WHEREAS, management has recommended and implemented certain changes to the FAP, including, without limitation, changes necessary to comply with law and, further, to include Lawrence + Memorial Hospital and Westerly Hospital, which hospitals joined Yale New Haven Health in September 2016; and

WHEREAS, the Board of Trustees has determined that the foregoing resolutions are in the best interest of LMH.

NOW, THEREFORE, BE IT RESOLVED, as follows:

Section 1. The Board of Trustees hereby ratifies, confirms and approves the FAP attached hereto as *Exhibit A*.

Section 2. The Board of Trustees hereby authorizes and directs the Yale New Haven Health Senior Vice President, Finance and the Senior Vice President and General Counsel, or their designees, to make such changes to the FAP as are required by law, or as they deem necessary or appropriate to effectuate or carry out fully the purpose and intent of the foregoing resolutions.

Section 3. Any and all actions previously taken by the officers or employees of LMH in connection with the foregoing resolutions are hereby ratified, approved and confirmed in all respects.

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CERTIFICATION

The undersigned assistant secretary of Lawrence + Memorial Hospital hereby certifies that the foregoing resolution was duly adopted by the Board of Trustees on January 23, 2017 and remains in full force and effect without amendment as of the date hereof.

Maureen J. Anderson, Assistant Secretary

2/16/17
Date

Yale
NewHaven
Health

Exhibit A

Service Area: Corporate Business Services	**YALE NEW HAVEN HEALTH SYSTEM POLICIES & PROCEDURES**
Title: Financial Assistance Programs Policy	
Date Approved: 09/20/2013	**Approved by:** Boards of Trustees Senior Vice President, Finance
Date Effective: 09/20/2013 1/1/2017 Lawrence + Memorial Hospital and Westerly Hospital	**Date Reviewed/Revised:** 01/21//2015, 09/30/2016, 12/16/2016
Distribution: MCN Policy Manager	**Policy Type (I or II):** Type I
Supersedes: Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4) Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13) Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services Lawrence + Memorial Hospital and Westerly Hospital Charity Care, Financial Assistance, Free Bed Fund Policy	

PURPOSE

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(ii) Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5, or such other amount set by the IRS; and

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    b. The charges for such services;

c. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and

d. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of financial assistance under the FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

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REFERENCES
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Internal Revenue Code 501(r)
Conn. Gen. Stat. § 19a-673 et seq.
RI Regulations 11.3 and 11.4

RELATED POLICIES
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Yale-New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2

Attachment 1

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> 250% FPG	69%	31%

Westerly Hospital:

Annual Family Income	Amount of Discount % of Charges	Patient Pays % of Charges
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**For calendar year 2016, AGB (% of charges): BH 68%, GH 68%, LMH 67%, YNHH 67% and WH 72%*

Attachment 2

EXTRAORDINARY COLLECTION ACTIONS

Property Liens

Liens on personal residences are permitted only if:

a) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;

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c) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;

d) The aggregate of account balances is over $10,000 and the property(ies) to be made subject to the lien are at least $300,000 in assessed value; and

e) The lien will not result in a foreclosure on a personal residence.

Attachment 3

Limited English Proficiency Languages

Albanian
Arabic
Simplified Chinese
French
French Creole (Haitian Creole)
German
Greek
Hindi
Italian
Japanese
Korean
Pashto
Persian Dari
Persian Farsi
Polish
Portuguese
Portuguese Creole (Cape Verdean)
Russian
Spanish
Swahili
Tagalog
Tigrinya
Turkish
Vietnamese

User, OHCA

From: PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Sent: Tuesday, March 07, 2017 1:52 PM
To: User, OHCA
Cc: 'ynhhscohcamonitor@deloitte.com'; Capozzalo, Gayle; Gonsalves, Elizabeth; Willcox, Jennifer; Tammaro, Vincent; PERRONE, BRETT
Subject: Docket #15-32033-CON: Condition 6 and Condition 32f (or 7c of Docket #15-32032-CON)
Attachments: Condition 6 - L+MH Top 25 Most Frequently Utilized Services (030717) SENT TO OHCA 030717.pdf; Condition 32f (or 7c) - Projected 5-year Savings Plan (022017) SENT TO OHCA 030717.pdf

Attached please find documents submitted to comply with Docket #15-32033-CON Condition 6 and Condition 32f (or 7c of Docket #15-32032-CON).

Condition 6 requires L+MH to file with OHCA the total price per unit of service for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services.

Condition 32f (or 7c) requires L+MH to submit a five-year plan to generate and achieve efficiencies.

If you have any questions, please feel free to contact me.

Thank you,
Shraddha

Shraddha Patel, FACHE
Director of Strategy and Regulatory Planning & Reporting
2 Howe 3rd Floor
New Haven, CT 06519
Phone: 860-912-5324
Email: shraddha.patel@ynhh.org

YaleNewHavenHealth

Templates for Reporting on L+MH Top 25 Most Frequently Utilized Services
MS-DRGs (Inpatient) and CPT (Outpatient)
Docket #15-32033-CON: Condition 6

OHCA will receive an annual report of the total price per "unit of service" for MS-DRG and CPT codes each fiscal year through the end of FY 2019.

Condition 6: Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015 - August 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.

Templates for Reporting on YNHHS/L+M Five-Year Synergy Financial Plan
Docket #15-32033-CON: Condition 32f and Docket #15-32032-CON: Condition 7c
FY 2017 - FY 2021

Condition 32

FY 2017 - FY 2018 and each fiscal year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October-March (due May 31st) and April-September (due November 30th) certifying the achievement of each and every commitment described herein:

Condition 32f (L+M Healthcare and L+M Hospital)

A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of teh plan in its six month report, YNHHSC shall include the following additional information in its annual report.

i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M ofYNHHSC non-clinical shared services opportunities

ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each ofthese major expense categories

iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports (no template)

iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report (no template)

Condition 7c (LMMG/NEMG) (reported as part of 32f)

A detailed and comprehensive document showing a five-year plan (the “plan”) to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M’s integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC’s supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M’s reduced cost of capital, and L+M’s participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA’s HRS Report 100 and Report 150 or successor reports (no template for balance sheet or statement of operations of NEMG/LMMG)

Lawrence + Memorial Healthcare (including L+M Hospital and LMMG)

Projected 5- year Synergy Savings Plan

By Fiscal Year

Docket # 15-32033-CON: Condition 32f and Docket #15-32032-CON: Condition 7c

Due: March 7, 2017

Categories	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Wages	$1,601,400	$5,118,511	$5,295,470	$5,379,660	$5,361,533
Fringe Benefits	$283,680	$906,720	$938,067	$952,981	$949,770
Contractual Labor Fees	$0	$0	$0	$0	$0
Medical Supplies and Pharmaceuticals	$1,340,000	$1,340,000	$1,340,000	$1,340,000	$1,340,000
Depreciation/Amortization	$0	$0	$0	$0	$0
Interest Expense	$0	$0	$0	$0	$0
Malpractice Expense	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0
Business Expense	$913,403	$1,720,985	$1,720,985	$1,720,985	$1,720,985
Other Operating Expense	$0	$0	$0	$0	$0
Total Synergies	**$4,138,484**	**$9,086,215**	**$9,294,522**	**$9,393,626**	**$9,372,287**

L+MH Top 25 Most Frequently Utilized Services - MS-DRG (Inpatient) & CPT (Outpatient)

CT OHCA 15-32033 Condition 6

Due March 7, 2017

October 1, 2015 - September 30, 2016

	L+MH Top 25 MS-DRG Inpatient Codes	Total Price		L+MH Top 25 CPT Outpatient Codes	Total Price
1)	795 - NORMAL NEWBORN	$ 1,552.90	1)	36415 - Routine venipuncture	$ 4.56
2)	470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOW	$ 19,514.20	2)	99218 - Initial observation care	$ 103.73
3)	775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	$ 5,689.94	3)	85025 - Complete cbc w/auto diff wbc	$ 12.23
4)	885 - PSYCHOSES	$ 8,108.08	4)	97110 - Therapeutic exercises	$ 62.59
5)	766 - CESAREAN SECTION W/O CC/MCC	$ 8,656.05	5)	99283 - Emergency dept visit	$ 351.39
6)	794 - NEONATE W OTHER SIGNIFICANT PROBLEMS	$ 2,424.58	6)	80053 - Comprehen metabolic panel	$ 19.81
7)	871 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W M(	$ 14,100.96	7)	84443 - Assay thyroid stim hormone	$ 26.02
8)	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/	$ 6,492.97	8)	85610 - Prothrombin time	$ 6.67
9)	603 - CELLULITIS W/O MCC	$ 6,440.90	9)	80061 - Lipid panel	$ 21.52
10)	292 - HEART FAILURE & SHOCK W CC	$ 7,335.68	10)	97140 - Manual therapy 1/> regions	$ 65.97
11)	765 - CESAREAN SECTION W CC/MCC	$ 9,463.06	11)	81001 - Urinalysis auto w/scope	$ 6.20
12)	190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	$ 8,536.55	12)	96361 - Hydrate iv infusion add-on	$ 55.03
13)	378 - G.I. HEMORRHAGE W CC	$ 8,426.83	13)	82565 - Assay of creatinine	$ 6.48
14)	683 - RENAL FAILURE W CC	$ 7,689.48	14)	80048 - Metabolic panel total ca	$ 16.31
15)	191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	$ 7,258.16	15)	84520 - Assay of urea nitrogen	$ 5.27
16)	65 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W	$ 12,439.54	16)	82947 - Assay glucose blood quant	$ 4.82
17)	194 - SIMPLE PNEUMONIA & PLEURISY W CC	$ 7,754.68	17)	88305 - Tissue exam by pathologist	$ 47.29
18)	287 - CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/	$ 11,604.50	18)	87086 - Urine culture/colony count	$ 12.50
19)	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$ 6,332.41	19)	77052 - Comp screen mammogram add-on	$ 96.00
20)	774 - VAGINAL DELIVERY W COMPLICATING DIAGNOSES	$ 7,139.31	20)	82306 - Vitamin d 25 hydroxy	$ 44.25
21)	872 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O	$ 8,667.49	21)	82310 - Assay of calcium	$ 5.82
22)	460 - SPINAL FUSION EXCEPT CERVICAL W/O MCC	$ 32,547.90	22)	84450 - Transferase (ast) (sgot)	$ 6.32
23)	291 - HEART FAILURE & SHOCK W MCC	$ 10,826.09	23)	93005 - Electrocardiogram tracing	$ 86.92
24)	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILIT/	$ 6,023.86	24)	71020 - Chest x-ray 2vw frontal&latl	$ 77.14
25)	641 - MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELI	$ 5,705.87	25)	97530 - Therapeutic activities	$ 80.31

*Total Price is defined as the weighted average price for all governmental and non-governmental payers

Due internally to Regulatory 30 days prior to OHCA due date

User, OHCA

From: Roberts, Karen
Sent: Thursday, March 23, 2017 12:08 PM
To: User, OHCA
Subject: FW: Docket# 15-32033-CON Condition 33d
Attachments: DT_Public Forum 3.1.17 Minutes final.docx; Public Forum Sign In Sheet 3.1.17.pdf; Public Meeting FINAL 030117.pptx

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From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, March 23, 2017 11:58 AM
To: Martone, Kim; Roberts, Karen
Cc: Capozzalo, Gayle; PATEL, SHRADDHA; Mitchell, Kelly Rose (US - Boston)
Subject: RE: Docket# 15-32033-CON Condition 33d

Hi Kim and Karen-

Please see the attached presentation, meeting minutes and sign-in sheet from the YNHH/L+MH Public Forum held in New London on March 1st. This meeting was hosted by Yale New Haven Health and Deloitte representatives attended per the Monitoring role.

Feel free to contact me if you have any questions. I would appreciate it if you would confirm that you have received this information.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, NY 10112

Tel: +212 436 3180
Fax: +212 653 7033
www.deloitte.com

Minutes

Meeting:	L+MH New London Public Forum
Held on:	March 1, 2017 at 6:00 pm
Location:	Holiday Inn, New London, CT
Introduction	The meeting began at 6:00pm EST. Vin Petrini provided an introduction and opening remarks. He emphasized YNHHSC's excitement about the affiliation and stated there have been several signs of progress over the first five months. Mr. Petrini provided an overview of the agenda for the evening and introduced Kelly Sauders from Deloitte and Cathy Zall, Board member.
Presentation	Mr. Petrini provided an overview of the rationale for the YNHHS affiliation with L+MH. Examples included enhancing access to comprehensive care in eastern CT and western RI, fortifying the physician network to support population health, increasing access to YNHHS specialty services in local communities, developing scale to realize cost savings and identifying efficiencies to enhance financial viability of L+MH. Mr. Petrini described opportunities to provide value, such as brand identification, expanded clinical offerings in eastern CT, IT integration to enhance care, employed physician integration to create one standard of care and reduced administrative costs, corporate services integration, and furthering the population health network. Kelly Sauders provided an overview of the Office of Healthcare Access (OHCA) conditions for which both YNHHS and L+MH must comply and described the independent monitor role with regard to oversight and analysis as well as reporting. Ms. Sauders also described Cathy Zall's role as community representative. Finally, Ms. Sauders provided the group with some of the observations from her site visit to L+MH earlier in the day. Mr. Petrini reviewed several key investments that have been made in the first five months, including the ~$4.3M investment for Epic, capital investments, clinical investments and marketing efforts. He provided examples of positive clinical statistics. Mr. Petrini concluded with a timeline of key milestones since the start of the affiliation and opened up the meeting for questions.
Questions and Answers	1. Question to Vin Petrini: What are your plans for recruitment from specialties? There are problems with patients being able to find someone able to take new patients. A: Vin Petrini responded: We are assessing overall needs: one is primary care and we have a plan to recruit primary care, looking at all areas, and we are also tracking who is leaving to identify new opportunities/needs.

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2. Question to Kelly Sauders: I have a hard time believing your visit to L+MH was "all rosy" and wonder if you talked to the staff. There are problems with Epic and folks that used to be treated at L+MH are now being sent to Yale. What diagnoses are no longer being treated at L+MH that used to be?
    A: Vin Petrini responded: If it is a very difficult procedure that cannot be done at L+MH it is a situation where the patient would be sent to Yale New Haven.
3. Question: How was tonight's meeting advertised? With regard to community health assessment and implementation, is there a plan to improve resources available in critical priorities?
    A: Vin Petrini responded: He listed where tonight's event was advertised including the L+MH website and local paper.
    A: Vin Petrini responded: A $5,000 investment viewed as supporting critical priorities was recently made to a local organization to support sober houses.
4. Question about community benefits: A participant commented about how community needs assessment was great, identified diabetes, but asked about the specific strategies and expressed concern about the implementation.
    A: Vin Petrini responded: We do not disagree with the community health needs assessment whatsoever. Our primary goal is to bring L+MH to full fruition. As we make investments in this community and this hospital, our community investments will follow. The environment is changing so rapidly. This affiliation will bring stability. We are confident we will be able to exceed the commitments made.
5. Comment suggesting Yale New Haven Health System spends too much money on advertising and referenced a commercial aired during the Super Bowl. Concern was that money should be focused in the community.
    A: Vin Petrini responded: It is our complete focus to reach out to community. We need to grow so we can drive down costs and deliver care at the bedside at a lower cost. We want this to succeed so we can create and grow access.
6. Question about fluctuating margin and request to discuss what the plan is?
    A: Vin Petrini responded: Strategic plan is posted online on OHCA. L+MH is an extraordinary organization that was challenged by factors including declining reimbursement. CT hospitals have also seen increases in taxes. We need to work together if we are concerned about driving access to care in the long run. It is critical to address these issues.
7. Cathy Zall commented that we are in a period of transition and there is focus and attention on trying to deal with the financial losses. She stated (to the audience) that we have the opportunity to build mutually beneficial partnerships going forward. She noted that she herself was learning so much more about the community health needs assessment and processes and looks forward to partnering going forward.
8. Another question about margin and concern about corporate structure of L+MH e.g. hospital vs. medical group, and if earnings be reinvested into L+MH?
    A: Vin Petrini responded: Other hospitals may have a much more centralized perspective. We look at investment overall in the system because we cannot get to a position of wellness without partnering with physicians. We continue to see fewer independent physicians practicing. As we recruit new physicians there will be losses associated but it is crucial for our patients to have them. We focus on the overall investment.

Deloitte.

	9. Question: Should we provide all of our contact information so we can be notified of the next meeting? A: Yes 10. Question: The OHCA website had ambiguous information about continued clinical services. Does L+MH plan to continue to offer pediatric services? A: Yes. 11. Question about Medicaid block grants (general). A: Vin Petrini responded: Block grants would give state a pool of dollars and flexibility to do with it whatever they want. Noted some concern over this and that there are other possible solutions.
Closing	Mr. Petrini closed the meeting by thanking everyone for attending and confirmed there will be another public meeting likely in May. The meeting was adjourned at 7:10pm EST.

Deloitte.

Lawrence + Memorial Healthcare
Independent Monitor Public Forum
Holiday Inn, New London, CT
March 1, 2017

Name	Signature	Organization
Jerry & Ed Cramer		
Nabmi Packleff		
Laurel Holmes		
Kelly Mitchell		Deloitte
Kelly Sanders		Deloitte
Bill Stanley		YNHHS
Vin Petrini		YNHHS
Gayle Capozzalo		YNHHS
Cathy Zell		
Michael Arnold		
Angela Arnold		
Pam & Rod Arbo		
Jane + Rich Bucklin		
Brenda Kramer		
Bill Kramer		
Alessandra Melendez-Cooper		
Lenaessen Bobroff		
LEN Wolmmd		
STEVE DARLEN		
Bill + Christine Crawford		
FRED ZIEGLER		
Martha E Marx		City Council NL
Stephanie Johnsen	A Johnsen	UNLocal 5051
Lor. Lindfors		
Jeanne Milstein		City of New London
Steve Smith	Sobrio	NPA

Deloitte.

Lawrence + Memorial Healthcare
Independent Monitor Public Forum
Holiday Inn, New London, CT
March 1, 2017

Andy Russell		
Alan Gardiner		
ALYCE HEMSTREET		
EDWARD HEMSTREET		
Edw Cramer		
Efrain Dominguez Jr.		
Kevin Hennessy		
Tom [illegible]		
Kristen Powers		
Shemon Powers		
Mariana Salas-Vega		
Pat Doherty		
Laura Doherty		
Kathy Hauser		

Yale NewHaven Health

Lawrence + Memorial Healthcare Independent Monitor

Public Forum

March 1, 2017

Agenda

Opening and Introductions
Rationale for YNHHS Affiliation with L+MH
Office of Healthcare Access (OHCA) Affiliation Conditions
Role of the Independent Monitor
YNHHS Investments to Date
Questions

Why Yale New Haven Health System Affiliated with L+M Healthcare

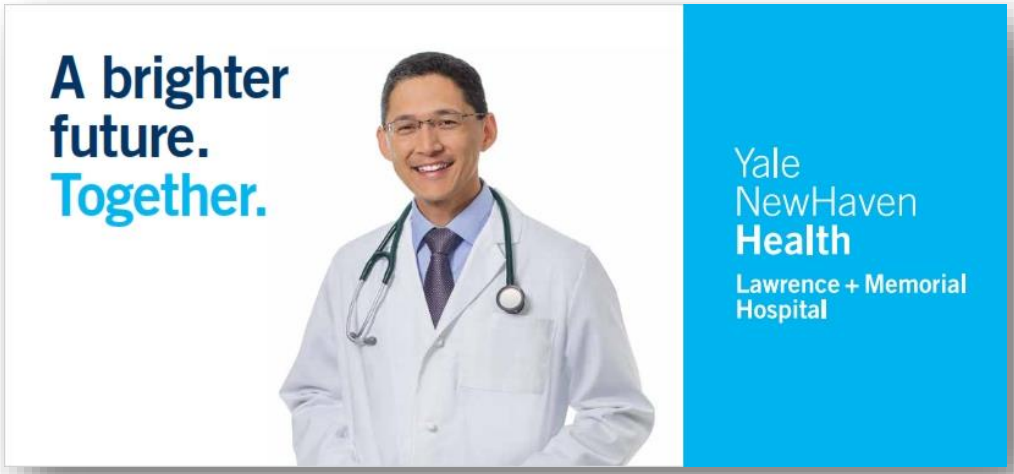
- Enhance access to comprehensive care in eastern Connecticut and western Rhode Island with strong healthcare provider
- Fortify physician network to support population health strategy

- Increase access to YNHHS specialty services in local communities
- Develop scale to realize cost savings and efficiencies to enhance financial viability of L+M Healthcare
- Support Yale New Haven Health highly specialized services

Yale
NewHaven
Health

Lawrence + Memorial Healthcare
Opportunities to Provide Value

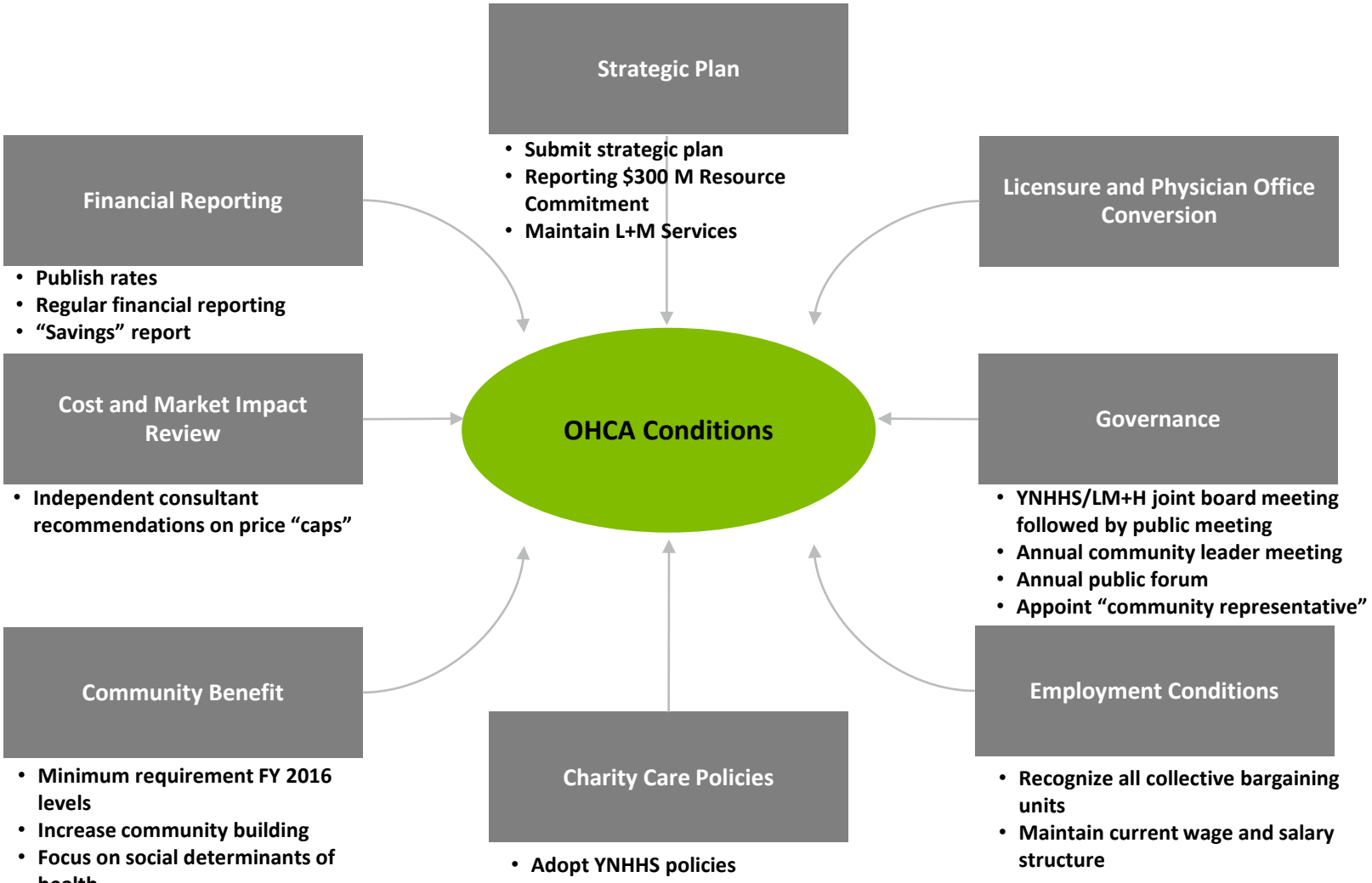
- Brand identification
- Expand clinical offerings in Eastern Connecticut
- IT integration to enhance care
- Employed physician integration to create one standard of care and reduce administrative costs
- Corporate services integration
- Population health network



Office of Healthcare Access (OHCA) Conditions

- The affiliation of L+M Healthcare with Yale New Haven Health was fully approved by the State of Connecticut's Office of Healthcare Access (OHCA) in September 2016
- OHCA has set forth conditions to which both YNHHS and L+M must comply
- OHCA appointed an Independent Monitor, Deloitte & Touche (D&T), to ensure the OHCA conditions are met.
- Independent Monitor reports to OHCA

OHCA Conditions



Yale NewHaven Health

Independent Monitor Role

Ongoing Oversight and Analysis

- As the Independent Monitor, D&T is responsible for monitoring YNHHS compliance with the conditions set forth in the Order. Additional monitoring activities include:
  - Meet annually with Community Representative
  - Meet regularly with YNHHSC leadership team
  - Hold annual Public Forum

Reporting

- D&T will obtain and evaluate documentation for accuracy and completeness prior to submission to OHCA
- D&T will report to DPH and will conduct on-site visits of L+MH
- D&T shall furnish a written report of an assessment to DPH within 30 days of the on-site review
- YNHHSC will have the opportunity to review and provide written responses to the report
- As OHCA deems necessary, D&T shall meet with DPH personnel to discuss the written report

OHCA Appointed "Community Representative" Board Member: Cathy Zall

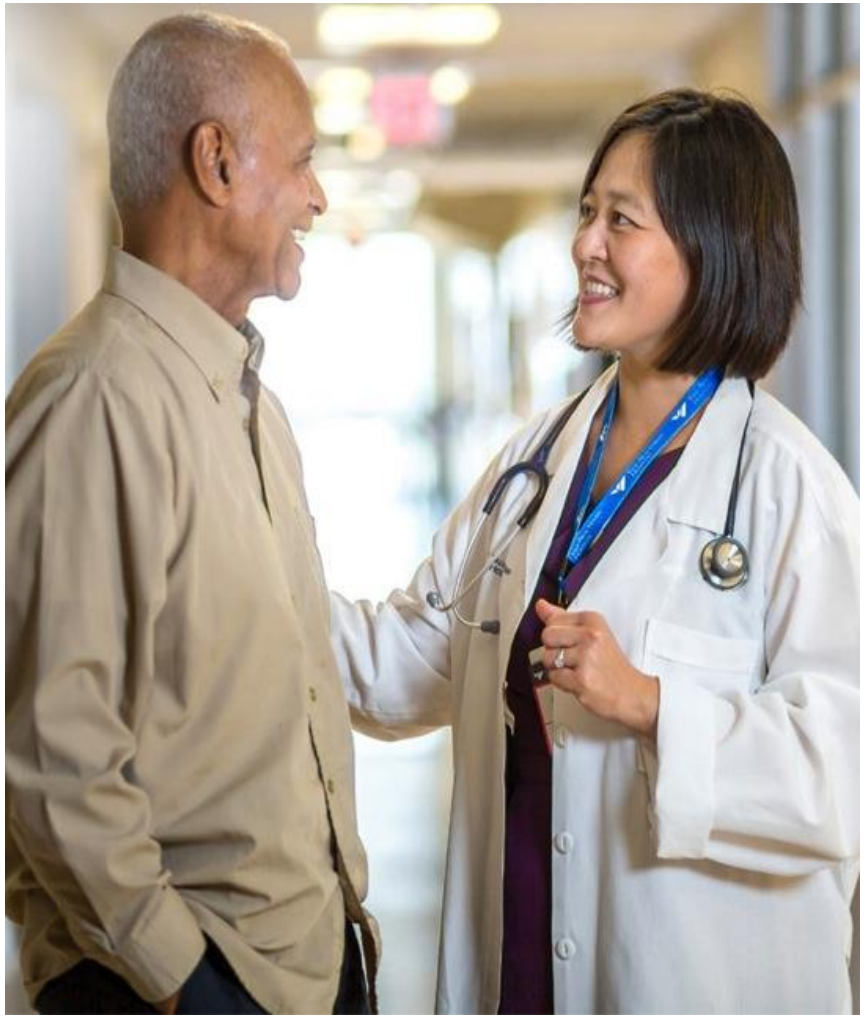
Cathy's Experience

- Executive Director of the New London Homeless Hospitality Center since 2007
- Pastor of the First Congregational Church of New London
- Project Manager for the Connecticut Department of Social Services
- Program Director for the Connecticut Child Care Assistance Program
- Deputy Commissioner of the New York City Department of Social Services
- Master of Divinity degree from Yale University
- MBA from New York University
- Bachelor's Degree from Brown University

Key Investments and Clinical Statistics

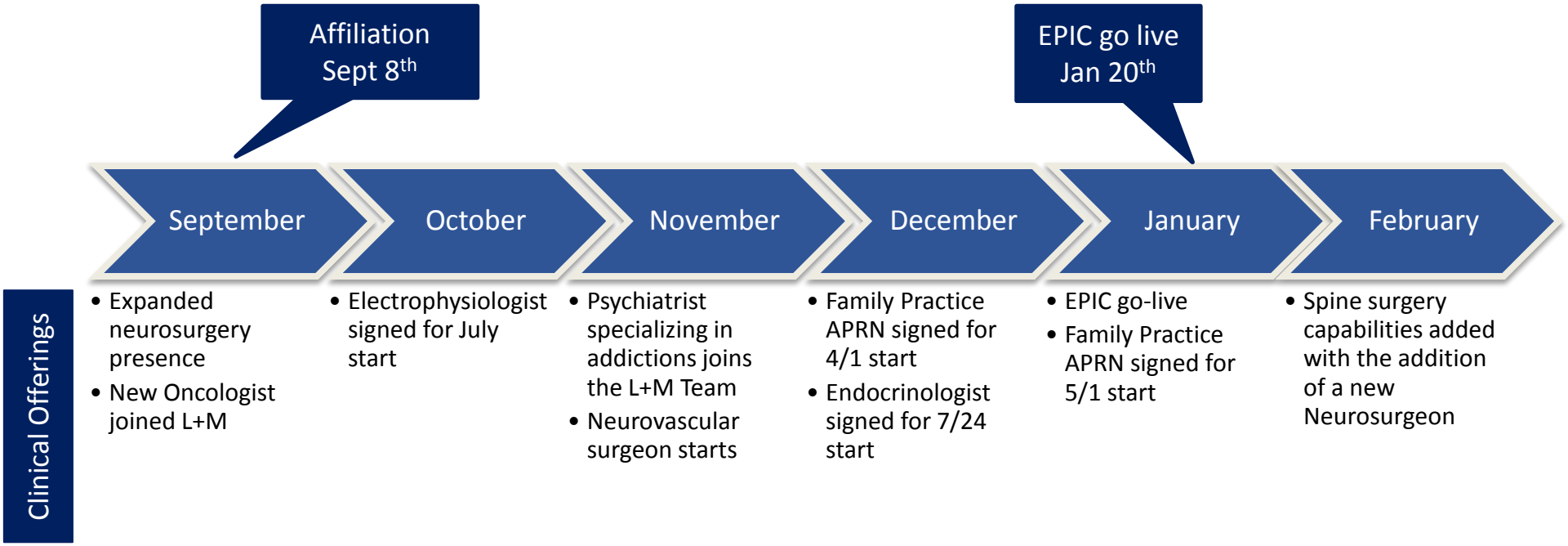
Key Facts Since Affiliation:

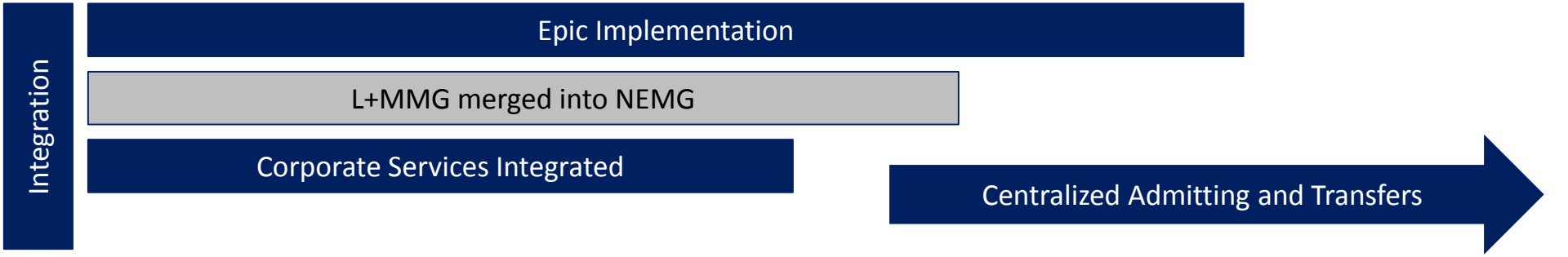
- ~$4.3M has been invested by YNHHS for the successful Epic electronic health record implementation
- Capital investments of more than $8 million
- Clinical Investments to date total ~$1.15M including:
  - Psychiatric Services
  - Neurosurgical Services
  - Oncology Services
  - Heart and Vascular Services
- Signage/marketing efforts
- The average daily census has been trending up since the onset of affiliation
- Patients from the community who presented to the YNHHS Shoreline ED have been triaged back to L+M for admission since the Epic Go-Live
- L+M has had over 100,000 outpatient encounters
- Investments in tele-consult services will give patients access to Yale's world class clinical care without leaving the community



Yale NewHaven Health

L+M Timeline of Milestones Since Affiliation





Yale NewHaven Health

User, OHCA

From: Roberts, Karen
Sent: Friday, March 24, 2017 12:52 PM
To: Sauders, Kelly (US - New York)
Cc: Martone, Kim; Cotto, Carmen; User, OHCA
Subject: Compliance and monitoring for DNs 15-32032-CON and 32033-CON

Hi Kelly – the timeframe you set forth in your email below appears reasonable for the submission of the initial Independent Monitor report for both of these docket numbers. The timeframe will encompass the transaction date of 9/8/2016 until the end of this calendar quarter, which is March 31st. We will expect the report 7-10 days after the end of the calendar quarter then. In your submission, please identify both docket numbers and the number of any related conditions in the agreed settlements that the filing if being made in accordance with.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, March 23, 2017 4:49 PM
To: Roberts, Karen
Cc: Cotto, Carmen; Martone, Kim
Subject: RE: Question - YNHH/L+MH Monitor - Deloitte 6-month report due date?

Thanks Karen. We can be prepared to submit it earlier if that is what is required – it's just not entirely clear what the "due date" is if this is a six-month measurement report.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, March 23, 2017 4:38 PM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: RE: Question - YNHH/L+MH Monitor - Deloitte 6-month report due date?

Kelly – I'll try to get back to you tomorrow or Monday on your question. Karen

Karen Roberts

Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, March 23, 2017 4:05 PM
To: Martone, Kim; Roberts, Karen
Cc: DeMerlis, Ryan John (US - Philadelphia); Mitchell, Kelly Rose (US - Boston)
Subject: RE: Question - YNHH/L+MH Monitor - Deloitte 6-month report due date?

Hi Kim and Karen – I have one point I'd like to clarify. We are reading/interpreting the "due date" of our six month report to be in early April. It would seem that we are reporting out on a first full 6-months of activity up through and including items due March 31, 2017. That would mean we can finalize and issue our report within 7-10 days after.

Is this a correct interpretation? Please let me know.

Thanks,
Kelly

User, OHCA

From: PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Sent: Wednesday, March 29, 2017 3:21 PM
To: User, OHCA
Cc: 'ynhhscohcamonitor@deloitte.com'; Capozzalo, Gayle; Gonsalves, Elizabeth; Salsgiver, Carolyn; Willcox, Jennifer; Tammaro, Vincent; PERRONE, BRETT
Subject: FW: Docket #15-32033-CON: Condition 25
Attachments: Condition 32f (or 7c) - Projected 5-year Savings Plan (022017) SENT TO OHCA 030717.pdf

Regarding the filing on 3/7/17 for Docket #15-32033-CON (below and attached), please note that documentation submitted on that date related to Condition 32f (or 7c of Docket #15-32032-CON) also complies with Condition 25 of Docket #15-32033-CON.

If you have any questions, please feel free to contact me.

Thank you,
Shraddha

From: PATEL, SHRADDHA
Sent: Tuesday, March 07, 2017 1:52 PM
To: 'ohca@ct.gov' <ohca@ct.gov>
Cc: 'ynhhscohcamonitor@deloitte.com' <ynhhscohcamonitor@deloitte.com>; Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; Gonsalves, Elizabeth <Elizabeth.Gonsalves@ynhh.org>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>; PERRONE, BRETT <Brett.Perrone@ynhh.org>
Subject: Docket #15-32033-CON: Condition 6 and Condition 32f (or 7c of Docket #15-32032-CON)

Attached please find documents submitted to comply with Docket #15-32033-CON Condition 6 and Condition 32f (or 7c of Docket #15-32032-CON).

Condition 6 requires L+MH to file with OHCA the total price per unit of service for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services.

Condition 32f (or 7c) requires L+MH to submit a five-year plan to generate and achieve efficiencies.

If you have any questions, please feel free to contact me.

Thank you,
Shraddha

Shraddha Patel, FACHE
Director of Strategy and Regulatory Planning & Reporting
2 Howe 3rd Floor
New Haven, CT 06519
Phone: 860-912-5324

Email: shraddha.patel@ynhh.org

YaleNewHavenHealth

Templates for Reporting on YNHHS/L+M Five-Year Synergy Financial Plan
Docket #15-32033-CON: Condition 32f and Docket #15-32032-CON: Condition 7c
FY 2017 - FY 2021

Condition 32

FY 2017 - FY 2018 and each fiscal year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October-March (due May 31st) and April-September (due November 30th) certifying the achievement of each and every commitment described herein:

Condition 32f (L+M Healthcare and L+M Hospital)

A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of teh plan in its six month report, YNHHSC shall include the following additional information in its annual report.

i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M ofYNHHSC non-clinical shared services opportunities

ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each ofthese major expense categories

iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports (no template)

iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report (no template)

Condition 7c (LMMG/NEMG) (reported as part of 32f)

A detailed and comprehensive document showing a five-year plan (the “plan”) to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M’s integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC’s supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M’s reduced cost of capital, and L+M’s participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA’s HRS Report 100 and Report 150 or successor reports (no template for balance sheet or statement of operations of NEMG/LMMG)

Lawrence + Memorial Healthcare (including L+M Hospital and LMMG)

Projected 5- year Synergy Savings Plan

By Fiscal Year

Docket # 15-32033-CON: Condition 32f and Docket #15-32032-CON: Condition 7c

Due: March 7, 2017

Categories	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Wages	$1,601,400	$5,118,511	$5,295,470	$5,379,660	$5,361,533
Fringe Benefits	$283,680	$906,720	$938,067	$952,981	$949,770
Contractual Labor Fees	$0	$0	$0	$0	$0
Medical Supplies and Pharmaceuticals	$1,340,000	$1,340,000	$1,340,000	$1,340,000	$1,340,000
Depreciation/Amortization	$0	$0	$0	$0	$0
Interest Expense	$0	$0	$0	$0	$0
Malpractice Expense	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0
Business Expense	$913,403	$1,720,985	$1,720,985	$1,720,985	$1,720,985
Other Operating Expense	$0	$0	$0	$0	$0
Total Synergies	**$4,138,484**	**$9,086,215**	**$9,294,522**	**$9,393,626**	**$9,372,287**

User, OHCA

From: Roberts, Karen
Sent: Friday, April 07, 2017 4:14 PM
To: User, OHCA
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON
Attachments: Deloitte Independent Monitor Year 1 Six Month Report 04 07 2017.pdf

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From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, April 7, 2017 4:13 PM
To: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hello all – please see the attached report from Deloitte & Touche LLP which is the first six-month report due from the Independent Monitor for the period ending March 31, 2017. Let me know if you have any questions.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Deloitte.

YNHHSC Independent Monitor Review Report for Six Month Reporting Period Ending March 31, 2017

April 7, 2017

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, NY 10112

www.deloitte.com

April 7, 2017

Ms. Gayle Capozzalo
Executive Vice President and Chief Strategy Officer
Yale New Haven Health
789 Howard Avenue
New Haven, CT 06519

Dear Ms. Capozzalo,

Re: Deloitte & Touche LLP Six-Month Report as Independent Monitor per Docket Numbers 15-32032-CON and 15-32033-CON

In accordance with our engagement letter dated November 7, 2016 ("Engagement Letter"), the attached report summarizes the findings from the work steps performed by Deloitte & Touche LLP ("D&T"), as requested by Yale New Haven Health ("YNHHSC"), with respect to the Independent Monitor role for the 6-month reporting period ending March 31, 2017.

Pursuant to the Engagement Letter, YNHHSC agrees that any deliverables provided to YNHHSC by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with their regulatory oversight.

The services were performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). The services did not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, D&T does not express an opinion or any other form of assurance as a result of performing the services.

Sincerely,

Kelly J. Sanders

Deloitte & Touche LLP

Contents

Key	
Complete	
In Progress	

I. Executive Summary Table

Condition Number	Milestone Date	Completion Status
Strategic Plan		
15-32033-CON Condition 4	3/7/2017	
15-32033-CON Condition 19	3/7/2017	
15-32033-CON Condition 32b	5/31/2017	
15-32033-CON Condition 7	5/31/2017	
15-32033-CON Condition 5	1/19/2017	
15-32033-CON Condition 18	5/31/2017	
15-32033-CON Condition 32a	5/31/2017	
Financial Reporting		
15-32033-CON Condition 8	5/31/2017	
15-32033-CON Condition 32f	3/7/2017	
15-32032-CON Condition 7c	5/31/2017	
15-32033-CON Condition 6	3/7/2017	
Cost and Market Impact Review		
15-32033-CON Condition 22	12/7/2016	
15-32032-CON Condition 3	12/7/2016	
15-32032-CON Condition 4	12/7/2016	
15-32033-CON Condition 23	12/7/2016	
15-32033-CON Condition 20 Paragraph 1	12/31/2017	
15-32033-CON Condition 32c	5/31/2017	
15-32033-CON Condition 20 Paragraphs 2/3	6/30/2018	
15-32032-CON Condition 1	12/31/2017	
15-32032-CON Condition 7a	5/31/2017	
15-32033-CON Condition 21a	12/7/2016	
15-32032-CON Condition 2a	12/7/2016	
15-32033-CON Condition 21b	12/7/2016	
15-32032-CON Condition 2b	12/7/2016	
Independent Monitor		
15-32033-CON Condition 15	11/7/2016	
15-32033-CON Condition 16	2 per year; report due 30 days after visit	
15-32033-CON Condition 33	3/31/2017	
15-32032-CON Condition 8	Ongoing	

Key	
Complete	
In Progress	

Condition Number	Milestone Date	Completion Status
Community Benefit		
15-32033-CON Condition 11	Ongoing	
15-32033-CON Condition 31	12/31/2016	
15-32033-CON Condition 32h	11/30/2017	
15-32033-CON Condition 12	11/30/2017	
Charity Care Policies		
15-32033-CON Condition 9	Following closing	
15-32033-CON Condition 10	11/30/2017	
15-32033-CON Condition 32e	5/31/2017	
Employment Conditions		
15-32033-CON Condition 27	5/31/2017	
15-32033-CON Condition 32g	5/31/2017	
15-32033-CON Condition 28	5/31/2017	
15-32032-CON Condition 6	5/31/2017	
15-32033-CON Condition 29	5/31/2017	
15-32033-CON Condition 30	5/31/2017	
Governance		
15-32033-CON Condition 14	Following closing	
15-32033-CON Condition 17	Twice a year	
15-32033-CON Condition 26	9/28/2016	
Licensure and Physician Office Conversion		
15-32033-CON Condition 13	Ongoing	
15-32033-CON Condition 24	5/31/2017	
15-32033-CON Condition 32d	5/31/2017	
15-32032-CON Condition 5	5/31/2017	
15-32032-CON Condition 7b	5/31/2017	
15-32033-CON Condition 25	3/31/2017	

I. Detailed Observations Table

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 4	Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHSC. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties. Note 2: Refer to Condition #19 which addresses the same/similar requirements	3/7/2017	D&T will obtain a copy of the Services Plan/Strategic Plan submitted for Condition #4 and #19, verify timely submission, verify that it incorporates the required elements (e.g. describing any planned consolidation, reduction, or elimination of existing services or introduction of new services) and that it meets the 3-year requirement.	YNHHS submitted Services and Strategy Plan to OHCA in accordance with Conditions 4 and 19 on 1/19/2017.	**Pg. 478** (submission email) **Pg. 479 – 482** (documentation)
15-32033-CON Condition 19	L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components: a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals. b. YNHHSC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement. NOTE 1: Refer to Condition #4 which addresses the same requirements.	3/7/2017	D&T will obtain the Services Plan/Strategic Plan submitted for Condition #4 and #19 and review the plan for inclusion of these required components (as compared to the needs described within the Community Needs Assessment and the resource commitments within the Affiliation Agreement).	YNHHS submitted Services and Strategy Plan to OHCA in accordance with Conditions 4 and 19 on 1/19/2017.	**Pg. 478** (submission email) **Pg. 479 – 482** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 5	Until such time as the Services Plan is submitted , YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18	1/19/2017	D&T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days. Per related 15-32033-CON Condition #18, D&T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.	Confirmed with YNHHS that through the submission of the Services Plan on 1/19/2017, no reallocation or relocation of inpatient beds or outpatient services was performed.	**N/A**

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 32f	A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report. i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities; ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories; iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.	3/7/2017	For 15-32033-CON Condition #32F, D&T will obtain the Five-Year Plan prepared by YNHHSC and the ongoing six month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175 and succession reports to OHCA.	YNHHS submitted Five-Year Plan to OHCA in accordance with Condition 32f on 3/7/2017. The milestone date for the six month report is 5/31/2017 for 15-32033-CON Condition 32f and 15-32032-CON Condition 7c.	**Pg. 734** (submission email) **Pg. 736 – 737** (documentation)

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 6	Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.	3/7/2017	D&T will obtain YNHHSC's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information. D&T will review work papers to confirm information and timely filing. * 1st filing is due within 180 days (March 2017); 2nd filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3rd filing is due 60 dates after the close of FY2018 which is 11/30/18.	YNHHS submitted analysis to OHCA in accordance with Condition 6 on 3/7/2017.	**Pg. 734** (submission email) **Pg. 735 and 738** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 22	Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	12/7/2016	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 22 (continued)	c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.	12/7/2016	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.	No noted instances of non-compliance.	**Pg. 430** (submission email) **Pg. 431-454** (documentation

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 3	Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below) for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	12/7/2016	Refer to procedures for 15-32033-CON Condition #22 above.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 3 (continued)	c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section l 9a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.	12/7/2016	Refer to procedures for 15-32033-CON Condition #22 above.	No noted instances of non-compliance.	**Pg. 430** (submission email) **Pg. 431-454** (documentation

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 23	For purposes of determining the price per unit of service: f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	12/7/2016	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 4	For purposes of determining the price per unit of service: a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	12/7/2016	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 21a	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	12/7/2016	D&T will receive samples of payer submissions for LMMG physicians and obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 21a to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)
15-32032-CON Condition 2a	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	12/7/2016	Refer to procedures for 15-32033-CON Condition #21a above.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 2a to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)
15-32033-CON Condition 21b	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.	12/7/2016	D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 21b to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 2b	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.	12/7/2016	Refer to procedures for 15-32033-CON Condition #21b above.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 21b to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation
15-32033-CON Condition 15	Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein. NOTE: See Condition #33a (appointment of Monitor requirement)	11/7/2016	D&T and YNHHSC will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.	Engagement Letter signed and submitted to OHCA on 11/7/2016.	**Pg. 322-324** (submission email) **Pg. 325-372** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 16	The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	2 per year; report due 30 days after visit	D&T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&T. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.	The first semi-annual site visit was completed on 3/1/2017. A brief report summarizing the site visit was submitted in accordance with Condition 16 on 3/23/2017. D&T submitted report summarizing YNHHS activities to fulfill Conditions from the prior six month period on 04/07/2017.	**Pg. 739** (submission email) **Pg. 740-754** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 33	In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	3/31/2017	For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15. 15-32033-CON Condition #33b – D&T will meet with CHNA/CHIP "participation group" in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&T of these meetings and provided to OHCA upon request. With respect to 15-32033-CON #33d, D&T will review the public notice and attend the public forum held by YNHHSC and confirm that it includes members of the CHIP (Community Health Improvement Program) group.	Engagement Letter signed and submitted to OHCA on 11/7/2016. Community Forum with "participation group" completed on 1/24/2017. Minutes were submitted to OHCA to summarize the Community Forum on 1/27/2017. D&T reviewed the public notice and attended the public forum on 3/1/2017 and submitted Public Forum minutes to OHCA on 3/23/2017.	**Engagement Letter Pg. 322-324** (submission email) **Pg. 325-372** (documentation) **Community Forum Pg. 488** (submission email) **Pg. 488-506** (documentation) **Public Forum Pg. 739** (submission email) **Pg. 740-754** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 33 (continued)	e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	3/31/2017	With respect to 15-32033-CON #33e, D&T agrees to provide written notice of any deficiencies as required.	No noted instances of non-compliance.	**N/A**

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 8	In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. a.L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	3/31/2017	Refer to procedures for 15-32033-CON Condition #33 a through e above.	Community Forum with "participation group" completed on 1/24/2017. Minutes were submitted to OHCA to summarize the Community Forum on 1/27/2017. D&T reviewed the public notice and attended the public forum on 3/1/2017 and submitted Public Forum minutes to OHCA on 3/23/2017.	**Community Forum Pg. 488** (submission email) **Pg. 488-506** (documentation) **Public Forum Pg. 739** (submission email) **Pg. 740-754** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 8 (continued)	e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such noncompliance.	Ongoing	Refer to procedures for 15-32033-CON Condition #33 a through e above.	No noted instances of non-compliance.	**N/A**
15-32033-CON Condition 31	L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.	12/31/2016	After obtaining L+M's baseline Schedule H of IRS Form 990, D&T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5). Cross-reference to 15-32033-CON Condition #11.	Schedule H of 2015 IRS Form 990 was obtained on 1/6/2017. Page references refer to submission letter for Condition 21 and CHNA.	**Pg. 161** (submission letter) **Pg. 162-262** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 9	Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Following closing	D&T will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSC's financial assistance policies (or policies at least as generous as these policies) using L+M Hospital board resolutions. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.	YNHHS submitted documentation to OHCA in accordance with Condition 9 including financial assistance policies on 2/21/2017.	**Pg. 514** (submission email) **Pg. 515-733** (documentation)
15-32033-CON Condition 32e	Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.	5/31/2017	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.	YNHHS submitted documentation to OHCA in accordance with Condition 9 including financial assistance policies on 2/21/2017. If future changes to policies are made, Independent Monitor will obtain YNHHS management representation that such policies are at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect.	**Pg. 514** (submission email) **Pg. 515-733** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 14	For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Following closing	D&T will confirm the appointment of this individual (community representative) to the L+MH Board as evidenced by Board minutes. We will discuss the selection process with Management and document our understanding of the selection process/qualifications of the individual.	Cathy Zall appointed as community representative as a voting member of the L+MH's Board of Directors on 12/8/2016.	**Pg. 465** (submission email) **Pg. 466-473** (documentation)
15-32033-CON Condition 17	For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Twice a year	To confirm compliance with this provision, D&T will obtain minutes from these Joint Board Meetings and confirm notice of the public meetings is posted with proper notice. D&T will attend the public meetings as part of the Monitor role.	The first Joint Board Meeting of the YNHHSC Board and L+MH Board is scheduled for May 18-19, 2017.	**N/A**
15-32033-CON Condition 26	As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.	9/28/2016	D&T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.	YNHHS provided Board of Directors bylaws to OHCA on 9/28/2016.	**Pg. 1** (submission email) **Pg. 55-66** (documentation)
15-32033-CON Condition 25	L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	3/31/2017	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.	YNHHS provided reporting to OHCA in accordance with Condition 25 on 3/29/2017.	**Pg. 757-758** (submission email) **Pg. 759-760** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

User, OHCA

From: PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Sent: Tuesday, April 11, 2017 4:22 PM
To: User, OHCA
Cc: 'ynhhscohcamonitor@deloitte.com'; Capozzalo, Gayle; Gonsalves, Elizabeth; Salsgiver, Carolyn; Willcox, Jennifer; Anderson, Maureen (LMHOSP); Tammaro, Vincent; Miller, Thomas
Subject: Docket #15-32033-CON: Condition 21a (or 2a of Docket #15-32032-CON)

In accordance with 15-32033-CON Condition 21a and 15-32032-CON Condition 2a, LMMG and NEMG merged on April 1, 2017. The purpose of this email is to confirm compliance with the above referenced conditions. Further, related to 15-32033-CON Condition 20 and 15-32032-CON Condition 1, L+M and YNHHSC agree to maintain the current LMMG commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017.

If you have any questions, please feel free to contact me.

Thank you,
Shraddha

Shraddha Patel, FACHE
Director of Strategy and Regulatory Planning & Reporting
2 Howe 3rd Floor
New Haven, CT 06519
Phone: 860-912-5324
Email: shraddha.patel@ynhh.org

YaleNewHavenHealth

User, OHCA

From: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Sent: Thursday, April 20, 2017 11:16 AM
To: Roberts, Karen
Cc: User, OHCA; Cotto, Carmen
Subject: RE: Agenda for call tomorrow per your request

Perfect – thanks!

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, April 20, 2017 11:15 AM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: User, OHCA <OHCA@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Agenda for call tomorrow per your request

Hi Kelly – FYI - this conference call next week will also cover your recent emailed question about the filing of the six month report. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Wednesday, April 19, 2017 2:36 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Agenda for call tomorrow per your request

Perfect – I just sent you an invitation with a dial-in.

Thank you!

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Wednesday, April 19, 2017 2:27 PM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Agenda for call tomorrow per your request

Hi Kelly,

The best date for us to meet will be next Wednesday, April 26th@10:30 am. Let us know if it works for you.

Thank you,

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Monday, April 17, 2017 12:44 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Re: Agenda for call tomorrow per your request

Of course!! What might work for you?

On Apr 17, 2017, at 12:38 PM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

> Hi Kelly – we are not yet ready to talk to you about your items #3 and #4 and I think we'd like to prepare better for the conversation on item #1, in particular, before getting on the phone with you about it. Can we reschedule this for some time next week instead?
>
> Karen
>
> Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

<image001.jpg><image002.jpg>

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Monday, April 17, 2017 11:26 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: RE: Agenda for call tomorrow per your request

Hi Karen and Carmen – here is a list of the questions I have/agenda I'd like to cover:

1. With respect to the article Carmen sent on March 24th re: Community Health Needs Assessment and Community Benefits, I wanted to further clarify what procedures you expect the Monitor to perform? Per 15-23022-CON Condition 11, D&T is performing some procedures relative to looking at the CHNA in comparison to Community Benefit and Community Building activities. As you likely know, there are far more needs identified in the CHNA and not all of those are funded each year. I wanted to discuss expectations and make sure that as the Monitor we are thinking about this requirement in the same manner as you/clarify your expectations.
2. With respect to meeting minutes (in general) from public forums – I wanted to clarify with you the level of detail expected/what you are comfortable seeing. In looking at other public forums, I realize the minutes from the community leaders meeting on 1/24 and the public forum (see example as condition 33d) may be more detailed. I am not sure that this level of detail is required or appropriate and wanted some feedback from you so that as the Monitor we handle this appropriately going forward.
3. I wanted to see if you have any questions or comments about the 6-month report submitted on April 7th
4. I wanted to see if you have any questions or comments relative to the Site Visit summary (conditions 16 and 18) that we submitted.

These are the areas I hoped we could cover. Just want to make sure we are handling these various areas in a way that is meeting OHCA's expectations as this is new for all of us.

Thanks,
Kelly

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Monday, April 17, 2017 10:51 AM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Time for a short check-in call Friday or early next week?

Hi Kelly – can you send a brief outline of the conditions you'd like to discuss so we pull the wording for those conditions in advance? Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-030
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, April 13, 2017 4:36 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Time for a short check-in call Friday or early next week?

Just sent an Outlook invitation for this time. Please confirm.

Thanks Karen!

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, April 13, 2017 12:35 PM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Subject: RE: Time for a short check-in call Friday or early next week?

Actually Kelly is from 10 – 10:30 on Tuesday, 4/18th okay? Both Carmen Cotto and I should be available at that time. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Wednesday, April 12, 2017 4:37 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Time for a short check-in call Friday or early next week?

How is 1pm on Monday the 17th?

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Wednesday, April 12, 2017 4:25 PM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Time for a short check-in call Friday or early next week?

Hi Kelly – our offices are closed on Friday, April 14th but we may be available to talk to you on Monday afternoon (April 17th). Let me know what time might work for you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Wednesday, April 12, 2017 4:22 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>
Cc: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: Time for a short check-in call Friday or early next week?

Hi Kim and Karen – hope all is well. I have a few minor questions I'd like to run by you relative to our ongoing Monitor work for YNHHSC/L+M. Would you have time Friday morning or perhaps early next week for a 20 – 30 minute call? It's nothing urgent but just a few things I wanted to clarify.

Thanks,
Kelly

User, OHCA

From: Cotto, Carmen
Sent: Thursday, May 18, 2017 4:34 PM
To: 'ksauders@deloitte.com'
Cc: Roberts, Karen; User, OHCA
Subject: FW: Time sensitive question - YNHHSC/L+M Monitor - 6 month report

Importance: High

To: Kelly J. Sauders, Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
ksauders@deloitte.com

Hi Kelly,

Please see below, highlighted in yellow, our responses to your question in reference to Conditions 7, 8, 25, 32.f and 7.c, Docket Numbers 15-32033 and 15-32032.

As you could see, for some of them, we still need further clarification from the Applicants.

Conditions from 15-32033 (hospital level affiliation)

7. … YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount… For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 – September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016. The reports shall be signed by L+MH's or L+M's Chief Financial Officer.
This report should include any and all capital investments YNHHSC made in the L+M system, including out of state services/entities.

8. … YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th, beginning November 30, 2016….
Would this information be able to be provided for both L+MH and L+M with two columns, one as a total (total L+MH and total L+M) and a column without any out of state locations (L+MH in Connecticut and L+M in Connecticut)

25. L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application. N/A in terms of the question.

32.f. A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report.

i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities;
N/A – this is a general narrative about progress of implementation

ii. A report identifying L+M and L+MH cost saving totals since the Closing Date … YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories;

iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and

iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.
As with #8, would this information be able to be provided for both L+MH and L+M with two columns, one as a total (total L+MH and total L+M) and a column without any out of state locations (L+MH in Connecticut and L+M in Connecticut)/

Conditions from 15-32032 (physician level affiliation)

7.c. A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and
Would this information be able to be provided for these providers, as a total and with just Connecticut service locations?

Thanks,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Wednesday, May 17, 2017 9:37 AM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Time sensitive question - YNHHSC/L+M Monitor - 6 month report
Importance: High

Good morning Kim, Karen and Carmen-

In working with YNHHSC to review their upcoming submissions, a question has come up.

Question: for reporting due from YNHHS on 5/31/2017 (the six month report elements represented, as appropriate, by 15-32033-CON Condition 32f, 15-32032-CON Condition 7c, 15-32033-CON Condition 25, 15-32033-CON Condition 8, 15-32033-CON Condition 7), does data reported for L+M and LMMG need only represent financial information from services and entities residing in Connecticut?

If you could please confirm by Thursday, 5/18, that would support YNHHS's completed progress on their May submission.

Thanks,
Kelly

User, OHCA

From: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Sent: Wednesday, May 31, 2017 2:51 PM
To: User, OHCA
Cc: 'ynhhscohcamonitor@deloitte.com'; Fiore, Denise; O'Connor, Christopher; PATEL, SHRADDHA; Petrini, Vincent; Tammaro, Vincent; Willcox, Jennifer; PERRONE, BRETT
Subject: Docket #15-32033-CON and Docket #15-32032-CON
Attachments: Condition 8 - Financial Measurements (053017) SENT TO OHCA 5-31-17).pdf; Conditions 7 and 32b - Investment Report (053017) SENT TO OHCA 5-31-17.pdf; Conditions 25 and 32f (i and ii) (and 7c of LMMG) - Savings Report (053117) SENT TO OHCA 5-31-17.pdf; Condition 32f (iii and iv) (and 7c of LMMG) - Financial Statements (053117) SENT TO OHCA 5-31-17.pdf; Conditions 18, 20, 24, 27-30, 32 (and 1, 5, 6, 7 of LMMG) - Management Affirmations (052417) SENT TO OHCA 5-31-17.pdf

Attached please find documents submitted to comply with Conditions of Docket #15-32033-CON: "Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation" and Docket #15-32032-CON: "Transfer of Ownership of Group Practice by the Merger of L+M Physician Association into Northeast Medical Group" for the 6-month reporting period ending March 31, 2017.

In the first six months of the affiliation between L+M Corporation (L+M) and Yale New Haven Health System (YNHHS), L+M has seen a tremendous improvement in financial performance. Leading up to the affiliation, L+M experienced declining financial performance, culminating in a $26 million loss in FY 2016. Because of the affiliation with YNHHS, L+M has benefited from numerous cost savings initiatives, clinical, strategy and operational investment, and efficiency process improvements. L+M is in a position to reduce its operating loss in FY 2017. This enhanced financial performance will support additional clinical investments in the region to produce greater depth and breadth of services to the people of Eastern Connecticut and Western Rhode Island.

The compliance documents attached address the following Conditions for Docket #15-32033-CON and Docket #15-32032-CON as noted:

- Condition 8 – Financial Measurement Report
- Conditions 7/32b – Investments Report
- Conditions 25, 32f (i and ii) (or 7c of Docket #15-32032-CON) – Savings Report
- Condition 32f (iii and iv) (or 7c of Docket #15-32032-CON) – Financial Statements
- Conditions 18/32a – Affirmation regarding retention of Services
- Conditions 20a/32c (or 1/7a of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Hospital
- Conditions 20b/32c (or 1 of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Foundation
- Conditions 27, 28, 29, 30, 32g (or 6 of Docket #15-32032-CON) – Affirmations regarding HR policies
- Conditions 24/32d (or 5/7b of Docket #15-32032-CON) – Affirmation regarding Physician Offices
- Condition 32e – Affirmation regarding Charity Care Policies

If you have any questions, please feel free to contact me.

Gayle

Gayle Capozzalo
Executive VP / Chief Strategy Officer

789 Howard Avenue; 1059 CB
New Haven, CT 06519

Phone: 203-688-2605
Fax: 203-688-3472
Email: gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Submitted to Comply with Docket # 15-32033-CON: Condition 8

Financial Measurements/Indicators
Semi-Annual Period: 10/1/16 – 3/31/17

OHCA Condition is as follows:

8. For 3 years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than 2 months after the end of each semi-annual period. Due dates are May 31st and November 30th. The following financial measurements/indicators should be addressed in the report:

A. Operating performance
    1. Operating margin
    2. Non-operating margin
    3. Total margin
B. Liquidity
    1. Current ratio
    2. Days cash on hand
    3. Days in net accounts receivables
    4. Average payment period
C. Leverage and capital structure
    1. Long-term debt to equity
    2. Long-term debt to capitalization
    3. Unrestricted cash to debt
    4. Times interest earned ratio
    5. Debt service coverage ratio
    6. Equity financing ratio
D. Additional statistics
    1. Income from operations
    2. Revenue over/(under) expense
    3. Cash from operations
    4. Cash and cash equivalents
    5. Net working capital
    6. Free cash flow (and the elements used in the calculation)
    7. Unrestricted net assets/retained earnings
    8. Bad debt as % of gross revenue
    9. Credit ratings (S&P, Fitch, or Moody's)

Narrative for Condition 8

L+M Corporation and Subsidiaries (L+M) is a healthcare system that provides a wide array of services throughout the region. The Corporation includes Lawrence + Memorial Hospital (L+MH), L&M Physician Association Inc., L&M Systems, Inc., VNA of Southeastern Connecticut, L+M Healthcare, L+M Indemnity Ltd, and LMW Healthcare Inc. (Westerly Hospital).

The Financial Measurements/Indicators Report has been submitted for L+M Corporation and for L+MH. Financial reporting and statistics included in this submission are based on mid-year information updated through March 31, 2017. All information is subject to audit.

As illustrated in the Financial Measurements/Indicators Report provided for the month ended March 31, 2017 and for the year-to-date periods ended March 31, 2017 and 2016, the affiliation of L+M with YNHHS has resulted in a positive financial outcome. A considerable number of the financial measurements / indicators for both the Corporation and L+MH have improved over the past six months since the affiliation. Specifically, total margin has turned profitable and income from operations has improved significantly. Additionally, it should be noted that these positive results for L+M were achieved while still including the operations of the Lawrence + Memorial Physician Association, which was not merged into the Northeast Medical Group (NEMG) until April 1, 2017.

FINANCIAL MEASUREMENTS/INDICATORS REPORT FOR LAWRENCE + MEMORIAL HEALTHCARE*

Docket # 15-32033-CON: Condition 8

Financial Measurement / Indicators	Month Ended 3/31/17	6 Months Ended 3/31/17	6 Months Ended 3/31/16
A. Operating Performance			
1. Operating Margin	2.58%	-2.28%	-5.80%
2. Non-Operating Margin	5.09%	3.60%	-0.44%
3. Total Margin	7.67%	1.32%	-6.24%
B. Liquidity			
1. Current Ratio	2.79	2.79	3.39
2. Days Cash on Hand	110	122	100
3. Days in Net Accounts Receivables	42.80	43.90	34.30
4. Average Payment Period	107.5	137.8	105.3
C. Leverage and Capital Structure			
1. Long-term Debt to Equity	37.85%	37.85%	92.34%
2. Long-term Debt to Capitalization	30.39%	30.39%	33.28%
3. Unrestricted Cash to Debt	20.65%	20.65%	12.68%
4. Times Interest Earned Ratio	13.1	2.7	(6.3)
5. Debt Service Coverage Ratio	3.73	3.73	2.88
6. Equity Financing Ratio	52.05%	52.05%	49.77%
D. Additional Statistics			
1. Income from Operations	$ 1,024,286	$ (5,129,280)	$ (12,784,251)
2. Revenue Over/(Under) Expense	$ 3,050,224	$ 2,970,890	$ (12,874,251)
3. Cash from Operations	N/A**	$ (18,172,288)	$ (7,664,586)
4. Cash and Cash Equivalents	$ 133,944,619	$ 133,944,619	$ 161,585,579
5. Net Working Capital	$ 142,315,958	$ 142,315,958	$ 161,397,929
6. Free Cash Flow (and the elements used in the calculation)	$ 53,858,961	$ 34,801,742	$ 6,685,133
7. Unrestricted Net Assets/Retained Earnings	86.67%	86.67%	85.54%
8. Bad Debt as % of Gross Revenue	4.11%	3.76%	3.03%
9. Credit Ratings (S&P, Fitch or Moody's)	S&P BBB+/Developing	S&P BBB+/Developing	S&P BBB+/Developing

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

*** The statistics presented above represent data for Lawrence + Memorial Corporation and Subsidiaries (L+M). L+M is a healthcare system that provides a wide array of services throughout the region, and includes: Lawrence + Memorial Hospital; L&M Physician Association, Inc.; L&M Systems, Inc.; VNA of Southeastern Connecticut; L+M Healthcare; L+M indemnity Ltd; and LMW Healthcare Inc. (Westerly Hospital).**

**** Current month Cash from Operations is not a statistic that can be calculated.**

Reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18; 10/1/18-3/31/19; 4/1/19-9/30/19

Report due to OHCA 5/31 and 11/30 each year. Due internally to Regulatory 30 days before.

FINANCIAL MEASUREMENTS/INDICATORS REPORT FOR LAWRENCE + MEMORIAL HOSPITAL *

Docket # 15-32033-CON: Condition 8

Financial Measurement / Indicators	Month Ended 3/31/17	6 Months Ended 3/31/17	6 Months Ended 3/31/16
A. Operating Performance			
1. Operating Margin	8.48%	3.69%	0.29%
2. Non-Operating Margin	3.70%	1.89%	-0.72%
3. Total Margin	12.19%	5.58%	-0.43%
B. Liquidity			
1. Current Ratio	2.27	2.27	2.85
2. Days Cash on Hand	133	130	102
3. Days in Net Accounts Receivables	42.80	45.70	45.90
4. Average Payment Period	117.6	140.9	106.5
C. Leverage and Capital Structure			
1. Long-term Debt to Equity	85.81%	85.81%	87.52%
2. Long-term Debt to Capitalization	52.79%	52.79%	52.81%
3. Unrestricted Cash to Debt	8.06%	8.06%	2.32%
4. Times Interest Earned Ratio	16.0	6.7	1.3
5. Debt Service Coverage Ratio	3.75	3.75	2.90
6. Equity Financing Ratio	31.55%	31.55%	35.42%
D. Additional Statistics			
1. Income from Operations	$ 2,630,529	$ 6,538,000	$ 509,035
2. Revenue Over/(Under) Expense	$ 3,779,199	$ 9,881,893	$ (752,622)
3. Cash from Operations	N/A**	$ 5,386,211	N/A**
4. Cash and Cash Equivalents	$ 76,225,892	$ 76,225,892	$ 94,320,873
5. Net Working Capital	$ 83,974,005	$ 83,974,005	$ 96,363,918
6. Free Cash Flow (and the elements used in the calculation)	$ 88,067,276	$ 79,064,668	N/A**
7. Unrestricted Net Assets/Retained Earnings	76.72%	76.72%	78.21%
8. Bad Debt as % of Gross Revenue	4.53%	4.05%	2.91%
9. Credit Ratings (S&P, Fitch or Moody's)	S&P BBB+/Developing	S&P BBB+/Developing	S&P BBB+/Developing

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

*** The statistics presented above represent data for Lawrence + Memorial Hospital only.**

**** Current month Cash from Operations is not a statistic that can be calculated. Data for 6 months ended 3/31/16 is not available because it was not L+M's practice to prepare a stand-alone balance sheet for the Hospital except at year-end during the audit process.**

Reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18; 10/1/18-3/31/19; 4/1/19-9/30/19

Report due to OHCA 5/31 and 11/30 each year. Due internally to Regulatory 30 days before.

Submitted to Comply with Docket # 15-32033-CON: Conditions 25, 32f(i), and 32f(ii) and Docket # 15-32032-CON: Condition 7c

Synergy Savings Report
Semi-Annual Period: 10/1/16 – 3/31/17

OHCA Conditions are as follows for Docket # 15-32033-CON:

25. L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.

32f(i). L+M and YNHHSC shall provide a narrative update on the progress of the implementation of the five-year plan to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives.

32f(ii). L+M and YNHHSC shall provide a report identifying L+M and L+MH cost savings totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, F, G, H, I, J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these expense categories.

OHCA Condition is as follows for Docket # 15-32032-CON:

7c. YNHHS and L+M shall submit a detailed and comprehensive document showing the five-year-plan to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices cross LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

Narrative for Docket # 15-32033-CON: Conditions 25, 32f(i), and 32f(ii) and Docket # 15-32032-CON: Condition 7c

As outlined in the CON document for Docket # 15-32033-CON, L+M and YNHHSC anticipated extensive cost savings as a result of the affiliation stemming from supply chain discounts and efficiencies, and economies of scale related to IT, finance, insurance, equipment, supplies, and other administrative services.

In the March 7, 2017 filing with OHCA, L+M and YNHHSC projected $4,138,484 in savings for FY 2017, which translates to a six month saving estimate of $2,069,242. Actual cost savings achieved in the first six months of FY 2017 are provided in the table below according to the major expense categories outlined by OHCA and Report 175.

Categories	Projected Savings for the Period*	Actual Savings for the Period*	Variance
Wages	$800,700	$1,103,133	$302,433
Fringe Benefits	$141,840	$330,536	$188,696
Contractual Labor Fees	-	-	-
Medical Supplies and Pharmaceuticals	$670,000	$679,868	$9,868
Depreciation/Amortization	-	-	-
Interest Expense	-	-	-
Malpractice Expense	-	-	-
Utilities	-	$157,054	$157,054
Business Expense	$456,702	$805,446	$348,745
Other Operating Expense	-	-	-
Total Synergies	**$2,069,242**	**$3,076,037**	**$1,006,795**

*note: semi-annual reporting period: 10/1/16 – 3/31/17

L+M's actual savings have surpassed those projected for the first six months of FY 2017 by over $1 million. Actual savings exceeded projected in every major expense category where savings were anticipated. Below includes a brief narrative for the relevant major expense categories with additional detail provided in the Tables that follow.

1. *Wages and Fringe Benefits*
   Corporate services integration in IT, finance, and other administrative areas were anticipated to be the primary driver of savings in the wages and fringe benefit expense category. Through 3/31/17, savings in these areas have been lower than expected due to slower than anticipated integration in some areas, and post-affiliation operational decisions to maintain, in-house, select business units. However, in the first six months of FY 2017, L+M was able to exceed projected savings in wages and fringe benefits overall by nearly $500,000 through savings in other areas. Management of vacancies and attrition to achieve efficiencies was a key focus for L+M and OHCA, as outlined in the Conditions in the Agreed Settlement. A YNHHS vacancy review process and management program newly instituted at L+M has resulted in significant savings for L+MH. LMMG also experienced savings through provider attrition.

2. *Medical and Supplies Expense*
   Actual savings within the medical supplies and pharmaceutical expense category were in-line with those projected. As anticipated, much of the savings were due to L+M becoming part of the system-wide group purchasing organization (GPO) since the affiliation and receiving reduced pricing under system contracts. The impact was experienced in a number of areas including surgical services, pharmacy, ancillary services, and cardiology/interventional radiology. L+M was also able to save on medical equipment service contracts through system pricing.

3. *Utilities*
   Although unanticipated, L+M achieved energy savings since coming into the YNHHS system by renewing its utilities contract to reduce spending on electricity.

4. *Business Expense*
   Within the business expense category, L+M and YNHHS anticipated savings as a result of reduced consulting fees and expenses from outside purchases services. Since the affiliation, L+M has been able to use system resources and save in these areas through a reduction in outside legal contract services, marketing agency services, and physician recruitment agency services. In addition, other opportunities have emerged and L+M has experienced savings due to a reduction in travel expenses by personnel; GPO pricing in IT, non-clinical functions, and facilities; better insurance and treasury options that reduced cost, yet improved coverage; and reduced bank fees through adoption of system bank fee arrangements.

L+M and YNHHS continue to explore opportunities for additional savings in the above major expense categories and other areas.

Lawrence + Memorial Healthcare (including L+M Hospital and LMMG)

Synergy Savings Report and Summary

Docket #15-32033-CON: Condition 25, 32f(i), and 32f(ii) and Docket #15-32032: Condition 7c

Semi-Annual Reporting Period: 10/1/16 - 3/31/17

Categories	Projected Savings for Period*	Actual Savings for Period*	Variance
Wages	$800,700	$1,103,133	$302,433
Fringe Benefits	$141,840	$330,536	$188,696
Contractual Labor Fees	$0	$0	$0
Medical Supplies and Pharmaceuticals	$670,000	$679,868	$9,868
Depreciation/Amortization	$0	$0	$0
Interest Expense	$0	$0	$0
Malpractice Expense	$0	$0	$0
Utilities	$0	$157,054	$157,054
Business Expense	$456,702	$805,446	$348,745
Other Operating Expense	$0	$0	$0
Total Synergies	$2,069,242	$3,076,037	$1,006,795

Semi-Annual reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18. **Annual** reporting periods: 10/1/18-9/30/19; 10/1/19-9/30/20; 10/1/20-9/30/21

Summary page due to OHCA with detailed narrative 60 days following reporting period. Due to Regulatory 30 days prior.

*Although projected summary showing plans annually, 6-month projections are required when reporting through 9/30/18.

Lawrence + Memorial Healthcare (Including L+M Hospital and LMMG)
Detailed Narrative Update on the Implementation Progress of the Synergy Savings Plan
Docket #15-32033-CON: Condition 25, 32f(i), and 32f(ii) and Docket #15-32032: Condition 7c
Semi-Annual Reporting Period: 10/1/16 - 3/31/17

COST SAVINGS INVESTMENT	DESCRIPTION OF AND RATIONALE FOR PROJECT	SAVINGS AMOUNT	APPLICABLE EXPENSE CATEGORY
Supply Chain / Information Technology Services (ITS) Savings			
Supply Chain Savings (including ITS)	Since the affiliation, L+M has become part of the system-wide GPO (group purchasing organization) and began receiving more optimal pricing under the YNHHS contracts or through combined volume tiers. Supply chain savings were experienced in a number of areas including ITS, surgical services, pharmacy, ancillary services, and cardiology/interventional radiology. L+M was also able to achieve savings on medical equipment service contracts through system pricing.	$895,853	Medical and Supplies Expense and Business Expense
Clinical and Business Practices Integration Across LMC/YNHHS and LMMG/NEMG			
Labor - Attrition, Integration Synergies, and Vacancy Management	To increase savings, FTEs that remained open during the entire prior 12 month period were not filled - the goal being to accomplish labor savings without impacting currently employed staff. LMMG also achieved savings through provider attrition. In addition, a number of positions within Corporate Services were realigned to better employ existing staff and capabilities across the company while aligning functions and removing redundancies. Also, after the affiliation, the standard practice of "Vacancy Review" employed at YNHHS (i.e., review by a committee of senior HR and operational leadership of all vacant positions before posting for hire) was implemented at L+M. This process enabled L+M to successfully redesign and better manage the staffing and types of labor in various areas to achieve savings without impacting currently employed staff.	$1,433,668	Wages and Fringe Benefits
Legal Services	As part of the affiliation, YNHHS was able to absorb work previously completed by outside legal firms for both L+M and LMMG utilizing the YNHHS in-house legal team. This resulted in costs savings for L+M.	$281,239	Business Expense
Banking, Insurance, Treasury Services	As a result of the affiliation, L+M was able to use YNHHS's existing banking, insurance, and treasury options to negotiate better arrangements that combined to improve coverage, reduce costs and increase operational efficiency.	$207,545	Business Expense
Marketing Services	Prior to the affiliation, L+MH used the services of an outside creative agency for advertising and marketing services. Since the affiliation, this work has been incorporated into work already being completed at the YNHHS system level.	$38,396	Business Expense
Travel Expense	An initiative at L+M to create more visibility and to target reduction of traveling expense incurred by personnel resulted in decreases in cost.	$52,738	Business Expense
Provider Recruitment Expense	As part of the affiliation with NEMG, LMMG was able to reduce contractual service expenses used for provider recruitment.	$9,544	Business Expense

Lawrence + Memorial Healthcare (Including L+M Hospital and LMMG)
Detailed Narrative Update on the Implementation Progress of the Synergy Savings Plan
Docket #15-32033-CON: Condition 25, 32f(i), and 32f(ii) and Docket #15-32032: Condition 7c
Semi-Annual Reporting Period: 10/1/16 - 3/31/17

COST SAVINGS INVESTMENT	DESCRIPTION OF AND RATIONALE FOR PROJECT	SAVINGS AMOUNT	APPLICABLE EXPENSE CATEGORY
Reduced Cost of Capital			
n/a	There were no savings from reducted cost of capital in the first six months of FY 2017. L+M is currently executing in this area against the plan.	n/a	
Population Health Initiatives			
n/a	There were no savings from population health initiatives in the first six months of FY 2017. L+M is currently executing in this area against the plan.	n/a	
Other			
Energy Savings	Since coming into the YNHHS, L+M renewed contract negotiations for utility services resulted in reduced expenditures on electricity.	$157,054	Utilites
	TOTAL	**$3,076,037**	

SIGNATURE: Vincent Tammaro

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

Semi-Annual reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18. **Annual** reporting periods: 10/1/18-9/30/19; 10/1/19-9/30/20; 10/1/20-9/30/21

Detailed narrative due to OHCA with summary page 60 days following reporting period. Due to Regulatory 30 days prior.

Submitted to Comply with Affirmations in Docket # 15-32033-CON and Docket # 15-32032-CON

Affirmations
Semi-Annual Period: 10/1/16 – 3/31/17

OHCA Conditions are as follows:

Docket # 15-32033 Condition 20a/20b/32c Docket # 15-32032 Condition 1/7a	L+MH and LMMG commercial health plan contracts in place as of the Closing are/were maintained through the remainder of their terms, and any new contracts are consistent with the commitments of paragraphs 20, 21 and 22 of the Agreed Settlement.
Docket # 15-32033 Condition 32e	L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.
Docket # 15-32033 Condition 18/32a	L+M shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. All L+MH services have been continued as required by the terms of the Agreed Settlement.
Docket # 15-32033 Condition 24/32d Docket # 15-32032 Condition 5/7b	No L+M physician office has been converted to hospital-based status.
Docket # 15-32033 Condition 32g	All labor and employment commitments described in the Agreed Settlement continue to be satisfied.
Docket # 15-32033 Condition 27	L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.
Docket # 15-32033 Condition 28 Docket # 15-32032 Condition 6	Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).
Docket # 15-32033 Condition 29	L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.
Docket # 15-32033 Condition 30	L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.

AFFIRMATION OF COMPLIANCE
WITH L+M AFFILIATION AGREED SETTLEMENT CONDITIONS

Docket No. 15-32033-CON, L+M Corporation and Yale New Haven Health Services Corp.

Docket No. 15-32032-CON, Northeast Medical Group and L&M Physicians Association

COMPLIANCE PERIOD: October 1, 2016 to March 31, 2017

I, Vincent Tammaro, Executive Vice President and Chief Financial Officer of Yale New Haven Health System, hereby certify that, based on my knowledge and belief, Yale New Haven Health Services Corporation (YNHHSC), Northeast Medical Group, Inc. (NEMG), L+M Corporation (L+M), Lawrence + Memorial Hospital (L+MH) and L&M Physician Association, Inc. (LMMG) have complied with the conditions of the Agreed Settlement as set forth below, effective September 8, 2016 and throughout the course of the Compliance Period described above.

☒	Docket # 15-32033 Condition 20a/20b/32c Docket # 15-32032 Condition 1/7a	L+MH and LMMG commercial health plan contracts in place as of the Closing are/were maintained through the remainder of their terms, and any new contracts are consistent with the commitments of paragraphs 20, 21 and 22 of the Agreed Settlement.
☒	Docket # 15-32033 Condition 32e	L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.

Signature: Vincent Tammaro Date: 5/25/17

Subscribed and sworn to before me on 5-25-2017

Signature of Notary Public Deanna Fowler

Deanna Fowler
Printed Name of Notary Public

Date Commission Expires 7-31-2018

Deanna Fowler
Notary Public-Connecticut
My Commission Expires
July 31, 2018

AFFIRMATION OF COMPLIANCE
WITH L+M AFFILIATION AGREED SETTLEMENT CONDITIONS

Docket No. 15-32033-CON, L+M Corporation and Yale New Haven Health Services Corp.

Docket No. 15-32032-CON, Northeast Medical Group and L&M Physicians Association

COMPLIANCE PERIOD: October 1, 2016 to March 31, 2017

I, Christopher O'Connor, Executive Vice President and Chief Operating Officer, Yale New Haven Health System, hereby certify that, based on my knowledge and belief, Yale New Haven Health Services Corporation (YNHHSC), Northeast Medical Group, Inc. (NEMG), L+M Corporation (L+M), Lawrence + Memorial Hospital (L+MH) and L&M Physician Association, Inc. (LMMG) have complied with the conditions of the Agreed Settlement as set forth below, effective September 8, 2016 and throughout the course of the Compliance Period described above.

☒	Docket # 15-32033 Condition 18/32a	L+M shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. All L+MH services have been continued as required by the terms of the Agreed Settlement.
☒	Docket # 15-32033 Condition 24/32d Docket # 15-32032 Condition 5/7b	No L+M physician office has been converted to hospital-based status.

Signature: _____ Date: May 25, 2017

Christopher M. O'Connor

Subscribed and sworn to before me on May 25, 2017

Signature of Notary Public Lynne R LaRock

Lynne R LaRock
Printed Name of Notary Public

Date Commission Expires July 31, 2017

AFFIRMATION OF COMPLIANCE
WITH L+M AFFILIATION AGREED SETTLEMENT CONDITIONS

Docket No. 15-32033-CON, L+M Corporation and Yale New Haven Health Services Corp.

Docket No. 15-32032-CON, Northeast Medical Group and L&M Physicians Association

COMPLIANCE PERIOD: October 1, 2016 to March 31, 2017

I, Kevin Myatt, Senior Vice President, Chief Human Resources Officer, Yale-New Haven Health System, hereby certify that, based on my knowledge and belief, Yale New Haven Health Services Corporation (YNHHSC), Northeast Medical Group, Inc. (NEMG), L+M Corporation (L+M), Lawrence + Memorial Hospital (L+MH) and L&M Physician Association, Inc. (LMMG) have complied with the conditions of the Agreed Settlement as set forth below, effective September 8, 2016 and throughout the course of the Compliance Period described above.

☒	Docket # 15-32033 Condition 32g	All labor and employment commitments described in the Agreed Settlement continue to be satisfied.
☒	Docket # 15-32033 Condition 27	L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.
☒	Docket # 15-32033 Condition 28 Docket # 15-32032 Condition 6	Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).
☒	Docket # 15-32033 Condition 29	L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.
☒	Docket # 15-32033 Condition 30	L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.

Signature: _____ Date: 5-25-2017

Subscribed and sworn to before me on 5.25.2017

Signature of Notary Public Deanna Fowler

Deanna Fowler
Printed Name of Notary Public

Date Commission Expires 7.31.2017

Deanna Fowler
Notary Public-Connecticut
My Commission Expires
July 31, 2018

Submitted to Comply with Docket # 15-32033-CON: Conditions 7 and 32b

Investment Report
Semi-Annual Period: 10/1/16 – 3/31/17

OHCA Conditions are as follows:

7. Within 180 days following the Closing Date and thereafter until the capital commitment is satisfied, YNHHSC shall submit to OHCA a report on the capital investments it has made in L+M and its affiliates from the $300M commitment amount. The investment report shall include the following in a format to be agreed upon:

a. A list of the capital expenditures that have been made in the prior 180 days with descriptions of each associated project; and
b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
c. The funding source of the capital investment indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source.

32b. L+M and YNHHSC shall provide a narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.

Narrative for Conditions 7 and 32b

L+M and YNHHS have pledged to make total commitments of $300 million in eastern Connecticut and western Rhode Island over 5 years. Anticipated resource commitments highlighted in the L+M/YNHHS Affiliation Agreement and strategic plan submitted to OHCA in January 2017 included investments in: primary care clinical services, specialty clinical services, ambulatory services, post-acute services, infrastructure within L+M facilities, information technology, population health, branding, operational improvements, and community need/community building. In the first six months of FY 2017, L+M and YNHHS have made or committed-to investments totaling $23,678,984 across these categories. Below includes a brief narrative for each strategic investment area with additional detail provided in the Tables that follow.

1. *Primary Care Clinical Services*
   Recruitment of primary care providers is a priority for L+M to ensure adequate access and meet demand. A number of providers have been recruited in the first six months of FY 2017, with start dates after 3/31/17.

2. *Specialty Clinical Services*
   L+M and YNHHS have made a solid commitment to enhance clinical services in the communities served by L+M to increase quality and improve access. The strategic plan highlighted a number of specialty areas that are a recruitment focus for L+M. In the first six months of FY 2017, L+M and YNHHS expanded clinical services in neurosurgery, spine surgery, oncology, and psychiatry, all areas required per the strategic plan, and noted in the Affiliation Agreement. In addition, providers were added in general surgery, cardiology, obstetrics, and crisis intervention.

3. *Ambulatory Services*
   There were no investments in ambulatory services in the first six months of FY 2017. L+M is currently executing in this area against the plan.

4. *Post-Acute Services*
   There were no investments in post-acute services in the first six months of FY 2017. L+M is currently executing in this area against the plan.

5. *Infrastructure within L+M Facilities*
   The affiliation with YNHHS has allowed L+M to undertake much-needed facilities and infrastructure projects that were delayed due to the financial pressures experienced at L+MH, L+MMG, and Westerly Hospital and the need to preserve liquidity and conserve cash. With a stronger financial foothold resulting from the affiliation, L+M has been able to move forward with several delayed projects including purchase of new beds, security systems, HVAC renovations, and other minor and major facility improvements.

6. *Information Technology*
   The build and implementation of the Epic EMR system throughout L+M facilities has been a major investment for L+M to improve quality of care, increase access to patient data, and

increase coordination of systems (e.g., supply chain, finance, HR) to effectively manage operations. In addition to Epic, capital has also been expended on access control initiatives for enhanced employee and patient safety, interfaces, and radiology systems.

7. *Population Health*
   Population health infrastructure and development of risk-contracting capabilities were key investments outlined in the strategic plan and Affiliation Agreement. Work is in-process to improve physician engagement and initiate clinical practice guidelines.

8. *Branding*
   YNHHS has committed to rebranding L+M and its entities to enhance the identity of the organizations with Yale New Haven Health. A considerable investment has been made in website design to better connect patients across the system and improve communication regarding services/physicians and locations. Advertising the affiliation through print, digital, and radio ads has enhanced communication to patients and physicians regarding the health care resources available in the eastern Connecticut and western Rhode Island regions. In addition, signage has been updated with new logos that better reflect the affiliation.

9. *Operational Improvements*
   L+M and YNHHS have undertaken a number of operational improvement initiatives in structures and processes in an effort to effectively provide high-quality, safe patient care. Such investments include:

   <u>Clinical Technologies</u>
   L+M has committed to enhancing and improving the quality of care provided to L+M patients. The latest technology including tomosynthesis units for breast cancer early detection is planned for five L+M sites. Also, the L+M Cancer Center in Waterford, CT has renovated its pharmacy to adhere to current and upcoming regulatory requirements and ensure the safety of patients. Other clinical investments included new equipment in radiology, anesthesia, and inpatient units.

   <u>Other</u>
   Since the affiliation, YNHHS personnel in corporate services departments (e.g., internal consulting group, IT, finance) have spent a significant amount of time and effort integrating L+M with YNHHS and identifying and achieving savings, standardizing processes, implementing process improvement initiatives, and merging systems. This work was imperative to achieve the savings and complete the resource investments to-date.

10. *Community Need/Community Building*
    L+MH has enhanced its investment in community needs/community building initiatives focusing on the priorities identified in the most recent community health needs assessment (CHNA). There are two new projects underway. In accordance with the strategic plan, the first addresses behavioral health and substance use abuse whereby L+MH is funding certification programs for local recovery providers so they may be educated on and meet national standards for quality and safety. The second investment addresses social

determinants of health in the City of New London. Proposed interventions to address social determinants will be generated for two distressed communities leveraging residents' input.

L+M and YNHHS continue to make progress towards achieving the commitments outlined in the Affiliation Agreement and strategic plan.

SUMMARY of Resource Commitment and Strategic Plan Accomplishments: Docket # 15-32033-CON, Condition 7/32b

Resource Commitment Summary Made to Strategic Investments		Expenditure Amounts						
		10/1/16-3/31/17	4/1/17-9/30/17	10/1/17-3/31/18	4/1/18-9/30/18	10/1/18-3/31/19	4/1/19-9/30/19	Total
1. Primary Care Clinical Services: Expansion of primary care network focusing on geriatric, general internal medicine, including the recruitment of 8 primary care physicians in Eastern CT. The primary care sites will ensure primary care availability as the population ages and physicians retire. Many sites will be established as medical neighborhoods, allowing easy access to part-time and full-time specialists.	Eastern CT	$0						$0
	Western RI	$0						$0
2. Specialty Clinical Services: Increased access to specialists within Eastern CT, including pediatrics; multi-disciplinary muscular-skeletal services, including orthopedics, neurosurgery, spine, physiatry; behavioral health, including psychiatrists, psychologists, etc.; vascular and cardiac services; enhanced obstetrics and maternal fetal medicine; expanded oncology services; neuromuscular and stroke programs; endocrinology/thyroid services; general surgery and specialized internal medicine. These part-time and full-time specialty services will be increased, taking advantage of primary care referrals and using technology to ensure access throughout the region. In addition, telestroke, tele-ICU and tele-ED coverage will be continued at L+M.	Eastern CT	$1,625,688						$1,625,688
	Western RI	$0						$0
3. Ambulatory Services: Expansion of laboratory, diagnostic, urgent care, ambulatory surgery centers to enhance access to ancillary services in the region.	Eastern CT	$0						$0
	Western RI	$0						$0
4. Post Acute Services: Creation of an integrated network of post-acute services to manage care across the continuum in order to reduce the total cost of care for community residents.	Eastern CT	$0						$0
	Western RI	$0						$0
5. Infrastructure within LMHC Facilities: Renovations and infrastructure repair to hospital.	Eastern CT	$874,585						$874,585
	Western RI	$1,086,849						$1,086,849

SUMMARY of Resource Commitment and Strategic Plan Accomplishments: Docket # 15-32033-CON, Condition 7/32b

Resource Commitment Summary Made to Strategic Investments		Expenditure Amounts						
		10/1/16-3/31/17	4/1/17-9/30/17	10/1/17-3/31/18	4/1/18-9/30/18	10/1/18-3/31/19	4/1/19-9/30/19	Total
6. Information Technology: Investment in Epic throughout L+M facilities, LMMG and independent physicians. In addition, the business systems will be replaced and fully integrated with Yale New Haven Health. Telehealth services will help reduce travel to YNHH.	Eastern CT	$9,934,718						$9,934,718
	Western RI	$1,569,119						$1,569,119
7. Population Health: Development of risk contracting capabilities and participation in the YNHHS Population Health infrastructure and Clinically Integrated Network.	Eastern CT	$204,896						$204,896
	Western RI	$44,408						$44,408
8. Branding: Re-branding of all facilities and services as Yale New Haven Health to enhance the identity of the organizations with Yale New Haven Health.	Eastern CT	$412,301						$412,301
	Western RI	$412,301						$412,301
9. Operational Improvements: Operational improvements in structures and processes to effectively provide high quality, safe patient care.	Eastern CT	$5,433,462						$5,433,462
	Western RI	$2,025,759						$2,025,759
10. Community Need / Community Building: Community health needs focused on improved services to support mental well-being and reduce substance abuse (opioid use and anxiety/depression); support and nurture healthy life styles specifically reducing contributing factors to diabetes; ensure access to care, particularly pre-natal care and related birth outcomes and access to care for low-income population to address socio-economic factors that have the greatest impact on the health and well-being of the communities.	Eastern CT	$54,898						$54,898
	Western RI	$0						$0
TOTAL		**$23,678,984**						**$23,678,984**

SIGNATURE: Vincent Tammaro

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

Expenditures at Lawrence Memorial Hospital and LMMG are categorized as "Eastern CT". Expenditures at Westerly Hospital comprise "Western RI".

Summary due to OHCA with detailed narrative semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 10/1/16 - 3/31/17

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)	ROLLOUT OF EXPENSES			EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG
			Est. Beg. Date	Est. End Date	Est. Startup Date				
Primary Care Clinical Services									
Primary Care Network Expansion	Recruitment of primary care physicians is a priority for L+M to ensure adequate access and meet demand. Several primary care providers have been recruited to-date (with start dates after 3/31/17).	n/a							
Specialty Clinical Services									
Specialty Services Access	Recruitments within neurosurgery, oncology and psychiatry were made to increase access to these services in the L+M service area. Additions in general surgery, cardiology, and obstetrics/midwifery were also made to replenish the medical staff.	$1,625,688	10/01/16	03/31/17	n/a	YNHHS or Baseline Cash Flow	$1,250,946	$0	$374,742
Ambulatory Services									
n/a	There were no investments made in ambulatory services in the first six months of FY 2017. L+M is currently executing in this area against the plan.	n/a							
Post Acute Services									
n/a	There were no investments made in ambulatory services in the first six months of FY 2017. L+M is currently executing in this area against the plan.	n/a							
Infrastructure within LMHC Facilities									
Investments in Infrastructure	Prior to the affiliation with YNHHS, L+MH and Westerly Hospitals (WH) were under growing financial pressure, and capital spending during that time was severely limited. Following the affiliation, significant catch-up was required to replenish aging and end-of-life equipment as well as perform necessary facility renovations. Capital expenditures for infrastructure during the time of the reporting period were made for new beds, repairs to parking garage, rebuild of elevators, security systems, and HVAC systems. In addition, the LMMG General Surgery practice was relocated to the L+MH main campus to enhance availability and improve timeliness of services for patients and physicians.	$1,961,434	10/01/16	03/31/17	n/a	L+M Baseline Cash Flow	$650,457	$1,086,849	$224,128

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 10/1/16 - 3/31/17

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)	ROLLOUT OF EXPENSES			EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG
			Est. Beg. Date	Est. End Date	Est. Startup Date				
Information Technology									
Epic System - Build and Installation	Capital investment related to the development and build of the Epic EMR system that went live at L+M and WH on 1/20/17 included software licenses; customization and development of interfaces to ensure integration with other 3rd party software; training time (prior to go-live) for clinicians and other personnel on using the new system; support during the actual go-live from Epic consultants; and hardware, including new servers. Replacing the older EMR systems and moving to the fully-integrated Epic system, had the advantage of improving quality of care by providing best practice protocols and enhancing patient engagement via patient portals, "MyChart", and other patient and physician-friendly features. By moving to Epic as part of a large System, L+M was able to mitigate risk by relying on the invaluable experience and expertise that YNHHS brought to the installation.	$10,808,478	10/01/16	03/31/17	n/a	YNHHS or Baseline Cash Flow	$9,398,203	$1,405,457	$4,818
Infor (ERP) Project	Investments were made at L+M for development, customization and installation of a new ERP (Enterprise Resource Planning) system to replace its legacy system. Incorporating Supply Chain, General Finance, and Human Resources functions within a single system (that also includes budgeting, decision support, and management reporting) is fundamental to effectively running the business. YNHHS has a long track record of leading the industry in these areas by innovatively leveraging these reporting capabilities to drive quality, patient engagement and physician efficiencies. While L+M is still in the building stages, progress toward full integration across the system is underway and remains a key corporate objective.	$355,649	10/01/16	03/31/17	n/a	YNHHS	$296,046	$59,603	$0
Other Information Technology Projects	Capital investments for other IT projects at L+M included Access Control Plan Implementation; Laboratory EMR Results Interfaces; and RIS/PACS Implementation, among other items. These systems - specifically integrating critical patient tests, imaging, and other diagnostics with the broader medical record system - were on the front line of improving access, optimizing care delivery, and coordinating patient care across the continuum.	$339,710	10/01/16	03/31/17	n/a	L+M Baseline Cash Flow	$216,085	$104,059	$19,566
Population Health									
Population Health Initiatives	As a result of the affiliation, L+M is able to move forward and participate in the YNHHS Population Health infrastructure and clinically integrated network. Work is in-process to improve physician engagement and initiate clinical practice guidelines.	$249,304	10/01/16	03/31/17	n/a	YNHHS	$204,896	$44,408	$0
Branding									
Advertising, Signage, Website	Investments were made in converting existing external and internal signage throughout L+M to formally recognize the affiliation and rebrand all facilities and services as Yale New Haven Health. A considerable investment was made in the website design to better connect patients across the system and improve communication regarding services, physicians and locations. Advertising the affiliation through print, digital, and radio ads has enhanced communication to patients and physicians regarding the health care resources available in the region.	$824,603	03/31/17	02/28/17	n/a	YNHHS	$412,301	$412,301	$0

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 10/1/16 - 3/31/17

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)	ROLLOUT OF EXPENSES Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG
Operational Improvements									
Corporate Services Support	Significant resources have been provided to L+M by YNHHS Corporate services departments (i.e., Internal Consulting Group, IT, Finance, etc.) over the past 6 months. As an integral part of the underlying value of the affiliation, Corporate Services personnel continue to assist L+M in identifying synergies, achieving savings, standardizing methodologies, introducing procedures, implementing Epic and other IT systems, and generally integrating L+M into the System.	$3,079,509	01/01/17	03/31/17	n/a	YNHHS	$2,530,967	$548,542	$0
Clinical Technology Investments	Investments in clinical technology were made at L+M to drive operational improvements including new diagnostic equipment (Tomosynthesis) for early breast cancer detection; state-of-the-art pharmacy at the L+M Cancer Center to adhere to regulatory requirements and enhance patient safety; new equipment on inpatient units to assure patient care quality; and other improvements in structures and processes to effectively provide high-quality, safe patient care.	$4,379,712	01/01/17	03/31/17	n/a	L+M Baseline Cash Flow	$2,902,495	$1,477,217	$0
Community Need / Community Building									
Recovery House Volunteer Certification Program in the City of New London	L+MH's expenditure to Community Speaks Out (a non-profit organization) supports a training program for New London sober houses who volunteer to meet national standards for quality and safety identified by the National Association of Recovery Residences. The rationale for this project is to ensure consistent quality at recovery residencies and all aspects of operations including health, safety, ethics, administrative practices, maintenance of a recovery support environment, and good neighbor practices. There is a demonstrated need for well-managed recovery housing in the City of New London.	$4,898	2/17/17	n/a	n/a	L+M Baseline Cash Flow	$4,898	$0	$0
City of New London Neighborhood Development	L+MH's expenditure supports neighborhood development strategies in two distressed areas of the city of New London. The neighborhoods will be identified through mapping of poverty and low educational attainment. Residents will then be engaged to generate input as to social determinant needs as well as proposed interventions. The rationale for this project is to address the health needs identified by the most recent CHNA and 2016 Community Health Improvement Plan (CHIP), including social determinants of health.	$50,000	3/27/17	n/a	n/a	L+M Baseline Cash Flow	$50,000	$0	$0
TOTAL		**$23,678,984**					**$17,917,294**	**$5,138,436**	**$623,254**

SIGNATURE: _____
Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

SIGNATURE: _____
Christopher O'Connor, Exec VP & Chief Operating Officer, YNHHS

* Financial information is based on unaudited financial statements.

** Based on % personnel time estimated by HSC department directors multiplied by YTD March 2017 departmental expense; gathering of statistics is still in process.

Detailed narrative due to OHCA with summary page semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

Submitted to Comply with Docket # 15-32033-CON: Conditions 32f(iii) and 32f(iv) and Docket # 15-32032-CON: Condition 7c

Financial Statements
Semi-Annual Period: 10/1/16 – 3/31/17

OHCA Conditions are as follows for Docket # 15-32033-CON:

32f(iii). YNHHS and L+M shall submit a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

32f(iv). YNHHS and L+M shall submit, for L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

OHCA Condition is as follows for Docket # 15-32032-CON:

7c. YNHHS and L+M shall submit a detailed and comprehensive document showing the five-year-plan to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices cross LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

Narrative for Docket # 15-32033-CON: Conditions 32f(iii) and 32f(iv) and Docket # 15-32032-CON: Condition 7c

In the first six months of the affiliation between L+M Corporation (L+M) and Yale New Haven Health System (YNHHS), L+M has seen an improvement in financial performance. L+MH is on-track to improve its operation margin and total margin compared to FY 2016 and its balance sheet has remained stable.

LAWRENCE AND MEMORIAL HOSPITAL

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	6 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	DIFFERENCE '15 vs '16	DIFFERENCE '15 vs '16
I.	**ASSETS**					
A.	**Current Assets:**					
1	Cash and Cash Equivalents	$13,348,901	$3,965,054	$8,014,677	($9,383,847)	-70%
2	Short Term Investments	$107,365,636	$92,026,239	$84,302,155	($15,339,397)	-14%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$37,925,784	$35,197,755	$39,987,639	($2,728,029)	-7%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0		$0	0%
5	Due From Affiliates	$2,065,142	$2,063,848	$0	($1,294)	0%
6	Due From Third Party Payers	$0	$0		$0	0%
7	Inventories of Supplies	$6,194,355	$6,339,039	$6,383,855	$144,684	2%
8	Prepaid Expenses	$3,125,348	$2,228,771	$12,257,137	($896,577)	-29%
9	Other Current Assets	$5,435,867	$4,774,484	$5,075,990	($661,383)	-12%
	Total Current Assets	**$175,461,033**	**$146,595,190**	**$156,021,452**	**($28,865,843)**	**-16%**
B.	**Noncurrent Assets Whose Use is Limited:**					
1	Held by Trustee	$926,080	$25,563	$26,385	($900,517)	-97%
2	Board Designated for Capital Acquisition	$0	$0		$0	0%
3	Funds Held in Escrow	$0	$0		$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$21,590,850	$23,128,435	$23,695,450	$1,537,585	7%
	Total Noncurrent Assets Whose Use is Limited:	**$22,516,930**	**$23,153,998**	**$23,721,835**	**$637,068**	**3%**
5	Interest in Net Assets of Foundation	$0	$0		$0	0%
6	Long Term Investments	$0	$0		$0	0%
7	Other Noncurrent Assets	$21,783,378	$36,989,211	$33,443,988	$15,205,833	70%
C.	**Net Fixed Assets:**					
1	Property, Plant and Equipment	$432,048,550	$440,717,310	$441,155,764	$8,668,760	2%
2	Less: Accumulated Depreciation	$283,857,350	$307,044,724	$319,471,223	$23,187,374	8%
	Property, Plant and Equipment, Net	**$148,191,200**	**$133,672,586**	**$121,684,541**	**($14,518,614)**	**-10%**
3	Construction in Progress	$2,785,773	$9,718,135	$16,186,789	$6,932,362	249%
	Total Net Fixed Assets	**$150,976,973**	**$143,390,721**	**$137,871,330**	**($7,586,252)**	**-5%**
	Total Assets	**$370,738,314**	**$350,129,120**	**$351,058,605**	**($20,609,194)**	**-6%**
II.	**LIABILITIES AND NET ASSETS**					
A.	**Current Liabilities:**					
1	Accounts Payable and Accrued Expenses	$43,009,002	$41,254,457	$48,272,770	($1,754,545)	-4%
2	Salaries, Wages and Payroll Taxes	$4,908,525	$2,526,943	$2,594,459	($2,381,582)	-49%
3	Due To Third Party Payers	$6,711,203	$7,944,521	$6,735,563	$1,233,318	18%
4	Due To Affiliates	$2,512,703	$2,860,336		$347,633	14%
5	Current Portion of Long Term Debt	$5,495,740	$5,729,505	$5,729,505	$233,765	4%
6	Current Portion of Notes Payable	$0	$0		$0	0%
7	Other Current Liabilities	$0	$0		$0	0%
	Total Current Liabilities	**$62,637,173**	**$60,315,762**	**$63,332,297**	**($2,321,411)**	**-4%**
B.	**Long Term Debt:**					
1	Bonds Payable (Net of Current Portion)	$102,938,747	$94,968,208	$93,849,184	($7,970,539)	-8%
2	Notes Payable (Net of Current Portion)	$0	$0		$0	0%
	Total Long Term Debt	**$102,938,747**	**$94,968,208**	**$93,849,184**	**($7,970,539)**	**-8%**

LAWRENCE AND MEMORIAL HOSPITAL

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	6 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	DIFFERENCE	DIFFERENCE
					'15 vs '16	'15 vs '16
3	Accrued Pension Liability	$52,989,394	$55,475,184	$54,924,544	$2,485,790	5%
4	Other Long Term Liabilities	$23,691,278	$26,768,140	$22,327,982	$3,076,862	13%
	Total Long Term Liabilities	**$179,619,419**	**$177,211,532**	**$171,101,710**	**($2,407,887)**	**-1%**
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0		$0	0%
C.	**Net Assets:**					
1	Unrestricted Net Assets or Equity	$103,558,083	$86,150,497	$89,541,387	($17,407,586)	-17%
2	Temporarily Restricted Net Assets	$18,960,042	$20,326,874	$21,000,450	$1,366,832	7%
3	Permanently Restricted Net Assets	$5,963,597	$6,124,455	$6,082,761	$160,858	3%
	Total Net Assets	**$128,481,722**	**$112,601,826**	**$116,624,598**	**($15,879,896)**	**-12%**
	Total Liabilities and Net Assets	**$370,738,314**	**$350,129,120**	**$351,058,605**	**($20,609,194)**	**-6%**

LAWRENCE AND MEMORIAL HOSPITAL

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	6 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	DIFFERENCE '15 vs '16	DIFFERENCE '15 vs '16
A.	**Operating Revenue:**					
1	Total Gross Patient Revenue	$839,272,512	$846,701,962	$444,891,216	$7,429,450	1%
2	Less: Allowances	$483,222,533	$503,815,087	$272,657,700	$20,592,554	4%
3	Less: Charity Care	$5,405,542	$5,374,494	$2,710,389	($31,048)	-1%
4	Less: Other Deductions	$12,823,282	$12,488,508	($885,860)	($334,774)	-3%
	Total Net Patient Revenue	**$337,821,155**	**$325,023,873**	**$170,408,987**	**($12,797,282)**	**-4%**
5	Provision for Bad Debts	$12,798,310	$12,339,856	$6,638,602	($458,454)	-4%
	Net Patient Service Revenue less provision for bad debts	**$325,022,845**	**$312,684,017**	**$163,770,385**	**($12,338,828)**	**-4%**
6	Other Operating Revenue	$30,854,159	$32,202,655	$13,451,161	$1,348,496	4%
7	Net Assets Released from Restrictions	$577,092	$453,686	$0	($123,406)	-21%
	Total Operating Revenue	**$356,454,096**	**$345,340,358**	**$177,221,546**	**($11,113,738)**	**-3%**
B.	**Operating Expenses:**					
1	Salaries and Wages	$140,640,103	$142,839,009	$70,948,624	$2,198,906	2%
2	Fringe Benefits	$51,694,855	$53,188,034	$26,812,588	$1,493,179	3%
3	Physicians Fees	$0	$0	$0	$0	0%
4	Supplies and Drugs	$56,133,288	$51,763,282	$22,155,539	($4,370,006)	-8%
5	Depreciation and Amortization	$23,641,535	$23,211,691	$12,433,051	($429,844)	-2%
6	Bad Debts	$0	$0	$0	$0	0%
7	Interest Expense	$3,553,690	$3,520,300	$1,722,174	($33,390)	-1%
8	Malpractice Insurance Cost	$4,818,820	$4,865,367	$2,022,043	$46,547	1%
9	Other Operating Expenses	$69,645,662	$65,443,417	$34,589,526	($4,202,245)	-6%
	Total Operating Expenses	**$350,127,953**	**$344,831,100**	**$170,683,545**	**($5,296,853)**	**-2%**
	Income/(Loss) From Operations	**$6,326,143**	**$509,258**	**$6,538,001**	**($5,816,885)**	**-92%**
C.	**Non-Operating Revenue:**					
1	Income from Investments	$9,936,909	$1,820,798	$3,340,590	($8,116,111)	-82%
2	Gifts, Contributions and Donations	$0	$0		$0	0%
3	Other Non-Operating Gains/(Losses)	$0	$0		$0	0%
	Total Non-Operating Revenue	**$9,936,909**	**$1,820,798**	**$3,340,590**	**($8,116,111)**	**-82%**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$16,263,052**	**$2,330,056**	**$9,878,591**	**($13,932,996)**	**-86%**
	Other Adjustments:					
	Unrealized Gains/(Losses)	$0	$0	$3,303	$0	0%
	All Other Adjustments	$0	$0		$0	0%
	Total Other Adjustments	**$0**	**$0**	**$3,303**	**$0**	**0%**
	Excess/(Deficiency) of Revenue Over Expenses	**$16,263,052**	**$2,330,056**	**$9,881,894**	**($13,932,996)**	**-86%**
	Principal Payments	$3,370,000	$3,540,000	$3,720,000	$170,000	5%

LAWRENCE AND MEMORIAL HOSPITAL

REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	6 Months	(5)	(6)
LINE	DESCRIPTION	FY 2015 ACTUAL	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE '15 vs '16	AMOUNT DIFFERENCE '15 vs '16
I.	**OPERATING EXPENSE BY CATEGORY**					
A.	**Salaries & Wages:**					
1	Nursing Salaries	$40,670,258	$42,101,513	$20,911,965	$1,431,255	4%
2	Physician Salaries	$389,032	$600,900	$298,469	$211,868	54%
3	Non-Nursing, Non-Physician Salaries	$99,580,813	$100,136,596	$49,738,190	$555,783	1%
	Total Salaries & Wages	**$140,640,103**	**$142,839,009**	**$70,948,624**	**$2,198,906**	**2%**
B.	**Fringe Benefits:**					
1	Nursing Fringe Benefits	$14,949,101	$15,677,067	$7,901,471	$727,966	5%
2	Physician Fringe Benefits	$142,996	$223,753	$117,815	$80,757	56%
3	Non-Nursing, Non-Physician Fringe Benefits	$36,602,758	$37,287,214	$18,793,302	$684,456	2%
	Total Fringe Benefits	**$51,694,855**	**$53,188,034**	**$26,812,588**	**$1,493,179**	**3%**
C.	**Contractual Labor Fees:**					
1	Nursing Fees	$182,310	$262,898	$149,444	$80,588	44%
2	Physician Fees	$0	$0		$0	0%
3	Non-Nursing, Non-Physician Fees	$1,062,834	$1,846,987	$385,199	$784,153	74%
	Total Contractual Labor Fees	**$1,245,144**	**$2,109,885**	**$534,643**	**$864,741**	**69%**
D.	**Medical Supplies and Pharmaceutical Cost:**					
1	Medical Supplies	$30,584,247	$27,076,356	$12,897,017	($3,507,891)	-11%
2	Pharmaceutical Costs	$25,549,041	$24,686,926	$9,258,521	($862,115)	-3%
	Total Medical Supplies and Pharmaceutical Cost	**$56,133,288**	**$51,763,282**	**$22,155,539**	**($4,370,006)**	**-8%**
E.	**Depreciation and Amortization:**					
1	Depreciation-Building	$4,870,793	$4,795,024	$2,371,986	($75,769)	-2%
2	Depreciation-Equipment	$17,811,015	$17,513,990	$9,609,435	($297,025)	-2%
3	Amortization	$959,727	$902,677	$451,630	($57,050)	-6%
	Total Depreciation and Amortization	**$23,641,535**	**$23,211,691**	**$12,433,051**	**($429,844)**	**-2%**
F.	**Bad Debts:**					
1	Bad Debts	$0	$0		$0	0%
G.	**Interest Expense:**					
1	Interest Expense	$3,553,690	$3,520,300	$1,722,174	($33,390)	-1%
H.	**Malpractice Insurance Cost:**					
1	Malpractice Insurance Cost	$4,818,820	$4,865,367	$2,022,043	$46,547	1%
I.	**Utilities:**					
1	Water	$179,870	$232,640	$102,696	$52,770	29%
2	Natural Gas	$1,083,143	$729,722	$463,107	($353,421)	-33%
3	Oil	$17,093	$17,818		$725	4%
4	Electricity	$3,177,410	$2,855,681	$1,188,801	($321,729)	-10%
5	Telephone	$903,759	$906,796	$472,119	$3,037	0%
6	Other Utilities	$0	$0	$0	$0	0%
	Total Utilities	**$5,361,275**	**$4,742,657**	**$2,226,723**	**($618,618)**	**-12%**
J.	**Business Expenses:**					
1	Accounting Fees	$744,087	$791,323	$841,800	$47,236	6%
2	Legal Fees	$938,011	$1,085,131	$288,803	$147,120	16%
3	Consulting Fees	$6,596,975	$2,318,907	$596,230	($4,278,068)	-65%
4	Dues and Membership	$385,002	$378,185	$151,258	($6,817)	-2%
5	Equipment Leases	$1,945,609	$1,415,529	$586,305	($530,080)	-27%
6	Building Leases	$2,702,266	$1,939,428	$1,067,644	($762,838)	-28%
7	Repairs and Maintenance	$11,575,820	$12,252,278	$5,669,788	$676,458	6%
8	Insurance	$1,040,315	$1,111,573	$545,974	$71,258	7%
9	Travel	$343,325	$312,714	$98,765	($30,611)	-9%
10	Conferences	$13,000	$0	$2,192	($13,000)	-100%
11	Property Tax	$179,170	$93,704	($126)	($85,466)	-48%

LAWRENCE AND MEMORIAL HOSPITAL

REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	6 Months	(5)	(6)
LINE	DESCRIPTION	FY 2015 ACTUAL	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE '15 vs '16	AMOUNT DIFFERENCE '15 vs '16
12	General Supplies	$1,779,347	$1,679,465	$855,889	($99,882)	-6%
13	Licenses and Subscriptions	$640,050	$586,409	$277,897	($53,641)	-8%
14	Postage and Shipping	$236,255	$219,189	$73,229	($17,066)	-7%
15	Advertising	$1,322,291	$1,311,432	$765,040	($10,859)	-1%
16	Corporate parent/system fees	$0	$0	$0	$0	0%
17	Computer Software	$632,110	$296,453	$158,254	($335,657)	-53%
18	Computer hardware & small equipment	$79,882	$79,311	$23,239	($571)	-1%
19	Dietary / Food Services	$1,982,677	$1,975,534	$1,060,108	($7,143)	0%
20	Lab Fees / Red Cross charges	$976,698	$975,852	$477,904	($846)	0%
21	Billing & Collection / Bank Fees	$487,671	$441,713	$229,934	($45,958)	-9%
22	Recruiting / Employee Education & Recognition	$363,597	$340,502	$89,849	($23,095)	-6%
23	Laundry / Linen	$40,977	$38,007	$10,133	($2,970)	-7%
24	Professional / Physician Fees	$8,776,142	$10,719,387	$6,552,870	$1,943,245	22%
25	Waste disposal	$0	$0	$0	$0	0%
26	Purchased Services - Medical	$4,768,761	$4,659,043	$2,159,173	($109,718)	-2%
27	Purchased Services - Non Medical	$12,719,370	$12,522,903	$8,709,009	($196,467)	-2%
28	Other Business Expenses	$1,168,984	$24,597	$537,002	($1,144,387)	-98%
	Total Business Expenses	**$62,438,392**	**$57,568,569**	**$31,828,162**	**($4,869,823)**	**-8%**
K.	**Other Operating Expense:**					
1	Miscellaneous Other Operating Expenses	$600,851	$1,022,306		$421,455	70%
	Total Operating Expenses - All Expense Categories*	**$350,127,953**	**$344,831,100**	**$170,683,545**	**($5,296,853)**	**-2%**
	***A.-K.The total operating expenses amount above must agree with the total operating expenses amount on Report 150**					
II.	**OPERATING EXPENSE BY DEPARTMENT**					
A.	**General Services:**					
1	General Administration	$21,854,054	$19,507,412	$10,038,818	($2,346,642)	-11%
2	General Accounting	$2,072,390	$1,835,415	$1,257,693	($236,975)	-11%
3	Patient Billing & Collection	$5,452,007	$5,390,293	$2,384,040	($61,714)	-1%
4	Admitting / Registration Office	$6,592,924	$5,712,315	$2,970,219	($880,609)	-13%
5	Data Processing	$10,695,890	$11,701,172	$6,004,157	$1,005,282	9%
6	Communications	$364,288	$372,207	$186,244	$7,919	2%
7	Personnel	$53,660,271	$55,138,738	$28,013,490	$1,478,467	3%
8	Public Relations	$1,740,465	$1,738,016	$957,979	($2,449)	0%
9	Purchasing	$2,537,020	$1,485,342	$1,609,210	($1,051,678)	-41%
10	Dietary and Cafeteria	$4,613,598	$4,660,587	$2,357,351	$46,989	1%
11	Housekeeping	$4,202,487	$4,108,803	$2,032,539	($93,684)	-2%
12	Laundry & Linen	$0	$0		$0	0%
13	Operation of Plant	$4,018,508	$4,515,484	$1,911,947	$496,976	12%
14	Security	$1,540,180	$1,591,639	$895,419	$51,459	3%
15	Repairs and Maintenance	$6,089,115	$4,737,571	$2,551,331	($1,351,544)	-22%
16	Central Sterile Supply	$2,028,759	$1,673,457	$764,751	($355,302)	-18%
17	Pharmacy Department	$29,691,993	$29,638,279	$11,698,467	($53,714)	0%
18	Other General Services	$7,478,875	$7,119,473	$2,718,113	($359,402)	-5%
	Total General Services	**$164,632,824**	**$160,926,203**	**$78,351,768**	**($3,706,621)**	**-2%**
B.	**Professional Services:**					
1	Medical Care Administration	$387,046	$420,247	$96,893	$33,201	9%
2	Residency Program	$122,349	$124,308	$62,154	$1,959	2%
3	Nursing Services Administration	$2,389,086	$2,514,763	$1,054,818	$125,677	5%
4	Medical Records	$4,750,469	$5,280,547	$2,168,642	$530,078	11%
5	Social Service	$2,727,088	$2,747,442	$1,432,425	$20,354	1%
6	Other Professional Services	$5,370,515	$6,850,062	$3,744,217	$1,479,547	28%
	Total Professional Services	**$15,746,553**	**$17,937,369**	**$8,559,150**	**$2,190,816**	**14%**
C.	**Special Services:**					
1	Operating Room	$24,566,779	$21,252,242	$10,407,932	($3,314,537)	-13%

LAWRENCE AND MEMORIAL HOSPITAL

REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	6 Months	(5)	(6)
LINE	DESCRIPTION	FY 2015 ACTUAL	FY 2016 ACTUAL	FY 2017 ACTUAL	AMOUNT DIFFERENCE '15 vs '16	AMOUNT DIFFERENCE '15 vs '16
2	Recovery Room	$994,955	$991,676	$554,377	($3,279)	0%
3	Anesthesiology	$496,839	$493,006	$215,158	($3,833)	-1%
4	Delivery Room	$118,500	$122,075	$57,283	$3,575	3%
5	Diagnostic Radiology	$3,565,288	$3,494,882	$1,699,935	($70,406)	-2%
6	Diagnostic Ultrasound	$2,935,254	$2,948,958	$1,443,352	$13,704	0%
7	Radiation Therapy	$2,994,087	$3,171,628	$1,415,368	$177,541	6%
8	Radioisotopes	$1,516,757	$1,724,505	$640,549	$207,748	14%
9	CT Scan	$2,037,069	$2,180,894	$1,005,320	$143,825	7%
10	Laboratory	$15,223,990	$14,517,400	$7,348,646	($706,590)	-5%
11	Blood Storing/Processing	$0	$0		$0	0%
12	Cardiology	$1,496,892	$1,525,030	$789,186	$28,138	2%
13	Electrocardiology	$4,158	$70	$53	($4,088)	-98%
14	Electroencephalography	$278,878	$285,771	$142,882	$6,893	2%
15	Occupational Therapy	$1,801,640	$1,874,416	$998,750	$72,776	4%
16	Speech Pathology	$744,589	$762,989	$367,802	$18,400	2%
17	Audiology	$755,221	$760,926	$382,932	$5,705	1%
18	Respiratory Therapy	$2,713,543	$2,694,154	$1,343,174	($19,389)	-1%
19	Pulmonary Function	$727	$0	$0	($727)	-100%
20	Intravenous Therapy	$2,154,621	$1,461,873	$702,881	($692,748)	-32%
21	Shock Therapy	$0	$0	$0	$0	0%
22	Psychiatry / Psychology Services	$1,736,261	$1,826,473	$955,563	$90,212	5%
23	Renal Dialysis	$468,917	$587,081	$295,915	$118,164	25%
24	Emergency Room	$10,593,872	$10,981,590	$6,665,280	$387,718	4%
25	MRI	$1,619,012	$1,604,322	$973,696	($14,690)	-1%
26	PET Scan	$0	$0	$0	$0	0%
27	PET/CT Scan	$0	$0	$0	$0	0%
28	Endoscopy	$982,511	$904,643	$405,771	($77,868)	-8%
29	Sleep Center	$1,106,596	$795,878	$329,950	($310,718)	-28%
30	Lithotripsy	$0	$0	$0	$0	0%
31	Cardiac Catheterization/Rehabilitation	$4,075,654	$4,615,958	$2,318,946	$540,304	13%
32	Occupational Therapy / Physical Therapy	$3,828,129	$3,886,438	$2,017,994	$58,309	2%
33	Dental Clinic	$0	$0	$0	$0	0%
34	Other Special Services	$7,600,420	$7,320,165	$4,818,081	($280,255)	-4%
	Total Special Services	**$96,411,159**	**$92,785,043**	**$48,296,776**	**($3,626,116)**	**-4%**
D.	**Routine Services:**					
1	Medical & Surgical Units	$20,272,594	$20,709,022	$10,787,492	$436,428	2%
2	Intensive Care Unit	$2,873,975	$3,177,006	$1,640,435	$303,031	11%
3	Coronary Care Unit	$3,260,733	$3,030,022	$1,535,263	($230,711)	-7%
4	Psychiatric Unit	$2,346,724	$2,439,777	$1,148,978	$93,053	4%
5	Pediatric Unit	$0	$110,789	$64,705	$110,789	0%
6	Maternity Unit	$5,986,189	$6,110,500	$3,054,998	$124,311	2%
7	Newborn Nursery Unit	$0	$0		$0	0%
8	Neonatal ICU	$3,397,794	$3,494,668	$1,630,518	$96,874	3%
9	Rehabilitation Unit	$2,628,328	$2,423,335	$1,118,092	($204,993)	-8%
10	Ambulatory Surgery	$2,000,875	$2,146,199	$1,098,316	$145,324	7%
11	Home Care	$0	$0		$0	0%
12	Outpatient Clinics	$0	$0		$0	0%
13	Other Routine Services	$1,211,298	$1,140,430	$503,273	($70,868)	-6%
	Total Routine Services	**$43,978,510**	**$44,781,748**	**$22,582,070**	**$803,238**	**2%**
E.	**Other Departments:**					
1	Miscellaneous Other Departments	$29,358,907	$28,400,737	$12,863,782	($958,170)	-3%
	Total Operating Expenses - All Departments*	**$350,127,953**	**$344,831,100**	**$170,653,545**	**($5,296,853)**	**-2%**
	***A.- E. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.**					

Lawrence + Memorial Corporation and Subsidiaries *
Statement of Cash Flows

	For the Six Months Ended March 31, 2017
Cash flows from operating activities	
Change in net assets	$ 3,443,153
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Depreciation & amortization	15,576,047
(Increase) decrease in funds held in trust by others	79,370
Decrease (increase) in contributions receivable	979,118
Net unreal & real (gain) loss on investments	8,100,170
Provision for bad debts	8,483,765
Changes in operating accounts:	
Patient accounts receivable, net	(13,907,344)
Other receivables	6,490,991
Inventories	(22,083)
Prepaid expenses	299,262
Accounts payable	(6,237,205)
Accrued vacation & sick pay	(851,038)
Salaries, wages, payroll taxes	(491,061)
Due to affiliates	(3,050,261)
Due to third parties	(5,896,803)
Due to MCIC	(16,122,688)
Other liabilities	(15,045,681)
Net cash used in operating activities	**(18,172,288)**
Cash flows from investing activities	
Debt service fund	(2,632,652)
Purchase of property, plant and equipment, net	(9,370,111)
(Increase)/decrease in investment	34,027,728
Net cash provided by investing activities	**22,024,965**
Cash flows from financing activities:	
Principal payments on long term debt	(857,900)
Net increase in cash and cash equivalents	2,994,777
Cash at beginning of year	18,792,715
Cash at end of year	**$ 21,787,492**

* The statistics presented above represent data for Lawrence + Memorial Corporation and Subsidiaries (L+M). L+M is a healthcare system that provides a wide array of services throughout the region, and includes: Lawrence + Memorial Hospital; L&M Physician Association, Inc.; L&M Systems, Inc.; VNA of Southeastern Connecticut; L+M Healthcare; L+M indemnity Ltd; and LMW Healthcare Inc. (Westerly Hospital).

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

Note: Six month data for FY 2017 provided as requested per applicable Condition

L&M PHYSICIAN ASSOCIATION

FISCAL YEAR 2017

REPORT 100 - BALANCE SHEET INFORMATION

(1)	(2)	6 Months FY 2017
LINE	**DESCRIPTION**	**ACTUAL**
I.	**ASSETS**	
A.	**Current Assets:**	
1	Cash and Cash Equivalents	($50,002)
2	Short Term Investments	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$1,145,732
4	Current Assets Whose Use is Limited for Current Liabilities	
5	Due From Affiliates	$0
6	Due From Third Party Payers	
7	Inventories of Supplies	$0
8	Prepaid Expenses	$35,753
9	Other Current Assets	$1,276,413
	Total Current Assets	**$2,407,896**
B.	**Noncurrent Assets Whose Use is Limited:**	
1	Held by Trustee	$0
2	Board Designated for Capital Acquisition	
3	Funds Held in Escrow	
4	Other Noncurrent Assets Whose Use is Limited	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**
5	Interest in Net Assets of Foundation	
6	Long Term Investments	
7	Other Noncurrent Assets	$0
C.	**Net Fixed Assets:**	
1	Property, Plant and Equipment	$3,057,388
2	Less: Accumulated Depreciation	$0
	Property, Plant and Equipment, Net	**$3,057,388**
3	Construction in Progress	$0
	Total Net Fixed Assets	**$3,057,388**
	Total Assets	**$5,465,284**

L&M PHYSICIAN ASSOCIATION		
FISCAL YEAR 2017		
REPORT 100 - BALANCE SHEET INFORMATION		
(1)	(2)	6 Months FY 2017
LINE	DESCRIPTION	ACTUAL
II.	**LIABILITIES AND NET ASSETS**	
A.	**Current Liabilities:**	
1	Accounts Payable and Accrued Expenses	$1,379,126
2	Salaries, Wages and Payroll Taxes	$1,180,217
3	Due To Third Party Payers	$5,544
4	Due To Affiliates	$5,187,377
5	Current Portion of Long Term Debt	
6	Current Portion of Notes Payable	
7	Other Current Liabilities	
	Total Current Liabilities	**$7,752,264**
B.	**Long Term Debt:**	
1	Bonds Payable (Net of Current Portion)	
2	Notes Payable (Net of Current Portion)	
	Total Long Term Debt	**$0**
3	Accrued Pension Liability	$309,654
4	Other Long Term Liabilities	$0
	Total Long Term Liabilities	**$309,654**
5	Interest in Net Assets of Affiliates or Joint Ventures	
C.	**Net Assets:**	
1	Unrestricted Net Assets or Equity	($2,596,634)
2	Temporarily Restricted Net Assets	$0
3	Permanently Restricted Net Assets	$0
	Total Net Assets	**($2,596,634)**
	Total Liabilities and Net Assets	**$5,465,284**
Note: Six months data for FY 2017 provided as requested per applicable Condition		

L&M PHYSICIAN ASSOCIATION		
FISCAL YEAR 2017		
REPORT 150 - STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	6 Months FY 2017
LINE	DESCRIPTION	ACTUAL
A.	**Operating Revenue:**	
1	Total Gross Patient Revenue	$30,119,375
2	Less: Allowances	$14,035,698
3	Less: Charity Care	$0
4	Less: Other Deductions	$0
	Total Net Patient Revenue	**$16,083,677**
5	Provision for Bad Debts	$266,238
	Net Patient Service Revenue less provision for bad debts	**$15,817,439**
6	Other Operating Revenue	$4,545,808
7	Net Assets Released from Restrictions	$0
	Total Operating Revenue	**$20,363,247**
B.	**Operating Expenses:**	
1	Salaries and Wages	$17,416,966
2	Fringe Benefits	$3,591,197
3	Physicians Fees	$0
4	Supplies and Drugs	$939,316
5	Depreciation and Amortization	$561,856
6	Bad Debts	$0
7	Interest Expense	$0
8	Malpractice Insurance Cost	$797,004
9	Other Operating Expenses	$6,132,801
	Total Operating Expenses	**$29,439,140**
	Income/(Loss) From Operations	**($9,075,893)**

L&M PHYSICIAN ASSOCIATION		
FISCAL YEAR 2017		
REPORT 150 - STATEMENT OF OPERATIONS INFORMATION		
(1)	(2)	6 Months FY 2017
LINE	DESCRIPTION	ACTUAL
C.	**Non-Operating Revenue:**	
1	Income from Investments	$0
2	Gifts, Contributions and Donations	
3	Other Non-Operating Gains/(Losses)	
	Total Non-Operating Revenue	**$0**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($9,075,893)**
	Other Adjustments:	
	Unrealized Gains/(Losses)	$0
	All Other Adjustments	
	Total Other Adjustments	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($9,075,893)**
	Principal Payments	$0

Note: Six months data for FY 2017 provided as requested per applicable Condition

L&M Physician Association *
Statement of Cash Flows

	For the Six Months Ended March 31, 2017
Cash flows from operating activities	
Change in net assets	$ (9,075,893)
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Depreciation & amortization	561,856
Provision for bad debts	266,238
Changes in operating accounts:	
Patient Accounts Receivable, Net	(845,999)
Other receivables	(951,071)
Prepaid expenses	15,322
Accounts Payable	1,328,908
Accrued vacation & sick pay	(1,418,915)
Salaries, wages, payroll taxes	(607,701)
Due to affiliates	4,990,813
Other liabilities	(1,869,906)
Net cash used in operating activities	**(7,606,348)**
Cash flows from investing activities	
Purchase of property, plant and equipment, net	(2,683,711)
Net cash used in investing activities	**(2,683,711)**
Cash flows from financing activities:	
Net asset transfer from LMH	9,790,918
Net decrease in cash and cash equivalents	(499,141)
Cash at beginning of year	449,139
Cash at end of year	**$ (50,002)**

* The statistics presented above represent data for L&M Physician Association, Inc. only.

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

Note: Six month data for FY 2017 provided as requested per applicable Condition

User, OHCA

From: Roberts, Karen
Sent: Friday, June 30, 2017 3:32 PM
To: Sauders, Kelly (US - New York)
Cc: User, OHCA
Subject: RE: Yale New Haven Health and Lawrence + Memorial Hospital - Invitation to July 6th public meeting

Thanks Kelly.

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, June 30, 2017 3:23 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Gayle Capozzalo <gayle.capozzalo@ynhh.org>
Subject: Re: Yale New Haven Health and Lawrence + Memorial Hospital - Invitation to July 6th public meeting

Hi - the final reports are going through QA by Milliman. I suspect by next Friday.

Thanks,
Kelly

On Jun 30, 2017, at 1:48 PM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

> Hi Kelly – do you know if we should be expecting the Yale/L+M Cost and Market Impact Report to be filed today? Karen
>
> Sincerely,
>
> *Karen Roberts*
> Principal Health Care Analyst

Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, June 8, 2017 10:53 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Subject: RE: RE: Yale New Haven Health and Lawrence + Memorial Hospital - Invitation to July 6th public meeting

Hi – I checked in with the client. They are hoping for end of June.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Thursday, June 8, 2017 10:33 AM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Subject: RE: RE: Yale New Haven Health and Lawrence + Memorial Hospital - Invitation to July 6th public meeting

Hi Kelly - question for you. Do you know on what date Yale/L+M will be filing the Cost and Market Impact Report? Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, June 8, 2017 10:04 AM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Subject: FW: RE: Yale New Haven Health and Lawrence + Memorial Hospital - Invitation to July 6th public meeting

Good morning – FYI only – in addition to the newspaper notice and posting on the website, YNHH wanted to share this invitation with the community forum and anyone else who has attended past meetings.

thanks

From: Sauders, Kelly (US - New York)
Sent: Thursday, June 8, 2017 9:53 AM
To: 'stephen_r_smith@brown.edu' <stephen_r_smith@brown.edu>; 'andrews@cthealthpolicy.org' <andrews@cthealthpolicy.org>; 'calvertr@childandfamilyagency.org'

<calvertr@childandfamilyagency.org>; 'carolyn.patierno@allsouls.net' <carolyn.patierno@allsouls.net>; 'cbunnell@moheganmail.com' <cbunnell@moheganmail.com>; 'chris@higheredgect.org' <chris@higheredgect.org>; 'czeiner@safefuturesct.org' <czeiner@safefuturesct.org>; 'director@newlondonmainstreet.org' <director@newlondonmainstreet.org>; 'doh@uncashd.org' <doh@uncashd.org>; 'edwardtessman@ccfsn.org' <edwardtessman@ccfsn.org>; 'g.demaio@soundcommunityservices.org' <g.demaio@soundcommunityservices.org>; 'jackmalone@scadd.org' <jackmalone@scadd.org>; 'jennob@cfect.org' <jennob@cfect.org>; 'jfischer@jfec.com' <jfischer@jfec.com>; 'jgranger@ucfs.org' <jgranger@ucfs.org>; 'jhaslam@connlegalservices.org' <jhaslam@connlegalservices.org>; 'jlokken@town.groton.ct.us' <jlokken@town.groton.ct.us>; 'jmilstein@ci.New-London.ct.us' <jmilstein@ci.New-London.ct.us>; 'johnpsilsby@yahoo.com' <johnpsilsby@yahoo.com>; 'jpkamish@hotmail.com' <jpkamish@hotmail.com>; 'kstauffer@thearcnlc.org' <kstauffer@thearcnlc.org>; 'kthompson@allianceforliving.org' <kthompson@allianceforliving.org>; 'lauren.pereira@ppsne.org' <lauren.pereira@ppsne.org>; 'megan.brown@tvcca.org' <megan.brown@tvcca.org>; 'ncowser@secter.org' <ncowser@secter.org>; 'nickfischer@yahoo.com' <nickfischer@yahoo.com>; 'oceanpellett@yahoo.com' <oceanpellett@yahoo.com>; 'pacopeco48@gmail.com' <pacopeco48@gmail.com>; 'pdavis@rcda.co' <pdavis@rcda.co>; 'president@mysticchamber.org' <president@mysticchamber.org>; 'president@sectwomensnetwork.org' <president@sectwomensnetwork.org>; 'riveram@newlondon.org' <riveram@newlondon.org>; 'rmelmed@llhd.org' <rmelmed@llhd.org>; 'rmoller@noankcss.org' <rmoller@noankcss.org>; 'rodneybutler@mptn-nsn.gov' <rodneybutler@mptn-nsn.gov>; 'rodrigd@chc1.com' <rodrigd@chc1.com>; 'steinmayer_j@mitchell.edu' <steinmayer_j@mitchell.edu>; 'stephanyerclarke@gmail.com' <stephanyerclarke@gmail.com>; 'tlrei@conncoll.edu' <tlrei@conncoll.edu>; 'tsheridan@chamberect.com' <tsheridan@chamberect.com>; 'unit2010@newlondonnaacp.org' <unit2010@newlondonnaacp.org>; 'victorg.villagra@gmail.com' <victorg.villagra@gmail.com>; 'virginia.mason@uwsect.org' <virginia.mason@uwsect.org>; 'franciyh@chc1.com' <franciyh@chc1.com>; 'president@sectwomensnetwork.org' <president@sectwomensnetwork.org>; 'sprinttrack@hotmail.com' <sprinttrack@hotmail.com>
Subject: RE: Yale New Haven Health and Lawrence + Memorial Hospital - Invitation to July 6th public meeting

As part of Yale New Haven Health and Lawrence + Memorial Hospital's ongoing commitment to the community and in accordance with the conditions of regulatory approvals, Yale New Haven Health and Lawrence + Memorial Hospital will be hosting an open public meeting on July 6, 2017 at 6:00 pm at the Holiday Inn in New London.

At this meeting, Yale New Haven Health and Lawrence + Memorial Hospital will be sharing information about the progress of the affiliation over the course of the last nine months. Your input and feedback is welcome. Notice of this meeting has been published and will also be available on L+MH's website.

Please let me know if you have any questions. There is no need to RSVP.

Regards,

Kelly Sauders
Independent Monitor

you should delete this message and any disclosure, copying, or distribution of this message, or the taking of any action based on it, by you is strictly prohibited.

v.E.1

User, OHCA

From: Roberts, Karen
Sent: Monday, July 03, 2017 11:10 AM
To: 'ksauders@deloitte.com'; User, OHCA
Cc: Cotto, Carmen; Martone, Kim
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON
Attachments: Deloitte Independent Monitor Year 1 Six Month Report 04 07 2017.pdf

Hi Kelly – I have a question for you to look into regarding the submission of material in response to **Condition #6** of Docket Number 15-32033-CON. In your report filed on 4/7th, you indicate that the first filing for Condition #6 was filed on 3/7/2017, which is correct, that is the date it was submitted (Total Price by Top 25 most frequently utilized services table). However, subsequent to the filing on 3/7th we spoke in a conference call that this table is incorrect as it reflects a Fiscal Year (10/1/2015 to 9/30/2016) which is not in compliance with the condition as written. We indicated in the conference call that the first (baseline) filing is prior to the affiliation date and says in the Condition, September 1, 2015 – August 30, 2016. I don't' see a refiling of this material in any of the subsequent emails for this docket number. Can you look into that and have it filed with OHCA using the correct dates at the earliest convenience.
Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, April 7, 2017 4:13 PM
To: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hello all – please see the attached report from Deloitte & Touche LLP which is the first six-month report due from the Independent Monitor for the period ending March 31, 2017. Let me know if you have any questions.

Regards,

Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

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Deloitte.

YNHHSC Independent Monitor Review Report for Six Month Reporting Period Ending March 31, 2017

April 7, 2017

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, NY 10112

www.deloitte.com

April 7, 2017

Ms. Gayle Capozzalo
Executive Vice President and Chief Strategy Officer
Yale New Haven Health
789 Howard Avenue
New Haven, CT 06519

Dear Ms. Capozzalo,

Re: Deloitte & Touche LLP Six-Month Report as Independent Monitor per Docket Numbers 15-32032-CON and 15-32033-CON

In accordance with our engagement letter dated November 7, 2016 ("Engagement Letter"), the attached report summarizes the findings from the work steps performed by Deloitte & Touche LLP ("D&T"), as requested by Yale New Haven Health ("YNHHSC"), with respect to the Independent Monitor role for the 6-month reporting period ending March 31, 2017.

Pursuant to the Engagement Letter, YNHHSC agrees that any deliverables provided to YNHHSC by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with their regulatory oversight.

The services were performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). The services did not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, D&T does not express an opinion or any other form of assurance as a result of performing the services.

Sincerely,

Kelly J. Sanders

Deloitte & Touche LLP

Contents

Key	
Complete	
In Progress	

I. Executive Summary Table

Condition Number	Milestone Date	Completion Status
Strategic Plan		
15-32033-CON Condition 4	3/7/2017	
15-32033-CON Condition 19	3/7/2017	
15-32033-CON Condition 32b	5/31/2017	
15-32033-CON Condition 7	5/31/2017	
15-32033-CON Condition 5	1/19/2017	
15-32033-CON Condition 18	5/31/2017	
15-32033-CON Condition 32a	5/31/2017	
Financial Reporting		
15-32033-CON Condition 8	5/31/2017	
15-32033-CON Condition 32f	3/7/2017	
15-32032-CON Condition 7c	5/31/2017	
15-32033-CON Condition 6	3/7/2017	
Cost and Market Impact Review		
15-32033-CON Condition 22	12/7/2016	
15-32032-CON Condition 3	12/7/2016	
15-32032-CON Condition 4	12/7/2016	
15-32033-CON Condition 23	12/7/2016	
15-32033-CON Condition 20 Paragraph 1	12/31/2017	
15-32033-CON Condition 32c	5/31/2017	
15-32033-CON Condition 20 Paragraphs 2/3	6/30/2018	
15-32032-CON Condition 1	12/31/2017	
15-32032-CON Condition 7a	5/31/2017	
15-32033-CON Condition 21a	12/7/2016	
15-32032-CON Condition 2a	12/7/2016	
15-32033-CON Condition 21b	12/7/2016	
15-32032-CON Condition 2b	12/7/2016	
Independent Monitor		
15-32033-CON Condition 15	11/7/2016	
15-32033-CON Condition 16	2 per year; report due 30 days after visit	
15-32033-CON Condition 33	3/31/2017	
15-32032-CON Condition 8	Ongoing	

Key	
Complete	
In Progress	

Condition Number	Milestone Date	Completion Status
Community Benefit		
15-32033-CON Condition 11	Ongoing	
15-32033-CON Condition 31	12/31/2016	
15-32033-CON Condition 32h	11/30/2017	
15-32033-CON Condition 12	11/30/2017	
Charity Care Policies		
15-32033-CON Condition 9	Following closing	
15-32033-CON Condition 10	11/30/2017	
15-32033-CON Condition 32e	5/31/2017	
Employment Conditions		
15-32033-CON Condition 27	5/31/2017	
15-32033-CON Condition 32g	5/31/2017	
15-32033-CON Condition 28	5/31/2017	
15-32032-CON Condition 6	5/31/2017	
15-32033-CON Condition 29	5/31/2017	
15-32033-CON Condition 30	5/31/2017	
Governance		
15-32033-CON Condition 14	Following closing	
15-32033-CON Condition 17	Twice a year	
15-32033-CON Condition 26	9/28/2016	
Licensure and Physician Office Conversion		
15-32033-CON Condition 13	Ongoing	
15-32033-CON Condition 24	5/31/2017	
15-32033-CON Condition 32d	5/31/2017	
15-32032-CON Condition 5	5/31/2017	
15-32032-CON Condition 7b	5/31/2017	
15-32033-CON Condition 25	3/31/2017	

I. Detailed Observations Table

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 4	Within one hundred and eighty (180) days following the Closing Date of 9/8/16, YNHHSC shall submit a plan demonstrating how health care services will be provided by L+MH for the first three years following the Transfer Agreement, including any consolidation, reduction, or elimination of existing services or introduction of new services (the "Services Plan"). The Services Plan will be provided in a format mutually agreed upon by OHCA and YNHHSC. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: This applies only to Eastern Connecticut which has been defined in the Affiliation Agreement as Tolland, Windham and New London counties. Note 2: Refer to Condition #19 which addresses the same/similar requirements	3/7/2017	D&T will obtain a copy of the Services Plan/Strategic Plan submitted for Condition #4 and #19, verify timely submission, verify that it incorporates the required elements (e.g. describing any planned consolidation, reduction, or elimination of existing services or introduction of new services) and that it meets the 3-year requirement.	YNHHS submitted Services and Strategy Plan to OHCA in accordance with Conditions 4 and 19 on 1/19/2017.	**Pg. 478** (submission email) **Pg. 479 – 482** (documentation)
15-32033-CON Condition 19	L+M and YNHHSC shall develop a strategic plan to focus on the retention and enhancement of healthcare services in the primary service area, i.e. towns served by L+M, which assures patient affordability and is consistent with appropriate standards of care, quality, and accessibility. Such plan shall seek to minimize travel for patients requiring clinical services that can be provided appropriately at L+M service sites, and to support the return of patients back to L+M and its medical staff for care should patients be referred to other YNHHSC affiliated facilities for specialized care not available locally. The strategic plan shall include but not be limited to the following components: a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals. b. YNHHSC and L+M shall abide by the resource commitments for clinical service programming as set forth in the Affiliation Agreement. NOTE 1: Refer to Condition #4 which addresses the same requirements.	3/7/2017	D&T will obtain the Services Plan/Strategic Plan submitted for Condition #4 and #19 and review the plan for inclusion of these required components (as compared to the needs described within the Community Needs Assessment and the resource commitments within the Affiliation Agreement).	YNHHS submitted Services and Strategy Plan to OHCA in accordance with Conditions 4 and 19 on 1/19/2017.	**Pg. 478** (submission email) **Pg. 479 – 482** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 5	Until such time as the Services Plan is submitted , YNHHSC shall provide OHCA with notice of any reallocation of inpatient beds and relocation of outpatient services for L+MH specific to those services that existed at L+MH as of the Decision Date. Such notice shall be provided within ten (10) days of any such reallocation or relocation and published on the website pages of L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. NOTE 1: Cross-reference to Condition #18	1/19/2017	D&T will confirm that notices of reallocation or relocation were submitted in a timely manner and published on the L+MH website within ten days. Per related 15-32033-CON Condition #18, D&T will confirm that any changes or reallocation of services are not in conflict with the requirements of 15-32033-CON Condition #18.	Confirmed with YNHHS that through the submission of the Services Plan on 1/19/2017, no reallocation or relocation of inpatient beds or outpatient services was performed.	**N/A**

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 32f	A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report. i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities; ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories; iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.	3/7/2017	For 15-32033-CON Condition #32F, D&T will obtain the Five-Year Plan prepared by YNHHSC and the ongoing six month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175 and succession reports to OHCA.	YNHHS submitted Five-Year Plan to OHCA in accordance with Condition 32f on 3/7/2017. The milestone date for the six month report is 5/31/2017 for 15-32033-CON Condition 32f and 15-32032-CON Condition 7c.	**Pg. 734** (submission email) **Pg. 736 – 737** (documentation)

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 6	Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.	3/7/2017	D&T will obtain YNHHSC's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information. D&T will review work papers to confirm information and timely filing. * 1st filing is due within 180 days (March 2017); 2nd filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3rd filing is due 60 dates after the close of FY2018 which is 11/30/18.	YNHHS submitted analysis to OHCA in accordance with Condition 6 on 3/7/2017.	**Pg. 734** (submission email) **Pg. 735 and 738** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 22	Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	12/7/2016	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 22 (continued)	c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.	12/7/2016	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.	No noted instances of non-compliance.	**Pg. 430** (submission email) **Pg. 431-454** (documentation

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 3	Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below) for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.	12/7/2016	Refer to procedures for 15-32033-CON Condition #22 above.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 3 (continued)	c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section l 9a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.	12/7/2016	Refer to procedures for 15-32033-CON Condition #22 above.	No noted instances of non-compliance.	**Pg. 430** (submission email) **Pg. 431-454** (documentation

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 23	For purposes of determining the price per unit of service: f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	12/7/2016	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 4	For purposes of determining the price per unit of service: a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	12/7/2016	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.	YNHHS submitted documentation to OHCA supporting engagement of Independent Consultant, Milliman, in accordance with Condition on 11/29/2016. The Independent Monitor and Independent Consultant currently meet via conference call on a monthly basis.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 21a	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	12/7/2016	D&T will receive samples of payer submissions for LMMG physicians and obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 21a to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)
15-32032-CON Condition 2a	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	12/7/2016	Refer to procedures for 15-32033-CON Condition #21a above.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 2a to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)
15-32033-CON Condition 21b	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.	12/7/2016	D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 21b to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 2b	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.	12/7/2016	Refer to procedures for 15-32033-CON Condition #21b above.	YNHHS submitted a Management Representation in accordance with engaging an Independent Consultant to assess Condition 21b to OHCA on 11/29/2016.	**Pg. 430** (submission email) **Pg. 431-454** (documentation
15-32033-CON Condition 15	Within sixty (60) days after the Closing Date, YNHHSC shall contract with an Independent Monitor who has experience in hospital administration and regulation. The Independent Monitor shall be retained at the sole expense of YNHHSC. Representatives of OHCA and FLIS will approve the Independent Monitor's appointment. The Independent Monitor shall be engaged for a minimum period of two (2) years following the Closing, which may be extended for another year at OHCA's and/or FLIS's discretion. The Independent Monitor will be responsible for monitoring the Applicants' compliance with the Conditions set forth in this Order. The Applicants shall provide the Independent Monitor with appropriate access to L+MH and its applicable records in order to enable the Independent Monitor to fulfill its functions hereunder. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the conditions set forth herein. NOTE: See Condition #33a (appointment of Monitor requirement)	11/7/2016	D&T and YNHHSC will execute an Engagement Letter by the required date. A copy of this Engagement Letter will be provided to OHCA.	Engagement Letter signed and submitted to OHCA on 11/7/2016.	**Pg. 322-324** (submission email) **Pg. 325-372** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 16	The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	2 per year; report due 30 days after visit	D&T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&T. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.	The first semi-annual site visit was completed on 3/1/2017. A brief report summarizing the site visit was submitted in accordance with Condition 16 on 3/23/2017. D&T submitted report summarizing YNHHS activities to fulfill Conditions from the prior six month period on 04/07/2017.	**Pg. 739** (submission email) **Pg. 740-754** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 33	In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	3/31/2017	For 15-32033-CON Condition #33a, refer to 15-32033-CON Condition #15. 15-32033-CON Condition #33b – D&T will meet with CHNA/CHIP "participation group" in March 2017 for an initial introduction and will meet with this group annually thereafter to present the annual Monitor report. Relative to (ii), Refer to the procedures performed per Conditions #11 and #31. Minutes will be maintained by D&T of these meetings and provided to OHCA upon request. With respect to 15-32033-CON #33d, D&T will review the public notice and attend the public forum held by YNHHSC and confirm that it includes members of the CHIP (Community Health Improvement Program) group.	Engagement Letter signed and submitted to OHCA on 11/7/2016. Community Forum with "participation group" completed on 1/24/2017. Minutes were submitted to OHCA to summarize the Community Forum on 1/27/2017. D&T reviewed the public notice and attended the public forum on 3/1/2017 and submitted Public Forum minutes to OHCA on 3/23/2017.	**Engagement Letter Pg. 322-324** (submission email) **Pg. 325-372** (documentation) **Community Forum Pg. 488** (submission email) **Pg. 488-506** (documentation) **Public Forum Pg. 739** (submission email) **Pg. 740-754** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 33 (continued)	e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate connective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653. In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such non-compliance.	3/31/2017	With respect to 15-32033-CON #33e, D&T agrees to provide written notice of any deficiencies as required.	No noted instances of non-compliance.	**N/A**

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 8	In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. a.L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	3/31/2017	Refer to procedures for 15-32033-CON Condition #33 a through e above.	Community Forum with "participation group" completed on 1/24/2017. Minutes were submitted to OHCA to summarize the Community Forum on 1/27/2017. D&T reviewed the public notice and attended the public forum on 3/1/2017 and submitted Public Forum minutes to OHCA on 3/23/2017.	**Community Forum Pg. 488** (submission email) **Pg. 488-506** (documentation) **Public Forum Pg. 739** (submission email) **Pg. 740-754** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32032-CON Condition 8 (continued)	e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such noncompliance.	Ongoing	Refer to procedures for 15-32033-CON Condition #33 a through e above.	No noted instances of non-compliance.	**N/A**
15-32033-CON Condition 31	L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.	12/31/2016	After obtaining L+M's baseline Schedule H of IRS Form 990, D&T will obtain and confirm that L+M and YNHHSC have increased community benefit by 1% per year for the first three (3) years of this agreement. Thereafter for years 4 and 5, we will confirm that the level of community benefit provided in year 3 was at least maintained (not required to increase in years 4 and 5). Cross-reference to 15-32033-CON Condition #11.	Schedule H of 2015 IRS Form 990 was obtained on 1/6/2017. Page references refer to submission letter for Condition 21 and CHNA.	**Pg. 161** (submission letter) **Pg. 162-262** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 9	Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least as generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law, OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Following closing	D&T will obtain copies of the relevant financial assistance policies and confirm that L+MH has adopted YNHHSC's financial assistance policies (or policies at least as generous as these policies) using L+M Hospital board resolutions. After verifying that this step has been properly completed, we will confirm that these policies are properly posted on L+MH's website.	YNHHS submitted documentation to OHCA in accordance with Condition 9 including financial assistance policies on 2/21/2017.	**Pg. 514** (submission email) **Pg. 515-733** (documentation)
15-32033-CON Condition 32e	Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.	5/31/2017	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.	YNHHS submitted documentation to OHCA in accordance with Condition 9 including financial assistance policies on 2/21/2017. If future changes to policies are made, Independent Monitor will obtain YNHHS management representation that such policies are at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect.	**Pg. 514** (submission email) **Pg. 515-733** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations	OHCA Document Page Reference
15-32033-CON Condition 14	For three (3) years following the Closing Date, the Applicants shall allow for one (1) community representative to serve as voting members of L+MH' s Board of Directors with rights and obligations consistent with other voting members under L+MH's Board of Director Bylaws. The Applicants shall select the community representative in a manner that ensures the appointment of an unbiased individual who will fairly represent the interests of the communities served by L+MH. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Following closing	D&T will confirm the appointment of this individual (community representative) to the L+MH Board as evidenced by Board minutes. We will discuss the selection process with Management and document our understanding of the selection process/qualifications of the individual.	Cathy Zall appointed as community representative as a voting member of the L+MH's Board of Directors on 12/8/2016.	**Pg. 465** (submission email) **Pg. 466-473** (documentation)
15-32033-CON Condition 17	For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Twice a year	To confirm compliance with this provision, D&T will obtain minutes from these Joint Board Meetings and confirm notice of the public meetings is posted with proper notice. D&T will attend the public meetings as part of the Monitor role.	The first Joint Board Meeting of the YNHHSC Board and L+MH Board is scheduled for May 18-19, 2017.	**N/A**
15-32033-CON Condition 26	As described in the Affiliation Agreement, YNHHSC is committed to maintaining local governance at L+M. The L+M Board of Directors shall continue as a fiduciary board composed of a majority of members who reside in the communities served by L+M with the only change in composition being the addition of the President/CEO of YNHHSC (or his or her designee) serving as an ex-officio member. Each director of the L+M Board of Directors shall have an equal vote. The L+M Board shall be empowered and supported to oversee local performance and to create and sustain connections with the community. Subject to certain reserved powers for YNHHSC, the L+M Board of directors will have the right to approve any major new programs and clinical services, or the discontinuation or consolidation of any such programs.	9/28/2016	D&T will obtain and evaluate the Board of Directors bylaws to confirm that L+M Board maintains rights and powers specified in the Order.	YNHHS provided Board of Directors bylaws to OHCA on 9/28/2016.	**Pg. 1** (submission email) **Pg. 55-66** (documentation)
15-32033-CON Condition 25	L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	3/31/2017	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.	YNHHS provided reporting to OHCA in accordance with Condition 25 on 3/29/2017.	**Pg. 757-758** (submission email) **Pg. 759-760** (documentation)

Note: OHCA page numbers referenced as they appeared on 4/7/17

User, OHCA

From: Roberts, Karen
Sent: Monday, July 03, 2017 11:44 AM
To: User, OHCA
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON
Attachments: Deloitte Independent Monitor Year 1 Six Month Report 04 07 2017.pdf

Follow Up Flag: Follow up
Flag Status: Completed

From: Roberts, Karen
Sent: Monday, July 3, 2017 11:43 AM
To: 'ksauders@deloitte.com' <ksauders@deloitte.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly – also, the material that was filed on 3/7/17 was in PDF and the service/procedure descriptions in the first column (inpatient) are cut off and not fully readable. Please have this corrected in the resubmission. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Roberts, Karen
Sent: Monday, July 3, 2017 11:10 AM
To: 'ksauders@deloitte.com' <ksauders@deloitte.com>; User, OHCA <OHCA@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly – I have a question for you to look into regarding the submission of material in response to **Condition #6** of Docket Number 15-32033-CON. In your report filed on 4/7th, you indicate that the first filing for Condition #6 was filed on 3/7/2017, which is correct, that is the date it was submitted (Total Price by Top 25 most frequently utilized services table). However, subsequent to the filing on 3/7th we spoke in a conference call that this table is incorrect as it reflects a Fiscal Year (10/1/2015 to 9/30/2016) which is not in compliance with the condition as written. We indicated in the conference call that the first (baseline) filing is prior to the affiliation date and says in the Condition, September 1, 2015 – August 30, 2016. I don't' see a refiling of this material in any of the subsequent emails for this docket number. Can you look into that and have it filed with OHCA using the correct dates at the earliest convenience.
Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, April 7, 2017 4:13 PM
To: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hello all – please see the attached report from Deloitte & Touche LLP which is the first six-month report due from the Independent Monitor for the period ending March 31, 2017. Let me know if you have any questions.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

v.E.1

User, OHCA

From: Cotto, Carmen
Sent: Friday, July 28, 2017 12:22 PM
To: Sauders, Kelly (US - New York); Roberts, Karen
Cc: Martone, Kim; User, OHCA
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly,

Please provide us with the status of our request below for missing information related to Condition#6, Docket #15-32033-CON.

Our records do not show the receipt of the information.

Thank you,
Carmen

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Monday, July 3, 2017 12:59 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Will do – I will follow up on both questions/comments with YNHHSC today (many people are out for the holiday). However, I'm sure they can fix this/respond quickly.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Monday, July 3, 2017 11:43 AM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly – also, the material that was filed on 3/7/17 was in PDF and the service/procedure descriptions in the first column (inpatient) are cut off and not fully readable. Please have this corrected in the resubmission. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Roberts, Karen
Sent: Monday, July 3, 2017 11:10 AM
To: 'ksauders@deloitte.com' <ksauders@deloitte.com>; User, OHCA <OHCA@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly – I have a question for you to look into regarding the submission of material in response to **Condition #6** of Docket Number 15-32033-CON. In your report filed on 4/7th, you indicate that the first filing for Condition #6 was filed on 3/7/2017, which is correct, that is the date it was submitted (Total Price by Top 25 most frequently utilized services table). However, subsequent to the filing on 3/7th we spoke in a conference call that this table is incorrect as it reflects a Fiscal Year (10/1/2015 to 9/30/2016) which is not in compliance with the condition as written. We indicated in the conference call that the first (baseline) filing is prior to the affiliation date and says in the Condition, September 1, 2015 – August 30, 2016. I don't' see a refiling of this material in any of the subsequent emails for this docket number. Can you look into that and have it filed with OHCA using the correct dates at the earliest convenience.
Thank you. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
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410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, April 7, 2017 4:13 PM
To: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hello all – please see the attached report from Deloitte & Touche LLP which is the first six-month report due from the Independent Monitor for the period ending March 31, 2017. Let me know if you have any questions.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

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User, OHCA

From: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Sent: Friday, July 28, 2017 12:24 PM
To: Cotto, Carmen; Roberts, Karen
Cc: Martone, Kim; User, OHCA
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Carmen – I followed up with YNHHS on this again yesterday and expect that they will send it next week.

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Friday, July 28, 2017 12:22 PM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>; Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly,

Please provide us with the status of our request below for missing information related to Condition#6, Docket #15-32033-CON.

Our records do not show the receipt of the information.

Thank you,
Carmen

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Monday, July 3, 2017 12:59 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Will do – I will follow up on both questions/comments with YNHHSC today (many people are out for the holiday). However, I'm sure they can fix this/respond quickly.

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Monday, July 3, 2017 11:43 AM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly – also, the material that was filed on 3/7/17 was in PDF and the service/procedure descriptions in the first column (inpatient) are cut off and not fully readable. Please have this corrected in the resubmission. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Roberts, Karen
Sent: Monday, July 3, 2017 11:10 AM
To: 'ksauders@deloitte.com' <ksauders@deloitte.com>; User, OHCA <OHCA@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly – I have a question for you to look into regarding the submission of material in response to **Condition #6** of Docket Number 15-32033-CON. In your report filed on 4/7th, you indicate that the first filing for Condition #6 was filed on 3/7/2017, which is correct, that is the date it was submitted (Total Price by Top 25 most frequently utilized services table). However, subsequent to the filing on 3/7th we spoke in a conference call that this table is incorrect as it reflects a Fiscal Year (10/1/2015 to 9/30/2016) which is not in compliance with the condition as written. We indicated in the conference call that the first (baseline) filing is prior to the affiliation date and says in the Condition, September 1, 2015 – August 30, 2016. I don't' see a refiling of this material in any of the subsequent emails for this docket number. Can you look into that and have it filed with OHCA using the correct dates at the earliest convenience.
Thank you. Karen

Sincerely,

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Principal Health Care Analyst
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Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, April 7, 2017 4:13 PM
To: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; PATEL, SHRADDHA <SHRADDHA.PATEL@YNHH.ORG>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hello all – please see the attached report from Deloitte & Touche LLP which is the first six-month report due from the Independent Monitor for the period ending March 31, 2017. Let me know if you have any questions.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

User, OHCA

From: Cotto, Carmen
Sent: Friday, July 28, 2017 12:30 PM
To: Sauders, Kelly (US - New York); Roberts, Karen
Cc: Martone, Kim; User, OHCA
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Kelly,

Okay, thank you.

Please keep us posted.

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Friday, July 28, 2017 12:24 PM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hi Carmen – I followed up with YNHHS on this again yesterday and expect that they will send it next week.

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Friday, July 28, 2017 12:22 PM
To: Sauders, Kelly (US - New York) <ksauders@deloitte.com>; Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Martone, Kim <Kimberly.Martone@ct.gov>; User, OHCA <OHCA@ct.gov>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

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Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: FW: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

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Cc: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>; Mitchell, Kelly Rose (US - Boston) <kellmitchell@deloitte.com>
Subject: RE: Six-Month Independent Monitor Report for docket numbers 15-32032-CON and 32033-CON

Hello all – please see the attached report from Deloitte & Touche LLP which is the first six-month report due from the Independent Monitor for the period ending March 31, 2017. Let me know if you have any questions.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

v.E.1

User, OHCA

From: Roberts, Karen
Sent: Wednesday, August 02, 2017 8:50 AM
To: User, OHCA
Subject: FW: YNHHSC/L+MH Condition 15-32033-CON Condition 17
Attachments: DT_Public Forum 7.6.17 Minutes_Final.pdf; Public Meeting Presentation FINAL 070617.pdf

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From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, July 27, 2017 3:25 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>
Subject: RE: YNHHSC/L+MH Condition 15-32033-CON Condition 17

Please see the attached presentation and minutes from the July 6th, 2017 Public Forum in New London, CT.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, NY 10112

Tel: +212 436 3180
Fax: +212 653 7033
www.deloitte.com

Minutes

Meeting:	L+MH New London Public Forum
Held on:	July 6, 2017 at 6:00 pm
Location:	Holiday Inn, New London, CT
Attendees	Patrick Green, Cathy Zall, Gayle Capozzalo, Vin Petrini, Kelly Sauders, Ryan DeMerlis, Martha Judd, Andrew Orefice, Naomi Rackleft, Barbara Sadowski, Jeanne Wehl, Dr. Steven Smith, Anita Dagan, Stephanie Johnson, Mirriam Thorbue, Christine Hammond, Julia Kushigan, Lynda McLAughlan, Representative Chris, Soto, Brad McCallister, Representative Kathleen McCarty, Ann Burbinski, Dale Cunnigh, Vicky Long, Rob Burick, Debbie Wyzatck, Brian Cole, Paul Read, Scott Martin, Janet Buckling, Rich Buckling, Diane Smith, William Schmaucker, Kelly Thomson, Mary Jackson, Donna Epps, Jeanne Milstein, Representative Holly Cheeseman, Mildred Devine, Bryl Hobart, George Shaw, Anna Shaw, Laurel Holmes, Kyle Ballou, El Parry, Steve Sigel, Jackie Blaice, Terry Mitchell, Ed Cramer, Jenny Cramer, Loch Spitz, Kristen Powers, Red Korecki, Harry Rodriguez, Neal Bobruff, Jackssan Bobruff, Paul Spirit, Lisa Dabroski, Alyssa Hammond, Ann Pratt, Frank Maclaughlin, Mayor Michael Passero, Andy Russell
Introduction	The meeting began at 6:00pm EST. Gayle Capozzalo (Executive Vice President, Strategy and System Development and Chief Strategy Officer) provided a brief introduction to the group. She shared a few accomplishments of the affiliation and concluded by introducing Patrick Green (President and CEO, L+MH), Cathy Zall (Community Representative to the Board) and Vin Petrini (Senior Vice President, Public Affairs, YNHHS). She then provided the agenda for the evening. **Agenda**: Introductions Welcome from Patrick Green Report to Community by Cathy Zall Affiliation Progress by Vin Petrini Questions & Answers
Welcome	Patrick Green provided a brief introduction and overview of his background. He stated that his focus is to continue to partner with YNHHS and the community to secure services in the New London community. Mr. Green briefly highlighted accomplishments of that partnership from the past nine months, which included the stabilization of L+MH's financials (reducing loss from $26m to $9m), promoting cost savings and operational improvements, creating new jobs / preserving existing jobs in New London, and issuing a $50,000 grant to the New London Community.
Report to the Community	Cathy Zall provided a series of brief remarks to provide a report to the community. She indicated that L+MH and YNHHS were progressing in prioritizing stabilizing the financials of

Deloitte.

	L+MH. She stated that she believes that there has already been a commitment demonstrated from YNHHS and L+MH to a community partnership for better health. Jeannie Milstein, Director of Human Services for the City of New London, provided an overview of partnerships and initiatives with the community, which included a $5,000 donation to launch the first Sober House certification, a $50,000 grant to the community to improve health outcomes, and other initiatives that foster coordination, communication, collaboration between hospital and community partners. One such example highlighted was establishing a system with first responders and hospitals to understand how best to triage transports to the hospital for those frequently hospitalized.
Affiliation Progress and Q&A	Vin Petrini reinforced that the relationship between YNHHS and L+MH was the beginning of an important relationship with not only L+MH but also with the community of New London and the region. He provided a few remarks about the healthcare environment at the federal and state levels. Mr. Petrini outlined affiliation initiatives and progress for first six months. Those included: ▪ Clinical Services Recruitment – highlighted mental health recruitment activities ▪ Infrastructure – messaged the success of the EPIC implementation ▪ Clinical Technology – outlined that there were two new units, 3D imaging, pharmacy renovation, and other technology to refresh the hospital. ▪ Community Need – stated that through the affiliation, they were working to build population health infrastructure to both reduce cost and improve early access to patients to improve detection. ▪ Group Purchasing – highlighted the benefits of purchasing supplies and goods at reduced costs, promoting efficiency. ▪ Employment – looking at effective ways to improve on structure while adding jobs where possible, including creating 40 new jobs in New London. Mr. Petrini responded to several questions from the audience about various aspects of the financials, community benefit and ongoing affiliation activities.
Closing	Mr. Petrini closed the meeting by thanking everyone for attending and confirmed there will be another public meeting, likely in the Fall. The meeting was adjourned at 6:50pm EST.

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Lawrence + Memorial Healthcare

Public Forum

July 6, 2017

Agenda

Introductions
Welcome from Patrick Green
Report to Community by Cathy Zall
Affiliation Progress by Vin Petrini
Questions & Answers

Investments for Period: 10/01/16 – 3/31/17

Clinical Services		
Primary care Specialty care Ambulatory care Post-acute care	$1.6 million	• Primary care providers recruited • Addition of new specialists in neurosurgery/spine, oncology, and psychiatry • Recruitment within LMMG (now NEMG) in cardiology, obstetrics, general surgery, and psychiatry

Investments for Period: 10/01/16 – 3/31/17

Infrastructure		
Facilities Information technology	$13.5 million	L+M • New inpatient rehab beds • Parking garage repairs • Elevator rebuild • Upgraded security systems • Build and implementation of Epic • New enterprise resource planning system • Other IT (e.g. access control) LMMG (now NEMG) • General surgery relocation to main campus WH • HVAC renovations • Build and implementation of Epic

Investments for Period: 10/01/16 – 3/31/17

Operational Improvements		
Clinical technology Corporate services support Branding	$8.3 million	• New tomosynthesis units at L+M and WH • L+M cancer center pharmacy renovation • Other minor equipment at L+M (e.g. video scope carts) • New gamma camera at WH • Support from corporate services to integrate L+M into the System • Website redesign • Increased advertising • Updated signage

Investments for Period: 10/01/16 – 3/31/17

Community Need / Building		
Community need / building Population health	$304,200	• Support to Community Speaks Out, a non-profit organization, to fund training programs for sober houses in New London so they may meet national standards for quality and safety • Support to identify and develop strategies to address social determinants of health in two distressed areas of New London working collaboratively with residents • Early developments of population health infrastructure

Savings for Period: 10/01/16 – 3/31/17

Categories	Projected Savings for the Period	Actual Savings for the Period	Variance
Wages and Benefits	$942,540	$1,433,669	$491,129
Medical Supplies and Pharmaceuticals	$670,000	$679,868	$9,868
Business Expense / Utilities	$456,702	$962,500	$505,798
Total	**$2,069,242**	**$3,076,037**	**$1,006,795**

Yale
NewHaven
Health

Questions?

User, OHCA

From: Roberts, Karen
Sent: Wednesday, August 02, 2017 8:51 AM
To: User, OHCA
Subject: FW: YNHHSC/L+MH Docket #15-32033-CON: Conditions 16 and 18
Attachments: Conditions 16 and 18 Independent Monitor Site Visit July 6 2017.pdf

---

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, July 27, 2017 3:27 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>
Subject: RE: YNHHSC/L+MH Docket #15-32033-CON: Conditions 16 and 18

Please see the attached summary re: our site visit on July 6, 2017.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Docket #15-32033-CON: Conditions 16 and 18
July 6, 2017

Condition 16:

The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis[1] to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.

Condition 18:

L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need.

NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHSC is bound by Condition #4 and the Services Plan created per Condition #4

Response:

Deloitte & Touche Independent Monitor Kelly Sauders and Ryan DeMerlis visited Lawrence + Memorial Hospital (L+MH) on July 6, 2017. The site visit included a meeting with Victoria Vickers, Director of Accreditation, Safety and Regulatory Affairs, and Oliver Mayorga, MD, Chief Medical Officer. This meeting included a discussion about recent Centers for Medicare and Medicaid (CMS) and/or Department of Public Health (DPH) matters and L+MH's response, as well as the upcoming Public Forum. It was noted that there had been no decrease in services or unit closures since the last site visit. This includes maintaining emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services.[2]

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[1] The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

[2] In support of this, the May 31, 2017 submission to OHCA on contained a management attestation to Condition 18.

User, OHCA

From: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Sent: Wednesday, August 02, 2017 8:06 AM
To: User, OHCA
Cc: 'YNHHSCOHCAMonitor@deloitte.com'
Subject: Docket 15-32033-CON: Condition 6
Attachments: Revised Condition 6 - L+MH Top 25 Most Frequently Utilized Services (073117) SENT TO OHCA 080217.pdf

Attached please find the refiled copy of Condition 6 for Docket 15-32033-CON, originally submitted on March 7, 2017. This updated file modifies the reporting timeframe for this Condition to 9/1/15-8/30/16. There are no significant changes to the previously filed document. Please retract pg. 738 of the OHCA compliance documentation online and replace with this new file.

If you have any questions, please feel free to contact me.

Gayle

Gayle Capozzalo
Executive VP / Chief Strategy Officer

789 Howard Avenue; 1059 CB
New Haven, CT 06519

Phone: 203-688-2605
Fax: 203-688-3472
Email: gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Templates for Reporting on L+MH Top 25 Most Frequently Utilized Services
MS-DRGs (Inpatient) and CPT (Outpatient)
Docket #15-32033-CON: Condition 6

OHCA will receive an annual report of the total price per "unit of service" for MS-DRG and CPT codes each fiscal year through the end of FY 2019.

Condition 6: Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015 - August 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.

L+MH Top 25 Most Frequently Utilized Services - MS-DRG (Inpatient) & CPT (Outpatient)

CT OHCA 15-32033 Condition 6

Re-submitted July 2017

September 1, 2015 - August 31, 2016

	L+MH Top 25 MS-DRG Inpatient Codes	Total Price		L+MH Top 25 CPT Outpatient Codes	Total Price
1)	795 - NORMAL NEWBORN	$ 1,517.97	1)	36415 - Routine venipuncture	$ 4.84
2)	470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	$ 19,396.64	2)	99218 - Initial observation care	$ 104.63
3)	775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	$ 5,594.68	3)	85025 - Complete cbc w/auto diff wbc	$ 12.20
4)	885 - PSYCHOSES	$ 8,142.37	4)	97110 - Therapeutic exercises	$ 61.05
5)	871 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	$ 13,864.71	5)	99283 -Emergency dept visit	$ 323.56
6)	766 - CESAREAN SECTION W/O CC/MCC	$ 8,739.97	6)	80053 -Comprehen metabolic panel	$ 19.69
7)	794 - NEONATE W OTHER SIGNIFICANT PROBLEMS	$ 2,365.08	7)	85610 -Prothrombin time	$ 6.64
8)	392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	$ 6,275.91	8)	84443 -Assay thyroid stim hormone	$ 25.88
9)	603 - CELLULITIS W/O MCC	$ 6,347.94	9)	80061 -Lipid panel	$ 21.44
10)	765 - CESAREAN SECTION W CC/MCC	$ 9,237.08	10)	97140 -Manual therapy 1/> regions	$ 63.58
11)	292 - HEART FAILURE & SHOCK W CC	$ 7,333.87	11)	96361 -Hydrate iv infusion add-on	$ 55.47
12)	190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	$ 8,400.01	12)	81001 -Urinalysis auto w/scope	$ 6.13
13)	683 - RENAL FAILURE W CC	$ 7,684.19	13)	82565 -Assay of creatinine	$ 6.46
14)	191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	$ 7,019.15	14)	80048 -Metabolic panel total ca	$ 16.24
15)	65 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	$ 12,079.98	15)	84520 -Assay of urea nitrogen	$ 5.19
16)	378 - G.I. HEMORRHAGE W CC	$ 8,400.39	16)	88305 -Tissue exam by pathologist	$ 47.23
17)	194 - SIMPLE PNEUMONIA & PLEURISY W CC	$ 7,773.52	17)	82947 -Assay glucose blood quant	$ 4.77
18)	287 - CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	$ 11,677.77	18)	87086 -Urine culture/colony count	$ 12.52
19)	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$ 6,241.27	19)	82306 -Vitamin d 25 hydroxy	$ 44.31
20)	872 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	$ 8,667.40	20)	82310 -Assay of calcium	$ 5.78
21)	460 - SPINAL FUSION EXCEPT CERVICAL W/O MCC	$ 31,941.23	21)	84450 -Transferase (ast) (sgot)	$ 6.28
22)	291 - HEART FAILURE & SHOCK W MCC	$ 10,603.92	22)	93005 -Electrocardiogram tracing	$ 87.28
23)	774 - VAGINAL DELIVERY W COMPLICATING DIAGNOSES	$ 6,503.77	23)	71020 -Chest x-ray 2vw frontal&latl	$ 69.84
24)	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	$ 6,158.13	24)	77052 -Comp screen mammogram add-on	$ 90.73
25)	641 - MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	$ 5,733.04	25)	97530 -Therapeutic activities	$ 72.23

*Total Price is defined as the weighted average price for all governmental and non-governmental payers

Due internally to Regulatory 30 days prior to OHCA due date

Olejarz, Barbara

Subject: FW: Docket 15-32033-CON Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation and Docket 15-32032-CON Merger of L&M Physician Association, Inc. and Northeast Medical Group

Attachments: YNHHS Response to L+M CMIR submitted by Milliman 090717.pdf

---

From: Capozzalo, Gayle [mailto:Gayle.Capozzalo@ynhh.org]
Sent: Thursday, September 7, 2017 4:26 PM
To: User, OHCA <OHCA@ct.gov>
Cc: 'YNHHSCOHCAMonitor@deloitte.com' <YNHHSCOHCAMonitor@deloitte.com>; Patel, Shraddha <SHRADDHA.PATEL@YNHH.ORG>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>; Petrini, Vincent <Vincent.Petrini@ynhh.org>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>; O'Connor, Christopher <christopher.oconnor@ynhh.org>; Green, Patrick <Patrick.Green@LMHOSP.ORG>; Varkey, Prathibha <Prathibha.Varkey@YNHH.ORG>; Borgstrom, Marna <Marna.Borgstrom@ynhh.org>
Subject: Docket 15-32033-CON Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation and Docket 15-32032-CON Merger of L&M Physician Association, Inc. and Northeast Medical Group

Dear Kim,

Please find YNHHS's response to the L+M CMIR submitted by Milliman to comply with requirements of the agreed settlement between Yale New Haven Health Services Corporation and the Connecticut Department of Public Health (i.e., Condition 22 of Docket 15-32033-CON and Condition 3 of Docket 15-32032-CON). We request that this document be posted on OHCA's website and accompany Milliman's CMIR.

Thank you,

Gayle

Gayle Capozzalo, FACHE
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472
gayle.capozzalo@ynhh.org

YaleNewHavenHealth

Yale NewHaven Health

September 7, 2017

Kimberly Martone
Director of Operations
Department of Public Health
Office of Health Care Access
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

RE: **15-32033-CON** Affiliation of Lawrence + Memorial Corporation with Yale New Haven Health Services Corporation

15-32032-CON Merger of L&M Physician Association, Inc. and Northeast Medical Group

Dear Ms. Martone,

As part of the approval of the affiliation of Lawrence + Memorial with Yale New Haven Health, an independent consultant reporting directly to the State Office of Health Care Access (OHCA) has delivered its conclusions regarding costs and pricing in the eastern Connecticut market and establishing caps on any increases Lawrence + Memorial Hospital and Northeast Medical Group can seek to negotiate with third party payers.

These conclusions are based upon a broad assessment of the eastern Connecticut market in high frequency inpatient, outpatient and physician services and comparisons between L+M's market basket fees and those of the rest of the defined market, inclusive of government payers. The report anticipates expected Medicare decreases for inpatient and outpatient services in January 2018 and declining reimbursements from the State's funding of inpatient and outpatient services covered by Medicaid. Medicare and Medicaid services represent 65 percent of L+M's discharges.

It is clear from this independent assessment that the impacts of Medicaid and Medicare cuts have seriously eroded L+M's financial position over time. While the impact of the state tax on hospitals was not directly factored into the report, it is equally clear that the provider tax on hospitals also had a direct and damaging impact on the financial viability of hospitals across the state, including Lawrence + Memorial Hospital.

Gayle Capozzalo,
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472

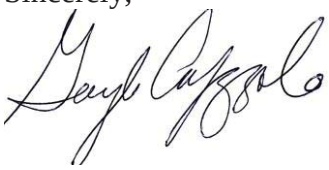
Gayle.Capozzalo@ynhh.org
ynhhs.org

These issues are complicated by the evolution of healthcare policy at the national level. With great concern about potential Medicaid cuts in the vicinity of $750-800 billion over the next ten years, the situation could grow more complicated and more serious. This is especially true since Connecticut was one of the first expansion states under the Affordable Care Act and is particularly vulnerable to eligibility restrictions and funding over time. These risk factors are not accounted for in the report and its conclusions.

As a result of its full review of the current market conditions in eastern Connecticut, Milliman, the independent consultant, has concluded that Lawrence + Memorial Hospital trails its counterparts in reimbursement and would be able to sustain increases capped at the amounts set forth in the report for inpatient, outpatient and physician services without exceeding the market price for similar services in the region.

However, it is important to note that these rate increase caps are not simply applied. Instead, any rate increases are the result of vigorous negotiations with third party payers who have a defined interest in keeping costs low. As a result, the likelihood of achieving overall rate increases of this magnitude is remote. Additionally, Yale New Haven Health will work to ensure costs are controlled and will develop a collaborative approach with insurance companies and third party payers to ensure any rate increases are reasonable and sustainable in the region.

Sincerely,



Gayle Capozzalo
Chief Strategy Officer

Gayle Capozzalo,
Chief Strategy Officer
789 Howard Avenue
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472

Gayle.Capozzalo@ynhh.org
ynhhs.org

User, OHCA

From: Tia Sawhney <Tia.Sawhney@milliman.com>
Sent: Thursday, September 07, 2017 5:15 PM
To: User, OHCA
Cc: YNHHSCOHCAMonitor@deloitte.com; gayle.capozzalo@ynhh.org; Vincent.tammaro@ynhh.org; Vincent.petrini@ynhh.org; jennifer.willcox@ynhh.org; shraddha.patel@ynhh.org; elizabeth.gonsalves@ynhh.org; Bruce Pyenson
Subject: Docket #15-32033-CON & #15-32032-CON - L+M/Yale compliance
Attachments: LM CT CMIR Report_20170810_for OHCA_submitted_20170907.pdf

Dear Office of Health Care Access:

Attached is our Lawrence + Memorial Corporation Cost and Market Impact Review (CMIR). Please let me know if you have questions.

Thank you,
Tia

Tia Goss Sawhney, DrPH, FSA, MAAA
Healthcare Consultant and Actuary

Milliman
1 Pennsylvania Plaza, 38th Floor
New York, NY 10119 USA

646-473-3234 Office
224-628-9876 Mobile

Lawrence + Memorial Corporation

Cost and Market Impact Review

August 10, 2017

Prepared for:

Yale New Haven Health Services Corporation
under the Auspices of the Connecticut Office of Health Care Access
To Comply with Requirements of the Agreed Settlement between
Yale New Haven Health Services Corporation
And the Connecticut Department of Public Health

Prepared by:

Milliman
Engaged as an Independent Consultant

Tia Goss Sawhney, DrPH, FSA, MAAA
Bruce Pyenson, FSA, MAAA
Mona Kelkar, MBA

One Penn Plaza
38th Floor
New York, NY 10019 USA

Tel +1 646 473 3000
Fax +1 646 473 3199

milliman.com

Table of Contents

KEY TERMS

The following key terms are referenced in the report.

Key Term	Acronym	Definition
Agreed Settlement		Document detailing terms of the agreement between YNHHSC and DPH authorizing the transfer of ownership of L+MC and its subsidiaries to YNHHSC
Ambulatory Payment Classification	APC	Unit used to determine reimbursement for outpatient services; an ambulatory payment classification is defined by a particular set of outpatient services
Calendar Year	CY	The year ending December 31 of a given year
Case Mix Adjusted Discharge	CMAD	Discharge with a relative weight of 1.00; see definition of relative weight below
Centers for Medicare and Medicaid Services	CMS	Federal agency responsible for Medicare and the partner with states for Medicaid
Charge		The total amount billed for a service, often has little relationship to price
Commercial Fee Cap		The limit on increases in total price per unit of service paid by commercial insurers
Commissioner		Commissioner of the Department of Public Health
Compound Annual Growth Rate	CAGR	Geometric average of the growth rate over a period of time, stated as percent growth per annum
Conversion Factor		Converts relative value units into payment rates; see definition of relative value units below
Cost Based Statistical Area	CBSA	Areas to which Medicare assigns wage indices
Cost and Market Impact Review	CMIR	A review required by Condition 22 of the Agreed Settlement
Department of Public Health	DPH	Connecticut department with hospital oversight responsibility; parent department of OHCA
Department of Social Services	DSS	Connecticut department responsible for Medicaid
Eastern Connecticut	E-CT	Tolland, Windham, and New London counties (includes Lawrence + Memorial Hospital)
Fee		Price per unit of service; see definition of price below
Fee Ratio		The ratio of L+MH average all payer fee to the market average all payer fee. Fee caps are set so that the ratio does not increase during the Agreed Settlement monitoring period
Fiscal Year	FY	The year ending September 30 of a given year, as defined by CT Hospital Financial Review Regulations for CT hospital reporting[1]
Freedom of Information Act	FOIA	An act that enables the requires the government to respond to public requests for information
Geographic Practice Cost Index	GPCI	GPCIs reflect the costs of intensity, practice expense, and malpractice insurance in an area compared to the national average costs
Hospital Fees		Hospital net revenue divided by the total MS-DRG relative weights for the hospital's discharges
Lawrence & Memorial Medical Group	LMMG	The physician group of Lawrence + Memorial Corporation

[1] State of Connecticut. Office of Health Care Access. *Hospital Financial Review Regulations*. N.p., n.d. Web. 4 May 2017. http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2017/hospital_financial_review_regulations.pdf.

Key Term	Acronym	Definition
Lawrence + Memorial Corporation	L+MC or L+M	The parent organization of Lawrence + Memorial Hospital and Lawrence & Memorial Medical Group
Lawrence + Memorial Hospital	L+MH	The hospital organization of Lawrence + Memorial Corporation
Market		All CT providers, both in and outside eastern CT, serving eastern CT patients
Medicare Severity Diagnosis Related Group	MS-DRG	Unit used to determine reimbursement for inpatient services; a Medicare Severity Diagnosis Related Groups is defined by a particular set of patient attributes, which include principal diagnosis, specific secondary diagnoses, procedures, sex and discharge status[2]
MS-DRG Relative Weight	RW	A weight assigned to a MS-DRG that reflects the expected relative cost to a hospital to provide that MS-DRG; *relative weights do not average to 1.00*
Net Revenue		Total price, after adjustments, as reported in hospital financial statements
Non-Eastern CT	Non-E-CT	All CT counties excluding eastern CT (Tolland, Windham, and New London counties); excludes out of state counties
Office of Health Care Access	OHCA	An office of Connecticut's Department of Public Health
Payer		Medicare, Medicaid, commercial insurers, and other third parties that cover the cost of care
Price		The total amount paid for a service, inclusive of patient cost-sharing
Relative Value Unit	RVU	RVUs account for the relative resources used in furnishing a service
Unit of Service		For inpatient care: a MS-DRG relative weight of 1.00; for outpatient care: an APC with a relative weight of 1.00
Yale New Haven Health Services Corporation	YNHHSC Or YNH	The organization acquiring Lawrence + Memorial Corporation

[2] Centers for Medicare and Medicaid Services (CMS). *Defining the Medicare Severity Diagnosis Related Groups (MS-DRGs), Version 34.0*. N.p., n.d. Web. 4 May 2017. https://www.cms.gov/ICD10Manual/version34-fullcode-cms/fullcode_cms/Defining_the_Medicare_Severity_Diagnosis_Related_Groups_(MS-DRGs)_PBL-038.pdf.

COST AND MARKET IMPACT REVIEW

In early September 2016, the Connecticut (CT) Office of Health Care Access (OHCA) granted Yale New Haven Health Services Corporation (YNHHSC) approval to acquire Lawrence + Memorial Corporation (L+MC). The Agreed Settlement between YNHHSC and the CT Department of Public Health authorized the transfer of ownership of L+MC and its subsidiaries to YNHHSC. The Agreed Settlement had a number of terms, including requiring YNHHSC to engage an independent consultant to prepare a Cost and Market Impact Review (CMIR), evaluate the non-governmental price per unit service (fees) of services provided by L+MC's Lawrence + Memorial Hospital (L+MH) and Lawrence & Memorial Medical Group (LMMG), and annually set maximum fee increases (for 5 years for L+MH and for 28 months for LMMG). With OHCA approval, YNHHSC engaged Milliman as the independent consultant.

As the independent consultant Milliman must satisfy the requirements of the Agreed Settlement and report to and take direction from the Commissioner. Milliman is a global actuarial and financial services consulting firm that has been serving clients as an independent consultant for over 70 years. We serve a diverse client base, representing virtually all types of private, non-profit, and public sector enterprises in healthcare, employee benefits, investment consulting, life insurance, financial services, and property and casualty insurance. We have no agenda other than high quality work.

This document is Milliman's 2017 report to OHCA and YNHHSC, which is intended to satisfy requirements of the Agreed Settlement. It may not be suitable for other purposes.

CMIR REQUIREMENTS

The Agreed Settlement's Condition 22 describes the information to be included in the CMIR. This report provides certain information specified in Conditions 22b, 22c, 22d, and 22e of the Agreed Settlement. Condition 22 is reproduced below (boldface added to highlight the role of the independent consultant).

22. Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review, which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:

a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.

*b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the **independent consultant determines** to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.*

c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially

increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the ***independent consultant shall conduct*** *the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the* ***independent consultant from considering and recommending*** *any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.*

d. *The* ***independent consultant shall report*** *to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.*

e. *The* ***independent consultant shall provide*** *the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.*

METHODOLOGY SUMMARY

Our commercial fee cap methodology, as approved by OHCA:

1. Establishes market baskets of high frequency services for inpatient and outpatient hospital services and physician services.
2. Estimates the fiscal year 2016 (FY2016) average fee per market basket service across all payers for services provided by L+M and all hospitals and physicians serving E-CT patients (aka “the market”), and calculates the FY2016 ratio of L+M fees to market fees.
3. Projects the market basket fee changes and service changes, other than L+M commercial fee changes, from FY2016 to calendar year 2018 (CY2018).
4. Estimates the L+M commercial fee change from FY2016 to CY2018 that will allow L+M to maintain the FY2016 ratio of L+M fees across all payers to market fees across all payers and establishes that change as the commercial fee cap.

Following the expectations of the Agreed Settlement, we also review the Eastern Connecticut (E-CT) healthcare market and make non-fee cap recommendations.

Fiscal years (FYs) for Connecticut hospitals end in September and calendar years (CYs) end in December. FY2016 is the year October 2015 through September 2016 and CY2018 is the year January 2018 through December 2018. Under the Agreed Settlement L+MC must maintain commercial fee contracts from the end of FY2016 to the beginning of CY2018 and may negotiate fee increases, subject to the fee cap, for CY2018 onward. Hence, for establishing the fee cap, FY2016 is our base period and CY2018 is the period for which we establish the fee cap. Next year we will establish inpatient and outpatient hospital fee caps for CY2019.

Medicare and Medicaid fees impact the commercial fee cap. The estimated average fees per market basket service and fee ratios are inclusive of all payers. Therefore, any Medicare or Medicaid fee change that differentially affects L+M relative to other hospitals serving E-CT patients will impact the calculation of L+M’s commercial fee cap. The differential impact may be the result of L+M having a different fee change than the other hospitals or it may be due to L+M providing a disproportionate share (more or less) of Medicare or Medicaid market basket services relative to the other hospitals.

MARKET REVIEW

Our review of the Eastern Connecticut (E-CT) healthcare market yielded the following observations:

Hospital Inpatient Care

1. **E-CT patients had about 51,000 discharges in FY2016.** About 25,000 or about 50% of the discharges were for market basket MS-DRGs. Of these about 25,000 market basket MS-DRGs, 27% were from L+MH (see Exhibit 1).
2. **E-CT hospitals lost market share between FY2014 and FY2016.** The percent of E-CT patients discharged from E-CT hospitals, inclusive of L+MH, declined from 67.0% to 62.3% of discharges – a -6.9% change[3]. In FY2016, nearly 40% of E-CT patient discharges were from non-E-CT hospitals (see Exhibit 1).
3. **E-CT patients with commercial insurance are disproportionately cared for outside of E-CT relative to Medicare patients**. In FY2016 46.6% of commercial market basket MS-DRG discharges were from non-E-CT hospitals vs. 32.9% for Medicare discharges and 19.0% for Medicaid discharges (see Exhibit 2A).
4. **Patient volume for government payers grew from FY2014 to FY2016.** In FY2016 35.8% of market basket MS-DRG discharges were paid for by commercial payers (see Exhibit 2B). From FY2014 to FY2016, E-CT patient market basket MS-DRG discharges declined for commercial payers (-4.3%) and grew for Medicaid (+5.5%) and Medicare (+2.1%) payers (see Exhibit 2B).
5. **In FY2016, non-E-CT hospitals, on average, provide more high intensity care than E-CT hospitals**. In FY2016, non-E-CT market basket MS-DRG discharges had an average case mix per discharge of 1.42, while E-CT hospitals had an average case mix of 1.25 (see Exhibit 3).
6. **In FY2016, government payers paid much less than commercial payers did**. In FY2016, Medicare fees were $7,717, Medicaid fees were $5,359, and commercial payers fees $12,467 per case mix adjusted discharge (CMAD), inclusive of patient cost sharing. Commercial payer fees more than double Medicaid fees (see Exhibit 4A).
7. **From FY2014 to FY2016, commercial fees per CMAD for hospitals serving E-CT patients increased by +4.3% per annum** (see Exhibit 4A).
8. **In FY2016, L+MH fees per CMAD were similar to other E-CT hospitals**. In FY2016, L+MH fees per CMAD were somewhat higher than that of other E-CT hospitals: +5.2% for Medicare, +3.5% for Medicaid, and +0.7% for commercial (see Exhibit 4B).
9. **Non-E-CT fees per CMAD were much higher than E-CT fees per CMAD across all payers**. In FY2016, fees per CMAD for non-E-CT hospitals were higher than that of E-CT hospitals: +9.2% for Medicare, +25.6% for Medicaid, and +22.6% for commercial (see Exhibit 4B).
10. **CT Medicaid has planned changes to fees that will disproportionately reduce fees for L+MH**. Medicaid has planned fee changes per CMAD between FY2016 and CY2018 of -12.8% for L+MH, -8.4% for other E-CT hospitals, and -6.8% for non-E-CT hospitals (see Exhibit 5A).
11. **L+MH's Medicare fees are expected to decrease significantly in January 2018 due to a change in L+MH's hospital geographic assignment while the fees for other E-CT and non-E-CT hospitals increase modestly.** January 2018 Medicare fees are expected to change -7.4% for L+MH, +1.9% for other E-CT hospitals, and +1.2% for non-E-CT hospitals (see Exhibit 5B).

Medicare payments are based on statistical area assignments. Medicare outpatient and inpatient payments are adjusted for local wage levels, using the wage indices that Medicare publishes for cost based statistical areas (CBSAs). CBSAs are typically metropolitan statistical areas (MSAs), and hospitals are generally assigned to the CBSA corresponding to their physical location. Medicare has, however, historically assigned L+MH to the Nassau County-Suffolk County, NY CBSA – a CBSA with a higher wage index than the New Haven-Milford, CT CBSA. Under the proposed Medicare rules for 2018, L+MH will be assigned to the CT CBSA – a CBSA with the same wage index as the New Haven-Milford, CT CBSA. L+MH is the only E-CT hospital that is currently assigned outside of its geographic CBSA.

[3] Changes in market share cited in this analysis are relative to the first period market share. For example if a hospital has a 20% market share that declines to 18%, then the hospital has lost 10% of its market share.

Hospital Outpatient Care

1. **Outpatient care is a significant portion of hospital net revenue, particularly for E-CT hospitals.** Outpatient care represented 60.4% of FY2015 hospital net revenue for E-CT hospitals, and 42.8% of FY2015 hospital net revenue for non-E-CT hospitals providing services to E-CT patients (see Exhibit 6).
2. **Medicaid and Medicare represent a significant portion of outpatient net revenue for hospitals serving E-CT patients.** Medicare and Medicaid represent 38.1% of outpatient net revenue for L+MH, 38.0% of outpatient net revenue for other E-CT hospitals, and 36.3% of outpatient net revenue for non-E-CT hospitals (see Exhibit 6).
3. **E-CT patients receive a higher portion of their outpatient surgical care than ED care at non-E-CT hospitals**. According to CHIME, 35.5% of FY2016 outpatient hospital surgery discharges[4] for E-CT patients were from non-E-CT hospitals and 11.9% of ED discharges were from non-E-CT hospitals (see Exhibit 7).
4. **E-CT patients with Medicare or commercial insurance receive a higher portion of their outpatient surgical and ED care at non-E-CT hospitals than E-CT patients with Medicaid**. According to CHIME, 35.4% of Medicare and 37.9% of commercial FY2016 outpatient hospital surgery discharges for E-CT patients were from non-E-CT hospitals, whereas 29.3% of Medicaid discharges were from non-E-CT hospitals. Similarly, 10.7% of Medicare and 17.0% of commercial FY2016 ED market basket services for E-CT patients were from non-E-CT hospitals, whereas 8.1% of Medicaid ED market basket services were from non-E-CT hospitals (see Exhibit 7).
5. **CT outpatient hospital Medicaid Modernization, which was a significant change in outpatient hospital methodology, disproportionately reduced fees for L+MH.** In July 2016, CT Medicaid introduced an APC payment methodology. Medicaid outpatient fees increased somewhat (1.4%) for all hospitals serving E-CT patients, whereas fees decreased significantly (-11.0%) for L+MH (see Exhibit 8).

   CT hospital outpatient Medicaid Modernization. Prior to July 2016, CT Medicaid hospital outpatient fees (for most services) were set at a hospital-specific percentage of the hospital's charges. The percentage was based on the hospital's cost to charge ratio. In July 2016, CT Medicaid implemented a Medicare-like payment system where most fees are paid using Medicare's APC methodology. Many individual hospitals saw significant outpatient fees change as a result of Medicaid Modernization, with some receiving higher fees while other received lower fees.

   Under the modernized payment system, CT Medicaid uses Medicare's APC assignment rules, relative weights, and wage indices but sets its own APC fee per relative weight unit. CT Medicaid adjusts for labor costs through a wage index based on each hospital's CBSA corresponding to their physical location. Wage indices for a given CBSA can "bounce" somewhat from year to year. L+MH's January 2017 fee change relative to some other hospitals is due to a decline in the New Haven-Milford, CT wage index relative to other CT CBSAs.
6. **The January 2017 CT Medicaid fee update also reduced fees for L+MH**. Routine updating of Medicaid APC fees, effective January 2017, resulted in 0.0% change for all hospitals serving E-CT patients, but a -1.2% change for L+MH (see Exhibit 8).
7. **L+MH's outpatient hospital Medicare fees are expected to decrease significantly in January 2018 due to a change in L+MH's hospital geographic assignment.** January 2018 Medicare APC fees are expected to change -7.7% for L+MH, +1.4% for other E-CT hospitals, and +0.8% for non-E-CT hospitals (see Exhibit 9).

Physician Care

1. **LMMG provided a consistent volume and payer-mix of market basket services in FY2015 and FY2016.** In FY2015, 43.6% LMMG's services were for E-CT patients with Medicare, 13.9% were for E-CT patients with Medicaid, and 41.5% were for E-CT patients with commercial insurance (see Exhibit 10). In FY2016, 44.1% LMMG's services were for E-CT patients with Medicare, 14.3% were for E-CT patients with Medicaid, and 40.8% were for E-CT patients with commercial insurance (see Exhibit 10).
2. **E-CT patients with Medicaid and Medicare receive the majority of their care in E-CT.** In CY2016, E-CT patients with Medicaid received 67.8% of their physician services from E-CT physicians and 32.2% from non-E-CT physicians

[4] "Discharges" is CHIMEs term for an outpatient surgery procedure or an emergency room visit.

(see Exhibit 11). In CY2014, E-CT patients with Medicare received 66.5% of their physician services from E-CT physicians and 33.5% from non-E-CT physicians (see Exhibit 11).

3. **Medicare fees for all Medicare physicians in Connecticut have changed very modestly from CY2015 to CY2017.** Medicare fees changed -0.3% from CY2015 to CY2017 (see Exhibit 12).
4. **Medicaid fees for all Medicaid physicians in Connecticut have remained flat since September 2015 (beginning of FY2016).**
5. **In FY2015, LMMG's average Medicaid fees were about 85% of what Medicare fees would have been for the same services**.
6. **There are no announcements that indicate that Medicaid and Medicare fees will significantly change between now and CY2018**.

FEE CAPS AND RECOMMENDATIONS

Overview

In this section, in our role as an independent consultant, working to satisfy requirements of the Agreed Settlement, we estimate the fee caps for L+MC's average commercial fees for hospital inpatient, hospital outpatient, and physician care. According to the Agreed Settlement, fee caps are the highest permitted aggregate increase in L+MC or LMMG fees for CY 2018 relative to FY2016 — a span of 2.25 years from midpoint to midpoint. Fee increases for a particular commercial health plan may be more or less than the cap.

> **Commercial fee increases within maintained health plan contracts are included in the fee cap**. Condition 20 of the Agreed Settlement requires L+MC to maintain health plan contracts that were in effect as of the date of closing (September 8, 2016) through December 31, 2017. Until January 1, 2018, L+MC commercial fees can increase only if there were fee increases already incorporated within these maintained contracts. L+MC must consider these previously negotiated fee increases when setting fees for CY 2018. According to the Agreed Settlement, the total commercial fee increase, including fee increases within maintained contracts, must not exceed the cumulative fee cap for inpatient, outpatient or physician services.

Hospital Inpatient Fee Cap

We estimate that L+MH could increase its commercial inpatient fees per market basket service +9.6% per annum or +22.9% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +22.9%.[5]

The fee cap is based upon the following considerations:

a. The facts outlined in the Market Review section, including
   i. Shifting of the distribution of E-CT hospital discharge market share to non-E-CT hospitals
   ii. Annual growth in the average case mix per market basket discharge between FY2016 and CY2018
   iii. Expected decrease in L+MH's Medicare fees in January 2018 due to a change in L+MH's hospital geographic assignment while the fees for other E-CT and non-E-CT hospitals increase modestly (see Exhibit 5B).
   iv. Planned changes to CT Medicaid fees that will disproportionately reduce fees for L+MH (see Exhibit 5A).

b. A 2.25 year span between FY2016 and CY2018.

c. No shifts in the distribution of inpatient service mix by payer between FY2016 and CY2018

d. Commercial fee increase of +4.0% for hospitals other than L+MH. The increase is consistent with the increase FY2014 to FY2016 by payer, rounded down (see Exhibit 4A).

Note: The three key determinates of the 5.6% per annum spread between L+MH's capped commercial fee increase (+9.6%) and the expected non-L+MH fee increase (+4.0%) are 1) the expected Medicare fee decrease in January 2018, 2) the planned CT Medicaid fee reductions, and 3) Medicare and Medicaid fee reductions on 65% of L+MH's discharges need to be balanced by commercial fee increases that are applicable to the other 35% of L+MH's discharges.

Hospital Outpatient Fee Cap

We estimate that L+MH could increase its commercial outpatient fees per market basket service +5.8% per annum or +13.5% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +13.5%.

The fee cap is based upon the following considerations:

a. The facts outlined in the Market Review section, including

[5] Fee changes are to be measured by comparing the average commercial fee in CY2018 to the average commercial fees in FY2016.

i. The significant decline in L+MH's Medicaid outpatient fees in July 2016 due to hospital outpatient Medicaid Modernization

ii. L+MH's anticipated Medicare outpatient fee decrease as of January 2018

b. A 2.25 year span between FY2016 and CY2018

c. No shifts in the distribution of outpatient services or service mix by payer or by hospital between FY2016 and CY2018

d. Assumptions for annual growth in fees

i. Commercial – for hospitals other than L+MH: +4.0% from CY2015 to CY2018

ii. Medicare – fee per APC relative weight unit: +0.5% from CY2017 to CY2018

iii. Medicaid – fee per APC relative weight unit: 0.0% from CY2017 to CY2018

Note: Only one-quarter of the impact of outpatient Medicaid Modernization is reflected L+MHs FY2016 fees and Medicare fees will in January 2018. Therefore, L+MH needs a significant above-market commercial outpatient fee increase to bring its CY2018 fee ratio (average all-payer fees relative to the market) to FY2016 levels.

Physician Fee Cap

We estimate that LMMG could increase its commercial physician fees per market basket service +3.5% per annum or +8.0% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +8.0%.

The cap is based upon the following considerations:

a. The facts outlined in the Market Review section, including

i. No change in Medicaid and Medicare fee levels. There are no announcements that indicate that Medicaid and Medicare fees will significantly change between now and CY2018

b. A 2.25 year span between FY2016 and CY2018

c. No shifts in the distribution of physician services or service mix by payer between FY2016 and CY2018

d. Assumptions for annual growth in fees

i. Commercial – for market and LMMG: +3.5% per annum from CY2015 to CY2016 based on various consultant reports

ii. Medicare – fee per service: flat from FY2016 to CY2018

iii. Medicaid – fee per service: flat from FY2016 to CY2018

Non-Fee Cap Recommendation

1. **We recommend that OHCA consider not making this CMIR public.** There is a risk that if other hospitals serving E-CT patients know that L+MH is seeking commercial fee increases, these other hospitals will request increases themselves, potentially creating a multi-year upward spiral of fee increases.

DATA AND METHODOLOGY

HOSPITAL INPATIENT CARE

Overview

As described in our methodology below, we created a market basket of hospital inpatient discharges for the top MS-DRGs associated with CT's top inpatient primary diagnoses, principal procedures, surgical procedures, and surgical MS-DRGs. We then used Medicare MS-DRG relative weight factors to adjust for the case mix of the market basket discharges[6], defining a case mix adjusted discharge (CMAD) as a discharge with a relative weight factor of 1.00. CMAD is our "unit of analysis" for purposes of recommending a fee cap.

For all payers, we estimated the fee per CMAD of a group of hospitals as the sum of its net revenue divided by the sum of its MS-DRG relative weight factors, where the sum of the MS-DRG relative weight factors is the sum of the product of the case mix index and number of discharges by hospital. The calculation for an individual hospital is the same, except without the summations.

$$Fee\ per\ CMAD_{group\ of\ hospitals} = \frac{\sum(Net\ Revenue)_{hospital}}{\sum(MS-DRG\ Relative\ Weight\ Factor)_{hospital}}$$

$$Where\ (MS-DRG\ Relative\ Weight\ Factor)_{hospital} = (Case\ Mix)_{hospital} * (Unweighted\ Discharges)_{hospital}$$

The fee per CMAD calculation relies upon:

1. CT Hospital Information Management Exchange (CHIME) data to identify which hospitals provide the market basket MS-DRG discharges.
2. "Twelve Month Actual Filing" data filed with OHCA to estimate market basket inpatient discharge fees.

We describe hospital discharges and fees for FY2014 – FY2016. We project hospital discharges and their case mixes from FY2016 to CY2018, estimate Medicaid and Medicare fee changes from FY2016 to CY2018, and calculate the fee increase as the maximum commercial fee increase from FY2016 to CY2018 that will maintain L+MH's average fee relative to the market.

Data

We relied upon the following data sources for our inpatient analysis:

- CT Department of Insurance most common inpatient hospital service lists[7].
- CT hospital discharge data from the CHIME[8] database as provided to us under a data use agreement by YNHHSC, for the period 10/2013 through 9/2016.
- CT hospital "Twelve Month Actual Filing"[9] operational and financial data filed with OHCA, for FY2014, FY2015, and FY2016. Tabs within the Filing are referred to as "Reports" and have a number, such as Report 165.
    - FY2016 annual reports have not been reviewed by OHCA.

[6] Medicare MS-DRG relative weight factors are used by Medicare and other payers to compensate hospitals for more and less costly hospital discharges.

[7] Connecticut Department of Public Health. Access Health CT. *Connecticut Acute Care Hospital and Outpatient Surgical Facility Data: FY2015*. N.p., 1 Aug. 2016. Web. 4 May 2017. http://www.ct.gov/dph/lib/dph/ohca/publications/2016/consumerhealthinformationreport.pdf.

[8] "ChimeData Overview." *Chime*. Connecticut Hospital Association, n.d. Web. 4 May 2017. http://www.chime.org/member-services/chimedata/chimedata-overview/.

[9] "Twelve Month Filing 2015." *Department of Public Health*. State of Connecticut, n.d. Web. 4 May 2017. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=583316.

  - Two hospitals, Manchester Memorial Hospital and Rockville General Hospital, have filing extensions, which means that FY2015 annual reports are the latest available. We assumed that their reported values are unchanged from FY2015.
  - If new or amended data becomes available, the fee and trend values cited in this report may change. The data, however, is unlikely to have a substantial impact on the conclusions.
- Medicare fee per CMAD developed from the corrected final rules for CY2015 to CY2017 and the proposed rule for CY2018[10,11,12,13,14].
- CT Medicaid fee schedules and fee schedule changes and analysis of fee schedule change impact by hospital from the DSS website[15].
- Medicare financial impact analysis produced by CMS[16,17,18].
- L+MH hospital outpatient claims and payment data.
- Other
  - County to zip code mapping provided by YNH and checked for reasonableness.
  - Medicare 2016 MS-DRG service weights[10,11,19].

[10] "FY 2015 Final Rule Tables *Centers for Medicare and Medicare Services (CMS)*. N.p., n.d. Web. 4 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

[11] "FY 2016 Final Rule and Correction Notice Data Files" *Centers for Medicare and Medicare Services (CMS)*. 4 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

[12] "FY 2017 Final Rule and Correction Notice Tables" *Centers for Medicare and Medicare Services (CMS)*. 23 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

[13] "FY 2018 Proposed Rule Tables" *Centers for Medicare and Medicare Services (CMS)*. 23 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Proposed-Rule-Home-Page-Items/FY2018-IPPS-Proposed-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

[14] "Acute Care Hospital Inpatient Prospective Payment System." 23 June 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf.

[15] "Hospital Rates: Inpatient Rates." *Department of Social Services*. State of Connecticut, 1 Jan. 2017. Web. 4 May 2017. http://www.ct.gov/dss/cwp/view.asp?a=4598&q=540318.

[16] Centers for Medicare and Medicare Services (CMS). *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low Volume Payment Adjustment for Hospitals; Correction*. 192nd ed. Vol. 80. N.p.: n.p., n.d. *Federal Register*. 5 Oct. 2015. Web. 4 May 2017. https://www.gpo.gov/fdsys/pkg/FR-2015-10-05/pdf/2015-25269.pdf.

[17] Centers for Medicare and Medicare Services (CMS). *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals; Correction* . 193rd ed. Vol. 81. N.p.: n.p., n.d. *Federal Register*. 5 Oct. 2016. Web. 4 May 2017. https://www.gpo.gov/fdsys/pkg/FR-2016-10-05/pdf/2016-24042.pdf.

[18] Centers for Medicare and Medicare Services (CMS). *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices*. 81st ed. Vol. 82. N.p.: n.p., n.d. *Federal Register*. 28 Apr. 2017. Web. 4 May 2017. https://www.gpo.gov/fdsys/pkg/FR-2017-04-28/pdf/2017-07800.pdf.

[19] "FY 2014 Final Rule Data Files" *Centers for Medicare and Medicare Services (CMS)*. N.p., 28 Jan. 2014. Web. 4 May 2017. https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/fy-2014-ipps-final-rule-home-page-items/fy-2014-ipps-final-rule-cms-1599-f-data-files.html.

Methodology

Summarize Historical Discharges

Step 1: Create set of inpatient market basket MS-DRGs.

a. **Identify relevant discharges:** Identify the CHIME FY2014-FY2015 statewide discharges related to one or more of the top inpatient primary diagnoses, principal procedures, surgical procedures, and surgical MS-DRGs as listed in the Department of Insurance (DOI) service lists.

b. **Create market-basket MS-DRG list** (see Table 1). Count the FY2015 statewide discharges for each MS-DRG identified in Step 1a. Create list of the 50 MS-DRGs with the most discharges – the "market basket MS-DRGs." Note: we used FY2014-FY2015 as the market basket years. Due to the October 2015 conversion to ICD-10, FY2015 was the last year that the ICD-9 codes corresponding to the DOI lists were available within CHIME.

Step 2: Identify hospitals providing inpatient services to E-CT patients.

a. **Identify E-CT zip codes** (see Table 2).

b. **Identify E-CT patient discharges.** Using patient residence zip codes, identify the CHIME FY2014-FY2015 statewide discharges for patients residing in E-CT.

c. **Create a list of hospitals caring for E-CT patients**. Create a list of the hospitals responsible for 99%+ of the E-CT patient discharges for FY2014 and FY2015. This list contains 13 hospitals (see Table 3).

d. **Group hospitals by region**. Group the 13 hospitals as L+M (1), other E-CT hospitals (5), non-E-CT hospitals (7) (see Table 3).

Step 3: Assign payer categories and service weights to FY2014 to FY2016 CHIME discharges.

a. **Assign payer categories**. Map CHIME payers to payer categories (see Table 4A).

b. **Assign relative weights**. Assign MS-DRG relative weights to each discharge.

Step 4: Summarize the number of CHIME discharges and service weights from E-CT patient hospitals for market basket MS-DRG discharges by FY, facility, payer category, region.

Calculate Historical Fees

Step 5: Collect data for the 13 hospitals from the **"Twelve Month Actual Filings"**. Specifically:

a. **Report 165**: Inpatient Net Revenue (by payer).

b. **Report 185**: Discharges (by payer) and Case Mix Index (by payer).

c. **Confirm that case mix index as reported in Twelve Month Actual Filings are average Medicare MS-DRG relative weights.**

Step 6: Calculate average net revenue per case mix adjusted discharge and average case mix by hospital and payer.

a. **Map "Twelve Month Actual Filings" payers** to Medicare, Medicaid, commercial, uninsured, and other (see Table 4B).

b. **Calculate average net revenue per case mix adjusted discharge by hospital and mapped payer.**

Summarize Historical Discharges and Fees

Step 7: Summarize historical discharges and fees.

a. Count market basket and non-market basket DRG discharges by fiscal year and hospital region and calculate the market basket percentage of total discharges (see Exhibit 1).

b. For market basket DRG discharges, quantify discharges by year, hospital region, and payer (see Exhibit 2A & Exhibit 2B).

c. For market basket DRG discharges, calculate average case mix by year, hospital region, and payer, where totals across regions and payers are weighted by market basket discharges (see Exhibit 3).

d. For market basket DRG discharges, calculate average fees per CMAD, where totals across regions and payers are weighted by the product of market basket discharges and relative weight factors (see Exhibit 4A & Exhibit 4B).

Project Future Discharges, Case Mix, and Fees

Step 8: Calculate scheduled Medicaid fee changes per CMAD from FY2016 to CY2018, where totals across regions and payers are weighted by the 2016 product of market basket MS-DRG discharges and average case mix.

Note: CT Medicaid has/is implementing two inpatient fee changes. One was an all hospital 5% fee reduction as of January 2017 to adjust for unexpected high inpatient intensity after the implementation of hospital inpatient Medicaid Modernization in 2015. The other is 4-year adjustment of hospital-specific base fees, starting January 2017. While the 4-year adjustment is neutral across the state, hospitals serving E-CT patients will (on average) receive fee decreases and the fee decreases will be (on average) larger for E-CT hospitals than non-E-CT hospitals. Between FY2016 and CY2018, hospital basket weighted Medicaid fee decrease will be -12.8% for L+H, -8.4% for other E-CT hospitals, and -6.8% for non-E-CT hospitals (see Exhibit 5A).

Step 9: Calculate scheduled Medicare fee changes per CMAD from FY2016 to CY2018, where totals across regions and payers are weighted by the product of the estimated market basket MS-DRG discharges and average case mix (see Exhibit 5B).

Step 10: Assign other values

a. A 2.25 year span between FY2016 and CY2018.

b. No shifts in the distribution of inpatient service mix by payer between FY2016 and CY2018

c. Assumptions for annual growth in fees per CMAD between FY2016 and CY2018:

i. Medicare, where L+MH's fees will increase modestly from FY2016 through CY2017, and then decrease in CY2018 due to a change in their geographic assignment. The rest of the market continues to increase modestly over FY2016 – CY2018. The figures below annualized and inclusive of all fee changes from FY2016 – CY2018(see Exhibit 5B)

1. -2.8% L+MH
2. +1.0% other E-CT
3. +1.0% non-E-CT

ii. Medicaid, where L+MH's fees have decreased more than the market (see Exhibit 5A)

1. -5.9% L+MH
2. -3.8% other E-CT
3. -3.1% non-E-CT

iii. Commercial fee increase of +4.0% for hospitals other than L+MH. The increase is consistent with the increase FY2014 to FY2016 by payer, rounded down (see Exhibit 4A).

Step 11: Find the L+MH commercial fee increase that maintains the FY2016 ratio of L+MH all-payer fees per CMAD to total all-payer market fees per CMAD.

HOSPITAL OUTPATIENT CARE

Overview

Hospital outpatient departments provide a variety of services, including emergency services, surgeries, diagnostic and screening tests, laboratory services, and imaging. A given outpatient visit, particularly an emergency or surgery visit, can result in a bill with a long list of service-line charges. Medicare pays for many, but not all, outpatient services using the Ambulatory Payment Classification (APC) system, a system that often groups the charges from a visit into a single payment – much like MS-DRGs are used to make a single payment for an inpatient admission. Some services, such as mammograms, are not grouped but paid as stand-alone services. On July 1, 2016, CT Medicaid implemented an outpatient payment system that is Medicare-like, including the use of APCs. Prior to July 2016, CT Medicaid paid for outpatient services using a cost-to-charge methodology.

Commercial payers are not required to use an APC methodology. If commercial payers do use an APC methodology, they may not use it consistently for all providers or all services. Furthermore, commercial fee levels vary dramatically among payers and providers paid by the same payer[20].

As described below, we created a market basket of APCs and stand-alone services associated with CT's top outpatient services. 95%+ of the market basket services are APCs; the remainder are mammogram services. We grouped L+MH and market commercial-payer claims data into APCs to calculate APC commercial fees for market basket services, whether or not the payer used an APC methodology.

Data

We relied upon the following data sources for our outpatient analysis:

- CT Department of Insurance most common outpatient hospital service lists[21].
- Medicare rules for assigning outpatient services to payment methodologies and within the APC methodology to specific APCs[22].
- CT hospital discharge data from the CT Hospital Information Management Exchange (CHIME)[23] database as provided to us under a data use agreement by YNHHSC, for FY2016.
- CT hospital "Twelve Month Actual Filing" data filed with OHCA, for FY2015[24]. Tabs within the Filing are referred to as "Reports" and have a number, such as Report 165.
- CT Medicaid fee schedules and hospital outpatient Medicaid Modernization impact analysis by hospital from the DSS website[25].
- CT Medicaid freedom of information act (FOIA) request for counts of outpatient market basket services provided July-December 2016 to E-CT Medicaid patients by hospital. Data was requested for the second half of 2016 as

[20] New York State Health Foundation. *Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement*. Gorman Actuarial, Dec. 2016. Web. 4 May 2017. http://nyshealthfoundation.org/resources-and-reports/resource/an-examination-of-new-york-hospital-reimbursement.

[21] Connecticut Department of Public Health. Access Health CT. *Connecticut Acute Care Hospital and Outpatient Surgical Facility Data: FY2015*. N.p., 1 Aug. 2016. Web. 4 May 2017. http://www.ct.gov/dph/lib/dph/ohca/publications/2016/consumerhealthinformationreport.pdf.

[22] "Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC)." *Connecticut Department of Social Services*. N.p., n.d. Web. 4 May 2017. https://www.ctdssmap.com/CTPortal/HospitalModernization/tabid/143/Default.aspx

[23] "ChimeData Overview." *Chime*. Connecticut Hospital Association, n.d. Web. 4 May 2017. http://www.chime.org/member-services/chimedata/chimedata-overview/.

[24] "Twelve Month Filing 2015." *Department of Public Health*. State of Connecticut, n.d. Web. 4 May 2017. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=583316.

[25] "Hospital Outpatient Reimbursement Modernization." *Connecticut Department of Social Services*. State of Connecticut, n.d. Web. 2 May 2017. http://www.ct.gov/dss/cwp/view.asp?a=4598&q=563932.

the market basket services are mostly APC services and CT Medicaid did not use an APC payment methodology until the second half of 2016.

- Medicare 5% sample of Medicare fee for service claims CY2014.[26]
- Medicare wage indices (known as "Table 2" and "Table 3"), from the corrected final rules for CY2015 to CY2017 and the proposed rule for CY2018[27,28].
- Medicare APC payment per relative weight units CY2015 to CY2017[29].
- Truven MarketScan and Milliman Consolidated Health Cost Guidelines Sources Database claims data for E-CT CY2014 and CY2015[30].
- L+MH hospital outpatient service billing and payment (claims) data CY2016.
- Other
    - County to zip code mapping provided by YNH and checked for reasonableness.
    - Data from various sources for commercial outpatient hospital fee trends[31].

Methodology

Summarize Outpatient Services

Step 1: Create set of outpatient market basket services.

a. **Identify the payment methodology for top procedures**. Identify the Medicare (and CT Medicaid July 2016+) payment methodology associated with the top outpatient procedures, outpatient surgical procedures, and outpatient imaging procedures listed in the Department of Insurance (DOI) service lists.

b. **Eliminate HCPCS codes that do not result in a distinct payment.** Eliminate HCPCS codes that are packaged into various APCs and are never or only sometimes distinctly paid and services are not eligible for payment.

c. **Create a market basket list of APCs and HCPCS codes** (see Table 5).

Step 2: Estimate the distribution of market basket outpatient services by hospital for E-CT patients.

a. **Identify E-CT (all-payer) CHIME patient emergency department and outpatient surgical discharges.** Using patient residence zip codes, identify the CHIME FY2016 statewide discharges for patients residing in E-CT.

b. **Identify E-CT Medicaid market basket services.** Using data from a FOIA request, identify the statewide hospitals providing Medicaid market basket services for patients residing in E-CT.

c. **Identify E-CT Medicare market basket services.** Using the Medicare 5% sample, identify the statewide hospitals providing Medicare market basket services for patient residing in the three counties of E-CT.

d. **Estimate the distribution by hospital of market basket outpatient services for residents of E-CT for Medicaid, Medicare, and commercial payers by hospital area** (see Exhibit 7).

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[26] Standard Analytical Files (Medicare Claims). *Centers for Medicare and Medicaid Services (CMS)*. N.p., n.d. Web. 23 Apr. 2017. https://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/standardanalyticalfiles.html.

[27] "CMS-1655-F; CMS-1664-F; CMS-1632-F2; CMS-1655-CN2."*Centers for Medicare and Medicaid Services*. N.p., 2 Aug. 2016. Web. 2 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Regulations.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

[28] "CMS-1677-P."*Centers for Medicare and Medicaid Services (CMS)*. N.p., 14 Apr. 2017. Web. 2 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Proposed-Rule-Home-Page-Items/FY2018-IPPS-Proposed-Rule-Regulations.html.

[29] "Hospital Outpatient PPS." *Centers for Medicare and Medicaid Services (CMS)*. N.p., 30 Dec. 2016. Web. 5 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospitaloutpatientpps/?agree=yes&next=Accept.

[30] MarketScan® Research Databases. *Truven Health Analytics*. N.p., n.d. Web. 25 Apr. 2017. http://truvenhealth.com/markets/life-sciences/products/data-tools/marketscan-databases.

[31] List of sources available upon request.

Calculate Historical and Current Fees

Step 3: **Track Medicare average APC fees from CY2015 to CY2017**.

a. **Develop hospital fees** using each hospital's geographic assignment, the wage factor for the geography, and the national fee per APC relative weight unit.

b. **Weight across hospitals** using each hospitals' proportion of Medicare market basket services, developed from the CY2015 Medicare 5% sample.

Step 4: **Track Medicaid average APC fees from July 2015 to CY2017**.

c. **Develop hospital fees** using APC fee data and the hospital outpatient Medicaid Modernization impact analysis from the CT Medicaid website.

d. **Weight across hospitals** using each hospitals' proportion of Medicaid market basket services, developed using data from the FOIA request.

Step 5: Estimate commercial E-CT fee levels for FY2015 using Truven MarketScan and Milliman Consolidated Health Cost Guidelines Sources Database claims data.

Step 6: Estimate commercial E-CT fee trends from FY2015 to FY2016 using various public sources.

Step 7: Estimate L+MH's commercial hospital outpatient fees levels for FY2016 using billing and payment data provided by L+MH.

Estimate Payer Distribution

Step 8: Estimate the service distribution by payer for the hospitals serving E-CT patients.

a. **Sum outpatient hospital net revenue by payer for the 13 hospitals.**

b. **Adjust the distribution from Step 8a for differences in relative fees and impute the service distribution by payer** using the relative fee levels by payer calculated from Steps 4, 5, and 7.

Project Future Fees

Step 9: Project CY2018 Medicare fees by hospital using Medicare proposed wage indices and proposed CBSA assignments. Assume 0.5% increase in APC fee per relative weight unit.

Step 10: Project CY2018 Medicaid fees by hospital using Medicaid proposed wage indices and geographical CBSA assignments. Assume no change in APC fee per relative weight unit.

Step 11: Project CY2018 commercial fees (in total for non-L+MH hospitals). Assume a 4% non-L+MH trend continues for the 2.25 year span between FY2016 and CY2018

Step 12: Find the L+MH FY2018 commercial fee that maintains the FY2016 ratio of L+MH fees to total market fee using the CY2016 historical fees and the projected CY2018 fees. Weight across hospitals using results from Step 3. Weight across payers (same weight for all hospitals) using result of Step 9.

PHYSICIAN CARE

Overview

Physician groups provide services including office visits, surgical procedures, anesthesia services, laboratory services, and other diagnostic and therapeutic services. Physician groups provide these services in several settings including offices, hospitals, skilled nursing facilities, and others. A physician may bill one or several services for a single patient interaction.

Medicare pays for most physician services using a formula that incorporates time and intensity of the service (work), costs of maintaining a practice (practice expense or PE), and costs of malpractice insurance (MP). Each component is quantified using relative value units (RVU) adjusted for geographic variations using geographic practice cost indices (GPCI). Medicare uses a different approach to set fees for laboratory services. The sum of these pieces is then multiplied by a conversion factor to generate the payment for a given service. This is described in the following formula:

$$\begin{aligned} Physician\ Fee = &(Work\ RVU\ x\ CT\ Work\ GPCI) \\ &+ (PE\ RVU\ x\ CT\ PE\ GPCI) \\ &+ (MP\ RVU\ x\ CT\ MP\ GPCI) \end{aligned}$$

CT Medicaid pays for physician services using a fee schedule available on the DSS website. Commercial fee levels vary between payers and between various providers paid by the same payer.

As described below, we created a market basket of HCPCS associated with LMMG's top physician services.

Data

We relied upon the following data sources for our physician analysis:

- LMMG physician billing data for physician services provided from October 2014 – June 2016.
- CT Medicaid fee schedules from the DSS website[32].
- CT Medicaid freedom of information act (FOIA) request for counts of market basket physician services provided CY2016 to E-CT patients by LMMG physicians and other physicians by geographical area.
- Medicare 5% sample of Medicare fee for service claims CY2014[33].
- Medicare conversion factors from CY2015 to CY2016[34] and for CY2017[35].
- Medicare geographic practice cost indices for CY2015[36] and from CY2016 to CY2017[37].

[32] Connecticut Provider Fee Schedule. *Connecticut Department of Social Services*. N.p., n.d. Web. 21 May 2017. https://www.ctdssmap.com/CTPortal/Provider/ProviderFeeScheduleDownload/tabid/54/Default.aspx.

[33] Standard Analytical Files (Medicare Claims). *Centers for Medicare and Medicaid Services (CMS)*. N.p., n.d. Web. 23 Apr. 2017. https://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/standardanalyticalfiles.html.

[34] "History of Medicare Conversion Factors." American Academy of Pediatrics, n.d. Web. 3 June 2017. https://www.aap.org/en-us/Documents/coding_valuationpayment_medicare_conversion_factor_history.pdf.

[35] "Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year (CY) 2017." *Centers for Medicare and Medicaid Services (CMS)*. N.p., 2 Nov. 2016. Web. 2 June 2017. https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-11-02.html.

[36] "CMS-1612-FC." *Centers for Medicare and Medicaid Services (CMS).* N.p., 13 Nov. 2014. Web. 3 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html.

[37] "CMS-1654-F." *Centers for Medicare and Medicaid Services (CMS).* N.p., 19 Jan. 2017. Web. 5 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html.

- Medicare HCPCS payment per relative weight units for CY2015[38] and from CY2016 to CY2017[39].
- NPI registry data[40].
- Other
    - County to zip code mapping provided by YNH and checked for reasonableness.
    - Data from various sources for commercial physician fee trends[41].

Methodology

Summarize Physician Services

Step 1: Create set of physician market basket services.

a. **Rank order by frequency of procedure codes for physician services provided by LMMG.** Count the number of procedures performed at LMMG in June 2016 by HCPCS code and select the most common procedures.

b. **Eliminate procedure codes that are not for payment purposes or are invalid.**

c. **Create a market basket list of 25 HCPCS codes** (see Table 6).

Step 2: Calculate the distribution of market basket physician services by payer for services performed at LMMG.

a. **Map "financial class" that appears in LMMG data to Medicare, Medicaid, commercial, or other** (see Table 7).

b. **Map each location in LMMG data as "facility" or "non-facility"**. Each location is first mapped to a CMS Location Type using a table provided by LMMG (see Table 8). The CMS Location Type is used to determine if the location is considered "Non-Facility" or "Facility".

c. **Calculate the distribution of market basket physician services by payer for E-CT patients for FY2015 and FY2016** (see Exhibit 10). The LMMG data contains all 12 months of FY2015, but only the first 8.5 months of FY2016, because L+MH switched accounting systems mid-June 2016. October 2015 – May 2016 services were annualized to estimate the total services provided in FY2016.

d. **Calculate Medicaid allowed as a percent of Medicare allowed for market basket physician services.** For market basket services provided to Medicaid patients, calculate the Medicare allowed amounts using the 2017 Medicare fee schedule.

Step 3: **Calculate the percent of market basket services provided by LMMG, other E-CT physicians, and non-E-CT physicians**.

a. **Calculate the percent of Medicaid market basket physician services provided by LMMG, other E-CT physicians, and non-E-CT physicians** using data provided by CT Medicaid via a FOIA request.

b. **Calculate the percent of Medicare market basket services provided by LMMG, other E-CT physicians, and non-E-CT physicians.**

    i. **Identify E-CT zip codes** (see Table 2).

    ii. **Identify the E-CT and non-E-CT market basket services by HCPCS code and physician NPI and listed zip code with the Medicare 5% sample.**

[38] "CMS-1612-FC." Centers for Medicare and Medicaid Services (CMS). N.p., 13 Nov. 2014. Web. 3 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html.

[39] "CMS-1654-F." *Centers for Medicare and Medicaid Services (CMS).* N.p., 19 Jan. 2017. Web. 5 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html.

[40] "DataDissemination." CMS.gov Centers for Medicare & Medicaid Services. N.p., 04 Aug. 2016. Web. 22 June 2017. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/DataDissemination.html.

[41] List of sources available upon request.

iii. **Estimate the total volume of E-CT and non-E-CT Medicare market basket services.** "Gross up" the 5% sample of fee-for-service Medicare services to 100% of total Medicare services (fee-for-service and Medicare Advantage).

iv. **Divide E-CT market basket services between LMMG and other E-CT physicians** using LMMG's data for LMMG's portion.

Calculate Historical and Current Fees

Step 4: **Develop Medicare fees for CY2015 to CY2017**.

a. **Develop Medicare fees by service, year, and location of service for market basket services paid using work, practice expense (PE), and malpractice (MP) RVUs** from Medicare fee data.

b. **List Medicare fees by service and year for market basket laboratory services** using Medicare fee data.

Step 5: Calculate Medicare trends. Weight the fees developed in Step 4 by LMMG's distribution of market basket services across all time periods in the LMMG billing data.

Step 6: Develop Medicaid fees for FY2016 to now using Medicaid fee data. Note: the data shows that there have been no changes since the beginning of FY2016.

Step 7: **Compare Medicaid fees to Medicare fees**. "Reprice" LMMG's market basket Medicaid services using CY2017 Medicare fees. Calculate the ratio of Medicaid fees to Medicare fees.

Project Future Fees

Step 8: Project CY2018 Medicaid fees for LMMG. Medicaid fees have remained flat since September 2015. There are no announcements that indicate that Medicaid fees will significantly change between now and CY2018.

Step 9: Project CY2018 Medicare fees for LMMG. Medicare fees have changed very modestly from CY2015 to CY2017. There are no announcements that indicate that Medicare fees will significantly change between now and CY2018.

Step 10: Project CY2018 commercial fee increase for the market. Based on a review of recent trends and trend predictions, assume a 4% non-L+MH trend continues for the 2.25 year span between FY2016 and CY2018

Step 11: Find the LMMG FY2018 commercial fee that maintains the FY2016 ratio of LMMG fees to total market fees. Unless there are changes in Medicaid and Medicare fee levels or changes in payer mix, LMMG will be able to maintain its fee ratio to the market if its commercial fee increases are the same as the market's commercial fee increases.

ESTIMATION CHALLENGES

In order to prepare the Cost and Market Impact Review, the independent consultant must estimate current and future prices for L+MC and for the eastern CT market (Tolland, Windham, and New London counties). Here we note important challenges inherent in the estimation process. Because of these challenges, actual current or future prices may vary from our estimates.

Lack of Publicly Available Data

Healthcare prices paid by private payers are generally not publicly available. By contrast, charges defined by hospital "charge masters" are available on the OHCA website[42]. Virtually no payer, however, pays the charges in these reports. Payers, including Medicare, Medicaid, and commercial insurance companies, declare or negotiate their prices. These negotiated prices often have little relationship to the reported charges, and may vary substantially from payer to payer. While prices (inclusive of patient cost sharing) are the "true cost" of care, hospitals and physician groups are not required to reveal the actual prices for the care that they provide. Therefore, we estimated historical prices from various public and non-public data sources. Connecticut has been working on developing an all payer claims database (APCD) for some time. We confirmed that at the time of this project, APCD data was not available[43]. Complete APCD data, if available in future years, will provide additional precision to our estimates of commercial prices.

Recent and Future Price Increases are Unknown

The goal of assuring that L+MC's future price increases per unit service (fees) do not exceed the market fee increases requires knowledge of recent and future fee increases in the market. Future fee increases are often unknown and may be subject to disruptive changes, such as a significant change in a government fee schedule. Furthermore, for commercial insurance, it may take months to years for public and non-public data sources to become available for the estimation of recent fee increases. We have made estimates of recent and future changes and will adjust them as further data becomes available.

Reliance on Data from Financial Reports

For hospital inpatient discharges, we estimate FY2016 prices using hospital net revenue as reported by the hospitals. The reported net revenue is the most recent (through September 2016), comprehensive (all patients and payers), and consistent (all CT hospitals) data source for estimating hospital prices. Reported net revenue, however, is subject to accounting adjustments that are not necessarily related to services rendered in the reporting period and the prices for the reporting period services. For example, there may be an adjustment for an over- or under-estimate of the prior year's net revenue. We have implicitly assumed that the adjustments are minor and/or "cancel-out" (negatives offset positives) across the hospitals within a region.

Changes in Payer Mix

Because different payers may pay different fees, changes in payer mix can affect a provider's fee across all payers, aside from any individual fee changes by payer. Therefore, the calculation of an allowed fee increase requires estimates of payer mix by hospital or group of hospitals. For example, Medicaid typically has the lowest fee and therefore a hospital that decreases Medicaid patient volume will collect higher average fees per patient without any fee increase. Conversely, a hospital that increases its Medicaid patient volume will need to increase its commercial fees in order to maintain its average fees level. We have made estimates of changes in payer mix.

Changes in Provider Mix

Because different providers may charge different fees, changes in provider mix can affect the market's fee, aside from any individual fee changes by provider. Therefore, the calculation of market fee increases requires estimates of the past and future provider mix for the market. For example, if patients shift to a hospital or group of hospitals with higher fees, then the

[42] "Hospital Pricemaster Filings" *Department of Public Health*. State of Connecticut, n.d. Web. 4 May 2017. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=526224.

[43] E-mail from Robert Blundo, acting Director of Access Health, 4 Apr 2017.

hospital fee for the market will increase without any hospital-level fee increases. We have made estimates of changes in provider mix.

LIMITATIONS AND CAVEATS

In performing our analysis, we relied on data and information as described above. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. The rate cap estimates are based on assumptions which we have summarized in our report. Our estimates should be viewed as best estimates. For some of the assumptions, there are reasonable alternative assumptions which would result in higher and lower estimates for the rate caps.

This work product was prepared to satisfy Conditions 22 b, c, d, and e of the Agreed Settlement between YNHHSC and the Commissioner of the Department of Public Health. It may be inappropriate to rely upon it for any other purpose. We were required to follow the terms of the Agreed Settlement, including reporting to and taking additional direction from the Commissioner. We believe we have satisfied the terms in the Agreed Settlement.

As required by the Agreed Settlement, YNHHSC engaged Milliman as an independent consultant. Milliman agrees that the work product may be provided to OHCA and the independent monitor that monitors YNHYSC's compliance with the Agreed Settlement. Milliman does not intend to benefit any third party recipient of work product, even when Milliman consents to the release of work product to such third party.

The American Academy of Actuaries requires its members to identify their qualifications in communications. Tia Goss Sawhney and Bruce Pyenson are actuaries employed by Milliman and meet the Academy's qualifications to issue this communication.

EXHIBITS

HOSPITAL INPATIENT CARE

Exhibit 1. Inpatient Discharges for Patients Residing in E-CT

Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges			FY2014 - 2016	
	FY2014	FY2015	FY2016	Δ in %	CAGR
Total Discharges	**51,337**	**51,900**	**51,037**	**-0.6%**	**-0.3%**
% L+MH	26.0%	25.5%	24.9%	-4.0%	-2.0%
% Other E-CT Hospitals	41.0%	39.3%	37.4%	-8.8%	-4.5%
% E-CT Hospitals (incl. L+MH)	67.0%	64.8%	62.3%	-6.9%	-3.5%
% Non-E-CT Hospitals	33.0%	35.2%	37.7%	+14.1%	+6.8%
Market Basket MS-DRGs	**25,338**	**26,164**	**25,417**	**+0.3%**	**+0.2%**
% L+MH	29.8%	28.6%	27.2%	-8.5%	-4.4%
% Other E-CT Hospitals	42.8%	41.8%	40.7%	-4.9%	-2.5%
% E-CT Hospitals (incl. L+MH)	72.6%	70.4%	67.9%	-6.4%	-3.2%
% Non-E-CT Hospitals	27.4%	29.6%	32.1%	+16.9%	+8.1%
All Other MS-DRGs	**25,999**	**25,736**	**25,620**	**-1.5%**	**-0.7%**
% L+MH	22.3%	22.3%	22.7%	+1.7%	+0.9%
% Other E-CT Hospitals	39.2%	36.8%	34.1%	-13.1%	-6.8%
% E-CT Hospitals (incl. L+MH)	61.5%	59.1%	56.8%	-7.7%	-3.9%
% Non-E-CT Hospitals	38.5%	40.9%	43.2%	+12.4%	+6.0%

Exhibit 2A. Inpatient Market Basket MS-DRG Discharges by Payer for Patients Residing in E-CT

Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges			Distribution by Payer		
	FY2014	FY2015	FY2016	FY2014	FY2015	FY2016
Total Market Basket MS-DRG Discharges	**25,338**	**26,164**	**25,417**	**100.0%**	**100.0%**	**100.0%**
Medicare	9,827	10,525	10,069	38.8%	40.2%	39.6%
Medicaid	5,407	5,896	5,720	21.3%	22.5%	22.5%
Commercial	9,474	9,161	9,091	37.4%	35.0%	35.8%
L+MH Market Basket MS-DRG Discharges	**7,539**	**7,490**	**6,916**	**100.0%**	**100.0%**	**100.0%**
Medicare	2,991	3,061	2,698	39.7%	40.9%	39.0%
Medicaid	1,734	1,763	1,666	23.0%	23.5%	24.1%
Commercial	2,666	2,524	2,437	35.4%	33.7%	35.2%
Other E-CT Market Basket MS-DRG Discharges	**10,849**	**10,935**	**10,351**	**100.0%**	**100.0%**	**100.0%**
Medicare	4,687	5,031	4,693	43.2%	46.0%	45.3%
Medicaid	2,530	2,703	2,505	23.3%	24.7%	24.2%
Commercial	3,233	2,884	2,860	29.8%	26.4%	27.6%
E-CT Market Basket MS-DRG Discharges	**18,388**	**18,425**	**17,267**	**100.0%**	**100.0%**	**100.0%**
Medicare	7,678	8,092	7,391	41.8%	43.9%	42.8%
Medicaid	4,264	4,466	4,171	23.2%	24.2%	24.2%
Commercial	5,899	5,408	5,297	32.1%	29.4%	30.7%
Non-E-CT Market Basket MS-DRG Discharges	**6,950**	**7,739**	**8,150**	**100.0%**	**100.0%**	**100.0%**
Medicare	2,149	2,433	2,678	30.9%	31.4%	32.9%
Medicaid	1,143	1,430	1,549	16.4%	18.5%	19.0%
Commercial	3,575	3,753	3,794	51.4%	48.5%	46.6%

Note: Totals include Uninsured and Other payer (not shown).

Exhibit 2B. Inpatient Market Basket MS-DRG Discharges by Payer for Patients Residing in E-CT
Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges					Distribution by Payer and Provider				
	FY2014	FY2015	FY2016	FY14-16 Δ in %	FY14-16 CAGR	FY2014	FY2015	FY2016	FY14-16 Δ in %	FY14-16 CAGR
Total Market Basket MS-DRG Discharges	**25,338**	**26,164**	**25,417**	**+0.3%**	**+0.2%**	**100.0%**	**100.0%**	**100.0%**	**-**	**-**
Medicare	9,827	10,525	10,069	+2.5%	+1.2%	38.8%	40.2%	39.6%	+2.1%	+1.1%
Medicaid	5,407	5,896	5,720	+5.8%	+2.9%	21.3%	22.5%	22.5%	+5.5%	+2.7%
Commercial	9,474	9,161	9,091	-4.0%	-2.0%	37.4%	35.0%	35.8%	-4.3%	-2.2%
L+MH Market Basket MS-DRG Discharges	**7,539**	**7,490**	**6,916**	**-8.3%**	**-4.2%**	**29.8%**	**28.6%**	**27.2%**	**-8.5%**	**-4.4%**
Medicare	2,991	3,061	2,698	-9.8%	-5.0%	11.8%	11.7%	10.6%	-10.1%	-5.2%
Medicaid	1,734	1,763	1,666	-3.9%	-2.0%	6.8%	6.7%	6.6%	-4.2%	-2.1%
Commercial	2,666	2,524	2,437	-8.6%	-4.4%	10.5%	9.6%	9.6%	-8.9%	-4.5%
Other E-CT Market Basket MS-DRG Discharges	**10,849**	**10,935**	**10,351**	**-4.6%**	**-2.3%**	**42.8%**	**41.8%**	**40.7%**	**-4.9%**	**-2.5%**
Medicare	4,687	5,031	4,693	+0.1%	+0.1%	18.5%	19.2%	18.5%	-0.2%	-0.1%
Medicaid	2,530	2,703	2,505	-1.0%	-0.5%	10.0%	10.3%	9.9%	-1.3%	-0.7%
Commercial	3,233	2,884	2,860	-11.5%	-5.9%	12.8%	11.0%	11.3%	-11.8%	-6.1%
E-CT Market Basket MS-DRG Discharges	**18,388**	**18,425**	**17,267**	**-6.1%**	**-3.1%**	**72.6%**	**70.4%**	**67.9%**	**-6.4%**	**-3.2%**
Medicare	7,678	8,092	7,391	-3.7%	-1.9%	30.3%	30.9%	29.1%	-4.0%	-2.0%
Medicaid	4,264	4,466	4,171	-2.2%	-1.1%	16.8%	17.1%	16.4%	-2.5%	-1.3%
Commercial	5,899	5,408	5,297	-10.2%	-5.2%	23.3%	20.7%	20.8%	-10.5%	-5.4%
Non-E-CT Market Basket MS-DRG Discharges	**6,950**	**7,739**	**8,150**	**+17.3%**	**+8.3%**	**27.4%**	**29.6%**	**32.1%**	**+16.9%**	**+8.1%**
Medicare	2,149	2,433	2,678	+24.6%	+11.6%	8.5%	9.3%	10.5%	+24.2%	+11.5%
Medicaid	1,143	1,430	1,549	+35.5%	+16.4%	4.5%	5.5%	6.1%	+35.1%	+16.2%
Commercial	3,575	3,753	3,794	+6.1%	+3.0%	14.1%	14.3%	14.9%	+5.8%	+2.9%

Note: Totals include Uninsured and Other payer (not shown).

Exhibit 3. Case Mix per Inpatient Market Basket MS-DRG Discharge for Patients Residing in E-CT

Source: Reports 165 and 185 filed with OHCA weighted across market basket hospitals and payers using CT CHIME E-CT patient market basket discharges; does not include out-of-state discharges.

	Case Mix per Discharge			FY2014 - 2016	
	FY2014	FY2015	FY2016	Δ in %	CAGR
Total Market Basket MS-DRG Discharges	**1.22**	**1.27**	**1.30**	**+6.6%**	**+3.3%**
Medicare	1.51	1.54	1.56	+3.3%	+1.6%
Medicaid	0.94	1.01	1.06	+12.6%	+6.1%
Commercial	1.09	1.15	1.18	+7.6%	+3.8%
L+MH Market Basket MS-DRG Discharges	**1.17**	**1.20**	**1.23**	**+5.7%**	**+2.8%**
Medicare	1.46	1.46	1.48	+1.2%	+0.6%
Medicaid	0.92	1.02	1.07	+15.4%	+7.4%
Commercial	1.00	1.02	1.08	+7.6%	+3.7%
Other E-CT Market Basket MS-DRG Discharges	**1.18**	**1.25**	**1.26**	**+7.0%**	**+3.4%**
Medicare	1.44	1.49	1.49	+3.0%	+1.5%
Medicaid	0.88	0.94	0.97	+10.0%	+4.9%
Commercial	1.05	1.14	1.16	+11.2%	+5.4%
E-CT Market Basket MS-DRG Discharges	**1.17**	**1.23**	**1.25**	**+6.5%**	**+3.2%**
Medicare	1.45	1.48	1.48	+2.3%	+1.2%
Medicaid	0.90	0.97	1.01	+12.2%	+5.9%
Commercial	1.03	1.08	1.12	+9.5%	+4.6%
Non-E-CT Market Basket MS-DRG Discharges	**1.35**	**1.38**	**1.42**	**+4.9%**	**+2.4%**
Medicare	1.73	1.73	1.77	+2.7%	+1.3%
Medicaid	1.11	1.12	1.21	+8.8%	+4.3%
Commercial	1.20	1.24	1.25	+3.9%	+1.9%

Note: Totals include Uninsured and Other payer (not shown); hospital inpatient Medicaid Modernization occurred in 2015.

Exhibit 4A. Estimated Fee per Market Basket MS-DRG per CMAD for Patients Residing in E-CT

Source: Reports 165 and 185 filed with OHCA weighted across market basket hospitals and payers using CT CHIME E-CT patient market basket discharges; does not include out-of-state discharges.

	Fee per CMAD			FY2014 - 2016	
	FY2014	FY2015	FY2016	Δ in %	CAGR
Total Market Basket MS-DRG Discharges	**$8,858**	**$8,640**	**$8,751**	**-1.2%**	**-0.6%**
Medicare	$8,411	$7,849	$7,717	-8.2%	-4.2%
Medicaid	$5,524	$5,200	$5,359	-3.0%	-1.5%
Commercial	$11,460	$12,132	$12,467	+8.8%	+4.3%
L+MH Market Basket MS-DRG Discharges	**$8,281**	**$7,961**	**$8,210**	**-0.9%**	**-0.4%**
Medicare	$8,088	$7,475	$7,755	-4.1%	-2.1%
Medicaid	$4,925	$4,878	$5,067	+2.9%	+1.4%
Commercial	$10,881	$11,065	$11,380	+4.6%	+2.3%
Other E-CT Market Basket MS-DRG Discharges	**$8,151**	**$7,760**	**$7,788**	**-4.5%**	**-2.3%**
Medicare	$8,155	$7,547	$7,368	-9.6%	-4.9%
Medicaid	$5,489	$4,819	$4,896	-10.8%	-5.6%
Commercial	$10,344	$11,121	$11,291	+9.1%	+4.5%
E-CT Market Basket MS-DRG Discharges	**$8,204**	**$7,840**	**$7,955**	**-3.0%**	**-1.5%**
Medicare	$8,129	$7,520	$7,509	-7.6%	-3.9%
Medicaid	$5,253	$4,843	$4,968	-5.4%	-2.7%
Commercial	$10,581	$11,096	$11,330	+7.1%	+3.5%
Non-E-CT Market Basket MS-DRG Discharges	**$10,359**	**$10,340**	**$10,239**	**-1.2%**	**-0.6%**
Medicare	$9,258	$8,783	$8,200	-11.4%	-5.9%
Medicaid	$6,341	$6,164	$6,238	-1.6%	-0.8%
Commercial	$12,695	$13,434	$13,891	+9.4%	+4.6%

Note: Totals include Uninsured and Other payer (not shown); hospital inpatient Medicaid Modernization occurred in 2015.

Exhibit 4B. Estimated Fee per Market Basket MS-DRG per CMAD for Patients Residing in E-CT

Source: Reports 165 and 185 filed with OHCA weighted across market basket hospitals and payers using CT CHIME E-CT patient market basket discharges; does not include out-of-state discharges.

	Fee per CMAD vs. All E-CT			Fee per CMAD vs. Total		
	FY2014	FY2015	FY2016	FY2014	FY2015	FY2016
L+MH Market Basket MS-DRG Discharges	**+100.9%**	**+101.5%**	**+103.2%**	**+93.5%**	**+92.1%**	**+93.8%**
Medicare	+99.5%	+99.4%	+103.3%	+96.2%	+95.2%	+100.5%
Medicaid	+93.8%	+100.7%	+102.0%	+89.2%	+93.8%	+94.5%
Commercial	+102.8%	+99.7%	+100.4%	+94.9%	+91.2%	+91.3%
Other E-CT Market Basket MS-DRG Discharges	**+99.4%**	**+99.0%**	**+97.9%**	**+92.0%**	**+89.8%**	**+89.0%**
Medicare	+100.3%	+100.4%	+98.1%	+97.0%	+96.2%	+95.5%
Medicaid	+104.5%	+99.5%	+98.5%	+99.4%	+92.7%	+91.4%
Commercial	+97.8%	+100.2%	+99.7%	+90.3%	+91.7%	+90.6%
E-CT Market Basket MS-DRG Discharges	**+100.0%**	**+100.0%**	**+100.0%**	**+92.6%**	**+90.7%**	**+90.9%**
Medicare	+100.0%	+100.0%	+100.0%	+96.6%	+95.8%	+97.3%
Medicaid	+100.0%	+100.0%	+100.0%	+95.1%	+93.1%	+92.7%
Commercial	+100.0%	+100.0%	+100.0%	+92.3%	+91.5%	+90.9%
Non-E-CT Market Basket MS-DRG Discharges	**+126.3%**	**+131.9%**	**+128.7%**	**+116.9%**	**+119.7%**	**+117.0%**
Medicare	+113.9%	+116.8%	+109.2%	+110.1%	+111.9%	+106.2%
Medicaid	+120.7%	+127.3%	+125.6%	+114.8%	+118.5%	+116.4%
Commercial	+120.0%	+121.1%	+122.6%	+110.8%	+110.7%	+111.4%

Note: Totals include Uninsured and Other payer (not shown); inpatient hospital Medicaid Modernization occurred in 2015.

Exhibit 5A. Change in CT Medicaid Fees per Market Basket MS-DRG per CMAD

Source: DSS Website, weighted across market basket hospitals using CT CHIME E-CT patient market basket discharges.

	FY16-CY18 Δ in %	FY16-CY18 CAGR
Total Market	**-9.2%**	**-4.2%**
L+MH	-12.8%	-5.9%
Other E-CT	-8.4%	-3.8%
E-CT	-10.4%	-4.8%
Non-E-CT	-6.8%	-3.1%

Notes: These are the combined changes of the January 1, 2017 fee change and the planned January 1, 2018 fee change.

Exhibit 5B. Change in Medicare Fees per CMAD

Source: CMS 2015, 2016, 2017 IPPS Final Rule, and CMS 2018 IPPS Proposed Rule; Milliman Analysis.

	CY15-CY16 Δ in %	CY16-CY17 Δ in %	CY17-CY18 Δ in %	FY16-CY18 Δ in %	FY16-CY18 CAGR
Total Market	**-0.6%**	**+1.2%**	**-0.9%**	**+0.1%**	**+0.0%**
L+MH	+3.8%	+0.4%	-7.4%	-6.1%	-2.8%
Other E-CT	-2.2%	+1.0%	+1.9%	+2.3%	+1.0%
E-CT	+0.3%	+0.8%	-2.0%	-1.2%	-0.5%
Non-E-CT	-3.2%	+1.9%	+1.2%	+2.3%	+1.0%

HOSPITAL OUTPATIENT CARE

Exhibit 6. Distribution of Net Revenue for CT Hospitals by Service Line and Payer

Source: Report 165 filed with OHCA.

	FY2015 Net Revenue by Service Line			
	L+MH	Other E-CT	Total E-CT	Non-E-CT
Net Revenue (%)	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Inpatient	41.7%	38.5%	39.6%	57.2%
Outpatient	58.3%	61.5%	60.4%	42.8%

	FY2015 Net Revenue by Payer			
	L+MH	Other E-CT	Total E-CT	Non-E-CT
Outpatient Net Revenue (%)	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Medicare	26.3%	24.6%	25.2%	23.3%
Medicaid	11.8%	13.4%	12.9%	12.9%
Commercial	61.4%	61.3%	61.3%	62.6%

Note: Totals include Uninsured and Other payer (not shown)

Exhibit 7. Hospital Outpatient Market Basket Services by Payer for Patients Residing in E-CT

Source: CT Medicaid OP FOIA request, Medicare 5% sample, and CHIME data.

	FY2016 Distribution of Discharges by Payer			
	L + MH	Other E-CT	Non-E-CT	Total E-CT
ED Visits	**29.5%**	**58.5%**	**11.9%**	**88.1%**
Medicare	28.1%	61.2%	10.7%	89.3%
Medicaid	29.4%	62.5%	8.1%	91.9%
Commercial	30.5%	52.5%	17.0%	83.0%
OP Surgeries	**20.1%**	**44.3%**	**35.5%**	**64.5%**
Medicare	18.3%	46.2%	35.4%	64.6%
Medicaid	24.8%	45.9%	29.3%	70.7%
Commercial	20.0%	42.2%	37.9%	62.1%
Market Basket Services				
Medicare	21.0%	53.9%	25.1%	74.9%
Medicaid	21.6%	58.8%	19.5%	80.5%
Commercial[1]	22.9%	77.1%		

Notes: 1) Medicare and Medicaid are calculated directly from their respective data sources, 2) Medicare and Commercial/Medicare relationships developed from CHIME data, and 3) percentages exclude out-of-state discharges

Exhibit 8. Medicaid APC Service Fee Changes

Source: CMS OPPS fee schedules and Milliman analysis.

	Medicaid APC Service Fee Changes by Hospital			
	L+MH	Other E-CT	Non-E-CT	Total
July 1, 2016				
Minimum, any hospital		-0.9%	-32.1%	-32.1%
Maximum, any hospital		+23.0%	+6.9%	+23.0%
Average	**-11.0%**	**+10.0%**	**-6.2%**	**+1.4%**
January 1, 2017				
Minimum, any hospital		-1.2%	-1.3%	-1.3%
Maximum, any hospital		+2.3%	+2.3%	+2.3%
Average	**-1.2%**	**-0.2%**	**+2.0%**	**0.0%**

Note: average values are weighted across hospitals using estimated volume of market basket services for E-CT patients.

Exhibit 9. Medicare APC Service Fee Changes by Calendar Year

Source: Medicare 5% sample data and CMS wage tables.

	Fee Changes by Medicare Calendar Year		
Area	2016	2017	2018
L+MH	+3.8%	+1.1%	-7.7%
Other E-CT	-2.7%	+2.3%	+1.4%
Non-E-CT	-2.6%	+3.3%	+0.8%
Market Basket	-1.3%	+2.3%	-0.8%
APC Base Fee	**-0.6%**	**+1.7%**	**+0.5%**

Note: 2018 is based on the CMS proposal for geographical assignments, wage indices, and an assumed +0.5% increase in the APC base fee.

PHYSICIAN CARE

Exhibit 10 - Count and Distribution of LMMG Market Basket Services by Payer

Source: LMMG billing data for physician services provided in October 2014 - May 2016.

Payer	FY2015		FY2016*	
	Services	% of Total	Services	% of Total
Total	**230,182**	**100.0%**	**230,760**	**100.0%**
Medicare	100,361	43.6%	101,783	44.1%
Medicaid	31,947	13.9%	32,897	14.3%
Commercial	95,636	41.5%	94,119	40.8%
Other	2,238	1.0%	1,962	0.9%

Note: Due to an accounting system change, FY2016 is estimated from 8 months of data.

Exhibit 11 – Distribution of Market Basket Services for E-CT Patients with Medicaid and Medicare

Source: Medicare 5% sample, CT Medicaid FOIA Request, LMMG data.

Area	Distribution of Market Basket Services	
	CY2016	CY2014
	Medicaid	Medicare
Total	**100.0%**	**100.0%**
Non-E-CT	**32.2%**	**33.5%**
Total E-CT	**67.8%**	**66.5%**
LMMG	7.1%	12.0%
Other E-CT	60.7%	54.4%

Exhibit 12 – Medicare Fee Trend

Source: CMS Fee Schedules for 2015, 2016, and 2017 for market basket services, weighted using LMMG billing data for physician services provided in October 2014 - May 2016.

Year	Average Fee
CY 2015	$77.59
CY 2016	$77.31
CY 2017	$77.37
CY2015-CY2017 Trend	**-0.3%**

Note: the average fee was weighted using LMMG's service mix.

APPENDIX – REFERENCE TABLES

Table 1. Summary of Inpatient Discharges

By MS-DRG for Patients Residing in CT for FY2014-FY2015

Source: CHIME, FY2014 and FY2015, IC9-CM Diagnosis and Procedure Codes were used in identification.

Order	MS-DRG	Description	ALL CHIME Inpatient Discharges	CT DOI Identified	
				Inpatient Discharges	% of ALL CHIME Inpatient Discharges
Total			**796,569**	**422,337**	**53.0%**
1	795	Normal newborn	47,772	38,821	81.3%
2	775	Vaginal delivery w/o complicating diagnoses	39,033	37,697	96.6%
3	470	Major joint replacement or reattachment of lower extremity w/o MCC	25,352	25,352	100.0%
4	766	Cesarean section w/o CC/MCC	15,509	15,509	100.0%
5	794	Neonate w other significant problems	16,491	12,351	74.9%
6	765	Cesarean section w CC/MCC	9,798	9,798	100.0%
7	871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	22,408	8,831	39.4%
8	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	11,410	7,190	63.0%
9	392	Esophagitis, gastroent & misc digest disorders w/o MCC	16,848	7,074	42.0%
10	774	Vaginal delivery w complicating diagnoses	7,097	6,726	94.8%
11	291	Heart failure & shock w MCC	9,003	6,630	73.6%
12	189	Pulmonary edema & respiratory failure	6,289	6,148	97.8%
13	292	Heart failure & shock w CC	8,421	6,131	72.8%
14	378	G.I. hemorrhage w CC	7,580	5,339	70.4%
15	460	Spinal fusion except cervical w/o MCC	4,830	4,830	100.0%
16	247	Perc cardiovasc proc w drug-eluting stent w/o MCC	4,794	4,794	100.0%
17	190	Chronic obstructive pulmonary disease w MCC	5,775	4,274	74.0%
18	621	O.R. procedures for obesity w/o CC/MCC	4,068	4,068	100.0%
19	743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	3,946	3,946	100.0%
20	330	Major small & large bowel procedures w CC	3,658	3,658	100.0%
21	481	Hip & femur procedures except major joint w CC	3,603	3,603	100.0%
22	310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	4,802	3,428	71.4%
23	309	Cardiac arrhythmia & conduction disorders w CC	5,185	3,363	64.9%
24	287	Circulatory disorders except AMI, w card cath w/o MCC	3,807	3,305	86.8%
25	191	Chronic obstructive pulmonary disease w CC	5,282	3,241	61.4%
26	065	Intracranial Hemorrhage Or Cerebral Infarction w CC or TPA In 24 Hrs	4,705	3,217	68.4%
27	792	Prematurity w/o major problems	4,009	3,164	78.9%
28	945	Rehabilitation w CC/MCC	2,995	2,992	99.9%
29	208	Respiratory system diagnosis w ventilator support <96 hours	2,927	2,927	100.0%
30	853	Infectious & parasitic diseases w O.R. procedure w MCC	2,892	2,892	100.0%
31	847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	2,894	2,867	99.1%
32	812	Red blood cell disorders w/o MCC	5,401	2,640	48.9%
33	308	Cardiac arrhythmia & conduction disorders w MCC	3,233	2,624	81.2%

Order	MS-DRG	Description	ALL CHIME Inpatient Discharges	CT DOI Identified	
				Inpatient Discharges	% of ALL CHIME Inpatient Discharges
34	280	Acute myocardial infarction, discharged alive w MCC	2,884	2,624	91.0%
35	331	Major small & large bowel procedures w/o CC/MCC	2,608	2,608	100.0%
36	419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	2,607	2,607	100.0%
37	793	Full term neonate w major problems	3,654	2,600	71.2%
38	603	Cellulitis w/o MCC	11,065	2,560	23.1%
39	473	Cervical spinal fusion w/o CC/MCC	2,253	2,253	100.0%
40	494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	2,248	2,248	100.0%
41	066	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	2,942	2,125	72.2%
42	064	Intracranial hemorrhage or cerebral infarction w MCC	3,341	2,123	63.5%
43	377	G.I. hemorrhage w MCC	2,726	2,060	75.6%
44	329	Major small & large bowel procedures w MCC	1,961	1,961	100.0%
45	281	Acute myocardial infarction, discharged alive w CC	2,028	1,822	89.8%
46	192	Chronic obstructive pulmonary disease w/o CC/MCC	3,121	1,807	57.9%
47	872	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC	8,894	1,803	20.3%
48	343	Appendectomy w/o complicated principal diag w/o CC/MCC	1,722	1,722	100.0%
49	253	Other vascular procedures w CC	1,712	1,712	100.0%
50	682	Renal failure w MCC	4,741	1,683	35.5%

Table 2. Zip Code to County Mappings

Source: YNH, verified by Milliman.

Zip Code	County
06249	New London, CT
06254	New London, CT
06320	New London, CT
06330	New London, CT
06333	New London, CT
06334	New London, CT
06335	New London, CT
06336	New London, CT
06338	New London, CT
06339	New London, CT
06340	New London, CT
06349	New London, CT
06350	New London, CT
06351	New London, CT
06353	New London, CT
06355	New London, CT
06357	New London, CT
06359	New London, CT
06360	New London, CT
06365	New London, CT
06370	New London, CT
06371	New London, CT
06372	New London, CT
06375	New London, CT
06376	New London, CT
06378	New London, CT
06379	New London, CT
06380	New London, CT
06382	New London, CT
06383	New London, CT
06384	New London, CT
06385	New London, CT
06388	New London, CT
06389	New London, CT
06415	New London, CT
06420	New London, CT
06439	New London, CT
06474	New London, CT
06029	Tolland, CT
06043	Tolland, CT
06066	Tolland, CT
06071	Tolland, CT
06072	Tolland, CT
06075	Tolland, CT
06076	Tolland, CT
06077	Tolland, CT
06084	Tolland, CT

Zip Code	County
06231	Tolland, CT
06232	Tolland, CT
06237	Tolland, CT
06238	Tolland, CT
06248	Tolland, CT
06250	Tolland, CT
06251	Tolland, CT
06265	Tolland, CT
06268	Tolland, CT
06269	Tolland, CT
06279	Tolland, CT
06226	Windham, CT
06230	Windham, CT
06233	Windham, CT
06234	Windham, CT
06235	Windham, CT
06239	Windham, CT
06241	Windham, CT
06242	Windham, CT
06243	Windham, CT
06244	Windham, CT
06245	Windham, CT
06246	Windham, CT
06247	Windham, CT
06255	Windham, CT
06256	Windham, CT
06258	Windham, CT
06259	Windham, CT
06260	Windham, CT
06262	Windham, CT
06263	Windham, CT
06264	Windham, CT
06266	Windham, CT
06267	Windham, CT
06277	Windham, CT
06278	Windham, CT
06280	Windham, CT
06281	Windham, CT
06282	Windham, CT
06331	Windham, CT
06332	Windham, CT
06354	Windham, CT
06373	Windham, CT
06374	Windham, CT
06377	Windham, CT
06387	Windham, CT

Table 3. Market Basket MS-DRG Discharges

By Facility for Patients Residing in E-CT for FY2014-FY2015

Source: CHIME, FY2014 and FY2015

Facility Name	Region	Hospital County	Market Basket MS-DRG Discharges
Total Market Basket MS-DRG Discharges			**51,837**
Hospitals of Serving the Majority of E-CT Patients			**51,502 / 99.4%**
Lawrence + Memorial Hospital	E-CT	New London, CT	15,029
The William W. Backus Hospital	E-CT	New London, CT	11,067
Hartford Hospital	Non-E-CT	Hartford, CT	4,106
Day Kimball Hospital	E-CT	Windham, CT	4,584
Saint Francis Hospital and Med. Center	Non-E-CT	Hartford, CT	3,215
Yale-New Haven Hospital	Non-E-CT	New Haven, CT	1,949
Windham Hospital	E-CT	Windham, CT	3,299
Manchester Memorial Hospital	Non-E-CT	Hartford, CT	3,369
Rockville General Hospital	E-CT	Tolland, CT	1,695
Middlesex Hospital	Non-E-CT	Middlesex, CT	1,250
Johnson Memorial Hospital	E-CT	Tolland, CT	1,139
Connecticut Children's Medical Center	Non-E-CT	Hartford, CT	403
John Dempsey Hospital	Non-E-CT	Hartford, CT	397
Other CT Hospitals Serving E-CT Patients			**335 / 0.6%**
The Hospital of Central Connecticut	Non-E-CT	Hartford, CT	117
St. Vincent's Medical Center	Non-E-CT	Fairfield, CT	47
Bridgeport Hospital	Non-E-CT	Fairfield, CT	22
MidState Medical Center	Non-E-CT	New Haven, CT	39
Norwalk Hospital	Non-E-CT	Fairfield, CT	12
Saint Mary's Hospital	Non-E-CT	New Haven, CT	20
Danbury Hospital	Non-E-CT	Fairfield, CT	18
Bristol Hospital	Non-E-CT	Hartford, CT	19
Milford Hospital	Non-E-CT	New Haven, CT	14
Waterbury Hospital	Non-E-CT	New Haven, CT	11
Stamford Hospital	Non-E-CT	Fairfield, CT	6
Griffin Hospital	Non-E-CT	New Haven, CT	8
Greenwich Hospital	Non-E-CT	Fairfield, CT	2

Table 4A. CHIME Payer Mappings to Payer Categories

Source: CHIME; Milliman categories

Payer Name in CHIME	Payer Category
Blue Cross	Commercial
Champus/Tricare	Commercial
Charter Oak	Other
Commercial Insur	Commercial
HMO	Commercial
Medicaid	Medicaid
Medicare	Medicare
Medicare Advantage	Medicare
No Charge	Other
Other	Other
Other Fed Prog	Other
PPO	Commercial
Self-Pay	Uninsured
Workers Comp	Commercial
Blank	Other

Table 4B. Twelve Month Actual Filings from OHCA Payer Mappings to Payer Categories

Source: Twelve Month Actual Filings from OHCA; Milliman categories

Payer Name in Report 165	Payer Category
Medicare Traditional	Medicare
Medicare Managed Care	Medicare
Medicaid	Medicaid
Medicaid Managed Care	Medicaid
Champus/Tricare	Commercial
Commercial Insurance	Commercial
Non-Government Managed Care	Commercial
Worker's Compensation	Commercial
Self-Pay/Uninsured	Uninsured
SAGA	Other
Other	Other

Payer Name in Report 185	Payer Category
Non-Government (Including Self Pay / Uninsured)	Commercial
Medicare	Medicare
Medical Assistance	N/A
Medicaid	Medicaid
Other Medical Assistance	Other
Champus / Tricare	Commercial
Uninsured (Included In Non-Government)	Uninsured
Non-Government (Excluding Self Pay / Uninsured)	Commercial

Table 5. Market Basket APCs and HCPCS for Outpatient Services

Source: Compiled from CT Department of Insurance (DOI) Top Outpatient Services Lists

Market Basket APCs for Outpatient Services		
2017	2016	2016 Name
5025	5025	Level 5 Type A ED Visits
5051	5051	Level 1 Skin Procedures
5052	5052	Level 2 Skin Procedures
5112	5112	Level 2 Closed Treatment Fracture and Related Services
5113	5113	Level 3 Closed Treatment Fracture and Related Services
5114	5123	Level 3 Musculoskeletal Procedures
5161	5161	Level 1 ENT Procedures
5163	5163	Level 3 ENT Procedures
5182	5182	Level 2 Vascular Procedures
5301	5301	Level 1 Upper GI Procedures
5311	5311	Level 1 Lower GI Procedures
5312	5312	Level 2 Lower GI Procedures
5361	5361	Level 1 Laparoscopy
5414	5414	Level 4 Gynecologic Procedures
5431	5431	Level 1 Nerve Procedures
5442	5442	Level 2 Nerve Injections
5443	5443	Level 3 Nerve Injections
5481	5481	Laser Eye Procedures
5491	5491	Level 1 Intraocular Procedures
5521	5521	Level 1 X-Ray and Related Services
5522	5522	Level 2 X-Ray and Related Services
5523	5523	Level 3 X-Ray and Related Services
5571	5571	Level 1 Computed Tomography with Contrast and Computed Tomography Angiography
5572	5572	Level 2 Computed Tomography with Contrast and Computed Tomography Angiography
5671	5671	Level 1 Pathology
5673	5673	Level 3 Pathology
5732	5732	Level 2 Minor Procedures
5733	5733	Level 3 Minor Procedures

Market Basket HCPCS for Outpatient Services			
2017	2017 Name	2016	2016 Name
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	G0202	Digital Mammography Screening
G0204	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	G0204	Diagnostic Mammogram, Digital, All Views , bilateral
G0206	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	G0206	Diagnostic Mammogram, Digital, All Views
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	77051	Computer-Aided Diagnostic Mammography Add-On
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	77052	Computer Screen Mammography Add-On
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		

Table 6. Market Basket HCPCS for Physician Services

Source: Market basket was developed from LMMG billing data for physician services provided in June 2016.

HCPCS	Description
11042	Deb subq tissue 20 sq cm/<
36415	Routine venipuncture
81003	Urinalysis auto w/o scope
83036	Glycosylated hemoglobin test
85610	Prothrombin time
90471	Immunization admin
90833	Psytx pt&/fam w/e&m 30 min
93000	Electrocardiogram complete
93010	Electrocardiogram report
93306	Tte w/doppler complete
97597	Rmvl devital tis 20 cm/<
99183	Hyperbaric oxygen therapy
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99232	Subsequent hospital care
99395	Prev visit est age 18-39
99396	Prev visit est age 40-64
G0439	PPPS, subseq visit

Table 7 - LMMG Billing Data Payer Mappings to Payer Categories

Financial Class in LMMG Billing Data	Financial Class Description	Payer Category
AN	Aetna	Commercial
BA	Business Accounts	Commercial
BH	Behavioral Health	Commercial
BS	Blue Cross/Blue Shield	Commercial
CA	Collection Agency	Commercial
CB	Consolidated Billing	Commercial
CC	Connecticare	Commercial
CG	Cigna	Commercial
CH	Charity/Free Care	Other
CI	Commercial Insurance	Commercial
CP	Contracted Payor	Commercial
GA	Grant Billing	Commercial
GC	Grant Billing	Commercial
GR	Grant Billing	Commercial
HN	Health Net Of Ct	Commercial
LC	Liability Charity Care	Other
LI	Liability Insurance	Other
MA	Medicaid	Medicaid
MC	Medicare	Medicare
OC	Outside Collection Agency	Commercial
OX	Oxford Health Plans	Commercial
SI	Self Pay After Insurance	Other
SP	Self Pay	Other
TR	Tricare	Commercial
UH	United Healthcare	Commercial
WC	Workers Compensation	Other

Table 8 – LMMG Location Mappings to CMS Location Type

Source: LMMG billing system.

Location Code	Facility Name	CMS Location Type Code	CMS Location Type Description
8U	Apple Rehab Clipper	31	Skilled Nursing Facility
8W	Apple Rehab Watch Hill	31	Skilled Nursing Facility
9P	Asc Pequot	24	Ambulatory Surgical Center
4B	Backus Hospital	21	Inpatient Hospital
8B	Bayview Health Care Center	32	Nursing Facility
8I	Bridebrook Rehab Center	32	Nursing Facility
8D	Bucks Hill Nursing And Rehabil	32	Nursing Facility
8N	Cheshire House	31	Skilled Nursing Facility
8F	Fairview Nursing Home	32	Nursing Facility
6S	L&M Op Sleep Ctr At Hilton	19	Unassigned
1C	L&M Physician Association	11	Office
7C	Lawrence & Memorial ER Crisis	23	Emergency Room - Hospital
4L	Lawrence & Memorial Hospital	21	Inpatient Hospital
5A	LM Physicians Westerly Bldg 46	11	Office
6W	LM Waterfall	19	Unassigned
7I	LMPA ER Cardiology Waterford	23	Emergency Room - Hospital
7Z	LMPA ER NL Medical Off Bldg	23	Emergency Room - Hospital
1E	LMPA General Surgery	11	Office
1G	LMPA Groton	11	Office
13	LMPA Infectious Disease	11	Office
4I	LMPA IP Cardiology Waterford	21	Inpatient Hospital
4Z	LMPA IP NL Medical Off Bldg	21	Inpatient Hospital
1Z	LMPA Mob	11	Office
12	LMPA Mystic	11	Office
1U	LMPA Neurosurgery	11	Office
1W	LMPA New London	11	Office
1J	LMPA New London Neuro & Ortho	11	Office
1N	LMPA Niantic	11	Office
1O	LMPA Old Lyme	11	Office
6H	LMPA Op Cariology Waterford	19	Unassigned
6T	LMPA Op NL Medical Off Bldg	19	Unassigned
1T	LMPA Physiatry	11	Office
1B	LMPA Physiatry Backus	11	Office
1D	LMPA Physiatry Day Kimball	11	Office
1H	LMPA Shaw General Surgery	11	Office
1P	LMPA Stonington	11	Office
1Q	LMPA Stonington Walkin	11	Office
5K	LMPA Wakefield	11	Office
1I	LMPA Waterford Crossroads	11	Office
5B	LMPA Westerly Morgan Bldg 45	11	Office
3J	Office Joslin New London	11	Office
8C	Paradigm Healthcare	31	Skilled Nursing Facility
8T	Paradigm Healthcare Waterbury	31	Skilled Nursing Facility
2H	Patient's Home CT	12	Home
2I	Patient's Home RI	12	Home
8P	Pendleton Health & Rehab Cntr	32	Nursing Facility
6P	Pequot Health Center	19	Unassigned
1F	Sound Medical Associates	11	Office
8V	Village Green Of Waterbury	31	Skilled Nursing Facility
8Z	Westerly Health Center	31	Skilled Nursing Facility

Location Code	Facility Name	CMS Location Type Code	CMS Location Type Description
7M	Westerly Hospital Emer Room	23	Emergency Room - Hospital
4M	Westerly Hospital Inpatient	21	Inpatient Hospital
6M	Westerly Hospital Outpatient	22	Outpatient Hospital
8Y	Westerly Nursing Home	31	Skilled Nursing Facility
6Y	Yale New Haven Outpatient	22	Outpatient Hospital

User, OHCA

From: Tia Sawhney <Tia.Sawhney@milliman.com>
Sent: Thursday, October 05, 2017 8:58 AM
To: User, OHCA; Martone, Kim
Cc: YNHHSCOHCAMonitor@deloitte.com; gayle.capozzalo@ynhh.org; Vincent.tammaro@ynhh.org; Vincent.petrini@ynhh.org; jennifer.willcox@ynhh.org; shraddha.patel@ynhh.org; Mccarthy, Laura; Bruce Pyenson
Subject: Docket #15-32033-CON & #15-32032-CON - L+M/Yale compliance -- UPDATE

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Kim,

As copied below, we submitted a CMIR for Lawrence + Memorial Corporation Cost and Market Impact Review. The CMIR was dated August 10, 2017.

As documented in multiple portions of the CMIR, our calculations relied upon Medicare's proposed 2018 rules. Under the proposed 2018 rules, L+M Hospital was being assigned a Connecticut wage index instead of the higher Nassau/Suffolk County (NY) wage index that it has been assigned in recent years. The reassignment would have reduced L+M Hospital's 2018 Medicare fees. But, under the final rules and the correction notice recently released by Medicare, L+M Hospital will continue to be assigned to Nassau/Suffolk County for 2018.

We are therefore revising the CMIR and L+M's 2018 commercial fee caps. Since there is no longer a need for commercial fees to offset Medicare fee reductions, the revised 2018 commercial fee cap will be lower than the fee cap in the August 10 CMIR.

We plan to have the revised CMIR ready for our Wednesday meeting with you. In the interim, can you remove the August 10 CMIR from your website or mark it "pending revision"?

Thank you,
Tia

Tia Goss Sawhney, DrPH, FSA, MAAA
Healthcare Consultant and Actuary

Milliman
1 Pennsylvania Plaza, 38th Floor
New York, NY 10119 USA

646-473-3234 Office
224-628-9876 Mobile

From: Tia Sawhney
Sent: Thursday, September 07, 2017 5:15 PM
To: 'OHCA@ct.gov' <OHCA@ct.gov>
Cc: 'YNHHSCOHCAMonitor@deloitte.com' <YNHHSCOHCAMonitor@deloitte.com>; 'gayle.capozzalo@ynhh.org' <gayle.capozzalo@ynhh.org>; 'Vincent.tammaro@ynhh.org' <Vincent.tammaro@ynhh.org>; 'Vincent.petrini@ynhh.org' <Vincent.petrini@ynhh.org>; 'jennifer.willcox@ynhh.org' <jennifer.willcox@ynhh.org>; 'shraddha.patel@ynhh.org' <shraddha.patel@ynhh.org>; 'elizabeth.gonsalves@ynhh.org' <elizabeth.gonsalves@ynhh.org>; Bruce Pyenson

<bruce.pyenson@milliman.com>
Subject: Docket #15-32033-CON & #15-32032-CON - L+M/Yale compliance

Dear Office of Health Care Access:

Attached is our Lawrence + Memorial Corporation Cost and Market Impact Review (CMIR). Please let me know if you have questions.

Thank you,
Tia

Tia Goss Sawhney, DrPH, FSA, MAAA
Healthcare Consultant and Actuary

Milliman
1 Pennsylvania Plaza, 38th Floor
New York, NY 10119 USA

646-473-3234 Office
224-628-9876 Mobile

User, OHCA

From: Roberts, Karen
Sent: Monday, November 06, 2017 9:48 AM
To: User, OHCA
Subject: FW: L+M CMIR question
Attachments: CMIR fee ratios 11-5-2017.docx

Follow Up Flag: Follow up
Flag Status: Flagged

From: Tia Sawhney [mailto:Tia.Sawhney@milliman.com]
Sent: Sunday, November 5, 2017 9:12 PM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Bruce Pyenson <bruce.pyenson@milliman.com>
Subject: RE: L+M CMIR question

Dear Karen,

As you have highlighted below, our fee caps are for the cumulative commercial fee increase between FY2016 and FY2018, a 2.25 year period. Specifically, the fee caps for the 2.25 year period are 16.5% for hospital inpatient, 11.6% for hospital outpatient, and 8.0% for physician services. We provide the equivalent annual fee increases in order to facilitate comparisons to annual market and national fee increases. The cumulative fee cap allows LM+C the *potential* to regain market fee position lost during the October 2015 to December 2017 contract freeze period.

I realize now that the "no change" entries in the table below (from the October 11 revised CMIR that is pending further revision) do not make it entirely clear that the revised values are "no change" from the original fee cap and not a fee cap of 0%. I will make the next iteration of the CMIR more clear.

Also, I have attached a memo with the further information that you requested concerning commercial fees.

Tia

Tia Goss Sawhney, DrPH, FSA, MAAA
Healthcare Consultant and Actuary

Milliman
1 Pennsylvania Plaza, 38th Floor
New York, NY 10119 USA

646-473-3234 Office
224-628-9876 Mobile

From: Roberts, Karen [mailto:Karen.Roberts@ct.gov]
Sent: Friday, November 03, 2017 10:14 AM
To: Tia Sawhney <Tia.Sawhney@milliman.com>
Subject: L+M CMIR question

Hi Tia – I've been asked to have you provide a clarifying email regarding what can be considered the Bottom Line in the L+M CMIR report draft from OHCA's perspective. In the report (original and draft) the following wording is included (noting that the #s changed in the draft version):

On page (i) of the Redraft

October 11, 2017 Revision

Prior to this report, we submitted a Cost and Market Impact Review dated August 10, 2017 which relied on the best available data as of late July 2017. As of that time, Medicare had proposed changing Lawrence and Memorial Hospital's geographic wage index assignment for 2018. The change would have reduced Lawrence and Memorial's inpatient and outpatient fees for 2018.

More recently, Medicare released final and corrected rules for 2018 which keeps Lawrence and Memorial Hospital's geographic wage index assignment the same as for 2017 and also changes the assignment for Backus Hospital – another hospital in the eastern Connecticut market. As a result, Lawrence and Memorial's inpatient and outpatient 2018 Medicare fees are increasing modestly and Backus Hospital's Medicare fees are increasing more substantially.

Lawrence and Memorial Hospital inpatient and outpatient 2018 commercial fee caps decline as a net result of these changes. The following table summarizes the original and revised fee caps.

Commercial Fee Caps

	Per Annum FY2016 to CY 2018		Cumulative FY2016 to CY 2018	
Service Line	Original	Revised	Original	Revised
Hospital Inpatient	9.6%	7.0%	22.9%	16.5%
Hospital Outpatient	5.8%	5.0%	13.5%	11.6%
Physician	3.5%	No Change	8.0%	No Change

On pages 6-7 of the Redraft

FEE CAPS AND RECOMMENDATIONS

Overview

In this section, in our role as an independent consultant, working to satisfy requirements of the Agreed Settlement, we estimate the fee caps for L+MC's average commercial fees for hospital inpatient, hospital outpatient, and physician care. According to the Agreed Settlement, fee caps are the highest permitted aggregate increase in L+MC or LMMG fees for CY 2018 relative to FY2016 — a span of 2.25 years from midpoint to midpoint. Fee increases for a particular commercial health plan may be more or less than the cap.

Commercial fee increases within maintained health plan contracts are included in the fee cap. Condition 20 of the Agreed Settlement requires L+MC to maintain health plan contracts that were in effect as of the date of closing (September 8, 2016) through December 31, 2017. Until January 1, 2018, L+MC commercial fees can increase only if there were fee increases already incorporated within these maintained contracts. L+MC must consider these previously negotiated fee increases when setting fees for CY 2018. According to the Agreed Settlement, the total **commercial fee increase**, including fee increases within maintained contracts, **must not exceed the cumulative** fee cap for inpatient, outpatient or physician services

Hospital Inpatient Fee Cap

We estimate that L+MH could increase its commercial inpatient fees per market basket service +7.0% per annum or +16.5% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +16.5%.[1]

Hospital Outpatient Fee Cap

We estimate that L+MH could increase its commercial outpatient fees per market basket service +5.0% per annum or +11.6% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +11.6%.

Physician Fee Cap

We estimate that LMMG could increase its commercial physician fees per market basket service +3.5% per annum or +8.0% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +8.0%.

Tia - As I indicated on our WebEx call, I think there has been some differing take-aways for what the Bottom Line is and we'd like to have cleared up both in a response Email and ultimately in the revised draft to be submitted.
From the highlighted wording above (from your report draft), is it a correct statement to say that, based on the report calculations and assumptions, L+M/LMMG can negotiated prices that can go no higher than the cumulative cap (16.5% for inpatient for example) for the upcoming CY 2018 timeframe. Or is it correct to say instead that just for this coming year (CY 2018) they can negotiate only up to 7% for inpatient. Please clarify this as soon as possible. Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

[1] Fee changes are to be measured by comparing the average commercial fee in CY2018 to the average commercial fees in FY2016.

Milliman

One Pennsylvania Plaza,
38th Floor
New York, NY 10119
Tel +1 646 473.3000
Fax +1 646 473.3199
www.milliman.com

MEMO

November 5, 2017

To: Karen Roberts, Connecticut Office of Healthcare Access (OHCA)
From: Tia Goss Sawhney
Subject: Commercial Market Basket Fees
For Lawrence + Memorial Corporation
Cost and Market Impact Review (L+MC CMIR)

Milliman (we) are serving as the independent consultant under the Agreed Settlement between Yale New Haven Health Services Corporation and the CT Department of Public Health for the transfer of ownership L+MC. We recently calculated the maximum commercial fee increases LM+C could receive for calendar year (CY) 2018 compared to fiscal year (FY) 2016 so as to maintain LM+C's average price per unit of service (fee), relative to the fees of all providers serving eastern Connecticut patients. We reported the maximum commercial fee increases in the CMIR, last revised October 9, 2017.

In my presentation at OHCA on October 11, I demonstrated that Lawrence + Memorial Corporation (L+M) will maintain the ratio of its average fees[1] relative to the average market fees (fee ratios) for inpatient facility, outpatient facility, and physician market basket services if its average fees increases match the market average fee increases – irrespective of L+MC's initial FY2016 fee ratios. For example, *if LM+C fees are 90% of market fees and both LM+C and market fees increase 5%, then LM+C fees will still be 90% of market fees. Likewise, if LM+C fees are 110% of market fees and LM+C and market fees each increase 7% the LM+C fees will still be 110% of market fees.*

After reviewing the CMIR, the OHCA team requested more information on L+M's FY2016 fee ratios and how we developed them.

For inpatient fee ratios, we relied upon public reports that each Connecticut hospital files with OHCA. The OCHA reports provide the data necessary to calculate the case mix adjusted discharge average fee per discharge by payer for each hospital serving patients in eastern Connecticut. For the average market fee, we weighted case-mix adjusted average fee per discharge across hospitals and payers according the percentage of total market basket discharges each payer and hospital provides to eastern Connecticut patients using CHIME data, another public data source. The inpatient fee ratio was then calculated as L+MC's average fee divided by the average market fee.

[1] Unless specified as commercial, Medicare, or Medicaid, "average fees" refer to fees for market basket services provided to eastern Connecticut patients across all payers (commercial, Medicare, and Medicaid) and Connecticut providers.

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Medicare and Medicaid outpatient and physician fees are public and followed a methodology similar to that for inpatient. Our development of commercial outpatient and physician FY2016 fee ratios, however, is different due to the lack of public data..

While the OHCA inpatient reports contain fee information for all hospital discharges in Connecticut, no such database exists for commercial outpatient and physician fees. The Connecticut All Payer Claims Database (APCD) may be such a source in the future, but we were informed by Robert Blundo, acting Director of Access Health (by email April 2, 2017) that APCD data would not be available this year. Consequently, we used other sources that are not comprehensive. If the Connecticut APCD data becomes available in future years, we may incorporate it into our CMIR updates.

For the 2017 CMIR, we used non-comprehensive market fee sources as described in this paragraph. For L+MC's commercial fees we obtained proprietary 2016 data from L+MC's hospital and physician billing system health insurance claims data. For commercial market fees we examined two, non-duplicative Milliman-licensed datasets, Truven MarketScan and the Milliman Consolidated Health Cost Guidelines Sources Database (CHSD). The L+MC data was comprehensive for L+MC services, and it is proprietary to L+MC because it consists of L+MC negotiated fees. The Milliman licensed data is for services provided in CY2015 to a substantial population of commercially insured eastern Connecticut patients and allows us to credibly estimate FY2016 commercial market rates for eastern Connecticut patients. However, the population underlying the data, about 300,000 people, may not be perfectly representative of the entire eastern Connecticut commercial population. Sources of potential imperfect representation include the inclusion of some people from outside eastern Connecticut[2] and uncertainty as to whether all commercial payers were proportionately represented. Additionally, there was somewhat of a time mismatch as 2015 was the most recent data available for the market and we needed to apply trend estimates to convert the CY2015 fees to FY2016 fees.

Fortunately, as we presented to OHCA, the key to maintaining a fee ratio overtime is assuring that LM+C fee increases do not exceed the market fee increases. The fee cap calculations do not require an exact estimate of the initial FY2016 commercial market fees or the resulting commercial market fee ratio. We tested this principle, by inserting a range of FY2016 commercial market fee values, centered on our commercial market fee estimate, into our fee cap calculation. A 20% change in the outpatient market fees for FY2016 (a big change) changes the cumulative fee cap by approximately 0.2% -- approximately 0.1% per annum. If we were to release our estimate of the commercial market fees, we would release them in the form of a range.

Public Disclosure

L+M commercial outpatient and physician market basket fees originate from proprietary data from L+M's billing system, which represent negotiated fees, and are non-public information. Therefore, per paragraph 22e of the Agreed Settlement, we consider the commercial fees and fee ratios to be confidential and non-disclosable without the consent of YNHHSC and L+M.

[2] Due to HIPAA de-identification requirements, data for eastern Connecticut patients overlaps with data for central Connecticut and western Massachusetts patients.

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Likewise, we consider the all-payer outpatient and physician fee ratios to be confidential as the all-payer fee ratios and the (public) Medicare and Medicaid ratios, a reader to “back into” the commercial fee ratios.

Caveats

Further information is available in our Lawrence + Memorial Corporation Cost and Market Impact Review, most recently revised October 11, 2017.

The American Academy of Actuaries requires its members to identify their qualifications in communications. I am an actuary, employed by Milliman, and meet the Academy's qualifications to issue this communication.

User, OHCA

From: Roberts, Karen
Sent: Wednesday, November 15, 2017 11:10 AM
To: Sauders, Kelly (US - New York)
Cc: Cotto, Carmen; Martone, Kim; User, OHCA
Subject: RE: L+M Monitor Requirement - Six Month Report - plan and question

Thanks Kelly. We will look forward to your six month Report. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Wednesday, November 15, 2017 10:59 AM
To: Roberts, Karen <Karen.Roberts@ct.gov>
Cc: Cotto, Carmen <Carmen.Cotto@ct.gov>
Subject: Re: L+M Monitor Requirement - Six Month Report - plan and question

Hi- yes so sorry I did - they are not and have not been subject to a Consent Order.

On Nov 15, 2017, at 10:44 AM, Roberts, Karen <Karen.Roberts@ct.gov> wrote:

> Hi Kelly – checking to see if you received this email. Let me know if you know the answer to this question. Thanks. Karen
>
> Sincerely,
>
> *Karen Roberts*
> Principal Health Care Analyst
> Office of Health Care Access
> Connecticut Department of Public Health
> 410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
> P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Roberts, Karen
Sent: Thursday, November 9, 2017 1:49 PM
To: 'Sauders, Kelly (US - New York)' <ksauders@deloitte.com>
Subject: RE: L+M Monitor Requirement - Six Month Report - plan and question

Kelly – can you clarify for me whether L+M Hospital had to enter a pre-licensing Consent Order with the facility licensing staff. Does L+M (or you) have to report regularly to DPH FLIS regarding any Consent Order? Thanks. Karen

Sincerely,

Karen Roberts
Principal Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308
P: (860) 418-7041 / F: (860) 418-7053 / E: *karen.roberts@ct.gov*

From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Thursday, November 9, 2017 11:03 AM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>
Cc: DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>
Subject: RE: L+M Monitor Requirement - Six Month Report - plan and question

Dear Kim –

I wanted to send across a note to inform you of our plan to fulfill our requirements related to our bi-annual reporting of YNHHS's Conditions under their Affiliation Agreement with Lawrence + Memorial. 15-32033-CON Condition 16 speaks to D&T's bi-annual written report summarizing activities from the prior six month period. In order to capture YNHHS's filings due November 30 and completing the first reporting period of the agreement, we intend to complete a site-visit and file our report on December 4, 2017. In doing so, we will monitor the reporting that YNHHS must adhere to for the first reporting period.

Please feel free to reach out to me with any questions. I have included a quick explanation of the Condition below, for your reference.

Thanks,
Kelly

15-32033-CON Condition 16: The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall	D&T will plan, at a minimum, two site visits per year. The site visits

conduct on-site visits of L+MH on no less than a semi-annual basis[1] to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	will include meetings with Administration/Leadership and review of any documentation requested by D&T. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.

v.E.1

[1] The semi-annual basis will be defined as six months post-closing and on the anniversary of the closing date to coincide with meetings with the community representatives per Conditions # 33b and 33d

User, OHCA

From: Topalian, Jeryl <Jeryl.Topalian@YNHH.ORG>
Sent: Thursday, November 30, 2017 2:14 PM
To: User, OHCA
Cc: Capozzalo, Gayle; Green, Patrick; Petrini, Vincent; Tammaro, Vincent; 'ynhhscohcamonitor@deloitte.com'; Willcox, Jennifer; Perrone, Brett
Subject: Docket Number 15-32032-CON and Docket Number 15-32033-CON
Attachments: OHCA - Condition 25, 32f, 7c -Synergy Savings Report.pdf; OHCA - Condition 25, 32f iii,32f iv, 7c - Financial Statements.pdf; OHCA - Condition 17 33b 33d - Community Meetings Narrative.pdf; OHCA - Condition 10 - Policy Amendment Narrative.pdf; OHCA - Condition 8 - Financial Measures and Indicators.pdf; OHCA - Condition 7, 19a, 32b - Resource Investment Report.pdf; OHCA - Condition 6 -Top 25 DRG and CPT Codes.pdf; OHCA FY17 Annual CON Filing Cover Letter with GC Signature.pdf; OHCA - Conditions 11,12 - Community Benefit and Cultural Services.pdf; OHCA - Conditions 1,5,6,10,7(a,b),18,20(a-c),24,27-30, 32(a,c,d,e,g) - Affirmations.pdf

Attached please find documents submitted to comply with Conditions of Docket #15-32033-CON: "Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation" and Docket #15-32032-CON: "Transfer of Ownership of Group Practice by the Merger of L+M Physician Association into Northeast Medical Group" for the 6-month reporting period ending September 30, 2017.

The compliance documents attached address the following Conditions for Docket #15-32033-CON and Docket #15-32032-CON as noted:

- Condition 6 – Top Most Frequent MSDRG-and CPT Codes for LM+H
- Conditions 7/19a/32b – Investments Report
- Condition 8 – Financial Measurement Report
- Condition 10 – Revision to Charity Care Policy
- Condition 11 and 12 – Annual Community Benefit Report and Cultural and Linguistically Appropriate Services Report
- Conditions 17/33b/33d – Community Meetings and Public Forums Report
- Conditions 25, 32f (i and ii) (or 7c of Docket #15-32032-CON) – Savings Report
- Condition 32f (iii and iv) (or 7c of Docket #15-32032-CON) – Financial Statements
- Conditions 20a/32c (or 1/7a of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Hospital
- Condition 32e – Affirmation regarding Charity Care Policies
- Conditions 18/32a – Affirmation regarding retention of Services
- Conditions 24/32d (or 5/7b of Docket #15-32032-CON) – Affirmation regarding Physician Offices
- Conditions 27, 28, 29, 30, 32g (or 6 of Docket #15-32032-CON) – Affirmations regarding HR policies

If you have any questions, please feel free to contact me.

Regards,
Jeryl

Jeryl Topalian
Director Strategy & Regulatory Planning
Strategy and Regulatory Planning & Reporting
Office: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

Submitted to Comply with Docket # 15-32033-CON: Conditions 25, 32f(i), and 32f(ii) and Docket # 15-32032-CON: Condition 7c

Synergy Savings Report
Semi-Annual Period: April 1, 2017 to September 30, 2017

OHCA Conditions are as follows for Docket # 15-32033-CON:

25. L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.

32f(i). L+M and YNHHSC shall provide a narrative update on the progress of the implementation of the five-year plan to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives.

32f(ii). L+M and YNHHSC shall provide a report identifying L+M and L+MH cost savings totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A, B, C, D, E, F, G, H, I, J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these expense categories.

OHCA Condition is as follows for Docket # 15-32032-CON:

7c. YNHHS and L+M shall submit a detailed and comprehensive document showing the five-year-plan to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices cross LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

Narrative for Docket # 15-32033-CON: Conditions 25, 32f(i), and 32f(ii) and Docket # 15-32032-CON: Condition 7c

As outlined in the CON document for Docket # 15-32033-CON, L+M and YNHHSC anticipated extensive cost savings as a result of the affiliation stemming from supply chain discounts and efficiencies, and economies of scale related to IT, finance, insurance, equipment, supplies, and other administrative services.

In the March 7, 2017 filing with OHCA, L+M and YNHHSC projected $4,138,484 in savings for FY 2017. Actual cost savings achieved in the full year FY 2017 as well as the second six months of the year are provided in the table below according to the major expense categories outlined by OHCA and Report 175.

	Semi-Annual Reporting Period: 4/1/17-9/30/17			Fiscal Year 2017: 10/1/16-9/30/17		
Categories	Projected Savings	Actual Savings	Variance	Projected Savings	Actual Savings	Variance
Wages	$800,700	$3,390,908	$2,590,208	$1,601,400	$4,494,042	$2,892,641
Fringe Benefits	$141,840	$963,807	$821,967	$283,680	$1,294,343	$1,010,662
Contractual Labor Fees	$0	$0	$0	$0	$0	$0
Medical Supplies and Pharmaceutica	$670,000	$1,186,367	$516,367	$1,340,000	$1,866,236	$526,236
Depreciation/Amortization	$0	$0	$0	$0	$0	$0
Interest Expense	$0	$0	$0	$0	$0	$0
Malpractice Expense	$0	$0	$0	$0	$0	$0
Utilities	$0	($52,492)	($52,492)	$0	$104,562	$104,562
Business Expense	$456,702	$910,039	$453,337	$913,403	$1,715,485	$802,082
Other Operating Expense	$0	$0	$0	$0	$0	$0
Total Synergies	**$2,069,242**	**$6,398,630**	**$4,329,388**	**$4,138,484**	**$9,474,667**	**$5,336,183**

Note: Results for the second six months of FY 2017 (the period 4/1/17-9/30/17) were calculated by taking full year results and subtracting results presented previously for the period 10/1/16-3/31/17. (Any changes that may have affected results previously reported for the period 10/1/16-3/31/17 are incorporated into the full year results. Such changes would have been due to updates to financial information received after submission of the previous report.)

L+M's actual savings of $9,474,667 for FY2017 have surpassed those projected by $5,336,183. Actual savings exceeded projected in every major expense category where savings were anticipated. Below includes a brief narrative for the relevant major expense categories with additional detail provided in the Tables that follow.

1. *Wages and Fringe Benefits*
   Corporate services integration in IT, finance, and other administrative areas were anticipated to be the primary driver of savings in the wages and fringe benefit expense category. During the second half the year, savings in wages and fringe benefits surpassed expectations due to successful integration efforts in several select business units. Management of vacancies and attrition to achieve efficiencies was a key focus for L+M and OHCA, as outlined in the Conditions in the Agreed Settlement. A YNHHS vacancy review process and management

program newly instituted at L+M has resulted in significant savings for L+MH. LMMG also experienced savings through provider attrition.

2. *Medical and Supplies Expense*
   Actual savings within the medical supplies and pharmaceutical expense category were in-line with those projected. As anticipated, much of the savings were due to L+M becoming part of the system-wide group purchasing organization (GPO) since the affiliation and receiving reduced pricing under system contracts. The impact was experienced in a number of areas including surgical services, pharmacy, ancillary services, and cardiology/interventional radiology. L+M was also able to save on medical equipment service contracts through system pricing.

3. *Utilities*
   Although unanticipated, L+M achieved energy savings since coming into the YNHHS system by renewing its utilities contract to reduce spending on electricity.

4. *Business Expense*
   Within the business expense category, L+M and YNHHS anticipated savings as a result of reduced consulting fees and expenses from outside purchases services. Since the affiliation, L+M has been able to use system resources and save in these areas through a reduction in outside legal contract services, marketing agency services, and physician recruitment agency services. In addition, other opportunities have emerged and L+M has experienced savings due to a reduction in travel expenses by personnel; GPO pricing in IT, non-clinical functions, and facilities; better insurance and treasury options that reduced cost, yet improved coverage; and reduced bank fees through adoption of system bank fee arrangements.

L+M and YNHHS continue to explore opportunities for additional savings in the above major expense categories and other areas.

Lawrence + Memorial Healthcare (including L+M Hospital and LMMG)

Synergy Savings Report and Summary

Docket #15-32033-CON: Condition 25, 32f(i), and 32f(ii) and Docket #15-32032: Condition 7c

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

	Semi-Annual Reporting Period: 4/1/17-9/30/17			Fiscal Year 2017: 10/1/16-9/30/17		
Categories	Projected Savings	Actual Savings	Variance	Projected Savings	Actual Savings	Variance
Wages	$800,700	$3,390,908	$2,590,208	$1,601,400	$4,494,042	$2,892,641
Fringe Benefits	$141,840	$963,807	$821,967	$283,680	$1,294,343	$1,010,662
Contractual Labor Fees	$0	$0	$0	$0	$0	$0
Medical Supplies and Pharmaceuticals	$670,000	$1,186,367	$516,367	$1,340,000	$1,866,236	$526,236
Depreciation/Amortization	$0	$0	$0	$0	$0	$0
Interest Expense	$0	$0	$0	$0	$0	$0
Malpractice Expense	$0	$0	$0	$0	$0	$0
Utilities	$0	($52,492)	($52,492)	$0	$104,562	$104,562
Business Expense	$456,702	$910,039	$453,337	$913,403	$1,715,485	$802,082
Other Operating Expense	$0	$0	$0	$0	$0	$0
Total Synergies	**$2,069,242**	**$6,398,630**	**$4,329,388**	**$4,138,484**	**$9,474,667**	**$5,336,183**

Results for the second six months of FY 2017 (the period 4/1/17-9/30/17) were calculated by taking the full year results and subtracting results presented previously for the period 10/1/16 - 3/31/17. Any changes that may have affected results previously reported (period 10/1/16-3/31/17) are incorporated into the full year results. Such changes would have been due to updates to financial information received after submission of previous report.

Semi-Annual reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18. **Annual** reporting periods: 10/1/18-9/30/19; 10/1/19-9/30/20; 10/1/20-9/30/21

Summary page due to OHCA with detailed narrative 60 days following reporting period. Due to Regulatory 30 days prior.

*Although projected summary showing plans annually, 6-month projections are required when reporting through 9/30/18.

Lawrence + Memorial Healthcare (Including L+M Hospital and LMMG)
Detailed Narrative Update on the Implementation Progress of the Plan Resulting from Non-Clinical Shared Services Opportunities
Docket #15-32033-CON: Condition 32f(i) and Docket #15-32032-CON: Condition 7c
Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

COST SAVINGS INVESTMENT	DESCRIPTION OF AND RATIONALE FOR PROJECT	SAVINGS AMOUNT 4/1/17 - 9/30/17	SAVINGS AMOUNT 10/1/16 - 9/30/17	APPLICABLE EXPENSE CATEGORY
Supply Chain Savings / Information Technology Services (ITS) Savings				
Supply Chain Savings (including ITS)	Since the affiliation, L+M has become part of the system-wide GPO (group purchasing organization) and began receiving more optimal pricing under the YNHHS contracts or through combined volume tiers. Supply chain savings were experienced in a number of areas including ITS, surgical services, pharmacy, ancillary services, and cardiology/interventional radiology. L+M was also able to achieve savings on medical equipment service contracts through system pricing.	$1,732,110	$2,627,963	Medical Supplies and Pharmaceuticals and Business Expense
Clinical and Business Practices Integration Across LMC/YNHHS and LMMG/NEMG				
Labor - Attrition, Integration Synergies, and Vacancy Management	To increase savings, FTEs that remained open during the entire prior 12 month period were not filled - the goal being to accomplish labor savings without impacting currently employed staff. LMMG also achieved savings through provider attrition. In addition, a number of positions within Corporate Services were realigned to better employ existing staff and capabilities across the company while aligning functions and removing redundancies. Also, after the affiliation, the standard practice of "Vacancy Review" employed at YNHHS (i.e., review by a committee of senior HR and operational leadership of all vacant positions before posting for hire) was implemented at L+M. This process enabled L+M to successfully redesign and better manage the staffing and types of labor in various areas to achieve savings without impacting currently employed staff.	$4,354,715	$5,788,384	Wages and Fringe Benefits
Legal Services	As part of the affiliation, YNHHS was able to absorb work previously completed by outside legal firms for both L+M and LMMG utilizing the YNHHS in-house legal team. This resulted in costs savings for L+M.	$0	$281,239	Business Expense
Banking, Insurance, Treasury Services	As a result of the affiliation, L+M was able to use YNHHS's existing banking, insurance, and treasury options to negotiate better arrangements that combined to improve coverage, reduce costs and increase operational efficiency.	$207,545	$415,089	Business Expense
Consulting	As part of the affiliation with NEMG, LMMG was able to reduce outside consulting services expenses.	$142,639	$142,639	Business Expense
Marketing Services	Prior to the affiliation, L+MH used the services of an outside creative agency for advertising and marketing services. Since the affiliation, this work has been incorporated into work already being completed at the YNHHS system level.	$46,500	$84,896	Business Expense
Travel Expense	An initiative at L+M to create more visibility and to target reduction of traveling expense incurred by personnel resulted in decreases in annual cost.	($43,943)	$8,795	Business Expense

Lawrence + Memorial Healthcare (Including L+M Hospital and LMMG)
Detailed Narrative Update on the Implementation Progress of the Plan Resulting from Non-Clinical Shared Services Opportunities
Docket #15-32033-CON: Condition 32f(i) and Docket #15-32032-CON: Condition 7c
Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

COST SAVINGS INVESTMENT	DESCRIPTION OF AND RATIONALE FOR PROJECT	SAVINGS AMOUNT 4/1/17 - 9/30/17	SAVINGS AMOUNT 10/1/16 - 9/30/17	APPLICABLE EXPENSE CATEGORY
Provider Recruitment Expense	As part of the affiliation with NEMG, LMMG was able to reduce contractual service expenses used for provider recruitment.	$11,556	$21,100	Business Expense
Reduced Cost of Capital				
n/a	n/a	n/a	n/a	
Population Health Initiatives				
n/a	n/a	n/a	n/a	
Other				
Energy Savings	Since coming into the YNHHS, L+M renewed contract negotiations for utility services resulted in reduced annual expenditures on electricity.	($52,492)	$104,562	Utilities
	TOTAL	**6,398,630**	**9,474,667**	

SIGNATURE: Vincent Tammaro

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

Financial information is based on unaudited financial statements.

Results for the second six months of FY 2017 (the period 4/1/17-9/30/17) were calculated by taking the full year results and subtracting results presented previously for the period 10/1/16 - 3/31/17. Any changes that may have affected results previously reported (period 10/1/16-3/31/17) are incorporated into the full year results. Such changes would have been due to updates to financial information received after submission of previous report.

Semi-Annual reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18. **Annual** reporting periods: 10/1/18-9/30/19; 10/1/19-9/30/20; 10/1/20-9/30/21

Detailed narrative due to OHCA with summary page 60 days following reporting period. Due to Regulatory 30 days prior.

Submitted to Comply with Docket # 15-32033-CON: Condition 10

Notice of Amendment to Policy

OHCA condition is as follows:

10. For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modifications, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH with thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population. *Legal and Factual Basis: Stat. §§ 19a-613(b), 10a-639(a)(5),(6) & (11); FF 26*

Narrative for Condition 10:

The YNNHS Financial Assistance (charity and free care) policy was adopted by L+MH in January, 2017 as specified in Condition 9 of Docket # 15-32033 which states:

Following the Closing Date, L+MH will adopt YNHHSC's financial assistance (charity and free care) policies or adopt other policies that are at least generous and benevolent to the community as L+MH's current policies, consistent with state and federal law. These policies shall be posted on the website pages of L+MH and as additionally required by applicable law. OHCA is imposing this Condition to ensure continued access to healthcare services for the patient population.

The policy was posted on the L+MH website, and a copy of the new policy accompanied the notification to OHCA on February 17, 2017.

The YNHHS Financial Assistance (charity and free care) policy was amended in June, 2017, and the amended policy covered all YNHHS hospitals, including L+M Hospital. The amended policy was posted on the L+MH website at that time. The YNHHS Financial Assistance policy continues to be at least as generous and benevolent to the community as L+MH policies in effect at the Closing Date. The amendment further defined the eligibility for discounted care, clarified terminology regarding hospital bed funds, and updated the Federal Poverty Guidelines to the 2017 standards.

The updated policy is included as an attachment to provide OHCA with written notice of this amendment to the L+MH Financial Assistance policy.

Service Area: Corporate Business Services	YALE NEW HAVEN HEALTH SYSTEM POLICIES & PROCEDURES
Title: Financial Assistance Programs Policy	
Date Approved: 09/20/2013	**Approved by:** Boards of Trustees Senior Vice President, Finance
Date Effective: 09/20/2013 1/1/2017 Lawrence + Memorial Hospital and Westerly Hospital	**Date Reviewed/Revised:** 01/21//2015, 09/30/2016, 12/16/2016, 6/1/2017
Distribution: MCN Policy Manager	**Policy Type (I or II):** Type I
Supersedes: Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4) Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13) Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services Lawrence + Memorial Hospital and Westerly Hospital Charity Care, Financial Assistance, Free Bed Fund Policy	

PURPOSE

Yale New Haven Health System ("YNHHS") recognizes that patients may not be able to pay for medically necessary health care without financial assistance. Consistent with its mission, YNHHS is committed to assuring that the ability to pay will be considered carefully when setting amounts due for emergency and other medically necessary hospital services.

In furtherance of its mission, YNHHS has established the Financial Assistance Programs ("FAP") to assist individuals with paying for emergency and other medically necessary care. The objectives of the FAP are to:

(i) Specify all financial assistance available under the FAP;

(ii) Provide clear information regarding eligibility criteria, application requirements and the method for applying for financial assistance;

(iii) Describe the basis for calculating amounts charged to FAP-eligible patients for emergency or other medically necessary care; and

(iv) Describe the steps YNHHS hospitals take to widely publicize this FAP within the communities served by YNHHS.

APPLICABILITY

This policy applies to each licensed hospital affiliated with YNHHS, including Bridgeport Hospital ("BH"), Greenwich Hospital ("GH"), Lawrence + Memorial Hospital ("LMH"), Yale New Haven Hospital ("YNHH") and Westerly Hospital ("WH") (each a "Hospital").

POLICY

I. Scope and Provider List

A. **Emergency and Other Medically Necessary Care**. The FAP apply to emergency and other medically necessary care, including inpatient and outpatient services, billed by a Hospital. The FAP exclude: (a) private room or private duty nurses; (b) services that are not medically necessary, such as elective cosmetic surgery; (c) other elective convenience fees, such as television or telephone charges, and (d) other discounts or reductions in charges not expressly described in this policy.

B. **Provider List**. A list of providers who provide emergency and other medically necessary care at a Hospital can be found here: https://www.ynhh.org/~/media/files/ynhhs/forms/financial/011117/ynhh_fap_policy_list_2017.pdf
The list indicates if the provider is covered under the FAP. If the provider is not covered under this FAP, patients should contact the provider's office to determine if the provider offers financial assistance and if so what the provider's financial assistance policy covers.

II. Financial Assistance Programs and Eligibility

Financial assistance is available to U.S. citizens and residents who complete the required financial assistance application and meet the additional eligibility requirements described below.

A. **Free Care.** The Free Care program provides care at no cost to Hospital patients with gross annual family income less than or equal to 250% of the Federal Poverty Guidelines (*see* Attachment 1). Any patient that may in the Hospital's discretion qualify for State medical assistance will be required to have a determination by the State, within the last six months.

In addition, YNHHS on behalf of BH, GH, and YNHH uses a third party screening tool to assist in identifying individuals with self-pay balances who have not applied for financial assistance, but whose income is less than or equal to 250% of the Federal Poverty Level (*i.e.*, eligible for free care). If a patient is identified through this process outstanding hospital balances may be adjusted to charity (free) care.

B. **Discounted Care.** If a Hospital patient does not have insurance and his or her gross annual family income is between 251% - 550% of the Federal Poverty Level the Hospital will discount care to the Hospital's AGB (as defined in Section III below and on Attachment 1).

C. **Hospital Bed Funds.** You may be eligible to receive financial assistance from hospital bed funds, which are funds that have been donated to the Hospital to provide medical care to patients at a hospital. There are no specific income limits for receipt of hospital bed funds. Eligibility is determined on a case-by-case basis by the fund nominators based on financial hardship. All patients who fill out the requisite financial assistance application will automatically be considered for hospital bed funds.

D. **Other Hospital-Specific Financial Assistance programs**.

(i) **Yale New Haven Hospital Me & My Baby Program**. This program is available to Yale New Haven Hospital patients. It provides prenatal, labor and delivery services, and some post-partum care free of charge. You may be eligible if you live in New Haven County, do not have any type of health insurance and your family earns less than 2 ½ times the Federal Poverty Level. For more information or to request an application see our representatives at the Yale New Haven Hospital Women's Center or call 203-688-5470.

(ii) **Greenwich Hospital Outpatient Clinic** serves patients insured by Medicare, Medicaid, or insurances offered through Access Health CT and whose family income is less than 4 times the Federal Poverty Level. Further, the clinic provides discounted care to individuals who are not eligible for insurance and who reside in Greenwich and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call 203-863-3334.

III. Limitation on Charges - Amounts Billed to FAP-Eligible Patients

Where there is an award of financial assistance that does not cover 100% of YNHHS charges for the service, the amounts charged to patients eligible for financial assistance under this Policy will not be more than the amount a Hospital generally bills patients who have insurance coverage for such care ("AGB"). YNHHS calculates AGB annually by Hospital using the "look back method" and based on Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts and all private health insurers that pay claims to each Hospital facility for the prior fiscal year. YNHHS may apply the percentage discount by Hospital, or may elect to use the percentage discount most favorable to YNHHS patients. AGB is set forth on Attachment 1 hereto.

As used herein, the "amount generally billed" and "look back method" have the meanings set forth in Internal Revenue Code §501(r)(5) and1.501(r)-5.

IV. Method of Applying for Assistance

To be eligible for financial assistance, the patient must complete the requisite application for financial assistance ("Application"). The Application sets forth (i) FAP available programs and eligibility requirements, (ii) the documentation requirements for determinations of eligibility, and (iii) the contact information for FAP assistance. The Application also specifies that (i) the Hospital will respond to each Application in writing, (ii) patients may re-apply for financial assistance under the FAP at any time, and (iii) additional free bed funds become available every year. Hospitals may not

deny financial assistance under the FAP based on failure to provide information or documents that the FAP or the Application do not require as part of the Application.

YNHHS Hospitals will make reasonable efforts to determine eligibility and document any determinations of financial assistance eligibility in the applicable patient accounts. Once Hospital identifies a patient is FAP-eligible, Hospital shall:

(i) Provide a billing statement indicating amount the individual owes as a FAP-eligible patient, including how the amount was determined and states, or describes, how the individual can get information regarding the AGB for the care;

(ii) Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5, or such other amount set by the IRS; and

(iii) Take reasonable measures to reverse any extraordinary collection actions.

V. Non-Payment – Legal Action

A Hospital (and any collection agency or other party to which it has referred debt) will not engage in any extraordinary collection action ("ECA") before making reasonable efforts to determine if a patient or any other individual having financial responsibility for a self-pay account (Responsible Individual(s)) is eligible for financial assistance under this FAP. Any ECA must be approved by the Vice President of Corporate Business Services or his designee(s), prior to the initiation of any ECA.

The Hospital will follow its A/R billing cycle in accordance with internal operational processes and practices. As part of such processes and practices, the Hospital will, at a minimum, notify patients about its FAP from the date care is provided and throughout the A/R billing cycle (or during such period as is required by law, whichever is longer) by:

1. All patients will be offered a plain language summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a Hospital.

2. At least three separate statements for collection of self-pay accounts will be mailed or emailed to the last known address of the patient and any other Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All single patient account statements of self-pay accounts will include but not limited to:

    a. An accurate summary of the hospital services covered by the statement;

    b. The charges for such services;

c. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and

d. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of financial assistance under the FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

3. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the billing deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A plain language summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

4. Prior to initiation of any ECA, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial assistance that may be available under the FAP.

5. Subject to compliance with the provisions of this policy, a YNHHS Hospital may take the ECA listed on Attachment 2 of this Policy to obtain payment for medical services provided.

VI. Policy Availability

Copies of the FAP, a plain language summary of the FAP and FAP application are available at https://www.ynhhs.org/billing-insurance.aspx.

Each Hospital makes available copies of the FAP, a plain language summary of the FAP and FAP application on request, free of charge, by mail or in the Hospital Emergency Department and at all points of registration in paper form in English and the primary language of any population with limited English proficiency that constitutes 5% or more of the population the Hospital serves. See Attachment 3 for a list of languages.

Contact Corporate Business Services toll free at (855) 547-4584 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, plain language summary of the FAP, FAP application form, or Billing and Collection Policy to be mailed to you, or if you need a copy of the FAP, plain language summary, or FAP application form translated to a language other than English. Further, patients may ask Patient Registration, Patient Financial Services and Social Work/Case Management about initiating the FAP application process.

Further efforts to widely publicize the FAP include publishing notices in newspapers of general circulation; providing written notice of FAP in billing statements; providing notice of FAP in oral communications with patients regarding the amount due; and holding open houses and other informational sessions.

VII. Management Oversight Committee

The FAP will be overseen by a management oversight committee chaired by a Senior Vice President, YNHHS and comprised of representatives from Corporate Business Services, patient financial services, patient relations, finance, and the medical staff, as necessary. This committee will meet at least quarterly.

VIII. Compliance with State Law

Each Hospital shall comply with relevant State laws, including, without limitation, Connecticut General Statutes governing Collections by Hospitals from Uninsured Patients and Rhode Island *Statewide Standard for the Provision of Charity Care* set forth in Section 11.3 of the Rhode Island Department of Health Rules and Regulations Pertaining to Hospital Conversions (the "RI Regulations") and the *Statewide Standard for the Provision of Uncompensated Care* set forth in Section 11.4 of the RI Regulations.

REFERENCES
Internal Revenue Code 501(c)(3)
Internal Revenue Code 501(r)
Conn. Gen. Stat. § 19a-673 et seq.
RI Regulations 11.3 and 11.4

RELATED POLICIES
YNHHS Billing and Collections Policy
Yale New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2

Attachment 1

250% of the Federal Poverty Guidelines (FPG)

Family size:	Maximum Income:
1	$30,150
2	$40,600
3	$51,050
4	$61,500
5	$71,950
6	$82,400

Add* **$10,450 *for each additional family member*

Amounts Generally Billed (AGB)

Patients eligible for financial assistance under this Policy will receive assistance according to the following:

All YNHHS Hospitals:

Annual Family Income	Amount of Discount % of Charges	Patient Pays % of Charges
< or = 250% FPG	100%	0
> 250% FPG	69%	31%

**For calendar year 2017, AGB (% of charges): BH 32%, GH 32%, LMH 55%, YNHH 31% and WH 31%*

Attachment 2

EXTRAORDINARY COLLECTION ACTIONS

Property Liens

Liens on personal residences are permitted only if:

a) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;

b) The patient has not applied or qualified for other financial assistance under the Hospital's Financial Assistance Policy, to assist in the payment of his/her debt, or has qualified, in part, but has not paid his/her responsible part;

c) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;

d) The aggregate of account balances is over $10,000 and the property(ies) to be made subject to the lien are at least $300,000 in assessed value; and

e) The lien will not result in a foreclosure on a personal residence.

Attachment 3

Limited English Proficiency Languages

Albanian
Arabic
Simplified Chinese
French
French Creole (Haitian Creole)
German
Greek
Hindi
Italian
Japanese
Korean
Pashto
Persian Dari
Persian Farsi
Polish
Portuguese
Portuguese Creole (Cape Verdean)
Russian
Spanish
Swahili
Tagalog
Tigrinya
Turkish
Vietnamese

Submitted to Comply with Docket # 15-32033-CON: Condition 6

Top Most Frequent MS-DRG and CPT Codes for L+MH
Annual Period: October 1, 2016 to September 30, 2017

OHCA will receive an annual report of the total price per "unit of service" for MS-DRG and CPT codes each fiscal year through the end of FY 2019.

Condition 6. Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and the top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period September 1, 2015 – August 30, 2016. The Applicant shall provide the same information for three (3) full fiscal years thereafter within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.

L+MH Top 25 Most Frequently Utilized Services - MS-DRG (Inpatient) & CPT (Outpatient)

CT OHCA 15-32033 Condition 6

October 1, 2016 - September 30, 2017

	L+MH Top 25 MS-DRG Inpatient Codes	Total Price
1)	775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	$5,389.85
2)	795 - NORMAL NEWBORN	$1,605.11
3)	871 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	$14,595.02
4)	470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EX	$20,473.07
5)	885 - PSYCHOSES	$7,906.42
6)	794 - NEONATE W OTHER SIGNIFICANT PROBLEMS	$2,701.94
7)	291 - HEART FAILURE & SHOCK W MCC	$11,948.79
8)	189 - PULMONARY EDEMA & RESPIRATORY FAILURE	$9,408.83
9)	765 - CESAREAN SECTION W CC/MCC	$9,469.95
10)	766 - CESAREAN SECTION W/O CC/MCC	$8,208.83
11)	378 - G.I. HEMORRHAGE W CC	$7,712.67
12)	872 - SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	$8,874.66
13)	392 - ESOPHAGITIS GASTROENT & MISC DIGEST DISORDERS W/O MC	$6,729.58
14)	897 - ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION	$5,825.62
15)	065 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	$9,299.02
16)	603 - CELLULITIS W/O MCC	$6,479.02
17)	190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	$9,107.65
18)	057 - DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	$25,790.24
19)	683 - RENAL FAILURE W CC	$7,575.31
20)	793 - FULL TERM NEONATE W MAJOR PROBLEMS	$6,365.62
21)	287 - CIRCULATORY DISORDERS EXCEPT AMI W CARD CATH W/O MC	$11,136.73
22)	682 - RENAL FAILURE W MCC	$11,085.58
23)	460 - SPINAL FUSION EXCEPT CERVICAL W/O MCC	$33,436.33
24)	690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$5,947.84
25)	309 - CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	$6,931.25

	L+MH Top 25 CPT Outpatient Codes	Total Price
1)	36415 - COLLECTION VENOUS BLOOD VENIPUNCTURE	$ 4.57
2)	99218 - INITIAL OBSERVATION CARE/DAY 30 MINUTES	$ 138.39
3)	J3490 - DRUGS UNCLASSIFIED INJECTION	$ 10.69
4)	85025 - BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	$ 16.23
5)	Q9967 - LOCM 300-399MG/ML IODINE1ML	$ 5.16
6)	97110 - THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES	$ 99.87
7)	80053 - COMPREHENSIVE METABOLIC PANEL	$ 25.86
8)	99283 - EMERGENCY DEPARTMENT VISIT MODERATE SEVERITY	$ 434.03
9)	84443 - ASSAY OF THYROID STIMULATING HORMONE TSH	$ 38.48
10)	80061 - LIPID PANEL	$ 29.36
11)	81001 - URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOP	$ 7.50
12)	85610 - PROTHROMBIN TIME	$ 7.74
13)	80048 - BASIC METABOLIC PANEL CALCIUM TOTAL	$ 20.80
14)	97140 - MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTE	$ 101.01
15)	82565 - CREATININE BLOOD	$ 7.40
16)	99284 - EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVER	$ 622.27
17)	96361 - IV INFUSION HYDRATION EACH ADDITIONAL HOUR	$ 79.14
18)	84520 - ASSAY OF UREA NITROGEN QUANTITATIVE	$ 5.58
19)	82306 - 25 HYDROXY INCLUDES FRACTIONS IF PERFORMED	$ 74.91
20)	97530 - THERAPEUT ACTVITY DIRECT PT CONTACT EACH 15 MI	$ 119.71
21)	88305 - LEVEL IV SURG PATHOLOGY GROSS&MICROSCOPIC EX	$ 54.52
22)	87086 - CULTURE BACTERIAL QUANTTATIVE COLONY COUNT U	$ 16.40
23)	82947 - GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP	$ 4.80
24)	71020 - RADIOLOGIC EXAM CHEST 2 VIEWS FRONTAL&LATERA	$ 124.80
25)	93005 - ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&	$ 74.11

*Total Price is defined as the weighted average price for all governmental and non-governmental payers

Due internally to Regulatory 30 days prior to OHCA due date

Submitted to Comply with Affirmations in Docket # 15-32033-CON and Docket # 15-32032-CON

Affirmations
Semi-Annual Period: 10/1/16 – 3/31/17

OHCA Conditions are as follows:

Docket # 15-32033 Condition 20a/20b/32c Docket # 15-32032 Condition 1/7a	L+MH and LMMG commercial health plan contracts in place as of the Closing are/were maintained through the remainder of their terms, and any new contracts are consistent with the commitments of paragraphs 20, 21 and 22 of the Agreed Settlement.
Docket # 15-32033 Condition 32e	L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.
Docket # 15-32033 Condition 18/32a	L+M shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. All L+MH services have been continued as required by the terms of the Agreed Settlement.
Docket # 15-32033 Condition 24/32d Docket # 15-32032 Condition 5/7b	No L+M physician office has been converted to hospital-based status.
Docket # 15-32033 Condition 32g	All labor and employment commitments described in the Agreed Settlement continue to be satisfied.
Docket # 15-32033 Condition 27	L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.
Docket # 15-32033 Condition 28 Docket # 15-32032 Condition 6	Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).
Docket # 15-32033 Condition 29	L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.
Docket # 15-32033 Condition 30	L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.
Docket # 15-32033 Condition 10	The YNHHSC Financial Assistance Program was amended in June 2017, as described in the Condition 10 narrative, and such amended Financial Assistance Program applies to L+M Hospital.

AFFIRMATION OF COMPLIANCE
WITH L+M AFFILIATION AGREED SETTLEMENT CONDITIONS

Docket No. 15-32033-CON, L+M Corporation and Yale New Haven Health Services Corp.

Docket No. 15-32032-CON, Northeast Medical Group and L&M Physicians Association

COMPLIANCE PERIOD: April 1, 2017 to September 30, 2017

I, Vincent Tammaro, Executive Vice President and Chief Financial Officer of Yale New Haven Health System, hereby certify that, based on my knowledge and belief, Yale New Haven Health Services Corporation (YNHHSC), Northeast Medical Group, Inc. (NEMG), L+M Corporation (L+M), Lawrence + Memorial Hospital (L+MH) and L&M Physician Association, Inc. (LMMG) have complied with the conditions of the Agreed Settlement as set forth below, effective September 8, 2016 and throughout the course of the Compliance Period described above.

☒	Docket # 15-32033 Condition 20a/20b/32c Docket # 15-32032 Condition 1/7a	L+MH and LMMG commercial health plan contracts in place as of the Closing are/were maintained through the remainder of their terms, and any new contracts are consistent with the commitments of paragraphs 20, 21 and 22 of the Agreed Settlement.
☒	Docket # 15-32033 Condition 32e	L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.
☒	Docket # 15-32033 Condition 10	The YNHHSC Financial Assistance Program was amended in June 2017, as described in the Condition 10 narrative, and such amended Financial Assistance Program applies to L+M Hospital.

Signature: Vincent Tammaro Date: 11/30/2017

Subscribed and sworn to before me on November 30, 2017

Signature of Notary Public Brenda L. White

Brenda L. White
Printed Name of Notary Public

BRENDA L. WHITE
NOTARY PUBLIC OF CONNECTICUT
My Commission Expires 6/30/2021

AFFIRMATION OF COMPLIANCE
WITH L+M AFFILIATION AGREED SETTLEMENT CONDITIONS

Docket No. 15-32033-CON, L+M Corporation and Yale New Haven Health Services Corp.

Docket No. 15-32032-CON, Northeast Medical Group and L&M Physicians Association

COMPLIANCE PERIOD: April 1, 2017 to September 30, 2017

I, Patrick Green, President and Chief Executive Officer, Lawrence and Memorial Hospital, hereby certify that, based on my knowledge and belief, Yale New Haven Health Services Corporation (YNHHSC), Northeast Medical Group, Inc. (NEMG), L+M Corporation (L+M), Lawrence + Memorial Hospital (L+MH) and L&M Physician Association, Inc. (LMMG) have complied with the conditions of the Agreed Settlement as set forth below, effective September 8, 2016 and throughout the course of the Compliance Period described above.

☒	Docket # 15-32033 Condition 18/32a	L+M shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. All L+MH services have been continued as required by the terms of the Agreed Settlement.
☒	Docket # 15-32033 Condition 24/32d Docket # 15-32032 Condition 5/7b	No L+M physician office has been converted to hospital-based status.

Signature: _____ Date: 11/15/17

Patrick L. Green

Subscribed and sworn to before me on 15th day November 2017

Signature of Notary Public Patti Roma Brooks

Patti Roma Brooks

Printed Name of Notary Public

PATTI L. ROMA-BROOKS
NOTARY PUBLIC
MY COMMISSION EXPIRES OCT. 31, 2022

Date Commission Expires _____

AFFIRMATION OF COMPLIANCE
WITH L+M AFFILIATION AGREED SETTLEMENT CONDITIONS

Docket No. 15-32033-CON, L+M Corporation and Yale New Haven Health Services Corp.

Docket No. 15-32032-CON, Northeast Medical Group and L&M Physicians Association

COMPLIANCE PERIOD: April 1, 2017 to September 30, 2017

I, Kevin Myatt, Senior Vice President, Chief Human Resources Officer, Yale-New Haven Health System, hereby certify that, based on my knowledge and belief, Yale New Haven Health Services Corporation (YNHHSC), Northeast Medical Group, Inc. (NEMG), L+M Corporation (L+M), Lawrence + Memorial Hospital (L+MH) and L&M Physician Association, Inc. (LMMG) have complied with the conditions of the Agreed Settlement as set forth below, effective September 8, 2016 and throughout the course of the Compliance Period described above.

☒	Docket # 15-32033 Condition 32g	All labor and employment commitments described in the Agreed Settlement continue to be satisfied.
☒	Docket # 15-32033 Condition 27	L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.
☒	Docket # 15-32033 Condition 28 Docket # 15-32032 Condition 6	Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).
☒	Docket # 15-32033 Condition 29	L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.
☒	Docket # 15-32033 Condition 30	L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.

Signature: Kevin D. Myatt Date: November 2, 2017

Subscribed and sworn to before me on November 2, 2017

Signature of Notary Public Deanna Fowler

Deanna Fowler
Printed Name of Notary Public

Date Commission Expires 7-31-2018

Deanna Fowler
Notary Public-Connecticut
My Commission Expires
July 31, 2018

Submitted to Comply with Docket # 15-32033-CON: Conditions 32f(iii) and 32f(iv) and Docket # 15-32032-CON: Condition 7c

Financial Statements
Semi-Annual Period: April 1, 2017 to September 30, 2017

OHCA Conditions are as follows for Docket # 15-32033-CON:

32f(iii). YNHHS and L+M shall submit a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

32f(iv). YNHHS and L+M shall submit, for L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.

OHCA Condition is as follows for Docket # 15-32032-CON:

7c. YNHHS and L+M shall submit a detailed and comprehensive document showing the five-year-plan to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices cross LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports.

Narrative for Docket # 15-32033-CON: Conditions 32f(iii) and 32f(iv) and Docket # 15-32032-CON: Condition 7c

In the full first year of the affiliation between L+M Corporation (L+M) and Yale New Haven Health System (YNHHS), L+M has seen an improvement in financial performance. L+MH is on track to improve its operation margin and total margin compared to FY 2016 and its balance sheet has remained stable.

As of April 1, 2017, Lawrence and Memorial Physician Association (LMPA) was dissolved and operations merged into the Northeast Medical Group (NEMG).

It should be noted that the 12 months FY2017 statements are draft preliminary numbers. Final audited statements were not available at the time of this submission. Final audited financial statements are expected in March 2018.

LAWRENCE AND MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	6 Months	12 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	ACTUAL - DRAFT FILING	DIFFERENCE	DIFFERENCE
I.	**ASSETS**						
A.	**Current Assets:**						
1	Cash and Cash Equivalents	$13,348,901	$3,965,054	$8,014,677	$17,545,451	$13,580,397	343%
2	Short Term Investments	$107,365,636	$92,026,239	$84,302,155	$82,582,061	($9,444,178)	-10%
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$37,925,784	$35,197,755	$39,987,639	$36,998,750	$1,800,995	5%
4	Current Assets Whose Use is Limited for Current Liabilities	$0	$0			$0	0%
5	Due From Affiliates	$2,065,142	$2,063,848	$0	$0	($2,063,848)	-100%
6	Due From Third Party Payers	$0	$0			$0	0%
7	Inventories of Supplies	$6,194,355	$6,339,039	$6,383,855	$6,890,045	$551,006	9%
8	Prepaid Expenses	$3,125,348	$2,228,771	$12,257,137	$21,647,544	$19,418,773	871%
9	Other Current Assets	$5,435,867	$4,774,484	$5,075,990	$2,239,443	($2,535,041)	-53%
	Total Current Assets	**$175,461,033**	**$146,595,190**	**$156,021,452**	**$167,903,293**	$21,308,103	15%
B.	**Noncurrent Assets Whose Use is Limited:**						
1	Held by Trustee	$926,080	$25,563	$26,385	$0	($25,563)	-100%
2	Board Designated for Capital Acquisition	$0	$0			$0	0%
3	Funds Held in Escrow	$0	$0			$0	0%
4	Other Noncurrent Assets Whose Use is Limited	$21,590,850	$23,128,435	$23,695,450	$37,703,894	$14,575,459	63%
	Total Noncurrent Assets Whose Use is Limited:	**$22,516,930**	**$23,153,998**	**$23,721,835**	**$37,703,894**	$14,549,896	63%
5	Interest in Net Assets of Foundation	$0	$0			$0	0%
6	Long Term Investments	$0	$0			$0	0%
7	Other Noncurrent Assets	$21,783,378	$36,989,211	$33,443,988	$3,158,958	($33,830,253)	-91%
C.	**Net Fixed Assets:**						
1	Property, Plant and Equipment	$432,048,550	$440,717,310	$441,155,764	$472,823,899	$32,106,589	7%
2	Less: Accumulated Depreciation	$283,857,350	$307,044,724	$319,471,223	$334,433,730	$27,389,006	9%
	Property, Plant and Equipment, Net	**$148,191,200**	**$133,672,586**	**$121,684,541**	**$138,390,169**	$4,717,583	4%
3	Construction in Progress	$2,785,773	$9,718,135	$16,186,789	$1,614,906	($8,103,229)	-83%
	Total Net Fixed Assets	**$150,976,973**	**$143,390,721**	**$137,871,330**	**$140,005,076**	($3,385,646)	-2%
	Total Assets	**$370,738,314**	**$350,129,120**	**$351,058,605**	**$348,771,221**	($1,357,899)	0%
II.	**LIABILITIES AND NET ASSETS**						
A.	**Current Liabilities:**						
1	Accounts Payable and Accrued Expenses	$43,009,002	$41,254,457	$48,272,770	$41,438,652	$184,195	0%
2	Salaries, Wages and Payroll Taxes	$4,908,525	$2,526,943	$2,594,459	$2,713,786	$186,843	7%
3	Due To Third Party Payers	$6,711,203	$7,944,521	$6,735,563	$11,361,561	$3,417,040	43%
4	Due To Affiliates	$2,512,703	$2,860,336			($2,860,336)	-100%
5	Current Portion of Long Term Debt	$5,495,740	$5,729,505	$5,729,505	$5,916,286	$186,781	3%
6	Current Portion of Notes Payable	$0	$0			$0	0%
7	Other Current Liabilities	$0	$0			$0	0%
	Total Current Liabilities	**$62,637,173**	**$60,315,762**	**$63,332,297**	**$61,430,285**	$1,114,523	2%
B.	**Long Term Debt:**						
1	Bonds Payable (Net of Current Portion)	$102,938,747	$94,968,208	$93,849,184	$88,789,805	($6,178,403)	-7%

LAWRENCE AND MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - HOSPITAL BALANCE SHEET INFORMATION

(1)	(2)	(3)	(4)	6 Months	12 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	ACTUAL - DRAFT FILING	DIFFERENCE	DIFFERENCE
2	Notes Payable (Net of Current Portion)	$0	$0			$0	0%
	Total Long Term Debt	**$102,938,747**	**$94,968,208**	**$93,849,184**	**$88,789,805**	($6,178,403)	-7%
3	Accrued Pension Liability	$52,989,394	$55,475,184	$54,924,544	$51,754,767	($3,720,417)	-7%
4	Other Long Term Liabilities	$23,691,278	$26,768,140	$22,327,982	$21,617,844	($5,150,296)	-19%
	Total Long Term Liabilities	**$179,619,419**	**$177,211,532**	**$171,101,710**	**$162,162,416**	($15,049,116)	-8%
5	Interest in Net Assets of Affiliates or Joint Ventures	$0	$0			$0	0%
C.	**Net Assets:**						
1	Unrestricted Net Assets or Equity	$103,558,083	$86,150,497	$89,541,387	$98,040,063	$11,889,566	14%
2	Temporarily Restricted Net Assets	$18,960,042	$20,326,874	$21,000,450	$20,814,208	$487,334	2%
3	Permanently Restricted Net Assets	$5,963,597	$6,124,455	$6,082,761	$6,324,249	$199,794	3%
	Total Net Assets	**$128,481,722**	**$112,601,826**	**$116,624,598**	**$125,178,520**	$12,576,694	11%
	Total Liabilities and Net Assets	**$370,738,314**	**$350,129,120**	**$351,058,605**	**$348,771,221**	($1,357,899)	0%

Note: 12 Months FY2017 ACTUAL DRAFT FILING are preliminary numbers. Final audited statements were not available at the time of this submission. Final audited financial statement are expected in March 2018.

LAWRENCE AND MEMORIAL HOSPITAL

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - HOSPITAL STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	(3)	(4)	6 Months	12 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	ACTUAL - DRAFT FILING	DIFFERENCE	DIFFERENCE
A.	**Operating Revenue:**						
1	Total Gross Patient Revenue	$839,272,512	$846,701,962	$444,891,216	$893,259,735	$46,557,773	5%
2	Less: Allowances	$483,222,533	$503,815,087	$272,657,700	$544,370,003	$40,554,916	8%
3	Less: Charity Care	$5,405,542	$5,374,494	$2,710,389	$3,625,010	($1,749,484)	-33%
4	Less: Other Deductions	$12,823,282	$12,488,508	($885,860)	$14,898,564	$2,410,056	19%
	Total Net Patient Revenue	**$337,821,155**	**$325,023,873**	**$170,408,987**	**$330,366,158**	$5,342,285	2%
5	Provision for Bad Debts	$12,798,310	$12,339,856	$6,638,602	$14,986,738	$2,646,882	21%
	Net Patient Service Revenue less provision for bad debts	**$325,022,845**	**$312,684,017**	**$163,770,385**	**$315,379,420**	$2,695,403	1%
6	Other Operating Revenue	$30,854,159	$32,202,655	$13,451,161	$22,484,199	($9,718,456)	-30%
7	Net Assets Released from Restrictions	$577,092	$453,686	$0	$677,909	$224,223	49%
	Total Operating Revenue	**$356,454,096**	**$345,340,358**	**$177,221,546**	**$338,541,528**	($6,798,830)	-2%
B.	**Operating Expenses:**						
1	Salaries and Wages	$140,640,103	$142,839,009	$70,948,624	$138,962,608	($3,876,401)	-3%
2	Fringe Benefits	$51,694,855	$53,188,034	$26,812,588	$41,296,186	($11,891,848)	-22%
3	Physicians Fees	$0	$0	$0	$0	$0	0%
4	Supplies and Drugs	$56,133,288	$51,763,282	$22,155,539	$43,723,418	($8,039,864)	-16%
5	Depreciation and Amortization	$23,641,535	$23,211,691	$12,433,051	$17,462,754	($5,748,937)	-25%
6	Bad Debts	$0	$0	$0	$0	$0	0%
7	Interest Expense	$3,553,690	$3,520,300	$1,722,174	$3,302,242	($218,058)	-6%
8	Malpractice Insurance Cost	$4,818,820	$4,865,367	$2,022,043	$4,047,930	($817,437)	-17%
9	Other Operating Expenses	$69,645,662	$65,443,417	$34,589,526	$84,392,031	$18,948,614	29%
	Total Operating Expenses	**$350,127,953**	**$344,831,100**	**$170,683,545**	**$333,187,169**	($11,643,931)	-3%
	Income/(Loss) From Operations	**$6,326,143**	**$509,258**	**$6,538,001**	**$5,354,359**	$4,845,101	951%
C.	**Non-Operating Revenue:**						
1	Income from Investments	$9,936,909	$1,820,798	$3,340,590	$6,926,870	$5,106,072	280%
2	Gifts, Contributions and Donations	$0	$0			$0	0%
3	Other Non-Operating Gains/(Losses)	$0	$0			$0	0%
	Total Non-Operating Revenue	**$9,936,909**	**$1,820,798**	**$3,340,590**	**$6,926,870**	$5,106,072	280%
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**$16,263,052**	**$2,330,056**	**$9,878,591**	**$12,281,229**	$9,951,173	427%
	Other Adjustments:						
	Unrealized Gains/(Losses)	$0	$0	$3,303	$0	$0	0%
	All Other Adjustments	$0	$0			$0	0%
	Total Other Adjustments	**$0**	**$0**	**$3,303**	**$0**	$0	0%
	Excess/(Deficiency) of Revenue Over Expenses	**$16,263,052**	**$2,330,056**	**$9,881,894**	**$12,281,229**	$9,951,173	427%
	Principal Payments	$3,370,000	$3,540,000	$3,720,000	$3,720,000	$180,000	5%

Note: 12 Months FY2017 ACTUAL DRAFT FILING are preliminary numbers. Final audited statements were not available at the time of this submission. Final audited financial statement are expected in March 2018.

LAWRENCE AND MEMORIAL HOSPITAL
TWELVE MONTHS ACTUAL FILING
FISCAL YEAR 2017
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	6 Months	12 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	ACTUAL - DRAFT FILING	DIFFERENCE	DIFFERENCE
I.	**OPERATING EXPENSE BY CATEGORY**						
A.	**Salaries & Wages:**						
1	Nursing Salaries	$40,670,258	$42,101,513	$20,911,965	$40,958,952	($1,142,561)	-3%
2	Physician Salaries	$389,032	$600,900	$298,469	$584,593	($16,307)	-3%
3	Non-Nursing, Non-Physician Salaries	$99,580,813	$100,136,596	$49,738,190	$97,419,064	($2,717,532)	-3%
	Total Salaries & Wages	**$140,640,103**	**$142,839,009**	**$70,948,624**	**$138,962,609**	($3,876,400)	-3%
B.	**Fringe Benefits:**						
1	Nursing Fringe Benefits	$14,949,101	$15,677,067	$7,901,471	$12,169,680	($3,507,387)	-22%
2	Physician Fringe Benefits	$142,996	$223,753	$117,815	$181,456	($42,297)	-19%
3	Non-Nursing, Non-Physician Fringe Benefits	$36,602,758	$37,287,214	$18,793,302	$28,945,049	($8,342,165)	-22%
	Total Fringe Benefits	**$51,694,855**	**$53,188,034**	**$26,812,588**	**$41,296,185**	($11,891,849)	-22%
C.	**Contractual Labor Fees:**						
1	Nursing Fees	$182,310	$262,898	$149,444	$563,439	$300,541	114%
2	Physician Fees	$0	$0			$0	0%
3	Non-Nursing, Non-Physician Fees	$1,062,834	$1,846,987	$385,199	$1,328,966	($518,021)	-28%
	Total Contractual Labor Fees	**$1,245,144**	**$2,109,885**	**$534,643**	**$1,892,404**	($217,481)	-10%
D.	**Medical Supplies and Pharmaceutical Cost:**						
1	Medical Supplies	$30,584,247	$27,076,356	$12,897,017	$25,245,886	($1,830,470)	-7%
2	Pharmaceutical Costs	$25,549,041	$24,686,926	$9,258,521	$18,477,532	($6,209,394)	-25%
	Total Medical Supplies and Pharmaceutical Cost	**$56,133,288**	**$51,763,282**	**$22,155,539**	**$43,723,418**	($8,039,864)	-16%
E.	**Depreciation and Amortization:**						
1	Depreciation-Building	$4,870,793	$4,795,024	$2,371,986	$5,658,005	$862,981	18%
2	Depreciation-Equipment	$17,811,015	$17,513,990	$9,609,435	$11,106,107	($6,407,883)	-37%
3	Amortization	$959,727	$902,677	$451,630	$698,642	($204,035)	-23%
	Total Depreciation and Amortization	**$23,641,535**	**$23,211,691**	**$12,433,051**	**$17,462,754**	($5,748,937)	-25%
F.	**Bad Debts:**						
1	Bad Debts	$0	$0			$0	0%
G.	**Interest Expense:**						
1	Interest Expense	$3,553,690	$3,520,300	$1,722,174	$3,302,242	($218,058)	-6%
H.	**Malpractice Insurance Cost:**						
1	Malpractice Insurance Cost	$4,818,820	$4,865,367	$2,022,043	$4,047,930	($817,437)	-17%
I.	**Utilities:**						
1	Water	$179,870	$232,640	$102,696	$174,294	($58,346)	-25%
2	Natural Gas	$1,083,143	$729,722	$463,107	$814,197	$84,475	12%
3	Oil	$17,093	$17,818		$1,803	($16,015)	-90%
4	Electricity	$3,177,410	$2,855,681	$1,188,801	$2,724,476	($131,205)	-5%
5	Telephone	$903,759	$906,796	$472,119	$1,078,620	$171,824	19%
6	Other Utilities	$0	$0	$0	$0	$0	0%
	Total Utilities	**$5,361,275**	**$4,742,657**	**$2,226,723**	**$4,793,390**	$50,733	1%
J.	**Business Expenses:**						
1	Accounting Fees	$744,087	$791,323	$841,800	$717,179	($74,144)	-9%
2	Legal Fees	$938,011	$1,085,131	$288,803	$319,216	($765,915)	-71%
3	Consulting Fees	$6,596,975	$2,318,907	$596,230	$906,880	($1,412,027)	-61%
4	Dues and Membership	$385,002	$378,185	$151,258	$298,502	($79,683)	-21%
5	Equipment Leases	$1,945,609	$1,415,529	$586,305	$988,129	($427,400)	-30%
6	Building Leases	$2,702,266	$1,939,428	$1,067,644	$2,076,961	$137,533	7%
7	Repairs and Maintenance	$11,575,820	$12,252,278	$5,669,788	$10,856,242	($1,396,036)	-11%
8	Insurance	$1,040,315	$1,111,573	$545,974	$800,601	($310,972)	-28%
9	Travel	$343,325	$312,714	$98,765	$288,013	($24,701)	-8%
10	Conferences	$13,000	$0	$2,192	$2,192	$2,192	0%
11	Property Tax	$179,170	$93,704	($126)	$45,354	($48,350)	-52%
12	General Supplies	$1,779,347	$1,679,465	$855,889	$1,659,592	($19,873)	-1%
13	Licenses and Subscriptions	$640,050	$586,409	$277,897	$522,084	($64,325)	-11%
14	Postage and Shipping	$236,255	$219,189	$73,229	$148,612	($70,578)	-32%
15	Advertising	$1,322,291	$1,311,432	$765,040	$1,305,374	($6,058)	0%
16	Corporate parent/system fees	$0	$0	$0	$0	$0	0%
17	Computer Software	$632,110	$296,453	$158,254	$192,645	($103,808)	-35%
18	Computer hardware & small equipment	$79,882	$79,311	$23,239	$92,137	$12,826	16%

LAWRENCE AND MEMORIAL HOSPITAL
TWELVE MONTHS ACTUAL FILING
FISCAL YEAR 2017
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	6 Months	12 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	ACTUAL - DRAFT FILING	DIFFERENCE	DIFFERENCE
19	Dietary / Food Services	$1,982,677	$1,975,534	$1,060,108	$2,059,185	$83,651	4%
20	Lab Fees / Red Cross charges	$976,698	$975,852	$477,904	$983,514	$7,662	1%
21	Billing & Collection / Bank Fees	$487,671	$441,713	$229,934	$324,271	($117,442)	-27%
22	Recruiting / Employee Education & Recognition	$363,597	$340,502	$89,849	$278,867	($61,635)	-18%
23	Laundry / Linen	$40,977	$38,007	$10,133	$46,075	$8,068	21%
24	Professional / Physician Fees	$8,776,142	$10,719,387	$6,552,870	$13,199,035	$2,479,648	23%
25	Waste disposal	$0	$0	$0	$0	$0	0%
26	Purchased Services - Medical	$4,768,761	$4,659,043	$2,159,173	$5,027,359	$368,316	8%
27	Purchased Services - Non Medical	$12,719,370	$12,522,903	$8,709,009	$33,059,451	$20,536,548	164%
28	Other Business Expenses	$1,168,984	$24,597	$537,002	$152,948	$128,351	522%
	Total Business Expenses	**$62,438,392**	**$57,568,569**	**$31,828,162**	**$76,350,418**	$18,781,849	33%
K.	**Other Operating Expense:**						
1	Miscellaneous Other Operating Expenses	$600,851	$1,022,306		$677,909	($344,397)	-34%
	Total Operating Expenses - All Expense Categories*	**$350,127,953**	**$344,831,100**	**$170,683,545**	**$332,509,260**	($12,321,840)	-4%
	***A.-K.The total operating expenses amount above must agree with the total operating expenses amount on Report 150**						
II.	**OPERATING EXPENSE BY DEPARTMENT**						
A.	**General Services:**						
1	General Administration	$21,854,054	$19,507,412	$10,038,818	$35,929,438	$16,422,026	84%
2	General Accounting	$2,072,390	$1,835,415	$1,257,693	$1,766,525	($68,890)	-4%
3	Patient Billing & Collection	$5,452,007	$5,390,293	$2,384,040	$4,381,257	($1,009,036)	-19%
4	Admitting / Registration Office	$6,592,924	$5,712,315	$2,970,219	$5,796,950	$84,635	1%
5	Data Processing	$10,695,890	$11,701,172	$6,004,157	$8,875,546	($2,825,626)	-24%
6	Communications	$364,288	$372,207	$186,244	$372,318	$111	0%
7	Personnel	$53,660,271	$55,138,738	$28,013,490	$43,699,538	($11,439,200)	-21%
8	Public Relations	$1,740,465	$1,738,016	$957,979	$1,650,063	($87,953)	-5%
9	Purchasing	$2,537,020	$1,485,342	$1,609,210	$2,121,647	$636,305	43%
10	Dietary and Cafeteria	$4,613,598	$4,660,587	$2,357,351	$4,713,201	$52,614	1%
11	Housekeeping	$4,202,487	$4,108,803	$2,032,539	$4,108,438	($365)	0%
12	Laundry & Linen	$0	$0			$0	0%
13	Operation of Plant	$4,018,508	$4,515,484	$1,911,947	$4,331,233	($184,251)	-4%
14	Security	$1,540,180	$1,591,639	$895,419	$1,827,780	$236,141	15%
15	Repairs and Maintenance	$6,089,115	$4,737,571	$2,551,331	$4,861,415	$123,844	3%
16	Central Sterile Supply	$2,028,759	$1,673,457	$764,751	$1,648,218	($25,239)	-2%
17	Pharmacy Department	$29,691,993	$29,638,279	$11,698,467	$23,653,080	($5,985,199)	-20%
18	Other General Services	$7,478,875	$7,119,473	$2,718,113	$4,710,269	($2,409,204)	-34%
	Total General Services	**$164,632,824**	**$160,926,203**	**$78,351,768**	**$154,446,915**	($6,479,288)	-4%
B.	**Professional Services:**						
1	Medical Care Administration	$387,046	$420,247	$96,893	$206,466	($213,781)	-51%
2	Residency Program	$122,349	$124,308	$62,154	$124,308	$0	0%
3	Nursing Services Administration	$2,389,086	$2,514,763	$1,054,818	$2,163,887	($350,876)	-14%
4	Medical Records	$4,750,469	$5,280,547	$2,168,642	$4,294,341	($986,206)	-19%
5	Social Service	$2,727,088	$2,747,442	$1,432,425	$2,902,996	$155,554	6%
6	Other Professional Services	$5,370,515	$6,850,062	$3,744,217	$7,794,356	$944,294	14%
	Total Professional Services	**$15,746,553**	**$17,937,369**	**$8,559,150**	**$17,486,354**	($451,015)	-3%
C.	**Special Services:**						
1	Operating Room	$24,566,779	$21,252,242	$10,407,932	$20,307,461	($944,781)	-4%
2	Recovery Room	$994,955	$991,676	$554,377	$1,090,072	$98,396	10%
3	Anesthesiology	$496,839	$493,006	$215,158	$441,070	($51,936)	-11%
4	Delivery Room	$118,500	$122,075	$57,283	$111,688	($10,387)	-9%
5	Diagnostic Radiology	$3,565,288	$3,494,882	$1,699,935	$3,468,885	($25,997)	-1%
6	Diagnostic Ultrasound	$2,935,254	$2,948,958	$1,443,352	$3,030,207	$81,249	3%
7	Radiation Therapy	$2,994,087	$3,171,628	$1,415,368	$2,950,862	($220,766)	-7%
8	Radioisotopes	$1,516,757	$1,724,505	$640,549	$1,222,457	($502,048)	-29%
9	CT Scan	$2,037,069	$2,180,894	$1,005,320	$2,168,880	($12,014)	-1%
10	Laboratory	$15,223,990	$14,517,400	$7,348,646	$14,560,042	$42,642	0%
11	Blood Storing/Processing	$0	$0			$0	0%
12	Cardiology	$1,496,892	$1,525,030	$789,186	$1,544,340	$19,310	1%
13	Electrocardiology	$4,158	$70	$53	$82	$12	18%
14	Electroencephalography	$278,878	$285,771	$142,882	$286,858	$1,087	0%
15	Occupational Therapy	$1,801,640	$1,874,416	$998,750	$1,989,416	$115,000	6%

LAWRENCE AND MEMORIAL HOSPITAL
TWELVE MONTHS ACTUAL FILING
FISCAL YEAR 2017
REPORT 175 - HOSPITAL OPERATING EXPENSES BY EXPENSE CATEGORY AND DEPARTMENT

(1)	(2)	(3)	(4)	6 Months	12 Months	(5)	(6)
		FY 2015	FY 2016	FY 2017	FY 2017	AMOUNT	%
LINE	DESCRIPTION	ACTUAL	ACTUAL	ACTUAL	ACTUAL - DRAFT FILING	DIFFERENCE	DIFFERENCE
16	Speech Pathology	$744,589	$762,989	$367,802	$776,692	$13,703	2%
17	Audiology	$755,221	$760,926	$382,932	$842,303	$81,377	11%
18	Respiratory Therapy	$2,713,543	$2,694,154	$1,343,174	$2,667,672	($26,482)	-1%
19	Pulmonary Function	$727	$0	$0	$0	$0	0%
20	Intravenous Therapy	$2,154,621	$1,461,873	$702,881	$1,421,337	($40,536)	-3%
21	Shock Therapy	$0	$0	$0	$0	$0	0%
22	Psychiatry / Psychology Services	$1,736,261	$1,826,473	$955,563	$1,960,443	$133,970	7%
23	Renal Dialysis	$468,917	$587,081	$295,915	$579,982	($7,099)	-1%
24	Emergency Room	$10,593,872	$10,981,590	$6,665,280	$10,502,840	($478,750)	-4%
25	MRI	$1,619,012	$1,604,322	$973,696	$1,951,367	$347,045	22%
26	PET Scan	$0	$0	$0	$0	$0	0%
27	PET/CT Scan	$0	$0	$0	$0	$0	0%
28	Endoscopy	$982,511	$904,643	$405,771	$813,063	($91,580)	-10%
29	Sleep Center	$1,106,596	$795,878	$329,950	$668,601	($127,277)	-16%
30	Lithotripsy	$0	$0	$0	$0	$0	0%
31	Cardiac Catheterization/Rehabilitation	$4,075,654	$4,615,958	$2,318,946	$4,539,324	($76,634)	-2%
32	Occupational Therapy / Physical Therapy	$3,828,129	$3,886,438	$2,017,994	$3,943,002	$56,564	1%
33	Dental Clinic	$0	$0	$0	$0	$0	0%
34	Other Special Services	$7,600,420	$7,320,165	$4,818,081	$9,581,297	$2,261,132	31%
	Total Special Services	**$96,411,159**	**$92,785,043**	**$48,296,776**	**$93,420,245**	$635,202	1%
D.	**Routine Services:**						
1	Medical & Surgical Units	$20,272,594	$20,709,022	$10,787,492	$21,716,658	$1,007,636	5%
2	Intensive Care Unit	$2,873,975	$3,177,006	$1,640,435	$3,205,792	$28,786	1%
3	Coronary Care Unit	$3,260,733	$3,030,022	$1,535,263	$2,998,087	($31,935)	-1%
4	Psychiatric Unit	$2,346,724	$2,439,777	$1,148,978	$2,414,681	($25,096)	-1%
5	Pediatric Unit	$0	$110,789	$64,705	$136,231	$25,442	23%
6	Maternity Unit	$5,986,189	$6,110,500	$3,054,998	$6,124,682	$14,182	0%
7	Newborn Nursery Unit	$0	$0			$0	0%
8	Neonatal ICU	$3,397,794	$3,494,668	$1,630,518	$3,235,554	($259,114)	-7%
9	Rehabilitation Unit	$2,628,328	$2,423,335	$1,118,092	$2,316,466	($106,869)	-4%
10	Ambulatory Surgery	$2,000,875	$2,146,199	$1,098,316	$2,237,271	$91,072	4%
11	Home Care	$0	$0			$0	0%
12	Outpatient Clinics	$0	$0			$0	0%
13	Other Routine Services	$1,211,298	$1,140,430	$503,273	$955,361	($185,069)	-16%
	Total Routine Services	**$43,978,510**	**$44,781,748**	**$22,582,070**	**$45,340,782**	$559,034	1%
E.	**Other Departments:**						
1	Miscellaneous Other Departments	$29,358,907	$28,400,737	$12,863,782	$21,814,963	($6,585,774)	-23%
	Total Operating Expenses - All Departments*	**$350,127,953**	**$344,831,100**	**$170,653,545**	**$332,509,260**	($12,321,840)	-4%
	***A.- E. The total operating expenses amount above must agree with the total operating expenses amount on Report 150.**						

Note: 12 Months FY2017 ACTUAL DRAFT FILING are preliminary numbers. Final audited statements were not available at the time of this submission. Final audited financial statement are expected in March 2018.

Lawrence+Memorial Corporation and Subsidiaries *
Statement of Cash Flows

DRAFT FILING - PRELIMINARY and SUBJECT to CHANGE

	For the Twelve Months Ended September 30, 2017
Cash flows from operating activities	
Change in net assets	$ 31,565,000
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Depreciation & amortization	23,803,000
Net unreal & real (gain) loss on investments	15,836,000
Provision for bad debts	17,985,000
Pension and postretirement related changes	13,259,000
Changes in operating accounts:	
Patient accounts receivable, net	(15,009,000)
Other assets	4,912,000
Accounts payable and accrued expenses	(13,041,000)
Other liabilities	(56,338,000)
Net cash provided by operating activities	**22,972,000**
Cash flows from investing activities	
Debt service fund	(1,000)
Equity adjustment upon affiliation	53,246,000
Purchase of property, plant and equipment, net	(12,000,000)
(Increase)/decrease in investment	(46,120,000)
Net cash used in investing activities	**(4,875,000)**
Cash flows from financing activities:	
Principal payments on long term debt	(5,726,000)
Bequests and contributions	(1,391,000)
Net cash used in investing activities	**(7,117,000)**
Net increase in cash and cash equivalents	10,980,000
Cash at beginning of year	18,978,000
Cash at end of year	**$ 29,958,000**

* The statistics presented above represent data for Lawrence+Memorial Corporation and Subsidiaries (LMC). LMC, a system of healthcare that provides a wide array of services throughout the region, includes: Lawrence+Memorial Hospital; L+M Physician Association, Inc.; L+M Systems, Inc.; VNA of Southeastern Connecticut; L+M Healthcare; L+M Indemnity Ltd; VNA of Southeastern

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

LAWRENCE AND MEMORIAL PHYSICIAN ASSOCIATION

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 100 - BALANCE SHEET INFORMATION

(1)	(2)	6 Months FY 2017	12 Months FY 2017
LINE	DESCRIPTION	ACTUAL	ACTUAL -DRAFT FILING
I.	**ASSETS**		
A.	**Current Assets:**		
1	Cash and Cash Equivalents	($50,002)	($79,175)
2	Short Term Investments	$0	$0
3	Accounts Receivable (Less: Allowance for Doubtful Accounts)	$1,145,732	$1,145,733
4	Current Assets Whose Use is Limited for Current Liabilities		
5	Due From Affiliates	$0	$0
6	Due From Third Party Payers		
7	Inventories of Supplies	$0	$0
8	Prepaid Expenses	$35,753	$35,753
9	Other Current Assets	$1,276,413	$1,271,954
	Total Current Assets	**$2,407,896**	**$2,374,265**
B.	**Noncurrent Assets Whose Use is Limited:**		
1	Held by Trustee	$0	$0
2	Board Designated for Capital Acquisition		
3	Funds Held in Escrow		
4	Other Noncurrent Assets Whose Use is Limited	$0	$0
	Total Noncurrent Assets Whose Use is Limited:	**$0**	**$0**
5	Interest in Net Assets of Foundation		
6	Long Term Investments		
7	Other Noncurrent Assets	$0	$0
C.	**Net Fixed Assets:**		
1	Property, Plant and Equipment	$3,057,388	$3,091,387
2	Less: Accumulated Depreciation	$0	$0
	Property, Plant and Equipment, Net	**$3,057,388**	**$3,091,387**
3	Construction in Progress	$0	$0
	Total Net Fixed Assets	**$3,057,388**	**$3,091,387**
	Total Assets	**$5,465,284**	**$5,465,652**
II.	**LIABILITIES AND NET ASSETS**		
A.	**Current Liabilities:**		
1	Accounts Payable and Accrued Expenses	$1,379,126	$1,334,158
2	Salaries, Wages and Payroll Taxes	$1,180,217	$1,176,263
3	Due To Third Party Payers	$5,544	$5,544
4	Due To Affiliates	$5,187,377	$5,187,433
5	Current Portion of Long Term Debt		
6	Current Portion of Notes Payable		
7	Other Current Liabilities		
	Total Current Liabilities	**$7,752,264**	**$7,703,398**
B.	**Long Term Debt:**		
1	Bonds Payable (Net of Current Portion)		
2	Notes Payable (Net of Current Portion)		
	Total Long Term Debt	**$0**	**$0**
3	Accrued Pension Liability	$309,654	$309,654
4	Other Long Term Liabilities	$0	$0
	Total Long Term Liabilities	**$309,654**	**$309,654**
5	Interest in Net Assets of Affiliates or Joint Venture		
C.	**Net Assets:**		
1	Unrestricted Net Assets or Equity	($2,596,634)	($2,547,400)
2	Temporarily Restricted Net Assets	$0	$0
3	Permanently Restricted Net Assets	$0	$0
	Total Net Assets	**($2,596,634)**	**($2,547,400)**
	Total Liabilities and Net Assets	**$5,465,284**	**$5,465,652**

On March 31, 2017, Lawrence and Memorial Physician Association (LMPA) was dissolved and operations merged into the Northeast Medical Group (NEMG). Activity for the period 4/1/17 through 9/30/17 is included in NEMG financial statements.

Note: 12 Months FY2017 ACTUAL DRAFT FILING are preliminary numbers. Final audited statements were not available at the time of this submission.

LAWRENCE AND MEMORIAL PHYSICIAN ASSOCIATION

TWELVE MONTHS ACTUAL FILING

FISCAL YEAR 2017

REPORT 150 - STATEMENT OF OPERATIONS INFORMATION

(1)	(2)	6 Months FY 2017	12 Months FY 2017
LINE	DESCRIPTION	ACTUAL	ACTUAL - DRAFT FILING
A.	**Operating Revenue:**		
1	Total Gross Patient Revenue	$30,119,375	$30,119,375
2	Less: Allowances	$14,035,698	$14,035,698
3	Less: Charity Care	$0	$0
4	Less: Other Deductions	$0	$0
	Total Net Patient Revenue	**$16,083,677**	**$16,083,677**
5	Provision for Bad Debts	$266,238	$266,238
	Net Patient Service Revenue less provision for bad debts	**$15,817,439**	**$15,817,439**
6	Other Operating Revenue	$4,545,808	$4,541,349
7	Net Assets Released from Restrictions	$0	$0
	Total Operating Revenue	**$20,363,247**	**$20,358,788**
B.	**Operating Expenses:**		
1	Salaries and Wages	$17,416,966	$17,422,240
2	Fringe Benefits	$3,591,197	$3,592,194
3	Physicians Fees	$0	$0
4	Supplies and Drugs	$939,316	$941,885
5	Depreciation and Amortization	$561,856	$527,856
6	Bad Debts	$0	$0
7	Interest Expense	$0	$0
8	Malpractice Insurance Cost	$797,004	$797,004
9	Other Operating Expenses	$6,132,801	$6,165,742
	Total Operating Expenses	**$29,439,140**	**$29,446,921**
	Income/(Loss) From Operations	**($9,075,893)**	**($9,088,133)**
C.	**Non-Operating Revenue:**		
1	Income from Investments	$0	$0
2	Gifts, Contributions and Donations		
3	Other Non-Operating Gains/(Losses)		
	Total Non-Operating Revenue	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses (Before Other Adjustments)	**($9,075,893)**	**($9,088,133)**
	Other Adjustments:		
	Unrealized Gains/(Losses)	$0	$0
	All Other Adjustments		
	Total Other Adjustments	**$0**	**$0**
	Excess/(Deficiency) of Revenue Over Expenses	**($9,075,893)**	**($9,088,133)**
	Principal Payments	$0	$0

On March 31, 2017, Lawrence and Memorial Physician Association (LMPA) was dissolved and operations merged into the Northeast Medical Group (NEMG). Activity for the period 4/1/17 through 9/30/17 is included in NEMG financial statements.

Note: 12 Months FY2017 ACTUAL DRAFT FILING are preliminary numbers. Final audited statements were not available at the time of this submission.

Lawrence+Memorial Physician Association, Inc. *

Statement of Cash Flows

	For the Twelve Months Ended September 30, 2017
Cash flows from operating activities	
Change in net assets	$ (9,075,893)
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Depreciation & amortization	561,856
Provision for bad debts	266,238
Changes in operating accounts:	
Patient Accounts Receivable, Net	(845,999)
Other receivables	(951,071)
Prepaid expenses	15,322
Accounts Payable	1,328,908
Accrued vacation & sick pay	(1,418,915)
Salaries, wages, payroll taxes	(607,701)
Due to affiliates	4,990,813
Other liabilities	(1,869,906)
Net cash used in operating activities	**(7,606,348)**
Cash flows from investing activities	
Purchase of property, plant and equipment, net	(2,683,711)
Net cash used in investing activities	**(2,683,711)**
Cash flows from financing activities:	
Net asset transfer from LMH	9,790,918
Net decrease in cash and cash equivalents	(499,141)
Cash at beginning of year	449,139
Cash at end of year	**$ (50,002)**

* The statistics presented above represent data for Lawrence+Memorial Physician Association, Inc. (LMPA) only. On April 1, 2017, LMPA was dissolved and its operations merged into Northeast Medical Group.

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

Submitted to Comply with Docket # 15-32033-CON: Condition 8

Financial Measurements/Indicators
Semi-Annual Period: April 1, 2017 to September 30, 2017

OHCA Condition is as follows:

8. For 3 years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than 2 months after the end of each semi-annual period. Due dates are May 31st and November 30th. The following financial measurements/indicators should be addressed in the report:

A. Operating performance
    1. Operating margin
    2. Non-operating margin
    3. Total margin
B. Liquidity
    1. Current ratio
    2. Days cash on hand
    3. Days in net accounts receivables
    4. Average payment period
C. Leverage and capital structure
    1. Long-term debt to equity
    2. Long-term debt to capitalization
    3. Unrestricted cash to debt
    4. Times interest earned ratio
    5. Debt service coverage ratio
    6. Equity financing ratio
D. Additional statistics
    1. Income from operations
    2. Revenue over/(under) expense
    3. Cash from operations
    4. Cash and cash equivalents
    5. Net working capital
    6. Free cash flow (and the elements used in the calculation)
    7. Unrestricted net assets/retained earnings
    8. Bad debt as % of gross revenue
    9. Credit ratings (S&P, Fitch, or Moody's)

Narrative for Condition 8

L+M Corporation and Subsidiaries (L+M) is a healthcare system that provides a wide array of services throughout the region. The Corporation includes Lawrence + Memorial Hospital (L+MH), L&M Physician Association Inc., L&M Systems, Inc., VNA of Southeastern Connecticut, L+M Healthcare, L+M Indemnity Ltd, and LMW Healthcare Inc. (Westerly Hospital).

The Financial Measurements/Indicators Report has been submitted for L+M Corporation and for L+MH. Financial reporting and statistics included in this submission are based on information updated through September 30, 2017. Note: this is a draft filing and numbers are preliminary. Final audited numbers were not available at the time of this submission.

As illustrated in the Financial Measurements/Indicators Report provided for the month ended September 30, 2017 and for the year-to-date periods ended September 30, 2017 and 2016, the affiliation of L+M with YNHHS has resulted in a positive financial outcome. A considerable number of the financial measurements / indicators for both the Corporation and L+MH have improved over the past twelve months since the affiliation. Specifically, total margin has turned profitable and income from operations has improved significantly. Additionally, it should be noted that these positive results for L+M were achieved while still including the operations of the Lawrence + Memorial Physician Association (LMPA) through the first six months of the fiscal year. LMPA was dissolved and operations merged into the Northeast Medical Group (NEMG) on April 1, 2017.

FINANCIAL MEASUREMENTS/INDICATORS REPORT FOR LAWRENCE+MEMORIAL HEALTHCARE*

Docket # 15-32033-CON: Condition 8

Financial Measurement / Indicators	Month Ended 9/30/17	12 Months Ended 9/30/17	12 Months Ended 9/30/16
A. Operating Performance			
1. Operating Margin	1.80%	-0.07%	-6.32%
2. Non-Operating Margin	4.06%	4.20%	0.59%
3. Total Margin	5.86%	4.13%	-5.74%
B. Liquidity			
1. Current Ratio	3.03	3.03	3.15
2. Days Cash on Hand	158	156	133
3. Days in Net Accounts Receivable	39.50	38.20	39.70
4. Average Payment Period	57.1	52.5	88.1
C. Leverage and Capital Structure			
1. Long-term Debt to Equity	33.06%	33.06%	45.12%
2. Long-term Debt to Capitalization	27.37%	27.37%	35.03%
3. Unrestricted Cash to Debt	162.14%	162.14%	186.19%
4. Times Interest Earned Ratio	8.2	6.1	(6.1)
5. Debt Service Coverage Ratio	3.73	5.01	1.28
6. Equity Financing Ratio	55.93%	55.93%	49.71%
D. Additional Statistics			
1. Income from Operations	$ 586,625	$ (282,903)	$ (27,615,202)
2. Revenue Over/(Under) Expense	$ 1,906,869	$ 16,872,989	$ (25,022,060)
3. Cash from Operations	N/A**	$ 22,972,000	$ 12,848,690
4. Cash and Cash Equivalents	$ 128,861,708	$ 128,861,708	$ 175,208,734
5. Net Working Capital	$ 129,642,848	$ 129,642,848	$ 165,590,270
6. Free Cash Flow (and the elements used in the calculation)	N/A**	$ 4,572,000	$ (13,765,053)
7. Unrestricted Net Assets/Retained Earnings	87.71%	87.71%	83.68%
8. Bad Debt as % of Gross Revenue	4.51%	4.21%	3.62%
9. Credit Ratings (S&P, Fitch or Moody's)	S&P A+/Stable	S&P A+/Stable	S&P BBB+/Developing

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

* The statistics presented above represent data for Lawrence+Memorial Corporation and Subsidiaries (LMC). LMC, a system of healthcare that provides a wide array of services throughout the region, includes: Lawrence+Memorial Hospital; L+M Physician Association, Inc.; L+M Systems, Inc.; VNA of Southeastern Connecticut; L+M Healthcare; L+M Indemnity Ltd; VNA of Southeastern Connecticut, Inc.; and LMW Healthcare Inc. (Westerly Hospital).

** Current month Cash from Operations and Free Cash Flow are not statistics that can be calculated.

Reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18; 10/1/18-3/31/19; 4/1/19-9/30/19

Report due to OHCA 5/31 and 11/30 each year. Due internally to Regulatory 30 days before.

FINANCIAL MEASUREMENTS/INDICATORS REPORT FOR LAWRENCE+MEMORIAL HOSPITAL *

Docket # 15-32033-CON: Condition 8

Financial Measurement / Indicators	Month Ended 9/30/17	12 Months Ended 9/30/17	12 Months Ended 9/30/16
A. Operating Performance			
1. Operating Margin	-3.11%	1.36%	-0.38%
2. Non-Operating Margin	1.54%	2.06%	0.53%
3. Total Margin	-1.57%	3.42%	0.14%
B. Liquidity			
1. Current Ratio	2.18	2.18	2.40
2. Days Cash on Hand	141	153	141
3. Days in Net Accounts Receivable	44.20	32.60	41.20
4. Average Payment Period	124.9	108.7	129.9
C. Leverage and Capital Structure			
1. Long-term Debt to Equity	56.87%	56.87%	89.96%
2. Long-term Debt to Capitalization	40.15%	40.15%	54.08%
3. Unrestricted Cash to Debt	86.51%	86.51%	92.05%
4. Times Interest Earned Ratio	(0.5)	4.5	0.6
5. Debt Service Coverage Ratio	4.97	4.97	4.30
6. Equity Financing Ratio	43.50%	43.50%	31.96%
D. Additional Statistics			
1. Income from Operations	$ (786,538)	$ 4,563,725	$ (1,325,236)
2. Revenue Over/(Under) Expense	$ (396,519)	$ 11,490,595	$ 495,562
3. Cash from Operations	N/A**	$ 8,140,152	$ (9,256,615)
4. Cash and Cash Equivalents	$ 87,775,485	$ 87,775,485	$ 92,696,969
5. Net Working Capital	$ 71,265,829	$ 71,265,829	$ 85,639,707
6. Free Cash Flow (and the elements used in the calculation)	N/A**	$ (10,259,848)	$ (24,666,161)
7. Unrestricted Net Assets/Retained Earnings	84.79%	84.79%	76.37%
8. Bad Debt as % of Gross Revenue	5.67%	4.21%	3.79%
9. Credit Ratings (S&P, Fitch or Moody's)	S&P A+/Stable	S&P A+/Stable	S&P BBB+/Developing

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

* The statistics presented above represent data for Lawrence+Memorial Hospital only.

** Current month Cash from Operations and Free Cash Flow are not statistics that can be calculated.

Reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18; 10/1/18-3/31/19; 4/1/19-9/30/19

Report due to OHCA 5/31 and 11/30 each year. Due internally to Regulatory 30 days before.

Yale
NewHaven
Health

November 30, 2017

Ms. Kimberly Martone
Director of Operations
Office of Healthcare Access
410 Capitol Avenue
MS #13HCA
P.O. Box 340308
Hartford, CT 06106

Re: Docket Number 15-32032-CON Transfer of Ownership of Group Practice by the Merger of L&M Physician Association into Northeast Medical Group
Docket Number 15-32033-CON Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation

Dear Ms. Martone:

Attached please find documents submitted to comply with Conditions of Docket #15-32033-CON: "Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation" and Docket #15-32032-CON: "Transfer of Ownership of Group Practice by the Merger of L+M Physician Association into Northeast Medical Group" for the 6-month reporting period ending September 30, 2017.

In the first year of the affiliation between L+M Corporation (L+M) and Yale New Haven Health System (YNHHS), L+M has continued to see tremendous improvement in financial performance. Because of the affiliation with YNHHS, L+M has benefited from numerous cost savings initiatives, clinical, strategy, and operational investment, and efficiency process improvements. This enhanced financial performance has supported additional clinical and community investments in the region to produce greater depth and breadth of services to the people of Eastern Connecticut and Western Rhode Island.

The compliance documents attached address the following Conditions for Docket #15-32033-CON and Docket #15-32032-CON as noted:

- Condition 6 – Top Most Frequent MSDRG-and CPT Codes for LM+H
- Conditions 7/19a/32b – Investments Report
- Condition 8 – Financial Measurement Report
- Condition 10 – Revision to Charity Care Policy

Strategy
789 Howard Avenue
1059 CB
New Haven, CT 06519
Phone: 203-688-2605
Fax: 203-688-3472

ynhhs.org

- Condition 11 and 12 – Annual Community Benefit Report and Cultural and Linguistically Appropriate Services Report
- Conditions 17/33b/33d – Community Meetings and Public Forums Report
- Conditions 25, 32f (i and ii) (or 7c of Docket #15-32032-CON) – Savings Report
- Condition 32f (iii and iv) (or 7c of Docket #15-32032-CON) – Financial Statements
- Conditions 20a/32c (or 1/7a of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Hospital
- Condition 32e – Affirmation regarding Charity Care Policies
- Conditions 18/32a – Affirmation regarding retention of Services
- Conditions 24/32d (or 5/7b of Docket #15-32032-CON) – Affirmation regarding Physician Offices
- Conditions 27, 28, 29, 30, 32g (or 6 of Docket #15-32032-CON) – Affirmations regarding HR policies

If you have any questions, please feel free to contact me at 203-688-2605 or Gayle.Capozzalo@ynhh.org

Sincerely,

Gayle Capozzalo
Executive VP / Chief Strategy Officer
789 Howard Avenue; 1059 CB
New Haven, CT 06519

Submitted to Comply with Docket # 15-32033-CON: Conditions 17, 33b and 33d

Joint Board Meetings
Public Forums & Independent Monitor Community Meetings
Annual Period: 10/1/16 – 9/30/17

OHCA Conditions are as follows:

17. For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.

33b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statues and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period.

33c. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.

Narrative for Conditions 17, 33b and 33d

Independent Monitor Community Meetings

Community meetings were held on January 24 and March 1 by the Independent Monitor, Deloitte & Touche, who were on-site at L+MH and toured the facility. The Independent Monitor participated in the July 6, 2017 Public Forum, and a second Public Forum is scheduled for December 4, 2017, which will again be a joint meeting with the Independent Monitor onsite.

Joint Board Meetings and Public Forum

The YNHHSC Board and the L+M Board held a Joint Board Meeting on May 18, 2017. Subsequent to the Joint Board meeting, a Public Forum was held on July 6, 2017. The agenda for this Public Forum is shown below:

Agenda

Introductions

Welcome – Patrick Green, President & CEO Lawrence & Memorial Hospital, EVP YNHHS

Report to Community – Cathy Zall, L+MH Board Member

Affiliation Progress – Vin Petrini, Senior VP, Public Affairs YNHHS

Questions & Answers

The second Joint Board Meeting is scheduled for November 28, 2017. A second Public Forum is scheduled for December 4, 2017.

Submitted to Comply with Docket # 15-32033-CON: Conditions 7, 19a and 32b

Resource Investment Report
Semi-Annual Period: April 1, 2017 to September 30, 2017

OHCA Conditions are as follows:

7. Within 180 days following the Closing Date and thereafter until the capital commitment is satisfied, YNHHSC shall submit to OHCA a report on the capital investments it has made in L+M and its affiliates from the $300M commitment amount. The investment report shall include the following in a format to be agreed upon:

a. A list of the capital expenditures that have been made in the prior 180 days with descriptions of each associated project; and
b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending and startup/operation dates); and
c. The funding source of the capital investment indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source.

19a. L+M shall enhance access to primary care physician services in the Eastern Connecticut region by recruiting and retaining eight additional primary care providers and other providers required to respond to local community need, in accordance with the community needs assessment in paragraph 31 herein and shall accommodate improvements to delivery models including value based care during such period. L+M shall demonstrate annual progress toward achieving these goals.

32b. L+M and YNHHSC shall provide a narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.

Narrative for Conditions 7, 19a and 32b

L+M and YNHHS have pledged to make total commitments of $300 million in eastern Connecticut and western Rhode Island over 5 years. Anticipated resource commitments highlighted in the L+M/YNHHS Affiliation Agreement and strategic plan submitted to OHCA in January 2017 included investments in: primary care clinical services, specialty clinical services, ambulatory services, post-acute services, infrastructure within L+M facilities, information technology, population health, branding, operational improvements, and community need/community building. In the second six months of FY 2017, L+M and YNHHS have made or committed to investments totaling $23,725,851 across these categories for a total of $47,404,835 for the full fiscal year. Below includes a brief narrative for each strategic investment area with additional detail provided in the Tables that follow.

1. *Primary Care Clinical Services*
   Recruitment of primary care providers is a priority for L+M to ensure adequate access and meet demand. Two additional physician providers have been recruited in the second half of FY 2017.

2. *Specialty Clinical Services*
   L+M and YNHHS have made a solid commitment to enhance clinical services in the communities served by L+M to increase quality and improve access. The strategic plan highlighted a number of specialty areas that are a recruitment focus for L+M. L+M and YNHHS continues to expand its clinical services in neurosurgery, spine surgery, oncology, psychiatry, vascular and electrophysiology, all areas required per the strategic plan, and noted in the Affiliation Agreement. In addition, providers were added in general surgery, cardiology, obstetrics, and crisis intervention.

3. *Ambulatory Services*
   There were no investments in ambulatory services in FY 2017. L+M is currently executing in this area against the plan.

4. *Post-Acute Services*
   There were no investments in post-acute services in FY 2017. L+M is currently executing in this area against the plan.

5. *Infrastructure within L+M Facilities*
   The affiliation with YNHHS has allowed L+M to undertake much-needed facilities and infrastructure projects that were delayed due to the financial pressures experienced at L+MH, LMMG, and Westerly Hospital and the need to preserve liquidity and conserve cash. With a stronger financial foothold resulting from the affiliation, L+M has been able to move forward with several delayed projects including purchase of new beds, security systems, HVAC, elevator and parking garage renovations, and other minor and major facility improvements.

6. *Information Technology*
   The build and implementation of the Epic EMR system throughout L+M facilities has been a major investment for L+M to improve quality of care, increase access to patient data, and

increase coordination of systems (e.g., supply chain, finance, HR) to effectively manage operations. In addition to Epic, capital has also been expended on access control initiatives for enhanced employee and patient safety, interfaces, and radiology systems.

7. *Population Health*
   Population health infrastructure and development of risk-contracting capabilities were key investments outlined in the strategic plan and Affiliation Agreement. Work is in-process to improve physician engagement and initiate clinical practice guidelines.

8. *Branding*
   YNHHS has committed to rebranding L+M and its entities to enhance the identity of the organizations with Yale New Haven Health. A considerable investment has been made in website design to better connect patients across the system and improve communication regarding services/physicians and locations. Advertising the affiliation through print, digital, and radio ads has enhanced communication to patients and physicians regarding the health care resources available in the eastern Connecticut and western Rhode Island regions. In addition, signage has been updated with new logos that better reflect the affiliation.

9. *Operational Improvements*
   L+M and YNHHS have undertaken a number of operational improvement initiatives in structures and processes in an effort to effectively provide high-quality, safe patient care. Such investments include:

   Clinical Technologies
   L+M has committed to enhancing and improving the quality of care provided to L+M patients. The latest technology including tomosynthesis units for breast cancer early detection is planned for five L+M sites. Also, the L+M Cancer Center in Waterford, CT has renovated its pharmacy to adhere to current and upcoming regulatory requirements and ensure the safety of patients. Other clinical investments included new equipment in radiology, anesthesia, and inpatient units.

   Other
   Since the affiliation, YNHHS personnel in corporate services departments (e.g., internal consulting group, IT, finance) have spent a significant amount of time and effort integrating L+M with YNHHS and identifying and achieving savings, standardizing processes, implementing process improvement initiatives, and merging systems. This work was imperative to achieve the savings and complete the resource investments to-date.

10. *Community Need/Community Building*
    L+MH has enhanced its investment in community needs/community building initiatives focusing on the priorities identified in the most recent community health needs assessment (CHNA). In accordance with the strategic plan, behavioral health and substance use abuse continues to be a focus. L+MH funded certification programs for local recovery providers so they may be educated on and meet national standards for quality and safety. Other investments addresses social determinants of health in the City of New London. Proposed

interventions to address economic development will be generated for two distressed communities leveraging residents' input.

L+M and YNHHS continue to make progress towards achieving the commitments outlined in the Affiliation Agreement and strategic plan.

SUMMARY of Resource Commitment and Strategic Plan Accomplishments: Docket # 15-32033-CON, Condition 7/32b

Resource Commitment Summary Made to Strategic Investments		Expenditure Amounts						
		10/1/16-3/31/17	4/1/17-9/30/17	10/1/17-3/31/18	4/1/18-9/30/18	10/1/18-3/31/19	4/1/19-9/30/19	Total
1. Primary Care Clinical Services: Expansion of primary care network focusing on geriatric, general internal medicine, including the recruitment of 8 primary care physicians in Eastern CT. The primary care sites will ensure primary care availability as the population ages and physicians retire. Many sites will be established as medical neighborhoods, allowing easy access to part-time and full-time specialists.	Eastern CT	$0	$136,725					$136,725
	Western RI	$0	$106,001					$106,001
2. Specialty Clinical Services: Increased access to specialists within Eastern CT, including pediatrics; multi-disciplinary muscular-skeletal services, including orthopedics, neurosurgery, spine, physiatry; behavioral health, including psychiatrists, psychologists, etc.; vascular and cardiac services; enhanced obstetrics and maternal fetal medicine; expanded oncology services; neuromuscular and stroke programs; endocrinology/thyroid services; general surgery and specialized internal medicine. These part-time and full-time specialty services will be increased, taking advantage of primary care referrals and using technology to ensure access throughout the region. In addition, telestroke, tele-ICU and tele-ED coverage will be continued at L+M.	Eastern CT	$1,457,485	$1,513,180					$2,970,665
	Western RI	$168,203	$230,587					$398,790
3. Ambulatory Services: Expansion of laboratory, diagnostic, urgent care, ambulatory surgery centers to enhance access to ancillary services in the region.	Eastern CT	$0	$0					$0
	Western RI	$0	$0					$0
4. Post Acute Services: Creation of an integrated network of post-acute services to manage care across the continuum in order to reduce the total cost of care for community residents.	Eastern CT	$0	$0					$0
	Western RI	$0	$0					$0
5. Infrastructure within LMHC Facilities: Renovations and infrastructure repair to hospital.	Eastern CT	$874,585	$3,803,474					$4,678,059
	Western RI	$1,086,849	$758,744					$1,845,593

SUMMARY of Resource Commitment and Strategic Plan Accomplishments: Docket # 15-32033-CON, Condition 7/32b

Resource Commitment Summary Made to Strategic Investments		Expenditure Amounts						
		10/1/16-3/31/17	4/1/17-9/30/17	10/1/17-3/31/18	4/1/18-9/30/18	10/1/18-3/31/19	4/1/19-9/30/19	Total
6. Information Technology: Investment in Epic throughout L+M facilities, LMMG and independent physicians. In addition, the business systems will be replaced and fully integrated with Yale New Haven Health. Telehealth services will help reduce travel to YNHH.	Eastern CT	$9,934,718	$5,220,500					$15,155,219
	Western RI	$1,569,119	$718,511					$2,287,630
7. Population Health: Development of risk contracting capabilities and participation in the YNHHS Population Health infrastructure and Clinically Integrated Network.	Eastern CT	$204,896	$1,438,851					$1,643,747
	Western RI	$44,408	$311,846					$356,254
8. Branding: Re-branding of all facilities and services as Yale New Haven Health to enhance the identity of the organizations with Yale New Haven Health.	Eastern CT	$412,301	$900,562					$1,312,864
	Western RI	$412,301	$438,142					$850,444
9. Operational Improvements: Operational improvements in structures and processes to effectively provide high quality, safe patient care.	Eastern CT	$5,433,462	$6,355,775					$11,789,237
	Western RI	$2,025,759	$1,725,516					$3,751,275
10. Community Need / Community Building: Community health needs focused on improved services to support mental well-being and reduce substance abuse (opioid use and anxiety/depression); support and nurture healthy life styles specifically reducing contributing factors to diabetes; ensure access to care, particularly pre-natal care and related birth outcomes and access to care for low-income population to address socio-economic factors that have the greatest impact on the health and well-being of the communities.	Eastern CT	$54,898	$67,437					$122,335
	Western RI	$0	$0					$0
TOTAL		**$23,678,984**	**$23,725,851**					**$47,404,835**

SIGNATURE: Vincent Tammaro

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

For Primary and Specialty Clinical Services categories, "Eastern CT" and "Western RI" are based on practice location.

For all other categories, expenditures at Lawrence Memorial Hospital and LMMG are categorized as "Eastern CT". Expenditures at Westerly Hospital comprise "Western RI".

Summary due to OHCA with detailed narrative semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Primary Care Clinical Services													
Family Medicine and Internal Medicine Recruitment	Recruitments in Family Practice and Internal Medicine to increase access to these services in the L+M service area were made during the second half of the fiscal year.	$242,726	$242,726	04/01/17	09/30/17	n/a	L+M Baseline Cash Flow	-	-	$242,726	-	-	$ 242,726
Specialty Clinical Services													
Specialty Services Access	Recruitments within neurosurgery, oncology, vascular, cardiology and psychiatry were made to increase access to these services in the L+M service area. Additions in endocrinology, general surgery, and obstetrics/midwifery were also made to replenish the medical staff.	$1,743,767	$3,369,454	10/01/16	09/30/17	n/a	YNHHS or L+M Baseline Cash Flow	$1,137,572	-	$606,195	$2,388,518	-	$980,937
Ambulatory Services													
Ambulatory Services	Several projects (including Outpatient Diagnostics, Urgent Care, and the Sleep Center, to name a few) are currently in the planning phase/pipeline. The expectation is that they will be initiated in the next fiscal year.	n/a	n/a										
Post Acute Services													
VNA and Other Post Acute Services	Planning around VNA Services are in process and expected to be initiated in the next fiscal year. Discussions about other post acute services are under way as well.	n/a	n/a										
Infrastructure within LMHC Facilities													
Investments in Infrastructure	Prior to the affiliation with YNHHS, L+MH and Westerly Hospitals (WH) were under growing financial pressure, and capital spending during that time was severely limited. Following the affiliation, significant catch-up was required to replenish aging and end-of-life equipment as well as perform necessary facility renovations. Capital expenditures for infrastructure during the time of the reporting period were made for new beds, repairs to parking garage, rebuild of elevators, security systems, and HVAC systems. In addition, the LMMG General Surgery practice was relocated to the L+MH main campus to enhance availability and improve timeliness of services for patients and physicians.	$4,562,218	$6,523,652	10/01/16	09/30/17	n/a	L+M Baseline Cash Flow	$3,444,419	$758,744	$359,055	$4,094,876	$1,845,593	$583,183

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Information Technology													
Epic System - Build and Installation	Capital investment related to the development and build of the Epic EMR system that went live at L+M and WH on 1/20/17 included software licenses; customization and development of interfaces to ensure integration with other 3rd party software; training time (prior to go-live) for clinicians and other personnel on using the new system; support during the actual go-live from Epic consultants; and hardware, including new servers. Replacing the older EMR systems and moving to the fully-integrated Epic system, had the advantage of improving quality of care by providing best practice protocols and enhancing patient engagement via patient portals, "MyChart", and other patient and physician-friendly features. By moving to Epic as part of a large System, L+M was able to mitigate risk by relying on the invaluable experience and expertise that YNHHS brought to the installation.	$3,235,507	$14,043,985	10/01/16	09/30/17	n/a	YNHHS or L+M Baseline Cash Flow	$2,647,611	$587,896	$0	$12,045,814	$1,993,353	$4,818
Infor (ERP) Project	Investments were made at L+M for development, customization and installation of a new ERP (Enterprise Resource Planning) system to replace its legacy system. Incorporating Supply Chain, General Finance, and Human Resources functions within a single system (that also includes budgeting, decision support, and management reporting) is fundamental to effectively running the business. YNHHS has a long track record of leading the industry in these areas by innovatively leveraging these reporting capabilities to drive quality, patient engagement and physician efficiencies. While L+M is still in the building stages, progress toward full integration across the system is underway and remains a key corporate objective.	$392,095	$747,744	10/01/16	09/30/17	n/a	YNHHS	$326,384	$65,711	-	$622,431	$125,314	-
Other Information Technology Projects	Capital investments for other IT projects at L+M included Access Control Plan Implementation; Laboratory EMR Results Interfaces; and RIS/PACS Implementation, among other items. These systems - specifically integrating critical patient tests, imaging, and other diagnostics with the broader medical record system - were on the front line of improving access, optimizing care delivery, and coordinating patient care across the continuum.	$2,311,409	$2,651,119	10/01/16	09/30/17	n/a	L+M Baseline Cash Flow	$2,230,635	$64,904	$15,870	$2,446,720	$168,963	$35,436
Population Health													
Population Health Initiatives **	As a result of the affiliation, L+M is able to move forward and participate in the YNHHS Population Health infrastructure and clinically integrated network. As part of the system, L+M will be able to utilize YNHHS resources and will avoid an estimated $10 million in operating/capital cost. $10 million ($2 million per year over the course of 5 years) was identified in the CON as the investment associated with population health infrastructure.	$1,750,696	$2,000,000	10/01/16	09/30/17	n/a	YNHHS	$1,438,851	$311,846	-	$1,643,747	$356,254	-

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Branding													
Advertising, Signage, Website	Investments were made in converting existing external and internal signage throughout L+M to formally recognize the affiliation and rebrand all facilities and services as Yale New Haven Health. A considerable investment was made in the website design to better connect patients across the system and improve communication regarding services, physicians and locations. Advertising the affiliation through print, digital, and radio ads has enhanced communication to patients and physicians regarding the health care resources available in the region.	$1,338,705	$2,163,307	03/31/17	09/30/17	n/a	YNHHS	$900,562	$438,142	-	$1,312,864	$850,444	-
Operational Improvements													
Corporate Services Support ***	Significant resources have been provided to L+M by YNHHS Corporate services departments (i.e., Internal Consulting Group, IT, Finance, etc.) over the past 6 months. As an integral part of the underlying value of the affiliation, Corporate Services personnel continue to assist L+M in identifying synergies, achieving savings, standardizing methodologies, introducing procedures, implementing Epic and other IT systems, and generally integrating L+M into the System.	$5,855,994	$8,935,503	01/01/17	09/30/17	n/a	YNHHS	$4,812,886	$1,043,108	-	$7,343,853	$1,591,650	-
Clinical Technology Investments	Investments in clinical technology were made at L+M to drive operational improvements including new diagnostic equipment (Tomosynthesis) for early breast cancer detection; state-of-the-art pharmacy at the L+M Cancer Center to adhere to regulatory requirements and enhance patient safety; new equipment on inpatient units to assure patient care quality; and other improvements in structures and processes to effectively provide high-quality, safe patient care.	$2,225,297	$6,605,009	01/01/17	09/30/17	n/a	L+M Baseline Cash Flow	$1,542,889	$682,408	-	$4,445,384	$2,159,625	-

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Community Need / Community Building													
Support for Physical Improvements and Housing	Community involvement and financial support for partner organizations' physical improvement and housing related activities. Partner organizations include Community Speak Out, the Homeless Hospitality Center, and the Jewish Federation. Includes support for transitional and shelter housing, sober house certification training, air conditioners for vulnerable residents, and other support. L+M Hospital is increasingly aware of how social determinants impact the health of individuals and communities. A person's health and chances of becoming sick and dying early are greatly influenced by powerful social factors such as education, income, nutrition, housing and neighborhoods. During Fiscal Year 2017, L+M Hospital invested in community building efforts that promote thriving and healthy communities in our region.	$6,302	$11,200	2/17/17	n/a	n/a	L+M Baseline Cash Flow	$6,302	-	-	$11,200	-	-
Social Determinants of Health	Community involvement and support for partner organizations' work to address social determinants of health not specific to the other categories. Includes support for education, youth development and neighborhood development strategies in distressed New London neighborhoods. The rationale for these investments is to address the health needs identified by the most recent CHNA and 2016 Community Health Improvement Plan (CHIP), including social determinants of health.	$46,055	$96,055	2/17/17	n/a	n/a	L+M Baseline Cash Flow	$46,055	-	-	$96,055	-	-
Support for Economic Development	Community involvement and financial support for partner organizations' economic development activities. Economic development supports a regional infrastructure that includes sufficient employment opportunities providing a living wage. In addition to income, such employment provides healthcare, retirement and other benefits. Being under- or unemployed is strongly correlated with poor health outcomes.	$15,080	$15,080	3/27/17	n/a	n/a	L+M Baseline Cash Flow	$15,080	-	-	$15,080	-	-
		$23,725,851	$47,404,835					$18,549,246	$3,952,759	$1,223,846	$36,466,541	$9,091,195	$1,847,099

SIGNATURE: Vincent Tammaro

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

SIGNATURE:

Patrick L. Green, President and Chief Executive Officer, Lawrence and Memorial

* Financial information is based on unaudited financial statements.

** Population Health: Methodology to quantify investment changed from prior submission. Previously based on % staff time in Population Health cost centers; now based on $10 million avoided cost identified in the CON (see project description).

*** Corporate Service Support: based on % staff time estimated by HSC department directors multiplied by departmental expense.

Any changes that may have affected results previously reported (period 10/1/16-3/31/17) are incorporated into the full year results. Such changes may have been due either to changes in methodology (e.g. Population Health) or updates to financial information received after submission of previous report.

Detailed narrative due to OHCA with summary page semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

Submitted to Comply with Docket # 15-32033-CON: Conditions 11 and 12

Annual Community Benefit Report
Annual Cultural and Linguistically Appropriate Services Report

OHCA Conditions are as follows**:**

11. The Applicants shall maintain community benefit programs and community building activities for L+MH, and the Applicants shall apply no less than a 1% increase per year toward the L+MH's community building activities in terms of dollars spent. YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives.

12. The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations, insurance navigator and cultural competency training.

Narrative for Condition 11:

Community Benefit
In 2016, Lawrence & Memorial Hospital ("L+MH") community benefit totaled $38,686,420 and in fiscal year (FY) 2017, community benefits are on track to exceed that amount (current estimate is $38,767,485 with data reporting and analysis not yet complete). The community building investment increased by 134%, from $52,237 in FY 2016 to an estimated $122,335 in FY 2017.

Following the analysis of data collected through the Community Health Needs Assessment, the Southeastern CT Health Improvement Collaborative ("Collaborative"), under the leadership of L+MH and Ledge Light Health District, engaged in a process to prioritize issues and develop strategies to improve health and well-being in the region. The Community Health Improvement Plan, developed by the Collaborative, is a dynamic document that serves as a roadmap for interventions going forward. Recognizing the significant contribution of social determinants to overall health and wellness, particular attention was paid in the assessment and plan development to the interaction between socioeconomic and environmental conditions as well as to health disparities.

Priority areas selected were:

1. Improve the conditions that support mental wellbeing and reduce substance use.
   Indicators: Opioid use and anxiety/depression rates among minorities

2. Support and nurture healthy lifestyles.
   Indicator: Contributing factors to diabetes.

3. Ensure access to care.
   Indicators: Prenatal care and related birth outcomes.
   Access to care for the low-income population.

Over 65 individuals, representing a broad range of community perspectives, participated in the prioritization work. In partnership with other organizations, all of the areas prioritized are being addressed. In addition, L+MH has continued existing programs, services and initiatives in the areas of

asthma, HIV outreach, maternal and child health, and breast and cervical cancer early detection and cardiovascular disease prevention. In addition to enhanced investment in community needs initiatives supporting the priorities identified in the 2016 CHNA, L+MH has continued its ongoing and community benefit support with a wide range of programs, services and in-kind support including: Breathe Well – Respira Bien Asthma Intervention ($66,136); support for the Homeless Hospitality Center Respite program ($47, 168); a dedicated social worker for the homeless population ($154, 580); and in-kind support for implementation of the Community Health Improvement Plan ($27,260).

A driving philosophy of L+MH's community benefit efforts is to build on existing community resources, programs and services in order to avoid duplication. As such, in examining each of the prioritized community health needs, existing community assets were identified before considering any new strategies that L+MH might initiate. Where there are existing community-based programs addressing any of the prioritized needs, L+MH will provide resources to support and build capacity of those programs rather than creating a new program, maximizing resources and avoiding duplication.

L+MH's community benefit programs and services support the organizational mission "To Improve the Health of the Region" and align with the principles as set forth in the organization's community benefit policy. Those principles include:

1. Emphasis on programs to meet a significant unmet health need including efforts to identify and include vulnerable populations or those most at-risk as determined by risk factors which predispose those populations toward a higher incidence of disease and/or barriers to obtaining appropriate healthcare.

2. Emphasis on primary prevention and including at least one of three primary prevention strategies: health promotion, disease prevention, and health protection. Health promotion entails encouraging healthy lifestyles; disease prevention focuses on individuals identified as at-risk for health problems; health protection activities influence the environment to support healthy behaviors.

3. Programs should develop evidence-based links between clinical services and health improvement activities delivered both inside and outside the hospital.

4. Programs should focus on targeting charitable resources that mobilize and build capacity within existing community assets while minimizing duplication of effort.

5. Programs should emphasis collaboration with community stakeholders.

As evidenced by the wide range of community benefit programs and services offered, L+MH is engaged in meeting the identified health needs of the communities we serve. There is an organizational history of collecting data to determine how best to direct our resources and how to make the greatest impact in promoting community health. Our annual community benefit report publication describes a sampling of programs and the amount of investment that L+MH makes in carrying out these programs.

Community Building

L+MH is increasingly aware of how social determinants impact the health of individuals and communities. An individual's health status and odds of developing chronic disease and/or premature death are greatly influenced by powerful social factors such as education, income, nutrition, housing and

neighborhoods. During Fiscal Year 2017, L+MH invested an estimated $122,335 in community building efforts that promote thriving and healthy communities in our region:

- Support for economic development: $15,080. Community involvement and financial support for partner organizations' economic development activities to support a regional infrastructure that includes sufficient employment opportunities providing a living wage.
- Support for physical improvements and housing: $11,200. Community involvement and financial support for partner organizations' physical improvement and housing related activities. Partner organizations include Community Speak Out, the Homeless Hospitality Center, and the Jewish Federation and includes support for transitional and shelter housing, sober house certification training, air conditioners for vulnerable residents, and other support.
- Community involvement and financial support for partner organizations' work to address social determinants of health not specific to the other categories: $96,055. Includes support for education, youth development and neighborhood development strategies in distressed New London neighborhoods with health needs identified by the most recent Community Health Needs Assessment and the 2016 Community Health Improvement Plan.

Narrative for Condition 12:

Culturally and Linguistically Appropriate Services

All patients and visitors at Yale New Haven Health and its member organizations (including L+MH) have the right to receive information in a language they understand, free of charge. Yale New Haven Health System ("YNHHS") complies with the Department of Health and Human Services' Section 1557 rule of the Affordable Care Act — which sets guidelines about language assistance for people with limited English proficiency or those who are deaf or hard-of-hearing — and takes reasonable steps to provide meaningful access to people with limited English proficiency who may require assistance within the health system.

Yale New Haven Health and its member organizations:

- Provide free aids and services to people with disabilities to enable effective communication with care providers, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- Post notices of nondiscrimination and taglines in Connecticut's fifteen most commonly used non-English languages, advising patients and visitors that language services are available free of charge.

Staff complete annual education on cultural competency to increase cultural awareness and sensitivity. Mandatory courses include: Diversity in the Workplace and Patient Rights. Classroom instruction is offered to all employees on cultural competency, and on-line courses are provided across YNHHS and are now available to employees at L+MH on:

- Cultural Competence: Background and Benefits,
- Cultural Competence: Providing Culturally Competent Care, and
- YNHH's Language Assistance.

New employees are given information in New Employee Orientation about language services available via telephone and on-line.

Financial Assistance Programs

YNHHS recognizes that patients may not be able to pay for medically necessary health care without financial assistance. Consistent with its mission, YNHHS is committed to assuring that the ability to pay will be considered carefully when setting amounts due for emergency and other medically necessary hospital services.

In recognition of its role to help those in need of financial assistance, YNHHS has established Financial Assistance Programs ("FAP") across the system to assist with emergency and other medically necessary care. The FAP apply to emergency and medically necessary inpatient and outpatient services billed by the hospitals to patients without insurance. In addition, help in completing financial assistance applications is available at Patient Financial and Admitting Services office located at L+MH.

Certified financial counseling resources are available to aid patients in navigating insurance issues on a scheduled and walk-in basis, and assist patients with the following:

1. Medicaid/Husky applications
2. Exchange applications
3. Free care applications
4. General/basic questions on bills, charges, estimates and payments

The L+MH website features a link for Financial Assistance Information for Non-English Speaking Patients: https://www.lmhospital.org/patients-visitors/patients/billing-insurance/financial-assistance.aspx The Financial Assistance Policy and Financial Assistance Summary and Applications are available in twenty-four languages, including Spanish, Chinese and Tagalog, the top three languages other than English spoken in the Greater New London area.

User, OHCA

From: Tia Sawhney <Tia.Sawhney@milliman.com>
Sent: Friday, December 01, 2017 8:50 AM
To: User, OHCA; Martone, Kim
Cc: YNHHSCOHCAMonitor@deloitte.com; gayle.capozzalo@ynhh.org; Vincent.tammaro@ynhh.org; Vincent.petrini@ynhh.org; jennifer.willcox@ynhh.org; shraddha.patel@ynhh.org; Mccarthy, Laura; Bruce Pyenson
Subject: RE: Docket #15-32033-CON & #15-32032-CON - L+M/Yale compliance
Attachments: LM CT CMIR Report_Final_11-30-2017.pdf; CMIR transmittal 11-30-2017.pdf

Dear Kim,

Attached is our revised and final CMIR and accompanying transmittal letter. Please let me know if you have any questions.

Tia

Tia Goss Sawhney, DrPH, FSA, MAAA
Healthcare Consultant and Actuary

Milliman
1 Pennsylvania Plaza, 38th Floor
New York, NY 10119 USA

646-473-3234 Office
224-628-9876 Mobile

Milliman

One Pennsylvania Plaza,
38th Floor
New York, NY 10119
Tel +1 646 473.3000
Fax +1 646 473.3199
www.milliman.com

MEMO

November 30, 2017

To: Kim Martone and Karen Roberts,
Connecticut Office of Healthcare Access (OHCA)
From: Tia Goss Sawhney
Subject: Submission of Final CMIR

Milliman (we) are serving as the independent consultant under the Agreed Settlement between Yale New Haven Health Services Corporation and the CT Department of Public Health for the transfer of ownership Lawrence and Memorial Corporation (L+MC). Per your request we have revised the Cost and Market Impact Review (CMIR) that we last submitted October 12, 2017 in order to provide more analysis supporting the expectations of Condition 22b of the Agreed Settlement. We have marked the revised CMIR as Final.

The substantive changes to the CMIR since the last draft are:

1. A new section: Monitoring and Future CMIRs (pg. 8)
2. A new exhibit: Exhibit 2C (pg. 24)
3. An expanded exhibit: Exhibit 7 (pg. 29)
4. Rewording: Fee Caps (pgs. 6-7)

We made these changes to better align the CMIR with the requirements of the Agreed Settlement and to better communicate the fee caps. The fee cap values did not change.

Also at your request, we have prepared Table 1 of this memo as a map between the subsections of the Condition 22b of the Agreed Settlement and the Final CMIR content.

Table 1: Mapping Between Condition 22b and the Final CMIR

Condition 22b	Final CMIR
Condition 22b: The cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically:	
(a) L+MH and LMMG's size and market share within their primary and secondary service areas	We provide extensive data regarding L+MH's size and market share for services relative to other providers in Eastern Connecticut (L+MC's primary service area) and providers outside of Eastern Connecticut. Data was not available to support a similar analysis for LMMG.
(b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut	The CMIR fee cap setting process examines L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services for Eastern

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Condition 22b	Final CMIR
	Connecticut and non-Eastern Connecticut providers serving Eastern Connecticut patients
(c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide	The CMIR fee cap setting process examines L+MH and LMMG cost and cost trends in comparison to hospital and physician healthcare expenditures statewide for providers serving Eastern Connecticut patients
(d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas	Throughout the CMIR we distinguish between services provided to Eastern Connecticut patients by L+MH and LMMG, other providers in Eastern Connecticut (L+MC's primary service area) and providers outside of Eastern Connecticut.
(e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas	Throughout the CMIR we distinguish between services provided to patients with government payer insurance (Medicare and Medicaid) and services to patients with commercial insurance. Exhibits 2C and 7 specifically examine L+MH behavioral health (mental illness and substance abuse) services. We also consider people in need of emergency care to be at-risk. Exhibit 7 examines L+MHs provision of emergency services. The section "Monitoring and Future CMIRs" describes how we will assess L+MH's continued provision of services to these vulnerable populations.
(f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas	Emergency care services, services to government payer populations, and services to patients with substance use and mental health disorders are generally considered low and negative margin hospital services. Therefore this expectation overlaps with 22b(e). Please see our response to 22b(e).
(g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular	The CMIR and the CMIR fee cap setting process examines the market conditions for Eastern Connecticut and other hospitals serving Eastern Connecticut patients.
(h) and other conditions that the independent consultant determines to be relevant	We have included other relevant information in the CMIR. For example, we document that an increasing number of Eastern Connecticut patients are obtaining care outside of Eastern Connecticut.

Lawrence + Memorial Corporation

Cost and Market Impact Review

Final

November 30, 2017

Prepared for:

Yale New Haven Health Services Corporation
under the Auspices of the Connecticut Office of Health Care Access
To Comply with Requirements of the Agreed Settlement between
Yale New Haven Health Services Corporation
And the Connecticut Department of Public Health

Prepared by:

Milliman
Engaged as an Independent Consultant

Tia Goss Sawhney, DrPH, FSA, MAAA
Bruce Pyenson, FSA, MAAA
Mona Kelkar, MBA

One Penn Plaza
38th Floor
New York, NY 10019 USA

Tel +1 646 473 3000
Fax +1 646 473 3199

milliman.com

Table of Contents

KEY TERMS

The following key terms are referenced in the report.

Key Term	Acronym	Definition
Agreed Settlement		Document detailing terms of the agreement between YNHHSC and DPH authorizing the transfer of ownership of L+MC and its subsidiaries to YNHHSC
Ambulatory Payment Classification	APC	Unit used to determine reimbursement for outpatient services; an ambulatory payment classification is defined by a particular set of outpatient services
Calendar Year	CY	The year ending December 31 of a given year
Case Mix Adjusted Discharge	CMAD	Discharge with a relative weight of 1.00; see definition of relative weight below
Centers for Medicare and Medicaid Services	CMS	Federal agency responsible for Medicare and the partner with states for Medicaid
Charge		The total amount billed for a service, often has little relationship to price
Commercial Fee Cap		The limit on increases in total price per unit of service paid by commercial insurers
Commissioner		Commissioner of the Department of Public Health
Compound Annual Growth Rate	CAGR	Geometric average of the growth rate over a period of time, stated as percent growth per annum
Conversion Factor		Converts relative value units into payment rates; see definition of relative value units below
Cost Based Statistical Area	CBSA	Areas to which Medicare assigns wage indices
Cost and Market Impact Review	CMIR	A review required by Condition 22 of the Agreed Settlement
Department of Public Health	DPH	Connecticut department with hospital oversight responsibility; parent department of OHCA
Department of Social Services	DSS	Connecticut department responsible for Medicaid
Eastern Connecticut	E-CT	Tolland, Windham, and New London counties (includes Lawrence + Memorial Hospital)
Fee		Price per unit of service; see definition of price below
Fee Ratio		The ratio of L+MH average all payer fee to the market average all payer fee. Fee caps are set so that the ratio does not increase during the Agreed Settlement monitoring period
Fiscal Year	FY	The year ending September 30 of a given year, as defined by CT Hospital Financial Review Regulations for CT hospital reporting[1]
Freedom of Information Act	FOIA	An act that enables the requires the government to respond to public requests for information
Geographic Practice Cost Index	GPCI	GPCIs reflect the costs of intensity, practice expense, and malpractice insurance in an area compared to the national average costs
Hospital Fees		Hospital net revenue divided by the total MS-DRG relative weights for the hospital's discharges
Lawrence & Memorial Medical Group	LMMG	The physician group of Lawrence + Memorial Corporation

[1] State of Connecticut. Office of Health Care Access. *Hospital Financial Review Regulations*. N.p., n.d. Web. 4 May 2017. http://www.ct.gov/dph/lib/dph/ohca/hospitalfillings/2017/hospital_financial_review_regulations.pdf.

Key Term	Acronym	Definition
Lawrence + Memorial Corporation	L+MC or L+M	The parent organization of Lawrence + Memorial Hospital and Lawrence & Memorial Medical Group
Lawrence + Memorial Hospital	L+MH	The hospital organization of Lawrence + Memorial Corporation
Market		All CT providers, both in and outside eastern CT, serving eastern CT patients
Medicare Severity Diagnosis Related Group	MS-DRG	Unit used to determine reimbursement for inpatient services; a Medicare Severity Diagnosis Related Groups is defined by a particular set of patient attributes, which include principal diagnosis, specific secondary diagnoses, procedures, sex and discharge status[2]
MS-DRG Relative Weight	RW	A weight assigned to a MS-DRG that reflects the expected relative cost to a hospital to provide that MS-DRG; *relative weights do not average to 1.00*
Net Revenue		Total price, after adjustments, as reported in hospital financial statements
Non-Eastern CT	Non-E-CT	All CT counties excluding eastern CT (Tolland, Windham, and New London counties); excludes out of state counties
Office of Health Care Access	OHCA	An office of Connecticut's Department of Public Health
Payer		Medicare, Medicaid, commercial insurers, and other third parties that cover the cost of care
Price		The total amount paid for a service, inclusive of patient cost-sharing
Relative Value Unit	RVU	RVUs account for the relative resources used in furnishing a service
Unit of Service		For inpatient care: a MS-DRG relative weight of 1.00; for outpatient care: an APC with a relative weight of 1.00
Yale New Haven Health Services Corporation	YNHHSC Or YNH	The organization acquiring Lawrence + Memorial Corporation

[2] Centers for Medicare and Medicaid Services (CMS). *Defining the Medicare Severity Diagnosis Related Groups (MS-DRGs), Version 34.0*. N.p., n.d. Web. 4 May 2017. https://www.cms.gov/ICD10Manual/version34-fullcode-cms/fullcode_cms/Defining_the_Medicare_Severity_Diagnosis_Related_Groups_(MS-DRGs)_PBL-038.pdf.

COST AND MARKET IMPACT REVIEW

In early September 2016, the Connecticut (CT) Office of Health Care Access (OHCA) granted Yale New Haven Health Services Corporation (YNHHSC) approval to acquire Lawrence + Memorial Corporation (L+MC). The Agreed Settlement between YNHHSC and the CT Department of Public Health authorized the transfer of ownership of L+MC and its subsidiaries to YNHHSC. The Agreed Settlement had a number of terms, including requiring YNHHSC to engage an independent consultant to prepare a Cost and Market Impact Review (CMIR), evaluate the non-governmental price per unit service (fees) of services provided by L+MC's Lawrence + Memorial Hospital (L+MH) and Lawrence & Memorial Medical Group (LMMG), and annually set maximum fee increases (for 5 years for L+MH and for 28 months for LMMG). With OHCA approval, YNHHSC engaged Milliman as the independent consultant.

As the independent consultant Milliman must satisfy the requirements of the Agreed Settlement and report to and take direction from the Commissioner. Milliman is a global actuarial and financial services consulting firm that has been serving clients as an independent consultant for over 70 years. We serve a diverse client base, representing virtually all types of private, non-profit, and public sector enterprises in healthcare, employee benefits, investment consulting, life insurance, financial services, and property and casualty insurance. We have no agenda other than high quality work.

This document is Milliman's 2017 report to OHCA and YNHHSC, which is intended to satisfy requirements of the Agreed Settlement. It may not be suitable for other purposes.

CMIR REQUIREMENTS

The Agreed Settlement's Condition 22 describes the information to be included in the CMIR. This report provides certain information specified in Conditions 22b, 22c, 22d, and 22e of the Agreed Settlement. Condition 22 is reproduced below (boldface added to highlight the role of the independent consultant).

22. Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review, which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below:

a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available.

*b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the **independent consultant determines** to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut.*

c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially

increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the ***independent consultant shall conduct*** *the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the* ***independent consultant from considering and recommending*** *any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases.*

d. *The* ***independent consultant shall report*** *to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area.*

e. *The* ***independent consultant shall provide*** *the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.*

METHODOLOGY SUMMARY

Our commercial fee cap methodology, as approved by OHCA:

1. Establishes market baskets of high frequency services for inpatient and outpatient hospital services and physician services.
2. Estimates the fiscal year 2016 (FY2016) average fee per market basket service across all payers for services provided by L+M and all hospitals and physicians serving E-CT patients (aka “the market”), and calculates the FY2016 ratio of L+M fees to market fees.
3. Projects the market basket fee changes and service changes, other than L+M commercial fee changes, from FY2016 to calendar year 2018 (CY2018).
4. Estimates the L+M commercial fee change from FY2016 to CY2018 that will allow L+M to maintain the FY2016 ratio of L+M fees across all payers to market fees across all payers and establishes that change as the commercial fee cap.

Following the expectations of the Agreed Settlement, we also review the Eastern Connecticut (E-CT) healthcare market and make non-fee cap recommendations.

Fiscal years (FYs) for Connecticut hospitals end in September and calendar years (CYs) end in December. FY2016 is the year October 2015 through September 2016 and CY2018 is the year January 2018 through December 2018. Under the Agreed Settlement L+MC must maintain commercial fee contracts from the end of FY2016 to the beginning of CY2018 and may negotiate fee increases, subject to the fee cap, for CY2018 onward. Hence, for establishing the fee cap, FY2016 is our base period and CY2018 is the period for which we establish the fee cap. Next year we will establish inpatient and outpatient hospital fee caps for CY2019.

Medicare and Medicaid fees impact the commercial fee cap. The estimated average fees per market basket service and fee ratios are inclusive of all payers. Therefore, any Medicare or Medicaid fee change that differentially affects L+M relative to other hospitals serving E-CT patients will impact the calculation of L+M’s commercial fee cap. The differential impact may be the result of L+M having a different fee change than the other hospitals or it may be due to L+M providing a disproportionate share (more or less) of Medicare or Medicaid market basket services relative to the other hospitals.

MARKET REVIEW

Our review of the Eastern Connecticut (E-CT) healthcare market yielded the following observations:

Hospital Inpatient Care

1. **E-CT patients had about 51,000 discharges in FY2016.** About 25,000 or about 50% of the discharges were for market basket MS-DRGs. Of these about 25,000 market basket MS-DRGs, 27% were from L+MH (see Exhibit 1).
2. **E-CT hospitals lost market share between FY2014 and FY2016.** The percent of E-CT patients discharged from E-CT hospitals, inclusive of L+MH, declined from 67.0% to 62.3% of discharges – a -6.9% change[3]. In FY2016, nearly 40% of E-CT patient discharges were from non-E-CT hospitals (see Exhibit 1).
3. **E-CT patients with commercial insurance are disproportionately cared for outside of E-CT relative to Medicare patients**. In FY2016 46.6% of commercial market basket MS-DRG discharges were from non-E-CT hospitals vs. 32.9% for Medicare discharges and 19.0% for Medicaid discharges (see Exhibit 2A).
4. **Patient volume for government payers grew from FY2014 to FY2016.** In FY2016 35.8% of market basket MS-DRG discharges were paid for by commercial payers (see Exhibit 2B). From FY2014 to FY2016, E-CT patient market basket MS-DRG discharges declined for commercial payers (-4.3%) and grew for Medicaid (+5.5%) and Medicare (+2.1%) payers (see Exhibit 2B).
5. **In each of FY's 2014-2016 L+MH provided more than a 1/5 of the inpatient behavioral health discharges for E-CT patients.** The percentage ranged from 21.4% in FY2015 to 22.1% in FY2016. Behavioral health discharges includes mental illness and substance abuse MS-DRGs (see Exhibit 2C).
6. **In FY2016, non-E-CT hospitals, on average, provide more high intensity care than E-CT hospitals**. In FY2016, non-E-CT market basket MS-DRG discharges had an average case mix per discharge of 1.42, while E-CT hospitals had an average case mix of 1.25 (see Exhibit 3).
7. **In FY2016, government payers paid much less than commercial payers did**. In FY2016, Medicare fees were $7,717, Medicaid fees were $5,359, and commercial payers fees $12,467 per case mix adjusted discharge (CMAD), inclusive of patient cost sharing. Commercial payer fees more than double Medicaid fees (see Exhibit 4A).
8. **From FY2014 to FY2016, commercial fees per CMAD for hospitals serving E-CT patients increased by +4.3% per annum** (see Exhibit 4A).
9. **In FY2016, L+MH fees per CMAD were similar to other E-CT hospitals**. In FY2016, L+MH fees per CMAD were somewhat higher than that of other E-CT hospitals: +5.2% for Medicare, +3.5% for Medicaid, and +0.7% for commercial (see Exhibit 4B).
10. **Non-E-CT fees per CMAD were much higher than E-CT fees per CMAD across all payers**. In FY2016, fees per CMAD for non-E-CT hospitals were higher than that of E-CT hospitals: +9.2% for Medicare, +25.6% for Medicaid, and +22.6% for commercial (see Exhibit 4B).
11. **CT Medicaid has planned changes to fees that will disproportionately reduce fees for L+MH**. Medicaid has planned fee changes per CMAD between FY2016 and CY2018 of -12.8% for L+MH, -8.4% for other E-CT hospitals, and -6.8% for non-E-CT hospitals (see Exhibit 5A).
12. **L+MH and non-E-CT hospital Medicare fees are expected to increase modestly in January 2018, while the fees for other E-CT hospitals are expected to have a larger increase due to changes in the geographic assignment for some hospitals.** January 2018 Medicare fees are expected to change +0.6% for L+MH, +0.4% for non-E-CT hospitals, and +2.8% for other E-CT hospitals (see Exhibit 5B).

Medicare payments are based on statistical area assignments. Medicare outpatient and inpatient payments are adjusted for local wage levels, using the wage indices that Medicare publishes for cost based statistical areas (CBSAs). CBSAs are typically metropolitan statistical areas (MSAs), and hospitals are generally assigned to the CBSA corresponding to their physical location. Medicare can, however, assign hospitals to CBSAs that do not correspond to their physical location. L+MH has been assigned to the Nassau County-Suffolk County, NY CBSA – a CBSA with a higher

[3] Changes in market share cited in this analysis are relative to the first period market share. For example if a hospital has a 20% market share that declines to 18%, then the hospital has lost 10% of its market share.

wage index than the New Haven-Milford, CT CBSA for several years. Another E-CT hospital, Backus Hospital, will be assigned to the Nassau County-Suffolk County, NY CBSA as of January 2018.

Hospital Outpatient Care

1. **Outpatient care is a significant portion of hospital net revenue, particularly for E-CT hospitals.** Outpatient care represented 60.4% of FY2015 hospital net revenue for E-CT hospitals, and 42.8% of FY2015 hospital net revenue for non-E-CT hospitals providing services to E-CT patients (see Exhibit 6).
2. **Medicaid and Medicare represent a significant portion of outpatient net revenue for hospitals serving E-CT patients.** Medicare and Medicaid represent 38.1% of outpatient net revenue for L+MH, 38.0% of outpatient net revenue for other E-CT hospitals, and 36.3% of outpatient net revenue for non-E-CT hospitals (see Exhibit 6).
3. **E-CT patients receive a higher portion of their outpatient surgical care than ED care at non-E-CT hospitals**. According to CHIME, 35.5% of FY2016 outpatient hospital surgery discharges[4] for E-CT patients were from non-E-CT hospitals and 11.9% of ED discharges were from non-E-CT hospitals (see Exhibit 7).
4. **E-CT patients with Medicare or commercial insurance receive a higher portion of their outpatient surgical and ED care at non-E-CT hospitals than E-CT patients with Medicaid**. According to CHIME, 35.4% of Medicare and 37.9% of commercial FY2016 outpatient hospital surgery discharges for E-CT patients were from non-E-CT hospitals, whereas 29.3% of Medicaid discharges were from non-E-CT hospitals. Similarly, 10.7% of Medicare and 17.0% of commercial FY2016 ED market basket services for E-CT patients were from non-E-CT hospitals, whereas 8.1% of Medicaid ED market basket services were from non-E-CT hospitals (see Exhibit 7).
5. **In FY2016 L+MH emergency department served the same proportion of E-CT patients with behavioral health primary diagnoses as patients with any diagnosis.** In FY2016 L+H provided 29.6% of emergency room discharges for E-CT patients with a behavioral health primary diagnosis (mental illness or substance abuse) and 29.5% of total emergency room discharges for E-CT patients (see Exhibit 7).
6. **CT outpatient hospital Medicaid Modernization, which was a significant change in outpatient hospital methodology, disproportionately reduced fees for L+MH.** In July 2016, CT Medicaid introduced an APC payment methodology. Medicaid outpatient fees increased somewhat (1.4%) for all hospitals serving E-CT patients, whereas fees decreased significantly (-11.0%) for L+MH (see Exhibit 8).

   CT hospital outpatient Medicaid Modernization. Prior to July 2016, CT Medicaid hospital outpatient fees (for most services) were set at a hospital-specific percentage of the hospital's charges. The percentage was based on the hospital's cost to charge ratio. In July 2016, CT Medicaid implemented a Medicare-like payment system where most fees are paid using Medicare's APC methodology. Many individual hospitals saw significant outpatient fees change as a result of Medicaid Modernization, with some receiving higher fees while other received lower fees.

   Under the modernized payment system, CT Medicaid uses Medicare's APC assignment rules, relative weights, and wage indices but sets its own APC fee per relative weight unit. CT Medicaid adjusts for labor costs through a wage index based on each hospital's CBSA corresponding to their physical location. Wage indices for a given CBSA can "bounce" somewhat from year to year. L+MH's January 2017 fee change relative to some other hospitals is due to a decline in the New Haven-Milford, CT wage index relative to other CT CBSAs.
7. **The January 2017 CT Medicaid fee update also reduced fees for L+MH**. Routine updating of Medicaid APC fees, effective January 2017, resulted in 0.0% change for all hospitals serving E-CT patients, but a -1.2% change for L+MH (see Exhibit 8).
8. **L+MH's outpatient hospital Medicare fees are expected to decrease modestly in January 2018, while the fees for other E-CT are expected to have increase due to changes in the geographic assignment for some hospitals.** January 2018 Medicare APC fees are expected to change -0.2% for L+MH, +3.6% for other E-CT hospitals, and -0.5% for non-E-CT hospitals (see Exhibit 9).

[4] "Discharges" is CHIMEs term for an outpatient surgery procedure or an emergency room visit.

Physician Care

1. **LMMG provided a consistent volume and payer-mix of market basket services in FY2015 and FY2016.** In FY2015, 43.6% LMMG's services were for E-CT patients with Medicare, 13.9% were for E-CT patients with Medicaid, and 41.5% were for E-CT patients with commercial insurance (see Exhibit 10). In FY2016, 44.1% LMMG's services were for E-CT patients with Medicare, 14.3% were for E-CT patients with Medicaid, and 40.8% were for E-CT patients with commercial insurance (see Exhibit 10).
2. **E-CT patients with Medicaid and Medicare receive the majority of their care in E-CT.** In CY2016, E-CT patients with Medicaid received 67.8% of their physician services from E-CT physicians and 32.2% from non-E-CT physicians (see Exhibit 11). In CY2014, E-CT patients with Medicare received 66.5% of their physician services from E-CT physicians and 33.5% from non-E-CT physicians (see Exhibit 11).
3. **Medicare fees for all Medicare physicians in Connecticut have changed very modestly from CY2015 to CY2017.** Medicare fees changed -0.3% from CY2015 to CY2017 (see Exhibit 12).
4. **Medicaid fees for all Medicaid physicians in Connecticut have remained flat since September 2015 (beginning of FY2016).**
5. **In FY2015, LMMG's average Medicaid fees were about 85% of what Medicare fees would have been for the same services**.
6. **There are no announcements that indicate that Medicaid and Medicare fees will significantly change between now and CY2018**.

FEE CAPS AND RECOMMENDATIONS

Overview

In this section, in our role as an independent consultant, working to satisfy requirements of the Agreed Settlement, we estimate the fee caps for L+MC's average commercial fees for hospital inpatient, hospital outpatient, and physician care. According to the Agreed Settlement, fee caps are the highest permitted aggregate increase in L+MC or LMMG fees for CY 2018 relative to FY2016 — a span of 2.25 years from midpoint to midpoint. Fee increases for a particular commercial health plan may be more or less than the cap.

> **Commercial fee increases within maintained health plan contracts are included in the fee cap**. Condition 20 of the Agreed Settlement requires L+MC to maintain health plan contracts that were in effect as of the date of closing (September 8, 2016) through December 31, 2017. Until January 1, 2018, L+MC commercial fees can increase only if there were fee increases already incorporated within these maintained contracts. L+MC must consider these previously negotiated fee increases when setting fees for CY 2018. According to the Agreed Settlement, the total commercial fee increase, including fee increases within maintained contracts, must not exceed the cumulative fee cap for inpatient, outpatient or physician services.

Hospital Inpatient Fee Cap

We estimate that L+MH could increase its commercial inpatient fees per market basket service 16.5% cumulative for the period between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +16.5%.[5] The +16.5% fee change for a 2.25 year period is the equivalent of +7.0% fee change per annum. The cumulative fee increase allows L+MC to attempt to regain the annual increases it may have lost during the maintained contract period.

The fee cap is based upon the following considerations:

a. The facts outlined in the Market Review section, including
   i. Shifting of the distribution of E-CT hospital discharge market share to non-E-CT hospitals
   ii. Annual growth in the average case mix per market basket discharge between FY2016 and CY2018
   iii. Modest growth in L+MH's Medicare fees in January 2018 relative to larger increases in Medicare fees for Other E-CT hospitals (see Exhibit 5B).
   iv. Planned changes to CT Medicaid fees that will disproportionately reduce fees for L+MH (see Exhibit 5A).

b. A 2.25 year span between FY2016 and CY2018.

c. No shifts in the distribution of inpatient service mix by payer between FY2016 and CY2018

d. Commercial fee increase of +4.0% for hospitals other than L+MH. The increase is consistent with the increase FY2014 to FY2016 by payer, rounded down (see Exhibit 4A).

Note: The two key determinates of the 3.0% per annum spread between L+MH's capped commercial fee increase (+7.0%) and the expected non-L+MH fee increase (+4.0%) are 1) the modest January 2018 Medicare fee increase for L+MH relative to larger fee increases for other E-CT hospitals and 2) the planned CT Medicaid fee reductions. The impact of these fee changes on 65% of L+MH's discharges needs to be balanced by commercial fee increases that are applicable to the other 35% of L+MH's discharges.

Hospital Outpatient Fee Cap

We estimate that L+MH could increase its commercial outpatient fees per market basket service 11.6% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +11.6%. The +11.6% fee change for a 2.25 year period is the equivalent of +5.0% fee change per annum. The cumulative fee increase allows L+MC to attempt to regain the annual increases it may have lost during the maintained contract period.

[5] Fee changes are to be measured by comparing the average commercial fee in CY2018 to the average commercial fees in FY2016.

The fee cap is based upon the following considerations:

a. The facts outlined in the Market Review section, including
   i. The significant decline in L+MH's Medicaid outpatient fees in July 2016 due to hospital outpatient Medicaid Modernization
   ii. L+MH's anticipated Medicare outpatient fee decrease as of January 2018
b. A 2.25 year span between FY2016 and CY2018
c. No shifts in the distribution of outpatient services or service mix by payer or by hospital between FY2016 and CY2018
d. Assumptions for annual growth in fees
   i. Commercial – for hospitals other than L+MH: +4.0% from CY2015 to CY2018
   ii. Medicare – fee per APC relative weight unit: +0.5% from CY2017 to CY2018
   iii. Medicaid – fee per APC relative weight unit: 0.0% from CY2017 to CY2018

Note: Only one-quarter of the impact of outpatient Medicaid Modernization is reflected L+MHs FY2016 fees and Medicare fees will in January 2018. Therefore, L+MH needs a significant above-market commercial outpatient fee increase to bring its CY2018 fee ratio (average all-payer fees relative to the market) to FY2016 levels.

Physician Fee Cap

We estimate that LMMG could increase its commercial physician fees per market basket service 8.0% cumulative between FY2016 and CY2018 and maintain the same fee ratio as FY2016. Therefore, the cumulative fee change cap for the period between FY2016 and CY2018 is +8.0%. The +8.0% fee change for a 2.25 year period is the equivalent of +3.5% fee change per annum. The cumulative fee increase allows L+MC to attempt to regain the annual increases it may have lost during the maintained contract period.

The cap is based upon the following considerations:

a. The facts outlined in the Market Review section, including
   i. No change in Medicaid and Medicare fee levels. There are no announcements that indicate that Medicaid and Medicare fees will significantly change between now and CY2018
b. A 2.25 year span between FY2016 and CY2018
c. No shifts in the distribution of physician services or service mix by payer between FY2016 and CY2018
d. Assumptions for annual growth in fees
   i. Commercial – for market and LMMG: +3.5% per annum from CY2015 to CY2016 based on various consultant reports
   ii. Medicare – fee per service: flat from FY2016 to CY2018
   iii. Medicaid – fee per service: flat from FY2016 to CY2018

Non-Fee Cap Recommendation

1. **We recommend that OHCA consider not making this CMIR public.** There is a risk that if other hospitals serving E-CT patients know that L+MH is seeking commercial fee increases, these other hospitals will request increases themselves, potentially creating a multi-year upward spiral of fee increases.

MONITORING AND FUTURE CMIRS

In this CMIR, Milliman, sets fee caps and otherwise performs the tasks that the Agreed Settlement describes for the independent *consultant*. The Agreed Settlement assigns another entity, the independent *monitor*, with the task of monitoring fee L+MCs fee changes and assuring the changes do not exceed the fee caps.

Condition 20 of the Agreed Settlement subjects L+MH fees to annual caps for the five year period following the September 2016 closing – therefore through August 2021. Since this CMIR is for CY2018, there will be three future CMIRs for L+MH: CY2019, CY2020, and CY2021. There will be no future CMIRs for LMMG as Condition 20 specifies that LMMG's fee caps end 28 months from the date of the closing and the fee caps for this CMIR extend through December 2018.

Because the L+MH CMIRs are ongoing and the fee caps are cumulative, the fee caps are also self-adjusting. As contemplated in Condition 22a of the Agreed Settlement, if data that is not available at the time of a CMIR subsequently becomes available or unexpected events occur in the market (such as an unanticipated change in government payer fees), the new data and events will be incorporated into the next CMIR and the next year's fee cap. Likewise, should L+MH not be able to obtain the fee increases that allow it to retain its pre-transfer of ownership fee ratio, LM+H will be able to attempt to do so the next year.

The annual CMIRs will also allow us to assess whether L+MH is continuing to provide emergency care services, services to government payer populations, and substance use disorder and mental health services at L+MH's FY2016 (pre-Agreed Settlement) levels as contemplated by Conditions 22b(e) and 22b(f) of the Agreed Settlement.[6] This CMIR establishes the baseline for the assessments.

[6] 22b(f) specifically asks us to examine L+MH's provision of low and negative margin services. Emergency care services, services to government payer populations, and services to substance use disorder and mental health services are generally considered low and negative margin services. Similarly the people needing these services are generally considered to be "vulnerable populations" as specified by 22b(e). We do not have the data for further examination of vulnerable populations and low and negative margin services.

DATA AND METHODOLOGY

HOSPITAL INPATIENT CARE

Overview

As described in our methodology below, we created a market basket of hospital inpatient discharges for the top MS-DRGs associated with CT's top inpatient primary diagnoses, principal procedures, surgical procedures, and surgical MS-DRGs. We then used Medicare MS-DRG relative weight factors to adjust for the case mix of the market basket discharges[7], defining a case mix adjusted discharge (CMAD) as a discharge with a relative weight factor of 1.00. CMAD is our "unit of analysis" for purposes of recommending a fee cap.

For all payers, we estimated the fee per CMAD of a group of hospitals as the sum of its net revenue divided by the sum of its MS-DRG relative weight factors, where the sum of the MS-DRG relative weight factors is the sum of the product of the case mix index and number of discharges by hospital. The calculation for an individual hospital is the same, except without the summations.

$$Fee\ per\ CMAD_{group\ of\ hospitals} = \frac{\sum(Net\ Revenue)_{hospital}}{\sum(MS-DRG\ Relative\ Weight\ Factor)_{hospital}}$$

$$Where\ (MS-DRG\ Relative\ Weight\ Factor)_{hospital} = (Case\ Mix)_{hospital} * (Unweighted\ Discharges)_{hospital}$$

The fee per CMAD calculation relies upon:

1. CT Hospital Information Management Exchange (CHIME) data to identify which hospitals provide the market basket MS-DRG discharges.
2. "Twelve Month Actual Filing" data filed with OHCA to estimate market basket inpatient discharge fees.

We describe hospital discharges and fees for FY2014 – FY2016. We project hospital discharges and their case mixes from FY2016 to CY2018, estimate Medicaid and Medicare fee changes from FY2016 to CY2018, and calculate the fee increase as the maximum commercial fee increase from FY2016 to CY2018 that will maintain L+MH's average fee relative to the market.

Data

We relied upon the following data sources for our inpatient analysis:

- CT Department of Insurance most common inpatient hospital service lists[8].
- CT hospital discharge data from the CHIME[9] database as provided to us under a data use agreement by YNHHSC, for the period 10/2013 through 9/2016.
- CT hospital "Twelve Month Actual Filing"[10] operational and financial data filed with OHCA, for FY2014, FY2015, and FY2016. Tabs within the Filing are referred to as "Reports" and have a number, such as Report 165.
    - FY2016 annual reports have not been reviewed by OHCA.

[7] Medicare MS-DRG relative weight factors are used by Medicare and other payers to compensate hospitals for more and less costly hospital discharges.

[8] Connecticut Department of Public Health. Access Health CT. *Connecticut Acute Care Hospital and Outpatient Surgical Facility Data: FY2015*. N.p., 1 Aug. 2016. Web. 4 May 2017. http://www.ct.gov/dph/lib/dph/ohca/publications/2016/consumerhealthinformationreport.pdf.

[9] "ChimeData Overview." *Chime*. Connecticut Hospital Association, n.d. Web. 4 May 2017. http://www.chime.org/member-services/chimedata/chimedata-overview/.

[10] "Twelve Month Filing 2015." *Department of Public Health*. State of Connecticut, n.d. Web. 4 May 2017. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=583316.

  - Two hospitals, Manchester Memorial Hospital and Rockville General Hospital, have filing extensions, which means that FY2015 annual reports are the latest available. We assumed that their reported values are unchanged from FY2015.
  - If new or amended data becomes available, the fee and trend values cited in this report may change. The data, however, is unlikely to have a substantial impact on the conclusions.
- Medicare fee per CMAD developed from the corrected final rules for CY2015 to CY2018[11,12,13,14,15].
- CT Medicaid fee schedules and fee schedule changes and analysis of fee schedule change impact by hospital from the DSS website[16].
- L+MH hospital outpatient claims and payment data.
- Other
  - County to zip code mapping provided by YNH and checked for reasonableness.
  - Medicare 2016 MS-DRG service weights[11~~10~~,12~~11~~,17].

Methodology

Summarize Historical Discharges

Step 1: Create a set of inpatient market basket MS-DRGs.

a. **Identify relevant discharges:** Identify the CHIME FY2014-FY2015 statewide discharges related to one or more of the top inpatient primary diagnoses, principal procedures, surgical procedures, and surgical MS-DRGs as listed in the Department of Insurance (DOI) service lists.

b. **Create market-basket MS-DRG list** (see Table 1). Count the FY2015 statewide discharges for each MS-DRG identified in Step 1a. Create list of the 50 MS-DRGs with the most discharges – the "market basket MS-DRGs." Note: we used FY2014-FY2015 as the market basket years. Due to the October 2015 conversion to ICD-10, FY2015 was the last year that the ICD-9 codes corresponding to the DOI lists were available within CHIME.

Step 2: Identify hospitals providing inpatient services to E-CT patients.

a. **Identify E-CT zip codes** (see Table 2).

b. **Identify E-CT patient discharges.** Using patient residence zip codes, identify the CHIME FY2014-FY2015 statewide discharges for patients residing in E-CT.

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[11] "FY 2015 Final Rule Tables *Centers for Medicare and Medicare Services (CMS)*. N.p., n.d. Web. 4 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

[12] "FY 2016 Final Rule and Correction Notice Data Files" *Centers for Medicare and Medicare Services (CMS)*. 4 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

[13] "FY 2017 Final Rule and Correction Notice Tables" *Centers for Medicare and Medicare Services (CMS)*. 23 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

[14] "FY 2018 Final Rule and Correction Notice Data Files" *Centers for Medicare and Medicare Services (CMS)*. 7 October 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

[15] "Acute Care Hospital Inpatient Prospective Payment System." 23 June 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf.

[16] "Hospital Rates: Inpatient Rates." *Department of Social Services*. State of Connecticut, 1 Jan. 2017. Web. 4 May 2017. http://www.ct.gov/dss/cwp/view.asp?a=4598&q=540318.

[17] "FY 2014 Final Rule Data Files" *Centers for Medicare and Medicare Services (CMS)*. N.p., 28 Jan. 2014. Web. 4 May 2017. https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/fy-2014-ipps-final-rule-home-page-items/fy-2014-ipps-final-rule-cms-1599-f-data-files.html.

c. **Create a list of hospitals caring for E-CT patients**. Create a list of the hospitals responsible for 99%+ of the E-CT patient discharges for FY2014 and FY2015. This list contains 13 hospitals (see Table 3).

d. **Group hospitals by region**. Group the 13 hospitals as L+M (1), other E-CT hospitals (5), non-E-CT hospitals (7) (see Table 3).

Step 3: Assign payer categories and service weights to FY2014 to FY2016 CHIME discharges.

a. **Assign payer categories**. Map CHIME payers to payer categories (see Table 4A).

b. **Assign relative weights**. Assign MS-DRG relative weights to each discharge.

Step 4A: Summarize the number of CHIME discharges and service weights from E-CT patient hospitals for market basket MS-DRG discharges by FY, facility, payer category, region.

Step 4B: Separately summarize CHIME discharges for mental illness and substance abuse MS-DRGs (MS-DRGs 880 to 897) by FY, facility, payer category, region.

Calculate Historical Fees

Step 5: Collect data for the 13 hospitals from the **"Twelve Month Actual Filings"**. Specifically:

a. **Report 165**: Inpatient Net Revenue (by payer).

b. **Report 185**: Discharges (by payer) and Case Mix Index (by payer).

c. Confirm that case mix index as reported in Twelve Month Actual Filings are average Medicare MS-DRG relative weights.

Step 6: Calculate average net revenue per case mix adjusted discharge and average case mix by hospital and payer.

a. **Map "Twelve Month Actual Filings" payers** to Medicare, Medicaid, commercial, uninsured, and other (see Table 4B).

b. **Calculate average net revenue per case mix adjusted discharge by hospital and mapped payer.**

Summarize Historical Discharges and Fees

Step 7: Summarize historical discharges and fees.

a. Count market basket and non-market basket DRG discharges by fiscal year and hospital region and calculate the market basket percentage of total discharges (see Exhibit 1).

b. For market basket DRG discharges, quantify discharges by year, hospital region, and payer (see Exhibit 2A & Exhibit 2B). For mental illness and substance abuse DRGs, quantify discharges by year, hospital region, and payer (see Exhibit 2C).

c. For market basket DRG discharges, calculate average case mix by year, hospital region, and payer, where totals across regions and payers are weighted by market basket discharges (see Exhibit 3).

d. For market basket DRG discharges, calculate average fees per CMAD, where totals across regions and payers are weighted by the product of market basket discharges and relative weight factors (see Exhibit 4A & Exhibit 4B).

Project Future Discharges, Case Mix, and Fees

Step 8: Calculate scheduled Medicaid fee changes per CMAD from FY2016 to CY2018, where totals across regions and payers are weighted by the 2016 product of market basket MS-DRG discharges and average case mix.

Note: CT Medicaid has/is implementing two inpatient fee changes. One was an all hospital 5% fee reduction as of January 2017 to adjust for unexpected high inpatient intensity after the implementation of hospital inpatient Medicaid Modernization in 2015. The other is 4-year adjustment of hospital-specific base fees, starting January 2017. While the 4-year adjustment is neutral across the state, hospitals serving E-CT patients will (on average) receive fee decreases and the fee decreases will be (on average) larger for E-CT hospitals than non-E-CT hospitals. Between FY2016 and CY2018, hospital basket weighted Medicaid fee decrease will be -12.8% for L+H, -8.4% for other E-CT hospitals, and -6.8% for non-E-CT hospitals (see Exhibit 5A).

Step 9: Calculate scheduled Medicare fee changes per CMAD from FY2016 to CY2018, where totals across regions and payers are weighted by the product of the estimated market basket MS-DRG discharges and average case mix (see Exhibit 5B).

> Note: In order to estimate the CY 2018 IP fee per CMAD, the CY 2017 IPPS corrected final rule was used, updated for the operating and capital base rates, wage indexes, and capital geographic adjustment factors from the CY 2018 corrected final rule.

Step 10: Assign other values

a. A 2.25 year span between FY2016 and CY2018.

b. No shifts in the distribution of inpatient service mix by payer between FY2016 and CY2018

c. Assumptions for annual growth in fees per CMAD between FY2016 and CY2018:

   i. Medicare, where L+MH's fees will increase modestly from FY2016 through CY2017, and then decrease in CY2018 due to a change in their geographic assignment. The rest of the market continues to increase modestly over FY2016 – CY2018. The figures below annualized and inclusive of all fee changes from FY2016 – CY2018(see Exhibit 5B)

      1. -2.8% L+MH
      2. +1.0% other E-CT
      3. +1.0% non-E-CT

   ii. Medicaid, where L+MH's fees have decreased more than the market (see Exhibit 5A)

      1. -5.9% L+MH
      2. -3.8% other E-CT
      3. -3.1% non-E-CT

   iii. Commercial fee increase of +4.0% for hospitals other than L+MH. The increase is consistent with the increase FY2014 to FY2016 by payer, rounded down (see Exhibit 4A).

Step 11: Find the L+MH commercial fee increase that maintains the FY2016 ratio of L+MH all-payer fees per CMAD to total all-payer market fees per CMAD.

HOSPITAL OUTPATIENT CARE

Overview

Hospital outpatient departments provide a variety of services, including emergency services, surgeries, diagnostic and screening tests, laboratory services, and imaging. A given outpatient visit, particularly an emergency or surgery visit, can result in a bill with a long list of service-line charges. Medicare pays for many, but not all, outpatient services using the Ambulatory Payment Classification (APC) system, a system that often groups the charges from a visit into a single payment – much like MS-DRGs are used to make a single payment for an inpatient admission. Some services, such as mammograms, are not grouped but paid as stand-alone services. On July 1, 2016, CT Medicaid implemented an outpatient payment system that is Medicare-like, including the use of APCs. Prior to July 2016, CT Medicaid paid for outpatient services using a cost-to-charge methodology.

Commercial payers are not required to use an APC methodology. If commercial payers do use an APC methodology, they may not use it consistently for all providers or all services. Furthermore, commercial fee levels vary dramatically among payers and providers paid by the same payer[18].

As described below, we created a market basket of APCs and stand-alone services associated with CT's top outpatient services. 95%+ of the market basket services are APCs; the remainder are mammogram services. We grouped L+MH and market commercial-payer claims data into APCs to calculate APC commercial fees for market basket services, whether or not the payer used an APC methodology.

Data

We relied upon the following data sources for our outpatient analysis:

- CT Department of Insurance most common outpatient hospital service lists[19].
- Medicare rules for assigning outpatient services to payment methodologies and within the APC methodology to specific APCs[20].
- CT hospital discharge data from the CT Hospital Information Management Exchange (CHIME)[21] database as provided to us under a data use agreement by YNHHSC, for FY2016.
- CT hospital "Twelve Month Actual Filing" data filed with OHCA, for FY2015[22]. Tabs within the Filing are referred to as "Reports" and have a number, such as Report 165.
- CT Medicaid fee schedules and hospital outpatient Medicaid Modernization impact analysis by hospital from the DSS website[23].
- CT Medicaid freedom of information act (FOIA) request for counts of outpatient market basket services provided July-December 2016 to E-CT Medicaid patients by hospital. Data was requested for the second half of 2016 as

[18] New York State Health Foundation. *Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement*. Gorman Actuarial, Dec. 2016. Web. 4 May 2017. http://nyshealthfoundation.org/resources-and-reports/resource/an-examination-of-new-york-hospital-reimbursement.

[19] Connecticut Department of Public Health. Access Health CT. *Connecticut Acute Care Hospital and Outpatient Surgical Facility Data: FY2015*. N.p., 1 Aug. 2016. Web. 4 May 2017. http://www.ct.gov/dph/lib/dph/ohca/publications/2016/consumerhealthinformationreport.pdf.

[20] "Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC)." *Connecticut Department of Social Services*. N.p., n.d. Web. 4 May 2017. https://www.ctdssmap.com/CTPortal/HospitalModernization/tabid/143/Default.aspx

[21] "ChimeData Overview." *Chime*. Connecticut Hospital Association, n.d. Web. 4 May 2017. http://www.chime.org/member-services/chimedata/chimedata-overview/.

[22] "Twelve Month Filing 2015." *Department of Public Health*. State of Connecticut, n.d. Web. 4 May 2017. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=583316.

[23] "Hospital Outpatient Reimbursement Modernization." *Connecticut Department of Social Services*. State of Connecticut, n.d. Web. 2 May 2017. http://www.ct.gov/dss/cwp/view.asp?a=4598&q=563932.

the market basket services are mostly APC services and CT Medicaid did not use an APC payment methodology until the second half of 2016.

- Medicare 5% sample of Medicare fee for service claims CY2014.[24]
- Medicare wage indices (known as "Table 2" and "Table 3"), from the corrected final rules for CY2015 to CY201~~10~~,~~11~~,~~12~~,~~13~~
- Medicare APC payment per relative weight units CY2015 to CY2017[25].
- Truven MarketScan and Milliman Consolidated Health Cost Guidelines Sources Database claims data for E-CT CY2014 and CY2015[26].
- L+MH hospital outpatient service billing and payment (claims) data CY2016.
- Other
    - County to zip code mapping provided by YNH and checked for reasonableness.
    - Data from various sources for commercial outpatient hospital fee trends[27].

Methodology

Summarize Outpatient Services

Step 1: Create a set of outpatient market basket services.

a. **Identify the payment methodology for top procedures**. Identify the Medicare (and CT Medicaid July 2016+) payment methodology associated with the top outpatient procedures, outpatient surgical procedures, and outpatient imaging procedures listed in the Department of Insurance (DOI) service lists.

b. **Eliminate HCPCS codes that do not result in a distinct payment.** Eliminate HCPCS codes that are packaged into various APCs and are never or only sometimes distinctly paid and services are not eligible for payment.

c. **Create a market basket list of APCs and HCPCS codes** (see Table 5).

Step 2A: Estimate the distribution of market basket outpatient services by hospital for E-CT patients.

a. **Identify E-CT (all-payer) CHIME patient emergency department and outpatient surgical discharges.** Using patient residence zip codes, identify the CHIME FY2016 statewide discharges for patients residing in E-CT.

b. **Identify E-CT Medicaid market basket services.** Using data from a FOIA request, identify the statewide hospitals providing Medicaid market basket services for patients residing in E-CT.

c. **Identify E-CT Medicare market basket services.** Using the Medicare 5% sample, identify the statewide hospitals providing Medicare market basket services for patient residing in the three counties of E-CT.

d. **Estimate the distribution by hospital of market basket outpatient services for residents of E-CT for Medicaid, Medicare, and commercial payers by hospital area** (see Exhibit 7A).

Step 2B: Summarize the distribution of emergency department discharges where the primary diagnosis if mental illness or substance abuse. From the emergency department discharges identified in Step 2A.a, identify all discharges where the primary ICD-10 diagnosis code starts with the letter F (F denotes mental illness or substance

[24] Standard Analytical Files (Medicare Claims). *Centers for Medicare and Medicaid Services (CMS)*. N.p., n.d. Web. 23 Apr. 2017. https://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/standardanalyticalfiles.html.

[25] "Hospital Outpatient PPS." *Centers for Medicare and Medicaid Services (CMS)*. N.p., 30 Dec. 2016. Web. 5 May 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospitaloutpatientpps/?agree=yes&next=Accept.

[26] MarketScan® Research Databases. *Truven Health Analytics*. N.p., n.d. Web. 25 Apr. 2017. http://truvenhealth.com/markets/life-sciences/products/data-tools/marketscan-databases.

[27] List of sources available upon request.

abuse) and summarize the discharges for Medicaid, Medicare, and commercial payers by hospital area (see Exhibit 7B).

Calculate Historical and Current Fees

Step 3: **Track Medicare average APC fees from CY2015 to CY2017**.

a. **Develop hospital fees** using each hospital's geographic assignment, the wage factor for the geography, and the national fee per APC relative weight unit.

b. **Weight across hospitals** using each hospitals' proportion of Medicare market basket services, developed from the CY2015 Medicare 5% sample.

Step 4: **Track Medicaid average APC fees from July 2015 to CY2017**.

c. **Develop hospital fees** using APC fee data and the hospital outpatient Medicaid Modernization impact analysis from the CT Medicaid website.

d. **Weight across hospitals** using each hospitals' proportion of Medicaid market basket services, developed using data from the FOIA request.

Step 5: Estimate commercial E-CT fee levels for FY2015 using Truven MarketScan and Milliman Consolidated Health Cost Guidelines Sources Database claims data.

Step 6: Estimate commercial E-CT fee trends from FY2015 to FY2016 using various public sources.

Step 7: Estimate L+MH's commercial hospital outpatient fees levels for FY2016 using billing and payment data provided by L+MH.

Estimate Payer Distribution

Step 8: Estimate the service distribution by payer for the hospitals serving E-CT patients.

a. **Sum outpatient hospital net revenue by payer for the 13 hospitals.**

b. **Adjust the distribution from Step 8a for differences in relative fees and impute the service distribution by payer** using the relative fee levels by payer calculated from Steps 4, 5, and 7.

Project Future Fees

Step 9: Project CY2018 Medicare fees by hospital using Medicare final wage indices and final CBSA assignments. Assume 0.5% increase in APC fee per relative weight unit.

Step 10: Project CY2018 Medicaid fees by hospital using Medicaid final wage indices and final geographical CBSA assignments. Assume no change in APC fee per relative weight unit.

Step 11: Project CY2018 commercial fees (in total for non-L+MH hospitals). Assume a 4% non-L+MH trend continues for the 2.25 year span between FY2016 and CY2018

Step 12: Find the L+MH FY2018 commercial fee that maintains the FY2016 ratio of L+MH fees to total market fee using the CY2016 historical fees and the projected CY2018 fees. Weight across hospitals using results from Step 3. Weight across payers (same weight for all hospitals) using result of Step 9.

PHYSICIAN CARE

Overview

Physician groups provide services including office visits, surgical procedures, anesthesia services, laboratory services, and other diagnostic and therapeutic services. Physician groups provide these services in several settings including offices, hospitals, skilled nursing facilities, and others. A physician may bill one or several services for a single patient interaction.

Medicare pays for most physician services using a formula that incorporates time and intensity of the service (work), costs of maintaining a practice (practice expense or PE), and costs of malpractice insurance (MP). Each component is quantified using relative value units (RVU) adjusted for geographic variations using geographic practice cost indices (GPCI). Medicare uses a different approach to set fees for laboratory services. The sum of these pieces is then multiplied by a conversion factor to generate the payment for a given service. This is described in the following formula:

$$\begin{aligned} Physician\ Fee = &(Work\ RVU\ x\ CT\ Work\ GPCI) \\ &+ (PE\ RVU\ x\ CT\ PE\ GPCI) \\ &+ (MP\ RVU\ x\ CT\ MP\ GPCI) \end{aligned}$$

CT Medicaid pays for physician services using a fee schedule available on the DSS website. Commercial fee levels vary between payers and between various providers paid by the same payer.

As described below, we created a market basket of HCPCS associated with LMMG's top physician services.

Data

We relied upon the following data sources for our physician analysis:

- LMMG physician billing data for physician services provided from October 2014 – June 2016.
- CT Medicaid fee schedules from the DSS website[28].
- CT Medicaid freedom of information act (FOIA) request for counts of market basket physician services provided CY2016 to E-CT patients by LMMG physicians and other physicians by geographical area.
- Medicare 5% sample of Medicare fee for service claims CY2014[29].
- Medicare conversion factors from CY2015 to CY2016[30] and for CY2017[31].
- Medicare geographic practice cost indices for CY2015[32] and from CY2016 to CY2017[33].

[28] Connecticut Provider Fee Schedule. *Connecticut Department of Social Services*. N.p., n.d. Web. 21 May 2017. https://www.ctdssmap.com/CTPortal/Provider/ProviderFeeScheduleDownload/tabid/54/Default.aspx.

[29] Standard Analytical Files (Medicare Claims). *Centers for Medicare and Medicaid Services (CMS)*. N.p., n.d. Web. 23 Apr. 2017. https://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/standardanalyticalfiles.html.

[30] "History of Medicare Conversion Factors." American Academy of Pediatrics, n.d. Web. 3 June 2017. https://www.aap.org/en-us/Documents/coding_valuationpayment_medicare_conversion_factor_history.pdf.

[31] "Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year (CY) 2017." *Centers for Medicare and Medicaid Services (CMS)*. N.p., 2 Nov. 2016. Web. 2 June 2017. https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2016-fact-sheets-items/2016-11-02.html.

[32] "CMS-1612-FC." *Centers for Medicare and Medicaid Services (CMS)*. N.p., 13 Nov. 2014. Web. 3 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html.

[33] "CMS-1654-F." *Centers for Medicare and Medicaid Services (CMS)*. N.p., 19 Jan. 2017. Web. 5 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html.

- Medicare HCPCS payment per relative weight units for CY2015[34] and from CY2016 to CY2017[35].
- NPI registry data[36].
- Other
    - County to zip code mapping provided by YNH and checked for reasonableness.
    - Data from various sources for commercial physician fee trends[37].

Methodology

Summarize Physician Services

Step 1: Create a set of physician market basket services.

a. **Rank order by frequency of procedure codes for physician services provided by LMMG.** Count the number of procedures performed at LMMG in June 2016 by HCPCS code and select the most common procedures.

b. **Eliminate procedure codes that are not for payment purposes or are invalid.**

c. **Create a market basket list of 25 HCPCS codes** (see Table 6).

Step 2: Calculate the distribution of market basket physician services by payer for services performed at LMMG.

a. **Map "financial class" that appears in LMMG data to Medicare, Medicaid, commercial, or other** (see Table 7).

b. **Map each location in LMMG data as "facility" or "non-facility"**. Each location is first mapped to a CMS Location Type using a table provided by LMMG (see Table 8). The CMS Location Type is used to determine if the location is considered "Non-Facility" or "Facility".

c. **Calculate the distribution of market basket physician services by payer for E-CT patients for FY2015 and FY2016** (see Exhibit 10). The LMMG data contains all 12 months of FY2015, but only the first 8.5 months of FY2016, because L+MH switched accounting systems mid-June 2016. October 2015 – May 2016 services were annualized to estimate the total services provided in FY2016.

d. **Calculate Medicaid allowed as a percent of Medicare allowed for market basket physician services.** For market basket services provided to Medicaid patients, calculate the Medicare allowed amounts using the 2017 Medicare fee schedule.

Step 3: **Calculate the percent of market basket services provided by LMMG, other E-CT physicians, and non-E-CT physicians**.

a. **Calculate the percent of Medicaid market basket physician services provided by LMMG, other E-CT physicians, and non-E-CT physicians** using data provided by CT Medicaid via a FOIA request.

b. **Calculate the percent of Medicare market basket services provided by LMMG, other E-CT physicians, and non-E-CT physicians.**

    i. **Identify E-CT zip codes** (see Table 2).

    ii. **Identify the E-CT and non-E-CT market basket services by HCPCS code and physician NPI and listed zip code with the Medicare 5% sample.**

[34] "CMS-1612-FC." Centers for Medicare and Medicaid Services (CMS). N.p., 13 Nov. 2014. Web. 3 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html.

[35] "CMS-1654-F." *Centers for Medicare and Medicaid Services (CMS).* N.p., 19 Jan. 2017. Web. 5 June 2017. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html.

[36] "DataDissemination." CMS.gov Centers for Medicare & Medicaid Services. N.p., 04 Aug. 2016. Web. 22 June 2017. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/DataDissemination.html.

[37] List of sources available upon request.

iii. **Estimate the total volume of E-CT and non-E-CT Medicare market basket services.** "Gross up" the 5% sample of fee-for-service Medicare services to 100% of total Medicare services (fee-for-service and Medicare Advantage).

iv. **Divide E-CT market basket services between LMMG and other E-CT physicians** using LMMG's data for LMMG's portion.

Calculate Historical and Current Fees

Step 4: **Develop Medicare fees for CY2015 to CY2017**.

a. **Develop Medicare fees by service, year, and location of service for market basket services paid using work, practice expense (PE), and malpractice (MP) RVUs** from Medicare fee data.

b. **List Medicare fees by service and year for market basket laboratory services** using Medicare fee data.

Step 5: Calculate Medicare trends. Weight the fees developed in Step 4 by LMMG's distribution of market basket services across all time periods in the LMMG billing data.

Step 6: Develop Medicaid fees for FY2016 to now using Medicaid fee data. Note: the data shows that there have been no changes since the beginning of FY2016.

Step 7: **Compare Medicaid fees to Medicare fees**. "Reprice" LMMG's market basket Medicaid services using CY2017 Medicare fees. Calculate the ratio of Medicaid fees to Medicare fees.

Project Future Fees

Step 8: Project CY2018 Medicaid fees for LMMG. Medicaid fees have remained flat since September 2015. There are no announcements that indicate that Medicaid fees will significantly change between now and CY2018.

Step 9: Project CY2018 Medicare fees for LMMG. Medicare fees have changed very modestly from CY2015 to CY2017. There are no announcements that indicate that Medicare fees will significantly change between now and CY2018.

Step 10: Project CY2018 commercial fee increase for the market. Based on a review of recent trends and trend predictions, assume a 4% non-L+MH trend continues for the 2.25 year span between FY2016 and CY2018

Step 11: Find the LMMG FY2018 commercial fee that maintains the FY2016 ratio of LMMG fees to total market fees. Unless there are changes in Medicaid and Medicare fee levels or changes in payer mix, LMMG will be able to maintain its fee ratio to the market if its commercial fee increases are the same as the market's commercial fee increases.

ESTIMATION CHALLENGES

In order to prepare the Cost and Market Impact Review, the independent consultant must estimate current and future prices for L+MC and for the eastern CT market (Tolland, Windham, and New London counties). Here we note important challenges inherent in the estimation process. Because of these challenges, actual current or future prices may vary from our estimates.

Lack of Publicly Available Data

Healthcare prices paid by private payers are generally not publicly available. By contrast, charges defined by hospital "charge masters" are available on the OHCA website[38]. Virtually no payer, however, pays the charges in these reports. Payers, including Medicare, Medicaid, and commercial insurance companies, declare or negotiate their prices. These negotiated prices often have little relationship to the reported charges, and may vary substantially from payer to payer. While prices (inclusive of patient cost sharing) are the "true cost" of care, hospitals and physician groups are not required to reveal the actual prices for the care that they provide. Therefore, we estimated historical prices from various public and non-public data sources. Connecticut has been working on developing an all payer claims database (APCD) for some time. We confirmed that at the time of this project, APCD data was not available[39]. Complete APCD data, if available in future years, will provide additional precision to our estimates of commercial prices.

Recent and Future Price Increases are Unknown

The goal of assuring that L+MC's future price increases per unit service (fees) do not exceed the market fee increases requires knowledge of recent and future fee increases in the market. Future fee increases are often unknown and may be subject to disruptive changes, such as a significant change in a government fee schedule. Furthermore, for commercial insurance, it may take months to years for public and non-public data sources to become available for the estimation of recent fee increases. We have made estimates of recent and future changes and will adjust them as further data becomes available.

Reliance on Data from Financial Reports

For hospital inpatient discharges, we estimate FY2016 prices using hospital net revenue as reported by the hospitals. The reported net revenue is the most recent (through September 2016), comprehensive (all patients and payers), and consistent (all CT hospitals) data source for estimating hospital prices. Reported net revenue, however, is subject to accounting adjustments that are not necessarily related to services rendered in the reporting period and the prices for the reporting period services. For example, there may be an adjustment for an over- or under-estimate of the prior year's net revenue. We have implicitly assumed that the adjustments are minor and/or "cancel-out" (negatives offset positives) across the hospitals within a region.

Changes in Payer Mix

Because different payers may pay different fees, changes in payer mix can affect a provider's fee across all payers, aside from any individual fee changes by payer. Therefore, the calculation of an allowed fee increase requires estimates of payer mix by hospital or group of hospitals. For example, Medicaid typically has the lowest fee and therefore a hospital that decreases Medicaid patient volume will collect higher average fees per patient without any fee increase. Conversely, a hospital that increases its Medicaid patient volume will need to increase its commercial fees in order to maintain its average fees level. We have made estimates of changes in payer mix.

Changes in Provider Mix

Because different providers may charge different fees, changes in provider mix can affect the market's fee, aside from any individual fee changes by provider. Therefore, the calculation of market fee increases requires estimates of the past and future provider mix for the market. For example, if patients shift to a hospital or group of hospitals with higher fees, then the hospital fee for the market will increase without any hospital-level fee increases. We have made estimates of changes in provider mix.

[38] "Hospital Pricemaster Filings" *Department of Public Health*. State of Connecticut, n.d. Web. 4 May 2017. http://www.ct.gov/dph/cwp/view.asp?a=3902&q=526224.

[39] E-mail from Robert Blundo, acting Director of Access Health, 4 Apr 2017.

LIMITATIONS AND CAVEATS

In performing our analysis, we relied on data and information as described above. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. The rate cap estimates are based on assumptions which we have summarized in our report. Our estimates should be viewed as best estimates. For some of the assumptions, there are reasonable alternative assumptions which would result in higher and lower estimates for the rate caps.

This work product was prepared to satisfy Conditions 22 b, c, d, and e of the Agreed Settlement between YNHHSC and the Commissioner of the Department of Public Health. It may be inappropriate to rely upon it for any other purpose. We were required to follow the terms of the Agreed Settlement, including reporting to and taking additional direction from the Commissioner. We believe we have satisfied the terms in the Agreed Settlement.

As required by the Agreed Settlement, YNHHSC engaged Milliman as an independent consultant. Milliman agrees that the work product may be provided to OHCA and the independent monitor that monitors YNHYSC's compliance with the Agreed Settlement. Milliman does not intend to benefit any third party recipient of work product, even when Milliman consents to the release of work product to such third party.

The American Academy of Actuaries requires its members to identify their qualifications in communications. Tia Goss Sawhney and Bruce Pyenson are actuaries employed by Milliman and meet the Academy's qualifications to issue this communication.

EXHIBITS

HOSPITAL INPATIENT CARE

Exhibit 1. Inpatient Discharges for Patients Residing in E-CT

Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges			FY2014 - 2016	
	FY2014	FY2015	FY2016	Δ in %	CAGR
Total Discharges	**51,337**	**51,900**	**51,037**	**-0.6%**	**-0.3%**
% L+MH	26.0%	25.5%	24.9%	-4.0%	-2.0%
% Other E-CT Hospitals	41.0%	39.3%	37.4%	-8.8%	-4.5%
% E-CT Hospitals (incl. L+MH)	67.0%	64.8%	62.3%	-6.9%	-3.5%
% Non-E-CT Hospitals	33.0%	35.2%	37.7%	+14.1%	+6.8%
Market Basket MS-DRGs	**25,338**	**26,164**	**25,417**	**+0.3%**	**+0.2%**
% L+MH	29.8%	28.6%	27.2%	-8.5%	-4.4%
% Other E-CT Hospitals	42.8%	41.8%	40.7%	-4.9%	-2.5%
% E-CT Hospitals (incl. L+MH)	72.6%	70.4%	67.9%	-6.4%	-3.2%
% Non-E-CT Hospitals	27.4%	29.6%	32.1%	+16.9%	+8.1%
Non-Market Basket MS-DRGs	**25,999**	**25,736**	**25,620**	**-1.5%**	**-0.7%**
% L+MH	22.3%	22.3%	22.7%	+1.7%	+0.9%
% Other E-CT Hospitals	39.2%	36.8%	34.1%	-13.1%	-6.8%
% E-CT Hospitals (incl. L+MH)	61.5%	59.1%	56.8%	-7.7%	-3.9%
% Non-E-CT Hospitals	38.5%	40.9%	43.2%	+12.4%	+6.0%

Exhibit 2A. Inpatient Market Basket MS-DRG Discharges by Payer for Patients Residing in E-CT

Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges			Distribution by Payer		
	FY2014	FY2015	FY2016	FY2014	FY2015	FY2016
Total Market Basket MS-DRG Discharges	**25,338**	**26,164**	**25,417**	**100.0%**	**100.0%**	**100.0%**
Medicare	9,827	10,525	10,069	38.8%	40.2%	39.6%
Medicaid	5,407	5,896	5,720	21.3%	22.5%	22.5%
Commercial	9,474	9,161	9,091	37.4%	35.0%	35.8%
L+MH Market Basket MS-DRG Discharges	**7,539**	**7,490**	**6,916**	**100.0%**	**100.0%**	**100.0%**
Medicare	2,991	3,061	2,698	39.7%	40.9%	39.0%
Medicaid	1,734	1,763	1,666	23.0%	23.5%	24.1%
Commercial	2,666	2,524	2,437	35.4%	33.7%	35.2%
Other E-CT Market Basket MS-DRG Discharges	**10,849**	**10,935**	**10,351**	**100.0%**	**100.0%**	**100.0%**
Medicare	4,687	5,031	4,693	43.2%	46.0%	45.3%
Medicaid	2,530	2,703	2,505	23.3%	24.7%	24.2%
Commercial	3,233	2,884	2,860	29.8%	26.4%	27.6%
E-CT Market Basket MS-DRG Discharges	**18,388**	**18,425**	**17,267**	**100.0%**	**100.0%**	**100.0%**
Medicare	7,678	8,092	7,391	41.8%	43.9%	42.8%
Medicaid	4,264	4,466	4,171	23.2%	24.2%	24.2%
Commercial	5,899	5,408	5,297	32.1%	29.4%	30.7%
Non-E-CT Market Basket MS-DRG Discharges	**6,950**	**7,739**	**8,150**	**100.0%**	**100.0%**	**100.0%**
Medicare	2,149	2,433	2,678	30.9%	31.4%	32.9%
Medicaid	1,143	1,430	1,549	16.4%	18.5%	19.0%
Commercial	3,575	3,753	3,794	51.4%	48.5%	46.6%

Note: Totals include Uninsured and Other payer (not shown).

Exhibit 2B. Inpatient Market Basket MS-DRG Discharges by Payer for Patients Residing in E-CT
Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges					Distribution by Payer and Provider				
	FY2014	FY2015	FY2016	FY14-16 Δ in %	FY14-16 CAGR	FY2014	FY2015	FY2016	FY14-16 Δ in %	FY14-16 CAGR
Total Market Basket MS-DRG Discharges	**25,338**	**26,164**	**25,417**	**+0.3%**	**+0.2%**	**100.0%**	**100.0%**	**100.0%**	**-**	**-**
Medicare	9,827	10,525	10,069	+2.5%	+1.2%	38.8%	40.2%	39.6%	+2.1%	+1.1%
Medicaid	5,407	5,896	5,720	+5.8%	+2.9%	21.3%	22.5%	22.5%	+5.5%	+2.7%
Commercial	9,474	9,161	9,091	-4.0%	-2.0%	37.4%	35.0%	35.8%	-4.3%	-2.2%
L+MH Market Basket MS-DRG Discharges	**7,539**	**7,490**	**6,916**	**-8.3%**	**-4.2%**	**29.8%**	**28.6%**	**27.2%**	**-8.5%**	**-4.4%**
Medicare	2,991	3,061	2,698	-9.8%	-5.0%	11.8%	11.7%	10.6%	-10.1%	-5.2%
Medicaid	1,734	1,763	1,666	-3.9%	-2.0%	6.8%	6.7%	6.6%	-4.2%	-2.1%
Commercial	2,666	2,524	2,437	-8.6%	-4.4%	10.5%	9.6%	9.6%	-8.9%	-4.5%
Other E-CT Market Basket MS-DRG Discharges	**10,849**	**10,935**	**10,351**	**-4.6%**	**-2.3%**	**42.8%**	**41.8%**	**40.7%**	**-4.9%**	**-2.5%**
Medicare	4,687	5,031	4,693	+0.1%	+0.1%	18.5%	19.2%	18.5%	-0.2%	-0.1%
Medicaid	2,530	2,703	2,505	-1.0%	-0.5%	10.0%	10.3%	9.9%	-1.3%	-0.7%
Commercial	3,233	2,884	2,860	-11.5%	-5.9%	12.8%	11.0%	11.3%	-11.8%	-6.1%
E-CT Market Basket MS-DRG Discharges	**18,388**	**18,425**	**17,267**	**-6.1%**	**-3.1%**	**72.6%**	**70.4%**	**67.9%**	**-6.4%**	**-3.2%**
Medicare	7,678	8,092	7,391	-3.7%	-1.9%	30.3%	30.9%	29.1%	-4.0%	-2.0%
Medicaid	4,264	4,466	4,171	-2.2%	-1.1%	16.8%	17.1%	16.4%	-2.5%	-1.3%
Commercial	5,899	5,408	5,297	-10.2%	-5.2%	23.3%	20.7%	20.8%	-10.5%	-5.4%
Non-E-CT Market Basket MS-DRG Discharges	**6,950**	**7,739**	**8,150**	**+17.3%**	**+8.3%**	**27.4%**	**29.6%**	**32.1%**	**+16.9%**	**+8.1%**
Medicare	2,149	2,433	2,678	+24.6%	+11.6%	8.5%	9.3%	10.5%	+24.2%	+11.5%
Medicaid	1,143	1,430	1,549	+35.5%	+16.4%	4.5%	5.5%	6.1%	+35.1%	+16.2%
Commercial	3,575	3,753	3,794	+6.1%	+3.0%	14.1%	14.3%	14.9%	+5.8%	+2.9%

Note: Totals include Uninsured and Other payer (not shown).

Exhibit 2C. Inpatient Behavioral Health MS-DRG Discharges by Payer for Patients Residing in E-CT
Source: CT CHIME Data; does not include out-of-state discharges.

	Discharges					Distribution by Payer and Provider				
	FY2014	FY2015	FY2016	FY14-16 Δ in %	FY14-16 CAGR	FY2014	FY2015	FY2016	FY14-16 Δ in %	FY14-16 CAGR
Total Market Basket MS-DRG Discharges	**3,479**	**3,485**	**3,609**	**+3.7%**	**+1.9%**	**100.0%**	**100.0%**	**100.0%**	**-**	**-**
Medicare	858	839	835	-2.7%	-1.3%	24.7%	24.1%	23.1%	-6.2%	-3.1%
Medicaid	1,521	1,655	1,760	+15.7%	+7.6%	43.7%	47.5%	48.8%	+11.5%	+5.6%
Commercial	959	898	909	-5.2%	-2.6%	27.6%	25.8%	25.2%	-8.6%	-4.4%
L+MH Market Basket MS-DRG Discharges	**757**	**746**	**796**	**+5.2%**	**+2.5%**	**21.8%**	**21.4%**	**22.1%**	**+1.4%**	**+0.7%**
Medicare	204	174	186	-8.8%	-4.5%	5.9%	5.0%	5.2%	-12.1%	-6.2%
Medicaid	362	388	389	+7.5%	+3.7%	10.4%	11.1%	10.8%	+3.6%	+1.8%
Commercial	177	171	208	+17.5%	+8.4%	5.1%	4.9%	5.8%	+13.3%	+6.4%
Other E-CT Market Basket MS-DRG Discharges	**1,509**	**1,466**	**1,515**	**+0.4%**	**+0.2%**	**43.4%**	**42.1%**	**42.0%**	**-3.2%**	**-1.6%**
Medicare	428	419	389	-9.1%	-4.7%	12.3%	12.0%	10.8%	-12.4%	-6.4%
Medicaid	640	688	783	+22.3%	+10.6%	18.4%	19.7%	21.7%	+17.9%	+8.6%
Commercial	369	312	300	-18.7%	-9.8%	10.6%	9.0%	8.3%	-21.6%	-11.5%
E-CT Market Basket MS-DRG Discharges	**2,266**	**2,212**	**2,311**	**+2.0%**	**+1.0%**	**65.1%**	**63.5%**	**64.0%**	**-1.7%**	**-0.8%**
Medicare	632	593	575	-9.0%	-4.6%	18.2%	17.0%	15.9%	-12.3%	-6.3%
Medicaid	1,002	1,076	1,172	+17.0%	+8.2%	28.8%	30.9%	32.5%	+12.8%	+6.2%
Commercial	546	483	508	-7.0%	-3.5%	15.7%	13.9%	14.1%	-10.3%	-5.3%
Non-E-CT Market Basket MS-DRG Discharges	**1,213**	**1,273**	**1,298**	**+7.0%**	**+3.4%**	**34.9%**	**36.5%**	**36.0%**	**+3.2%**	**+1.6%**
Medicare	226	246	260	+15.0%	+7.3%	6.5%	7.1%	7.2%	+10.9%	+5.3%
Medicaid	519	579	588	+13.3%	+6.4%	14.9%	16.6%	16.3%	+9.2%	+4.5%
Commercial	413	415	401	-2.9%	-1.5%	11.9%	11.9%	11.1%	-6.4%	-3.3%

Note: Totals include Uninsured and Other payer (not shown).

Exhibit 3. Case Mix per Inpatient Market Basket MS-DRG Discharge for Patients Residing in E-CT
Source: Reports 165 and 185 filed with OHCA weighted across market basket hospitals and payers using CT CHIME E-CT patient market basket discharges; does not include out-of-state discharges.

	Case Mix per Discharge			FY2014 - 2016	
	FY2014	FY2015	FY2016	Δ in %	CAGR
Total Market Basket MS-DRG Discharges	**1.22**	**1.27**	**1.30**	**+6.6%**	**+3.3%**
Medicare	1.51	1.54	1.56	+3.3%	+1.6%
Medicaid	0.94	1.01	1.06	+12.6%	+6.1%
Commercial	1.09	1.15	1.18	+7.6%	+3.8%
L+MH Market Basket MS-DRG Discharges	**1.17**	**1.20**	**1.23**	**+5.7%**	**+2.8%**
Medicare	1.46	1.46	1.48	+1.2%	+0.6%
Medicaid	0.92	1.02	1.07	+15.4%	+7.4%
Commercial	1.00	1.02	1.08	+7.6%	+3.7%
Other E-CT Market Basket MS-DRG Discharges	**1.18**	**1.25**	**1.26**	**+7.0%**	**+3.4%**
Medicare	1.44	1.49	1.49	+3.0%	+1.5%
Medicaid	0.88	0.94	0.97	+10.0%	+4.9%
Commercial	1.05	1.14	1.16	+11.2%	+5.4%
E-CT Market Basket MS-DRG Discharges	**1.17**	**1.23**	**1.25**	**+6.5%**	**+3.2%**
Medicare	1.45	1.48	1.48	+2.3%	+1.2%
Medicaid	0.90	0.97	1.01	+12.2%	+5.9%
Commercial	1.03	1.08	1.12	+9.5%	+4.6%
Non-E-CT Market Basket MS-DRG Discharges	**1.35**	**1.38**	**1.42**	**+4.9%**	**+2.4%**
Medicare	1.73	1.73	1.77	+2.7%	+1.3%
Medicaid	1.11	1.12	1.21	+8.8%	+4.3%
Commercial	1.20	1.24	1.25	+3.9%	+1.9%

Note: Totals include Uninsured and Other payer (not shown); hospital inpatient Medicaid Modernization occurred in 2015.

Exhibit 4A. Estimated Fee per Market Basket MS-DRG per CMAD for Patients Residing in E-CT

Source: Reports 165 and 185 filed with OHCA weighted across market basket hospitals and payers using CT CHIME E-CT patient market basket discharges; does not include out-of-state discharges.

	Fee per CMAD			FY2014 - 2016	
	FY2014	FY2015	FY2016	Δ in %	CAGR
Total Market Basket MS-DRG Discharges	**$8,858**	**$8,640**	**$8,751**	**-1.2%**	**-0.6%**
Medicare	$8,411	$7,849	$7,717	-8.2%	-4.2%
Medicaid	$5,524	$5,200	$5,359	-3.0%	-1.5%
Commercial	$11,460	$12,132	$12,467	+8.8%	+4.3%
L+MH Market Basket MS-DRG Discharges	**$8,281**	**$7,961**	**$8,210**	**-0.9%**	**-0.4%**
Medicare	$8,088	$7,475	$7,755	-4.1%	-2.1%
Medicaid	$4,925	$4,878	$5,067	+2.9%	+1.4%
Commercial	$10,881	$11,065	$11,380	+4.6%	+2.3%
Other E-CT Market Basket MS-DRG Discharges	**$8,151**	**$7,760**	**$7,788**	**-4.5%**	**-2.3%**
Medicare	$8,155	$7,547	$7,368	-9.6%	-4.9%
Medicaid	$5,489	$4,819	$4,896	-10.8%	-5.6%
Commercial	$10,344	$11,121	$11,291	+9.1%	+4.5%
E-CT Market Basket MS-DRG Discharges	**$8,204**	**$7,840**	**$7,955**	**-3.0%**	**-1.5%**
Medicare	$8,129	$7,520	$7,509	-7.6%	-3.9%
Medicaid	$5,253	$4,843	$4,968	-5.4%	-2.7%
Commercial	$10,581	$11,096	$11,330	+7.1%	+3.5%
Non-E-CT Market Basket MS-DRG Discharges	**$10,359**	**$10,340**	**$10,239**	**-1.2%**	**-0.6%**
Medicare	$9,258	$8,783	$8,200	-11.4%	-5.9%
Medicaid	$6,341	$6,164	$6,238	-1.6%	-0.8%
Commercial	$12,695	$13,434	$13,891	+9.4%	+4.6%

Note: Totals include Uninsured and Other payer (not shown); hospital inpatient Medicaid Modernization occurred in 2015.

Exhibit 4B. Estimated Fee per Market Basket MS-DRG per CMAD for Patients Residing in E-CT

Source: Reports 165 and 185 filed with OHCA weighted across market basket hospitals and payers using CT CHIME E-CT patient market basket discharges; does not include out-of-state discharges.

	Fee per CMAD vs. All E-CT			Fee per CMAD vs. Total		
	FY2014	FY2015	FY2016	FY2014	FY2015	FY2016
L+MH Market Basket MS-DRG Discharges	**+100.9%**	**+101.5%**	**+103.2%**	**+93.5%**	**+92.1%**	**+93.8%**
Medicare	+99.5%	+99.4%	+103.3%	+96.2%	+95.2%	+100.5%
Medicaid	+93.8%	+100.7%	+102.0%	+89.2%	+93.8%	+94.5%
Commercial	+102.8%	+99.7%	+100.4%	+94.9%	+91.2%	+91.3%
Other E-CT Market Basket MS-DRG Discharges	**+99.4%**	**+99.0%**	**+97.9%**	**+92.0%**	**+89.8%**	**+89.0%**
Medicare	+100.3%	+100.4%	+98.1%	+97.0%	+96.2%	+95.5%
Medicaid	+104.5%	+99.5%	+98.5%	+99.4%	+92.7%	+91.4%
Commercial	+97.8%	+100.2%	+99.7%	+90.3%	+91.7%	+90.6%
E-CT Market Basket MS-DRG Discharges	**+100.0%**	**+100.0%**	**+100.0%**	**+92.6%**	**+90.7%**	**+90.9%**
Medicare	+100.0%	+100.0%	+100.0%	+96.6%	+95.8%	+97.3%
Medicaid	+100.0%	+100.0%	+100.0%	+95.1%	+93.1%	+92.7%
Commercial	+100.0%	+100.0%	+100.0%	+92.3%	+91.5%	+90.9%
Non-E-CT Market Basket MS-DRG Discharges	**+126.3%**	**+131.9%**	**+128.7%**	**+116.9%**	**+119.7%**	**+117.0%**
Medicare	+113.9%	+116.8%	+109.2%	+110.1%	+111.9%	+106.2%
Medicaid	+120.7%	+127.3%	+125.6%	+114.8%	+118.5%	+116.4%
Commercial	+120.0%	+121.1%	+122.6%	+110.8%	+110.7%	+111.4%

Note: Totals include Uninsured and Other payer (not shown); inpatient hospital Medicaid Modernization occurred in 2015.

Exhibit 5A. Change in CT Medicaid Fees per Market Basket MS-DRG per CMAD

Source: DSS Website, weighted across market basket hospitals using CT CHIME E-CT patient market basket discharges.

	FY16-CY18 Δ in %	FY16-CY18 CAGR
Total Market	**-9.2%**	**-4.2%**
L+MH	-12.8%	-5.9%
Other E-CT	-8.4%	-3.8%
E-CT	-10.4%	-4.8%
Non-E-CT	-6.8%	-3.1%

Notes: These are the combined changes of the January 1, 2017 fee change and the planned January 1, 2018 fee change.

Exhibit 5B. Change in Medicare Fees per CMAD

Source: CMS 2015, 2016, 2017, and 2018 IPPS Final Rule; Milliman Analysis.

	CY15-CY16 Δ in %	CY16-CY17 Δ in %	CY17-CY18 Δ in %	FY16-CY18 Δ in %	FY16-CY18 CAGR
Total Market	**-0.6%**	**+1.2%**	**+2.1%**	**+3.2%**	**+1.4%**
L+MH	+3.8%	+0.4%	-0.0%	+1.3%	+0.6%
Other E-CT	-2.2%	+1.0%	+5.9%	+6.4%	+2.8%
E-CT	+0.3%	+0.8%	+3.4%	+4.2%	+1.9%
Non-E-CT	-3.2%	+1.9%	-0.2%	+0.9%	+0.4%

HOSPITAL OUTPATIENT CARE

Exhibit 6. Distribution of Net Revenue for CT Hospitals by Service Line and Payer

Source: Report 165 filed with OHCA.

	FY2015 Net Revenue by Service Line			
	L+MH	Other E-CT	Total E-CT	Non-E-CT
Net Revenue (%)	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Inpatient	41.7%	38.5%	39.6%	57.2%
Outpatient	58.3%	61.5%	60.4%	42.8%

	FY2015 Net Revenue by Payer			
	L+MH	Other E-CT	Total E-CT	Non-E-CT
Outpatient Net Revenue (%)	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Medicare	26.3%	24.6%	25.2%	23.3%
Medicaid	11.8%	13.4%	12.9%	12.9%
Commercial	61.4%	61.3%	61.3%	62.6%

Note: Totals include Uninsured and Other payer (not shown)

Exhibit 7. Hospital Outpatient Market Basket Services by Payer for Patients Residing in E-CT

Source: CT Medicaid OP FOIA request, Medicare 5% sample, and CHIME data; excludes out of state services

	FY2016 Distribution of Discharges by Payer			
	L + MH	Other E-CT	Non-E-CT	Total E-CT
ED Visits - All[1]	**29.5%**	**58.5%**	**11.9%**	**88.1%**
Medicare	28.1%	61.2%	10.7%	89.3%
Medicaid	29.4%	62.5%	8.1%	91.9%
Commercial	30.5%	52.5%	17.0%	83.0%
ED Visits - Behavioral Health[1]	**29.6%**	**58.9%**	**11.5%**	**88.5%**
Medicare	32.6%	60.8%	6.6%	93.4%
Medicaid	29.5%	60.1%	10.4%	89.6%
Commercial	27.6%	54.7%	17.7%	82.3%
OP Surgeries[1]	**20.1%**	**44.3%**	**35.5%**	**64.5%**
Medicare	18.3%	46.2%	35.4%	64.6%
Medicaid	24.8%	45.9%	29.3%	70.7%
Commercial	20.0%	42.2%	37.9%	62.1%
Market Basket Services[2]				
Medicare[2]	21.0%	53.9%	25.1%	74.9%
Medicaid[2]	21.6%	58.8%	19.5%	80.5%
Commercial	22.9%	77.1%		

Notes:
1) Calculated from CT CHIME data, 2) Medicare and Medicaid market basket services are calculated from their respective data sources, 2) commercial is estimated (by Milliman) using Medicare and Medicaid market basket data and CHIME data

Exhibit 8. Medicaid APC Service Fee Changes

Source: CMS OPPS fee schedules and Milliman analysis.

	Medicaid APC Service Fee Changes by Hospital			
	L+MH	Other E-CT	Non-E-CT	Total
July 1, 2016				
Minimum, any hospital		-0.9%	-32.1%	-32.1%
Maximum, any hospital		+23.0%	+6.9%	+23.0%
Average	**-11.0%**	**+10.0%**	**-6.2%**	**+1.4%**
January 1, 2017				
Minimum, any hospital		-1.2%	-1.3%	-1.3%
Maximum, any hospital		+2.3%	+2.3%	+2.3%
Average	**-1.2%**	**-0.2%**	**+2.0%**	**0.0%**

Note: average values are weighted across hospitals using estimated volume of market basket services for E-CT patients.

Exhibit 9. Medicare APC Service Fee Changes by Calendar Year

Source: Medicare 5% sample data and CMS wage tables.

	Fee Changes by Medicare Calendar Year		
Area	2016	2017	2018
L+MH	+3.8%	+1.1%	-0.2%
Other E-CT	-2.7%	+2.3%	+3.6%
Non-E-CT	-2.6%	+3.3%	-0.5%
Market Basket	-1.3%	+2.3%	+1.7%
APC Base Fee	**-0.6%**	**+1.7%**	**+0.5%**

Note: 2018 is based on the CMS corrected final rule for geographical assignments, wage indices, and an assumed +0.5% increase in the APC base fee.

PHYSICIAN CARE

Exhibit 10. Count and Distribution of LMMG Market Basket Services by Payer

Source: LMMG billing data for physician services provided in October 2014 - May 2016.

Payer	FY2015		FY2016*	
	Services	% of Total	Services	% of Total
Total	**230,182**	**100.0%**	**230,760**	**100.0%**
Medicare	100,361	43.6%	101,783	44.1%
Medicaid	31,947	13.9%	32,897	14.3%
Commercial	95,636	41.5%	94,119	40.8%
Other	2,238	1.0%	1,962	0.9%

Note: Due to an accounting system change, FY2016 is estimated from 8 months of data.

Exhibit 11. Distribution of Market Basket Services for E-CT Patients with Medicaid and Medicare

Source: Medicare 5% sample, CT Medicaid FOIA Request, LMMG data.

Area	Distribution of Market Basket Services	
	CY2016	CY2014
	Medicaid	Medicare
Total	**100.0%**	**100.0%**
Non-E-CT	**32.2%**	**33.5%**
Total E-CT	**67.8%**	**66.5%**
LMMG	7.1%	12.0%
Other E-CT	60.7%	54.4%

Exhibit 12. Medicare Fee Trend

Source: CMS Fee Schedules for 2015, 2016, and 2017 for market basket services, weighted using LMMG billing data for physician services provided in October 2014 - May 2016.

Year	Average Fee
CY 2015	$77.59
CY 2016	$77.31
CY 2017	$77.37
CY2015-CY2017 Trend	**-0.3%**

Note: the average fee was weighted using LMMG's service mix.

APPENDIX – REFERENCE TABLES

Table 1. Summary of Inpatient Discharges

By MS-DRG for Patients Residing in CT for FY2014-FY2015

Source: CHIME, FY2014 and FY2015, IC9-CM Diagnosis and Procedure Codes were used in identification.

Order	MS-DRG	Description	ALL CHIME Inpatient Discharges	CT DOI Identified	
				Inpatient Discharges	% of ALL CHIME Inpatient Discharges
Total			**796,569**	**422,337**	**53.0%**
1	795	Normal newborn	47,772	38,821	81.3%
2	775	Vaginal delivery w/o complicating diagnoses	39,033	37,697	96.6%
3	470	Major joint replacement or reattachment of lower extremity w/o MCC	25,352	25,352	100.0%
4	766	Cesarean section w/o CC/MCC	15,509	15,509	100.0%
5	794	Neonate w other significant problems	16,491	12,351	74.9%
6	765	Cesarean section w CC/MCC	9,798	9,798	100.0%
7	871	Septicemia or severe sepsis w/o MV 96+ hours w MCC	22,408	8,831	39.4%
8	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	11,410	7,190	63.0%
9	392	Esophagitis, gastroent & misc digest disorders w/o MCC	16,848	7,074	42.0%
10	774	Vaginal delivery w complicating diagnoses	7,097	6,726	94.8%
11	291	Heart failure & shock w MCC	9,003	6,630	73.6%
12	189	Pulmonary edema & respiratory failure	6,289	6,148	97.8%
13	292	Heart failure & shock w CC	8,421	6,131	72.8%
14	378	G.I. hemorrhage w CC	7,580	5,339	70.4%
15	460	Spinal fusion except cervical w/o MCC	4,830	4,830	100.0%
16	247	Perc cardiovasc proc w drug-eluting stent w/o MCC	4,794	4,794	100.0%
17	190	Chronic obstructive pulmonary disease w MCC	5,775	4,274	74.0%
18	621	O.R. procedures for obesity w/o CC/MCC	4,068	4,068	100.0%
19	743	Uterine & adnexa proc for non-malignancy w/o CC/MCC	3,946	3,946	100.0%
20	330	Major small & large bowel procedures w CC	3,658	3,658	100.0%
21	481	Hip & femur procedures except major joint w CC	3,603	3,603	100.0%
22	310	Cardiac arrhythmia & conduction disorders w/o CC/MCC	4,802	3,428	71.4%
23	309	Cardiac arrhythmia & conduction disorders w CC	5,185	3,363	64.9%
24	287	Circulatory disorders except AMI, w card cath w/o MCC	3,807	3,305	86.8%
25	191	Chronic obstructive pulmonary disease w CC	5,282	3,241	61.4%
26	065	Intracranial Hemorrhage Or Cerebral Infarction w CC or TPA In 24 Hrs	4,705	3,217	68.4%
27	792	Prematurity w/o major problems	4,009	3,164	78.9%
28	945	Rehabilitation w CC/MCC	2,995	2,992	99.9%
29	208	Respiratory system diagnosis w ventilator support <96 hours	2,927	2,927	100.0%
30	853	Infectious & parasitic diseases w O.R. procedure w MCC	2,892	2,892	100.0%
31	847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	2,894	2,867	99.1%
32	812	Red blood cell disorders w/o MCC	5,401	2,640	48.9%
33	308	Cardiac arrhythmia & conduction disorders w MCC	3,233	2,624	81.2%

Order	MS-DRG	Description	ALL CHIME Inpatient Discharges	CT DOI Identified	
				Inpatient Discharges	% of ALL CHIME Inpatient Discharges
34	280	Acute myocardial infarction, discharged alive w MCC	2,884	2,624	91.0%
35	331	Major small & large bowel procedures w/o CC/MCC	2,608	2,608	100.0%
36	419	Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC	2,607	2,607	100.0%
37	793	Full term neonate w major problems	3,654	2,600	71.2%
38	603	Cellulitis w/o MCC	11,065	2,560	23.1%
39	473	Cervical spinal fusion w/o CC/MCC	2,253	2,253	100.0%
40	494	Lower extrem & humer proc except hip,foot,femur w/o CC/MCC	2,248	2,248	100.0%
41	066	Intracranial hemorrhage or cerebral infarction w/o CC/MCC	2,942	2,125	72.2%
42	064	Intracranial hemorrhage or cerebral infarction w MCC	3,341	2,123	63.5%
43	377	G.I. hemorrhage w MCC	2,726	2,060	75.6%
44	329	Major small & large bowel procedures w MCC	1,961	1,961	100.0%
45	281	Acute myocardial infarction, discharged alive w CC	2,028	1,822	89.8%
46	192	Chronic obstructive pulmonary disease w/o CC/MCC	3,121	1,807	57.9%
47	872	Septicemia or severe sepsis w/o MV 96+ hours w/o MCC	8,894	1,803	20.3%
48	343	Appendectomy w/o complicated principal diag w/o CC/MCC	1,722	1,722	100.0%
49	253	Other vascular procedures w CC	1,712	1,712	100.0%
50	682	Renal failure w MCC	4,741	1,683	35.5%

Table 2. Zip Code to County Mappings

Source: YNH, verified by Milliman.

Zip Code	County
06249	New London, CT
06254	New London, CT
06320	New London, CT
06330	New London, CT
06333	New London, CT
06334	New London, CT
06335	New London, CT
06336	New London, CT
06338	New London, CT
06339	New London, CT
06340	New London, CT
06349	New London, CT
06350	New London, CT
06351	New London, CT
06353	New London, CT
06355	New London, CT
06357	New London, CT
06359	New London, CT
06360	New London, CT
06365	New London, CT
06370	New London, CT
06371	New London, CT
06372	New London, CT
06375	New London, CT
06376	New London, CT
06378	New London, CT
06379	New London, CT
06380	New London, CT
06382	New London, CT
06383	New London, CT
06384	New London, CT
06385	New London, CT
06388	New London, CT
06389	New London, CT
06415	New London, CT
06420	New London, CT
06439	New London, CT
06474	New London, CT
06029	Tolland, CT
06043	Tolland, CT
06066	Tolland, CT
06071	Tolland, CT
06072	Tolland, CT
06075	Tolland, CT
06076	Tolland, CT
06077	Tolland, CT
06084	Tolland, CT

Zip Code	County
06231	Tolland, CT
06232	Tolland, CT
06237	Tolland, CT
06238	Tolland, CT
06248	Tolland, CT
06250	Tolland, CT
06251	Tolland, CT
06265	Tolland, CT
06268	Tolland, CT
06269	Tolland, CT
06279	Tolland, CT
06226	Windham, CT
06230	Windham, CT
06233	Windham, CT
06234	Windham, CT
06235	Windham, CT
06239	Windham, CT
06241	Windham, CT
06242	Windham, CT
06243	Windham, CT
06244	Windham, CT
06245	Windham, CT
06246	Windham, CT
06247	Windham, CT
06255	Windham, CT
06256	Windham, CT
06258	Windham, CT
06259	Windham, CT
06260	Windham, CT
06262	Windham, CT
06263	Windham, CT
06264	Windham, CT
06266	Windham, CT
06267	Windham, CT
06277	Windham, CT
06278	Windham, CT
06280	Windham, CT
06281	Windham, CT
06282	Windham, CT
06331	Windham, CT
06332	Windham, CT
06354	Windham, CT
06373	Windham, CT
06374	Windham, CT
06377	Windham, CT
06387	Windham, CT

Table 3. Market Basket MS-DRG Discharges

By Facility for Patients Residing in E-CT for FY2014-FY2015
Source: CHIME, FY2014 and FY2015

Facility Name	Region	Hospital County	Market Basket MS-DRG Discharges
Total Market Basket MS-DRG Discharges			**51,837**
Hospitals of Serving the Majority of E-CT Patients			**51,502 / 99.4%**
Lawrence + Memorial Hospital	E-CT	New London, CT	15,029
The William W. Backus Hospital	E-CT	New London, CT	11,067
Hartford Hospital	Non-E-CT	Hartford, CT	4,106
Day Kimball Hospital	E-CT	Windham, CT	4,584
Saint Francis Hospital and Med. Center	Non-E-CT	Hartford, CT	3,215
Yale-New Haven Hospital	Non-E-CT	New Haven, CT	1,949
Windham Hospital	E-CT	Windham, CT	3,299
Manchester Memorial Hospital	Non-E-CT	Hartford, CT	3,369
Rockville General Hospital	E-CT	Tolland, CT	1,695
Middlesex Hospital	Non-E-CT	Middlesex, CT	1,250
Johnson Memorial Hospital	E-CT	Tolland, CT	1,139
Connecticut Children's Medical Center	Non-E-CT	Hartford, CT	403
John Dempsey Hospital	Non-E-CT	Hartford, CT	397
Other CT Hospitals Serving E-CT Patients			**335 / 0.6%**
The Hospital of Central Connecticut	Non-E-CT	Hartford, CT	117
St. Vincent's Medical Center	Non-E-CT	Fairfield, CT	47
Bridgeport Hospital	Non-E-CT	Fairfield, CT	22
MidState Medical Center	Non-E-CT	New Haven, CT	39
Norwalk Hospital	Non-E-CT	Fairfield, CT	12
Saint Mary's Hospital	Non-E-CT	New Haven, CT	20
Danbury Hospital	Non-E-CT	Fairfield, CT	18
Bristol Hospital	Non-E-CT	Hartford, CT	19
Milford Hospital	Non-E-CT	New Haven, CT	14
Waterbury Hospital	Non-E-CT	New Haven, CT	11
Stamford Hospital	Non-E-CT	Fairfield, CT	6
Griffin Hospital	Non-E-CT	New Haven, CT	8
Greenwich Hospital	Non-E-CT	Fairfield, CT	2

Table 4A. CHIME Payer Mappings to Payer Categories

Source: CHIME; Milliman categories

Payer Name in CHIME	Payer Category
Blue Cross	Commercial
Champus/Tricare	Commercial
Charter Oak	Other
Commercial Insur	Commercial
HMO	Commercial
Medicaid	Medicaid
Medicare	Medicare
Medicare Advantage	Medicare
No Charge	Other
Other	Other
Other Fed Prog	Other
PPO	Commercial
Self-Pay	Uninsured
Workers Comp	Commercial
Blank	Other

Table 4B. Twelve Month Actual Filings from OHCA Payer Mappings to Payer Categories

Source: Twelve Month Actual Filings from OHCA; Milliman categories

Payer Name in Report 165	Payer Category
Medicare Traditional	Medicare
Medicare Managed Care	Medicare
Medicaid	Medicaid
Medicaid Managed Care	Medicaid
Champus/Tricare	Commercial
Commercial Insurance	Commercial
Non-Government Managed Care	Commercial
Worker's Compensation	Commercial
Self-Pay/Uninsured	Uninsured
SAGA	Other
Other	Other

Payer Name in Report 185	Payer Category
Non-Government (Including Self Pay / Uninsured)	Commercial
Medicare	Medicare
Medical Assistance	N/A
Medicaid	Medicaid
Other Medical Assistance	Other
Champus / Tricare	Commercial
Uninsured (Included In Non-Government)	Uninsured
Non-Government (Excluding Self Pay / Uninsured)	Commercial

Table 5. Market Basket APCs and HCPCS for Outpatient Services

Source: Compiled from CT Department of Insurance (DOI) Top Outpatient Services Lists

Market Basket APCs for Outpatient Services		
2017	2016	2016 Name
5025	5025	Level 5 Type A ED Visits
5051	5051	Level 1 Skin Procedures
5052	5052	Level 2 Skin Procedures
5112	5112	Level 2 Closed Treatment Fracture and Related Services
5113	5113	Level 3 Closed Treatment Fracture and Related Services
5114	5123	Level 3 Musculoskeletal Procedures
5161	5161	Level 1 ENT Procedures
5163	5163	Level 3 ENT Procedures
5182	5182	Level 2 Vascular Procedures
5301	5301	Level 1 Upper GI Procedures
5311	5311	Level 1 Lower GI Procedures
5312	5312	Level 2 Lower GI Procedures
5361	5361	Level 1 Laparoscopy
5414	5414	Level 4 Gynecologic Procedures
5431	5431	Level 1 Nerve Procedures
5442	5442	Level 2 Nerve Injections
5443	5443	Level 3 Nerve Injections
5481	5481	Laser Eye Procedures
5491	5491	Level 1 Intraocular Procedures
5521	5521	Level 1 X-Ray and Related Services
5522	5522	Level 2 X-Ray and Related Services
5523	5523	Level 3 X-Ray and Related Services
5571	5571	Level 1 Computed Tomography with Contrast and Computed Tomography Angiography
5572	5572	Level 2 Computed Tomography with Contrast and Computed Tomography Angiography
5671	5671	Level 1 Pathology
5673	5673	Level 3 Pathology
5732	5732	Level 2 Minor Procedures
5733	5733	Level 3 Minor Procedures

Market Basket HCPCS for Outpatient Services			
2017	2017 Name	2016	2016 Name
G0202	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	G0202	Digital Mammography Screening
G0204	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	G0204	Diagnostic Mammogram, Digital, All Views , bilateral
G0206	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	G0206	Diagnostic Mammogram, Digital, All Views
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	77051	Computer-Aided Diagnostic Mammography Add-On
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral	77052	Computer Screen Mammography Add-On
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed		

Table 6. Market Basket HCPCS for Physician Services

Source: Market basket was developed from LMMG billing data for physician services provided in June 2016.

HCPCS	Description
11042	Deb subq tissue 20 sq cm/<
36415	Routine venipuncture
81003	Urinalysis auto w/o scope
83036	Glycosylated hemoglobin test
85610	Prothrombin time
90471	Immunization admin
90833	Psytx pt&/fam w/e&m 30 min
93000	Electrocardiogram complete
93010	Electrocardiogram report
93306	Tte w/doppler complete
97597	Rmvl devital tis 20 cm/<
99183	Hyperbaric oxygen therapy
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99232	Subsequent hospital care
99395	Prev visit est age 18-39
99396	Prev visit est age 40-64
G0439	PPPS, subseq visit

Table 7. LMMG Billing Data Payer Mappings to Payer Categories

Financial Class in LMMG Billing Data	Financial Class Description	Payer Category
AN	Aetna	Commercial
BA	Business Accounts	Commercial
BH	Behavioral Health	Commercial
BS	Blue Cross/Blue Shield	Commercial
CA	Collection Agency	Commercial
CB	Consolidated Billing	Commercial
CC	Connecticare	Commercial
CG	Cigna	Commercial
CH	Charity/Free Care	Other
CI	Commercial Insurance	Commercial
CP	Contracted Payor	Commercial
GA	Grant Billing	Commercial
GC	Grant Billing	Commercial
GR	Grant Billing	Commercial
HN	Health Net Of Ct	Commercial
LC	Liability Charity Care	Other
LI	Liability Insurance	Other
MA	Medicaid	Medicaid
MC	Medicare	Medicare
OC	Outside Collection Agency	Commercial
OX	Oxford Health Plans	Commercial
SI	Self Pay After Insurance	Other
SP	Self Pay	Other
TR	Tricare	Commercial
UH	United Healthcare	Commercial
WC	Workers Compensation	Other

Table 8. LMMG Location Mappings to CMS Location Type

Source: LMMG billing system.

Location Code	Facility Name	CMS Location Type Code	CMS Location Type Description
8U	Apple Rehab Clipper	31	Skilled Nursing Facility
8W	Apple Rehab Watch Hill	31	Skilled Nursing Facility
9P	Asc Pequot	24	Ambulatory Surgical Center
4B	Backus Hospital	21	Inpatient Hospital
8B	Bayview Health Care Center	32	Nursing Facility
8I	Bridebrook Rehab Center	32	Nursing Facility
8D	Bucks Hill Nursing And Rehabil	32	Nursing Facility
8N	Cheshire House	31	Skilled Nursing Facility
8F	Fairview Nursing Home	32	Nursing Facility
6S	L&M Op Sleep Ctr At Hilton	19	Unassigned
1C	L&M Physician Association	11	Office
7C	Lawrence & Memorial ER Crisis	23	Emergency Room - Hospital
4L	Lawrence & Memorial Hospital	21	Inpatient Hospital
5A	LM Physicians Westerly Bldg 46	11	Office
6W	LM Waterfall	19	Unassigned
7I	LMPA ER Cardiology Waterford	23	Emergency Room - Hospital
7Z	LMPA ER NL Medical Off Bldg	23	Emergency Room - Hospital
1E	LMPA General Surgery	11	Office
1G	LMPA Groton	11	Office
13	LMPA Infectious Disease	11	Office
4I	LMPA IP Cardiology Waterford	21	Inpatient Hospital
4Z	LMPA IP NL Medical Off Bldg	21	Inpatient Hospital
1Z	LMPA Mob	11	Office
12	LMPA Mystic	11	Office
1U	LMPA Neurosurgery	11	Office
1W	LMPA New London	11	Office
1J	LMPA New London Neuro & Ortho	11	Office
1N	LMPA Niantic	11	Office
1O	LMPA Old Lyme	11	Office
6H	LMPA Op Cariology Waterford	19	Unassigned
6T	LMPA Op NL Medical Off Bldg	19	Unassigned
1T	LMPA Physiatry	11	Office
1B	LMPA Physiatry Backus	11	Office
1D	LMPA Physiatry Day Kimball	11	Office
1H	LMPA Shaw General Surgery	11	Office
1P	LMPA Stonington	11	Office
1Q	LMPA Stonington Walkin	11	Office
5K	LMPA Wakefield	11	Office
1I	LMPA Waterford Crossroads	11	Office
5B	LMPA Westerly Morgan Bldg 45	11	Office
3J	Office Joslin New London	11	Office
8C	Paradigm Healthcare	31	Skilled Nursing Facility
8T	Paradigm Healthcare Waterbury	31	Skilled Nursing Facility
2H	Patient's Home CT	12	Home
2I	Patient's Home RI	12	Home
8P	Pendleton Health & Rehab Cntr	32	Nursing Facility
6P	Pequot Health Center	19	Unassigned
1F	Sound Medical Associates	11	Office
8V	Village Green Of Waterbury	31	Skilled Nursing Facility
8Z	Westerly Health Center	31	Skilled Nursing Facility

Location Code	Facility Name	CMS Location Type Code	CMS Location Type Description
7M	Westerly Hospital Emer Room	23	Emergency Room - Hospital
4M	Westerly Hospital Inpatient	21	Inpatient Hospital
6M	Westerly Hospital Outpatient	22	Outpatient Hospital
8Y	Westerly Nursing Home	31	Skilled Nursing Facility
6Y	Yale New Haven Outpatient	22	Outpatient Hospital

User, OHCA

From: Cotto, Carmen
Sent: Monday, December 04, 2017 4:08 PM
To: Jeryl.Topalian@YNHH.ORG
Cc: User, OHCA; Roberts, Karen; Capozzalo, Gayle (Gayle.Capozzalo@ynhh.org)
Subject: FW: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Follow Up Flag: Follow up
Flag Status: Completed

Good afternoon Jeryl,

In reference to the documents listed on your email below dated November 30, 2017, please also provide us with the same documents in Excel format, as applicable. In particular, those related to capital commitment investment, cost savings and quarterly financial measures.
As you might already know, Excel format makes it easier to filter and analyzed data. It will be very helpful to us to receive them in this format.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Topalian, Jeryl [mailto:Jeryl.Topalian@YNHH.ORG]
Sent: Thursday, November 30, 2017 2:14 PM
To: User, OHCA <OHCA@ct.gov>
Cc: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; Green, Patrick <Patrick.Green@LMHOSP.ORG>; Petrini, Vincent <Vincent.Petrini@ynhh.org>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>; 'ynhhscohcamonitor@deloitte.com' <ynhhscohcamonitor@deloitte.com>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>; Perrone, Brett <Brett.Perrone@ynhh.org>
Subject: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Attached please find documents submitted to comply with Conditions of Docket #15-32033-CON: “Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation” and Docket #15-

32032-CON: “Transfer of Ownership of Group Practice by the Merger of L+M Physician Association into Northeast Medical Group” for the 6-month reporting period ending September 30, 2017.

The compliance documents attached address the following Conditions for Docket #15-32033-CON and Docket #15-32032-CON as noted:

- Condition 6 – Top Most Frequent MSDRG-and CPT Codes for LM+H
- Conditions 7/19a/32b – Investments Report
- Condition 8 – Financial Measurement Report
- Condition 10 – Revision to Charity Care Policy
- Condition 11 and 12 – Annual Community Benefit Report and Cultural and Linguistically Appropriate Services Report
- Conditions 17/33b/33d – Community Meetings and Public Forums Report
- Conditions 25, 32f (i and ii) (or 7c of Docket #15-32032-CON) – Savings Report
- Condition 32f (iii and iv) (or 7c of Docket #15-32032-CON) – Financial Statements
- Conditions 20a/32c (or 1/7a of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Hospital
- Condition 32e – Affirmation regarding Charity Care Policies
- Conditions 18/32a – Affirmation regarding retention of Services
- Conditions 24/32d (or 5/7b of Docket #15-32032-CON) – Affirmation regarding Physician Offices
- Conditions 27, 28, 29, 30, 32g (or 6 of Docket #15-32032-CON) – Affirmations regarding HR policies

If you have any questions, please feel free to contact me.

Regards,
Jeryl

Jeryl Topalian
Director Strategy & Regulatory Planning
Strategy and Regulatory Planning & Reporting
Office: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

User, OHCA

From: Topalian, Jeryl <Jeryl.Topalian@YNHH.ORG>
Sent: Wednesday, December 06, 2017 9:48 AM
To: Cotto, Carmen
Cc: User, OHCA; Roberts, Karen; Capozzalo, Gayle; Perrone, Brett; Lipka, Susan; Willcox, Jennifer
Subject: RE: Docket Number 15-32032-CON and Docket Number 15-32033-CON
Attachments: Condition 8 - Financial Measurements_Indicators_Distribution_11-30-2017.xlsx; Financial Statements_distribution_11-30-17.xlsx; NOVEMBER OHCA SUBMISSION_INVESTMENTS_distribution_11-30-17.xlsx; NOVEMBER OHCA SUBMISSION_SYNERGY SAVINGS_Distribution_11-30-17.xlsx

Hi Carmen –
Attached please find the excel formats of the financial reports submitted as part of the November 30, 2017 filing in reference to DN 15-32032-CON and 15-32033-CON.

Please contact me if you have any questions.

Thank you,

Jeryl

Jeryl Topalian, Director Strategy & Regulatory Planning
Strategy and Regulatory Planning & Reporting
Office: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, December 04, 2017 4:08 PM
To: Topalian, Jeryl <Jeryl.Topalian@YNHH.ORG>
Cc: User, OHCA <OHCA@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Subject: FW: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Good afternoon Jeryl,

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Subject: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Attached please find documents submitted to comply with Conditions of Docket #15-32033-CON: "Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation" and Docket #15-32032-CON: "Transfer of Ownership of Group Practice by the Merger of L+M Physician Association into Northeast Medical Group" for the 6-month reporting period ending September 30, 2017.

The compliance documents attached address the following Conditions for Docket #15-32033-CON and Docket #15-32032-CON as noted:

- Condition 6 – Top Most Frequent MSDRG-and CPT Codes for LM+H
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- Condition 11 and 12 – Annual Community Benefit Report and Cultural and Linguistically Appropriate Services Report
- Conditions 17/33b/33d – Community Meetings and Public Forums Report
- Conditions 25, 32f (i and ii) (or 7c of Docket #15-32032-CON) – Savings Report
- Condition 32f (iii and iv) (or 7c of Docket #15-32032-CON) – Financial Statements
- Conditions 20a/32c (or 1/7a of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Hospital
- Condition 32e – Affirmation regarding Charity Care Policies
- Conditions 18/32a – Affirmation regarding retention of Services
- Conditions 24/32d (or 5/7b of Docket #15-32032-CON) – Affirmation regarding Physician Offices
- Conditions 27, 28, 29, 30, 32g (or 6 of Docket #15-32032-CON) – Affirmations regarding HR policies

If you have any questions, please feel free to contact me.

Regards,
Jeryl

Jeryl Topalian

Director Strategy & Regulatory Planning
Strategy and Regulatory Planning & Reporting
Office: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

FINANCIAL MEASUREMENTS/INDICATORS REPORT FOR LAWRENCE+MEMORIAL HOSPITAL *

Docket # 15-32033-CON: Condition 8

Financial Measurement / Indicators	Month Ended 9/30/17	12 Months Ended 9/30/17	12 Months Ended 9/30/16
A. Operating Performance			
1. Operating Margin	-3.11%	1.36%	-0.38%
2. Non-Operating Margin	1.54%	2.06%	0.53%
3. Total Margin	-1.57%	3.42%	0.14%
B. Liquidity			
1. Current Ratio	2.18	2.18	2.40
2. Days Cash on Hand	141	153	141
3. Days in Net Accounts Receivable	44.20	32.60	41.20
4. Average Payment Period	124.9	108.7	129.9
C. Leverage and Capital Structure			
1. Long-term Debt to Equity	56.87%	56.87%	89.96%
2. Long-term Debt to Capitalization	40.15%	40.15%	54.08%
3. Unrestricted Cash to Debt	86.51%	86.51%	92.05%
4. Times Interest Earned Ratio	(0.5)	4.5	0.6
5. Debt Service Coverage Ratio	4.97	4.97	4.30
6. Equity Financing Ratio	43.50%	43.50%	31.96%
D. Additional Statistics			
1. Income from Operations	$ (786,538)	$ 4,563,725	$ (1,325,236)
2. Revenue Over/(Under) Expense	$ (396,519)	$ 11,490,595	$ 495,562
3. Cash from Operations	N/A**	$ 8,140,152	$ (9,256,615)
4. Cash and Cash Equivalents	$ 87,775,485	$ 87,775,485	$ 92,696,969
5. Net Working Capital	$ 71,265,829	$ 71,265,829	$ 85,639,707
6. Free Cash Flow (and the elements used in the calculation)	N/A**	$ (10,259,848)	$ (24,666,161)
7. Unrestricted Net Assets/Retained Earnings	84.79%	84.79%	76.37%
8. Bad Debt as % of Gross Revenue	5.67%	4.21%	3.79%
9. Credit Ratings (S&P, Fitch or Moody's)	S&P A+/Stable	S&P A+/Stable	S&P BBB+/Developing

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

* The statistics presented above represent data for Lawrence+Memorial Hospital only.

** Current month Cash from Operations and Free Cash Flow are not statistics that can be calculated.

Reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18; 10/1/18-3/31/19; 4/1/19-9/30/19

Report due to OHCA 5/31 and 11/30 each year. Due internally to Regulatory 30 days before.

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Primary Care Clinical Services													
Family Medicine and Internal Medicine Recruitment	Recruitments in Family Practice and Internal Medicine to increase access to these services in the L+M service area were made during the second half of the fiscal year.	$242,726	$242,726	04/01/17	09/30/17	n/a	L+M Baseline Cash Flow	-	-	$242,726	-	-	$ 242,726
Specialty Clinical Services													
Specialty Services Access	Recruitments within neurosurgery, oncology, vascular, cardiology and psychiatry were made to increase access to these services in the L+M service area. Additions in endocrinology, general surgery, and obstetrics/midwifery were also made to replenish the medical staff.	$1,743,767	$3,369,454	10/01/16	09/30/17	n/a	YNHHS or L+M Baseline Cash Flow	$1,137,572	-	$606,195	$2,388,518	-	$980,937
Ambulatory Services													
Ambulatory Services	Several projects (including Outpatient Diagnostics, Urgent Care, and the Sleep Center, to name a few) are currently in the planning phase/pipeline. The expectation is that they will be initiated in the next fiscal year.	n/a	n/a										
Post Acute Services													
VNA and Other Post Acute Services	Planning around VNA Services are in process and expected to be initiated in the next fiscal year. Discussions about other post acute services are under way as well.	n/a	n/a										
Infrastructure within LMHC Facilities													
Investments in Infrastructure	Prior to the affiliation with YNHHS, L+MH and Westerly Hospitals (WH) were under growing financial pressure, and capital spending during that time was severely limited. Following the affiliation, significant catch-up was required to replenish aging and end-of-life equipment as well as perform necessary facility renovations. Capital expenditures for infrastructure during the time of the reporting period were made for new beds, repairs to parking garage, rebuild of elevators, security systems, and HVAC systems. In addition, the LMMG General Surgery practice was relocated to the L+MH main campus to enhance availability and improve timeliness of services for patients and physicians.	$4,562,218	$6,523,652	10/01/16	09/30/17	n/a	L+M Baseline Cash Flow	$3,444,419	$758,744	$359,055	$4,094,876	$1,845,593	$583,183

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Information Technology													
Epic System - Build and Installation	Capital investment related to the development and build of the Epic EMR system that went live at L+M and WH on 1/20/17 included software licenses; customization and development of interfaces to ensure integration with other 3rd party software; training time (prior to go-live) for clinicians and other personnel on using the new system; support during the actual go-live from Epic consultants; and hardware, including new servers. Replacing the older EMR systems and moving to the fully-integrated Epic system, had the advantage of improving quality of care by providing best practice protocols and enhancing patient engagement via patient portals, "MyChart", and other patient and physician-friendly features. By moving to Epic as part of a large System, L+M was able to mitigate risk by relying on the invaluable experience and expertise that YNHHS brought to the installation.	$3,235,507	$14,043,985	10/01/16	09/30/17	n/a	YNHHS or L+M Baseline Cash Flow	$2,647,611	$587,896	$0	$12,045,814	$1,993,353	$4,818
Infor (ERP) Project	Investments were made at L+M for development, customization and installation of a new ERP (Enterprise Resource Planning) system to replace its legacy system. Incorporating Supply Chain, General Finance, and Human Resources functions within a single system (that also includes budgeting, decision support, and management reporting) is fundamental to effectively running the business. YNHHS has a long track record of leading the industry in these areas by innovatively leveraging these reporting capabilities to drive quality, patient engagement and physician efficiencies. While L+M is still in the building stages, progress toward full integration across the system is underway and remains a key corporate objective.	$392,095	$747,744	10/01/16	09/30/17	n/a	YNHHS	$326,384	$65,711	-	$622,431	$125,314	-
Other Information Technology Projects	Capital investments for other IT projects at L+M included Access Control Plan Implementation; Laboratory EMR Results Interfaces; and RIS/PACS Implementation, among other items. These systems - specifically integrating critical patient tests, imaging, and other diagnostics with the broader medical record system - were on the front line of improving access, optimizing care delivery, and coordinating patient care across the continuum.	$2,311,409	$2,651,119	10/01/16	09/30/17	n/a	L+M Baseline Cash Flow	$2,230,635	$64,904	$15,870	$2,446,720	$168,963	$35,436
Population Health													
Population Health Initiatives **	As a result of the affiliation, L+M is able to move forward and participate in the YNHHS Population Health infrastructure and clinically integrated network. As part of the system, L+M will be able to utilize YNHHS resources and will avoid an estimated $10 million in operating/capital cost. $10 million ($2 million per year over the course of 5 years) was identified in the CON as the investment associated with population health infrastructure.	$1,750,696	$2,000,000	10/01/16	09/30/17	n/a	YNHHS	$1,438,851	$311,846	-	$1,643,747	$356,254	-

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Branding													
Advertising, Signage, Website	Investments were made in converting existing external and internal signage throughout L+M to formally recognize the affiliation and rebrand all facilities and services as Yale New Haven Health. A considerable investment was made in the website design to better connect patients across the system and improve communication regarding services, physicians and locations. Advertising the affiliation through print, digital, and radio ads has enhanced communication to patients and physicians regarding the health care resources available in the region.	$1,338,705	$2,163,307	03/31/17	09/30/17	n/a	YNHHS	$900,562	$438,142	-	$1,312,864	$850,444	-
Operational Improvements													
Corporate Services Support ***	Significant resources have been provided to L+M by YNHHS Corporate services departments (i.e., Internal Consulting Group, IT, Finance, etc.) over the past 6 months. As an integral part of the underlying value of the affiliation, Corporate Services personnel continue to assist L+M in identifying synergies, achieving savings, standardizing methodologies, introducing procedures, implementing Epic and other IT systems, and generally integrating L+M into the System.	$5,855,994	$8,935,503	01/01/17	09/30/17	n/a	YNHHS	$4,812,886	$1,043,108	-	$7,343,853	$1,591,650	-
Clinical Technology Investments	Investments in clinical technology were made at L+M to drive operational improvements including new diagnostic equipment (Tomosynthesis) for early breast cancer detection; state-of-the-art pharmacy at the L+M Cancer Center to adhere to regulatory requirements and enhance patient safety; new equipment on inpatient units to assure patient care quality; and other improvements in structures and processes to effectively provide high-quality, safe patient care.	$2,225,297	$6,605,009	01/01/17	09/30/17	n/a	L+M Baseline Cash Flow	$1,542,889	$682,408	-	$4,445,384	$2,159,625	-

DETAILED Strategic Plan Accomplishments and Resource Investment Narrative: Docket # 15-32033-CON, Condition 7/32b

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

NAME OF PROJECT	DESCRIPTION OF AND RATIONALE FOR PROJECT	EXPENDITURE AMOUNT (Total - All Sites)		ROLLOUT OF EXPENSES				Semi-Annual Reporting Period: 4/1/17 - 9/30/17			Full FY 2017 Reporting Period: 10/1/16 - 9/30/17		
		4/1/17-9/30/17	10/1/16-9/30/17	Est. Beg. Date	Est. End Date	Est. Startup Date	EXPECTED FUNDING SOURCE*	L+MH	Westerly	LMMG	L+MH	Westerly	LMMG
Community Need / Community Building													
Support for Physical Improvements and Housing	Community involvement and financial support for partner organizations' physical improvement and housing related activities. Partner organizations include Community Speak Out, the Homeless Hospitality Center, and the Jewish Federation. Includes support for transitional and shelter housing, sober house certification training, air conditioners for vulnerable residents, and other support. L+M Hospital is increasingly aware of how social determinants impact the health of individuals and communities. A person's health and chances of becoming sick and dying early are greatly influenced by powerful social factors such as education, income, nutrition, housing and neighborhoods. During Fiscal Year 2017, L+M Hospital invested in community building efforts that promote thriving and healthy communities in our region.	$6,302	$11,200	2/17/17	n/a	n/a	L+M Baseline Cash Flow	$6,302	-	-	$11,200	-	-
Social Determinants of Health	Community involvement and support for partner organizations' work to address social determinants of health not specific to the other categories. Includes support for education, youth development and neighborhood development strategies in distressed New London neighborhoods. The rationale for these investments is to address the health needs identified by the most recent CHNA and 2016 Community Health Improvement Plan (CHIP), including social determinants of health.	$46,055	$96,055	2/17/17	n/a	n/a	L+M Baseline Cash Flow	$46,055	-	-	$96,055	-	-
Support for Economic Development	Community involvement and financial support for partner organizations' economic development activities. Economic development supports a regional infrastructure that includes sufficient employment opportunities providing a living wage. In addition to income, such employment provides healthcare, retirement and other benefits. Being under- or unemployed is strongly correlated with poor health outcomes.	$15,080	$15,080	3/27/17	n/a	n/a	L+M Baseline Cash Flow	$15,080	-	-	$15,080	-	-
		$23,725,851	**$47,404,835**					**$18,549,246**	**$3,952,759**	**$1,223,846**	**$36,466,541**	**$9,091,195**	**$1,847,099**

SIGNATURE: _____

Vincent Tammaro, Exec VP & Chief Financial Officer, YNHHS and Chief Financial Officer, YNHH

SIGNATURE: _____

Patrick Green, President and

* Financial information is based on unaudited financial statements.

** Population Health: Methodology to quantify investment changed from prior submission. Previously based on % staff time in Population Health cost centers; now based on $10 million avoided cost identified in the CON (see project description).

*** Corporate Service Support: based on % staff time estimated by HSC department directors multiplied by departmental expense.

Any changes that may have affected results previously reported (period 10/1/16-3/31/17) are incorporated into the full year results. Such changes may have been due either to changes in methodology (e.g. Population Health) or updates to financial information received after submission of previous report.

Detailed narrative due to OHCA with summary page semi-annually 60 days following 3/31/17; 9/30/17; 3/31/18; 9/30/18; 3/31/19; 9/30/19 (3 years) and annually until end of FY 2021 (9/30/21)

Due internally to Regulatory 30 days prior to OHCA due date.

Lawrence+Memorial Physician Association, Inc. *

Statement of Cash Flows

	For the Twelve Months Ended September 30, 2017
Cash flows from operating activities	
Change in net assets	$ (9,075,893)
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Depreciation & amortization	561,856
Provision for bad debts	266,238
Changes in operating accounts:	
Patient Accounts Receivable, Net	(845,999)
Other receivables	(951,071)
Prepaid expenses	15,322
Accounts Payable	1,328,908
Accrued vacation & sick pay	(1,418,915)
Salaries, wages, payroll taxes	(607,701)
Due to affiliates	4,990,813
Other liabilities	(1,869,906)
Net cash used in operating activities	**(7,606,348)**
Cash flows from investing activities	
Purchase of property, plant and equipment, net	(2,683,711)
Net cash used in investing activities	**(2,683,711)**
Cash flows from financing activities:	
Net asset transfer from LMH	9,790,918
Net decrease in cash and cash equivalents	(499,141)
Cash at beginning of year	449,139
Cash at end of year	**$ (50,002)**

* The statistics presented above represent data for Lawrence+Memorial Physician Association, Inc. (LMPA) only. On April 1, 2017, LMPA was dissolved and its operations merged into Northeast Medical Group.

This data has been derived from internally generated (unaudited) financial statements that are prepared and presented, in all material aspects, in accordance with the annual audited financial statements.

Lawrence + Memorial Healthcare (including L+M Hospital and LMMG)

Synergy Savings Report and Summary

Docket #15-32033-CON: Condition 25, 32f(i), and 32f(ii) and Docket #15-32032: Condition 7c

Semi-Annual Reporting Period: 4/1/17-9/30/17 and Full Fiscal Year 2017

	Semi-Annual Reporting Period: 4/1/17-9/30/17			Fiscal Year 2017: 10/1/16-9/30/17		
Categories	**Projected Savings**	**Actual Savings**	**Variance**	**Projected Savings**	**Actual Savings**	**Variance**
Wages	$800,700	$3,390,908	$2,590,208	$1,601,400	$4,494,042	$2,892,641
Fringe Benefits	$141,840	$963,807	$821,967	$283,680	$1,294,343	$1,010,662
Contractual Labor Fees	$0	$0	$0	$0	$0	$0
Medical Supplies and Pharmaceuticals	$670,000	$1,186,367	$516,367	$1,340,000	$1,866,236	$526,236
Depreciation/Amortization	$0	$0	$0	$0	$0	$0
Interest Expense	$0	$0	$0	$0	$0	$0
Malpractice Expense	$0	$0	$0	$0	$0	$0
Utilities	$0	($52,492)	($52,492)	$0	$104,562	$104,562
Business Expense	$456,702	$910,039	$453,337	$913,403	$1,715,485	$802,082
Other Operating Expense	$0	$0	$0	$0	$0	$0
Total Synergies	**$2,069,242**	**$6,398,630**	**$4,329,388**	**$4,138,484**	**$9,474,667**	**$5,336,183**

`

Results for the second six months of FY 2017 (the period 4/1/17-9/30/17) were calculated by taking the full year results and subtracting results presented previously for the period 10/1/16 - 3/31/17. Any changes that may have affected results previously reported (period 10/1/16-3/31/17) are incorporated into the full year results. Such changes would have been due to updates to financial information received after submission of previous report.

Semi-Annual reporting periods: 10/1/16-3/31/17; 4/1/17-9/30/17; 10/1/17-3/31/18; 4/1/18-9/30/18. **Annual** reporting periods: 10/1/18-9/30/19; 10/1/19-9/30/20; 10/1/20-9/30/21

Summary page due to OHCA with detailed narrative 60 days following reporting period. Due to Regulatory 30 days prior.

*Although projected summary showing plans annually, 6-month projections are required when reporting through 9/30/18.

User, OHCA

From: Cotto, Carmen
Sent: Wednesday, December 06, 2017 10:02 AM
To: Topalian, Jeryl
Cc: User, OHCA; Roberts, Karen; Capozzalo, Gayle; Perrone, Brett; Lipka, Susan; Willcox, Jennifer
Subject: RE: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Hi Jeryl,

The Excel formatted reports will be very helpful. Thank you again for your assistance.

Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph

From: Topalian, Jeryl [mailto:Jeryl.Topalian@YNHH.ORG]
Sent: Wednesday, December 6, 2017 9:48 AM
To: Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: User, OHCA <OHCA@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; Perrone, Brett <Brett.Perrone@ynhh.org>; Lipka, Susan <susan.lipka@ynhh.org>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>
Subject: RE: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Hi Carmen –
Attached please find the excel formats of the financial reports submitted as part of the November 30, 2017 filing in reference to DN 15-32032-CON and 15-32033-CON.

Please contact me if you have any questions.

Thank you,

Jeryl

Jeryl Topalian, Director Strategy & Regulatory Planning
Strategy and Regulatory Planning & Reporting
Office: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

From: Cotto, Carmen [mailto:Carmen.Cotto@ct.gov]
Sent: Monday, December 04, 2017 4:08 PM
To: Topalian, Jeryl <Jeryl.Topalian@YNHH.ORG>
Cc: User, OHCA <OHCA@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>
Subject: FW: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Good afternoon Jeryl,

In reference to the documents listed on your email below dated November 30, 2017, please also provide us with the same documents in Excel format, as applicable. In particular, those related to capital commitment investment, cost savings and quarterly financial measures.
As you might already know, Excel format makes it easier to filter and analyzed data. It will be very helpful to us to receive them in this format.

Thank you in advance for your assistance.
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134
P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

DPH Connecticut Department of Public Health
ACCREDITED HEALTH DEPARTMENT PHAB PUBLIC HEALTH ACCREDITATION BOARD
www.ct.gov/dph

From: Topalian, Jeryl [mailto:Jeryl.Topalian@YNHH.ORG]
Sent: Thursday, November 30, 2017 2:14 PM
To: User, OHCA <OHCA@ct.gov>
Cc: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; Green, Patrick <Patrick.Green@LMHOSP.ORG>; Petrini, Vincent <Vincent.Petrini@ynhh.org>; Tammaro, Vincent <Vincent.Tammaro@ynhh.org>; 'ynhhscohcamonitor@deloitte.com' <ynhhscohcamonitor@deloitte.com>; Willcox, Jennifer <Jennifer.Willcox@ynhh.org>; Perrone, Brett <Brett.Perrone@ynhh.org>
Subject: Docket Number 15-32032-CON and Docket Number 15-32033-CON

Attached please find documents submitted to comply with Conditions of Docket #15-32033-CON: “Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation” and Docket #15-32032-CON: “Transfer of Ownership of Group Practice by the Merger of L+M Physician Association into Northeast Medical Group” for the 6-month reporting period ending September 30, 2017.

The compliance documents attached address the following Conditions for Docket #15-32033-CON and Docket #15-32032-CON as noted:

- Condition 6 – Top Most Frequent MSDRG-and CPT Codes for LM+H
- Conditions 7/19a/32b – Investments Report
- Condition 8 – Financial Measurement Report
- Condition 10 – Revision to Charity Care Policy
- Condition 11 and 12 – Annual Community Benefit Report and Cultural and Linguistically Appropriate Services Report
- Conditions 17/33b/33d – Community Meetings and Public Forums Report
- Conditions 25, 32f (i and ii) (or 7c of Docket #15-32032-CON) – Savings Report
- Condition 32f (iii and iv) (or 7c of Docket #15-32032-CON) – Financial Statements
- Conditions 20a/32c (or 1/7a of Docket #15-32032-CON) – Affirmation regarding Payer Contracts – Hospital
- Condition 32e – Affirmation regarding Charity Care Policies
- Conditions 18/32a – Affirmation regarding retention of Services
- Conditions 24/32d (or 5/7b of Docket #15-32032-CON) – Affirmation regarding Physician Offices
- Conditions 27, 28, 29, 30, 32g (or 6 of Docket #15-32032-CON) – Affirmations regarding HR policies

If you have any questions, please feel free to contact me.

Regards,
Jeryl

Jeryl Topalian
Director Strategy & Regulatory Planning
Strategy and Regulatory Planning & Reporting
Office: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

User, OHCA

From: Topalian, Jeryl <Jeryl.Topalian@YNHH.ORG>
Sent: Friday, December 08, 2017 2:56 PM
To: User, OHCA; 'US YNHHSC OHCA Monitor'
Cc: Willcox, Jennifer; Capozzalo, Gayle; Petrini, Vincent; Tammaro, Vincent; Green, Patrick; Perrone, Brett
Subject: Docket Number 15-32033-CON Condition 11: Annual Community Benefit Report Narrative Clarification

After review of the documents submitted to comply with Conditions of Docket # 15-32033-CON: Transfer of Ownership of Lawrence + Memorial Corporation to Yale New Haven Health Services Corporation, the independent monitor requested an explanation of a discrepancy between the community benefit/community building numbers reported in the Narrative submitted to comply with Condition 11 and the IRS Form 990 report of community benefit for FY 16.

The first paragraph of the submitted narrative reads:

Narrative for Condition 11:

Community Benefit
In 2016, Lawrence & Memorial Hospital ("L+MH") community benefit totaled $38,686,420 and in fiscal year (FY) 2017, community benefits are on track to exceed that amount (current estimate is $38,767,485 with data reporting and analysis not yet complete). The community building investment increased by 134%, from $52,237 in FY 2016 to an estimated $122,335 in FY 2017.

Explanation:
The community benefit total reported for FY 16 in the narrative includes both the community benefit figure reported in the IRS Form 990 ($38, 625,033) plus the community building figure ($61,387) reported in the IRS Form 990 added together for a total community benefit of $38,686,420. This ties to the narrative figure. The community building figure reported in the narrative ($52,237), however, was incorrect due to using the figure from an earlier draft. The correct community building figure is $61,387 for FY 2016. The correct estimated FY 2017 community building investment increase is 99% over FY 2016.

Please contact me if you have any questions or require further explanation.

Jeryl

Jeryl Topalian, **MS RD**
Director, Strategy & Regulatory Planning

Strategy and Regulatory Planning & Reporting
2 Howe Street, 3rd Floor
New Haven, CT 06519

Phone: 203-688-5721
Cell: 203-215-7872
Email: Jeryl.Topalian@ynhh.org

YaleNewHavenHealth

User, OHCA

From: Roberts, Karen
Sent: Tuesday, December 12, 2017 11:27 AM
To: User, OHCA
Subject: FW: Deloitte & Touche LLP Six-Month Report as Independent Monitor per Docket Numbers 15-32032-CON and 15-32033-CON
Attachments: Deloitte Independent Monitor Year 1 Six Month Report_12 11 2017_Final.pdf

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From: Sauders, Kelly (US - New York) [mailto:ksauders@deloitte.com]
Sent: Monday, December 11, 2017 9:22 PM
To: Martone, Kim <Kimberly.Martone@ct.gov>; Roberts, Karen <Karen.Roberts@ct.gov>; Cotto, Carmen <Carmen.Cotto@ct.gov>
Cc: Capozzalo, Gayle <Gayle.Capozzalo@ynhh.org>; DeMerlis, Ryan John (US - Philadelphia) <rdemerlis@DELOITTE.com>
Subject: RE: Deloitte & Touche LLP Six-Month Report as Independent Monitor per Docket Numbers 15-32032-CON and 15-32033-CON

Dear Kim-

Please see our attached six-month report dated as of today. This report incorporates work steps and completion status for the first full year. Let me know if you have any questions.

Regards,
Kelly

Kelly J. Sauders
Partner
Deloitte Advisory
30 Rockefeller Plaza
New York, NY 10112
Office: 212 436 3180
Fax: 212 653 7033
Mobile: 518 469 0890
Email: ksauders@deloitte.com

Deloitte.

YNHHSC Independent Monitor Review Report for Six Month Reporting Period

December 11, 2017

Deloitte & Touche LLP
30 Rockefeller Plaza
New York, NY 10112

www.deloitte.com

December 11, 2017

Ms. Gayle Capozzalo
Executive Vice President and Chief Strategy Officer
Yale New Haven Health
789 Howard Avenue
New Haven, CT 06519

Dear Ms. Capozzalo,

Re: Deloitte & Touche LLP Six-Month Report as Independent Monitor per Docket Numbers 15-32032-CON and 15-32033-CON

In accordance with our engagement letter dated November 7, 2016 ("Engagement Letter"), the attached report summarizes the findings from the work steps performed by Deloitte & Touche LLP ("D&T"), as requested by Yale New Haven Health ("YNHHSC"), with respect to the Independent Monitor role for the 6-month reporting period.

Pursuant to the Engagement Letter, YNHHSC agrees that any deliverables provided to YNHHSC by D&T may be disclosed to the State of Connecticut's Office of Health Care Access ("OHCA") to the extent required by such regulator in connection with their regulatory oversight.

The services were performed in accordance with the Statement on Standards for Consulting Services that is issued by the American Institute of Certified Public Accountants ("AICPA"). The services did not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body and, therefore, D&T does not express an opinion or any other form of assurance as a result of performing the services.

Sincerely,

Deloitte & Touche LLP

Contents

Key	
Complete	
In Progress	

I. Executive Summary Table

Condition Number	Milestone Date	Completion Status
Strategic Plan		
15-32033-CON Condition 4	3/7/17	
15-32033-CON Condition 19	3/7/17	
15-32033-CON Condition 32b	5/31/17 & 11/30/17	
15-32033-CON Condition 7	5/31/17 & 11/30/17	
15-32033-CON Condition 5	1/19/17	
15-32033-CON Condition 18	5/31/17 & 11/30/17	
15-32033-CON Condition 32a	5/31/17 & 11/30/17	
Financial Reporting		
15-32033-CON Condition 8	5/31/17 & 11/30/17	
15-32033-CON Condition 32f	5/31/17 & 11/30/17	
15-32032-CON Condition 7c	5/31/17 & 11/30/17	
15-32033-CON Condition 6	5/31/17 & 11/30/17	
Cost and Market Impact Review		
15-32033-CON Condition 22	11/30/17	
15-32032-CON Condition 3	11/30/17	
15-32032-CON Condition 4	11/30/17	
15-32033-CON Condition 23	11/30/17	
15-32033-CON Condition 20 Paragraph 1	5/31/17 & 11/30/17	
15-32033-CON Condition 32c	5/31/17 & 11/30/17	
15-32033-CON Condition 20 Paragraphs 2/3	5/31/17 & 11/30/17	
15-32032-CON Condition 1	5/31/17 & 11/30/17	
15-32032-CON Condition 7a	5/31/17 & 11/30/17	
15-32033-CON Condition 21a	5/31/17 & 11/30/17	
15-32032-CON Condition 2a	5/31/17 & 11/30/17	
15-32033-CON Condition 21b	5/31/17 & 11/30/17	
15-32032-CON Condition 2b	5/31/17 & 11/30/17	
Independent Monitor		
15-32033-CON Condition 15	11/7/16	
15-32033-CON Condition 16	2 per year; report due 30 days after visit	
15-32033-CON Condition 33	3/31/17	
15-32032-CON Condition 8	Ongoing	

Note – documentation has been referenced per YNHHS's submissions to the Monitor mailbox, as OHCA compliance webpage does not include 5/31/17 or 11/30/17 submissions.

Key	
Complete	
In Progress	

Condition Number	Milestone Date	Completion Status
Community Benefit		
15-32033-CON Condition 11	11/30/17	
15-32033-CON Condition 31	11/30/17	
15-32033-CON Condition 32h	11/30/17	
15-32033-CON Condition 12	11/30/17	
Charity Care Policies		
15-32033-CON Condition 9	Following closing	
15-32033-CON Condition 10	11/30/17	
15-32033-CON Condition 32e	5/31/17 & 11/30/17	
Employment Conditions		
15-32033-CON Condition 27	5/31/17 & 11/30/17	
15-32033-CON Condition 32g	5/31/17 & 11/30/17	
15-32033-CON Condition 28	5/31/17 & 11/30/17	
15-32032-CON Condition 6	5/31/17 & 11/30/17	
15-32033-CON Condition 29	5/31/17 & 11/30/17	
15-32033-CON Condition 30	5/31/17 & 11/30/17	
Governance		
15-32033-CON Condition 14	Following closing	
15-32033-CON Condition 17	Twice a year	
15-32033-CON Condition 26	9/28/16	
Licensure and Physician Office Conversion		
15-32033-CON Condition 13	Ongoing	
15-32033-CON Condition 24	5/31/17 & 11/30/17	
15-32033-CON Condition 32d	5/31/17 & 11/30/17	
15-32032-CON Condition 5	5/31/17 & 11/30/17	
15-32032-CON Condition 7b	5/31/17 & 11/30/17	
15-32033-CON Condition 25	5/31/17 & 11/30/17	

I. Detailed Observations Table

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 32b	A narrative description of the achievement of the strategic plan components to retain and enhance healthcare services in the communities served by L+M, including with respect to physician recruitment and resource commitments for clinical service programming, whether the commitments described in the Affiliation Agreement were achieved, as well as the purposes, dates and amounts for which expenditures were made.	5/31/17 & 11/30/17	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met including referencing specific locations of primary care physicians.	YNHHS submitted Management Representation to OHCA in accordance with Conditions 7, 19a and 32b on 5/31/17 and 11/30/17.
15-32033-CON Condition 7	Within one hundred and eighty (180) days following the Closing Date and thereafter until the capital commitment is satisfied, YNHHSC shall submit to OHCA a report on the capital investments ("Capital Investment Report") it has made in L+M and its affiliates from the $300M Commitment Amount. The Capital Investment Report shall include the following in a format to be agreed upon: a. A list of the capital expenditures that have been made in the prior one hundred and eighty (180) days with descriptions of each associated project; and b. An explanation of why each expenditure was made and a timeframe for the roll out of the associated capital project (including estimated beginning, ending a11d startup/operation dates); and c. The funding source of the capital investment indicating whether it was drawn from operating revenue, capital contributions from YNHHSC or another source and, if funding was drawn from another source, indicating the source. For purposes of this Order, semi-annual periods are October 1-March 31 and April 1 - September 30. The required information is due no later than two (2) months after the end of each semi-annual period. Due dates are May 31st and November 30th beginning May 31, 2017. The reports shall be signed by L+MH's or L+M's Chief Financial Officer. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify the continued financial feasibility of the project.	5/31/17 & 11/30/17	D&T will obtain the Plan (per 15-32033-CON Conditions #4 and #19). We will read the plan and verify that expenditures/investments made are in accordance with the Plan. We will discuss any questions/need for clarification with Management to ensure the expenditures are verified. D&T will confirm detailed, full and timely submissions, with appropriate signatures of all required reports.	YNHHS submitted reporting to OHCA in accordance with Conditions 7, 19a, and 32b on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 18	L+MH shall continue to maintain emergency room services, inpatient general medicine services, cardiology services (including emergency and elective PCI), inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services, and oncology services, which such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. NOTE 1: See related Condition #1 which applies to the first 180 dates post-closing. Following that time, YNHHSC is bound by Condition #4 and the Services Plan created per Condition #4.	5/31/17 & 11/30/17	D&T will confirm that these services are properly maintained by conducting site visits, and ongoing data analysis of unit and patient data (e.g. to see continuing patient volume/services). YNHHSC will provide a Management Attestation/Representation to OHCA that it is in compliance with 15-32033-CON Condition #18. D&T will obtain a copy of that Management Representation.	YNHHS submitted Management Representation to OHCA in accordance with Condition 18 on 5/31/17 and 11/30/17. The semi-annual site visits were completed on 3/1/17, 7/6/17, and 12/4/17.
15-32033-CON Condition 32a	Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 – September 30 with reports due November and May certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation of the continuation of all L+MH services as described herein.	5/31/17 & 11/30/17	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's notarized Management Representation to OHCA that 15-32033-CON Condition 32 requirements a through e and g have been met.	YNHHS submitted reporting to OHCA in accordance with Condition 32a on 5/31/17 and 11/30/17.
15-32033-CON Condition 8	For three (3) years following the Closing Date, YNHHSC shall submit to OHCA a financial measurement report. This report shall be submitted on a semi-annual basis and show current month and year-to-date data and comparable prior year period data for L+MH and L+M. The required information is due no later than two (2) months after the end of each semi-annual period (fiscal year). Due dates are May 31st and November 30th, beginning May 2017. The following financial measurements/indicators should be addressed in the report: (i) Operating performance to include operating margin, non-operating margin, and total margin; (ii) Liquidity to include current ratio, days cash on hand, days in net accounts receivables, and average payment period; (iii) Leverage and capital structure to include long-term debt to equity, long-term debt to capitalization, unrestricted cash to debt, times interest earned ratio, debt service coverage ratio, and equity financing ratio; and (iv) Additional Statistics to include income from operations, revenue over (under) expense, cash from operation, cash and cash equivalents, net working capital, free cash flow (and the elements used in the calculation, unrestricted net assets/retained earnings, bad debt as a percentage of gross revenue, and credit ratings.	5/31/17 & 11/30/17	D&T will obtain the financial measurement report and review work papers to ensure that they are consistent with financial reports being submitted to L+M Hospital Board and that the required elements and financial measurements are appropriately recorded in the report; we will confirm the timely submission of each report.	YNHHS submitted financial measurement reporting to OCHA in accordance with Condition 8 on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 32f	A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include the following additional information in its annual report. i. Narrative updates on the progress of implementation of the plan. These updates shall include the status of integration activities and adoption by L+MH and L+M of YNHHSC non-clinical shared services opportunities; ii. A report identifying L+M and L+MH cost saving totals since the Closing Date for the following Operating Expense Categories: Salaries and Wages, Fringe Benefits, Contractual Labor Fees, Medical Supplies and Pharmaceutical Costs, Depreciation and Amortization, Bad Debts, Interest Expense, Malpractice Expense, Utilities, Business Expenses and Other Operating Expenses. The categories shall be consistent with the major operating expense categories (Categories A,B,C,D,E,F,G,H,I,J, and K) that are in use at the time of reporting in the OHCA Hospital Reporting System ("HRS") Report 175 or successor report. YNHHSC shall also file a narrative describing the specifics of the cost savings for each of these major expense categories; iii. A completed Balance Sheet, Statement of Operations, Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and iv. For L+MH, a completed Hospital Operating Expenses by Expense Category and Department report. The format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 175 or successor report.	5/31/17 & 11/30/17	For 15-32033-CON Condition #32F, D&T will obtain the Five-Year Plan prepared by YNHHSC and the ongoing six-month reports based on fiscal year. We will verify that the required elements are included in the report and are documented and supported by underlying information. We will confirm timely submission of all reports (OHCA's, HRS, Report 100, Report 150 and Report 175) and succession reports to OHCA.	YNHHS submitted reporting to OHCA in accordance with Condition 32f on 5/31/17 and 11/30/17. The milestone dates for the six-month report are 5/31/17 and 11/30/17 for 15-32033-CON Condition 32f and 15-32032-CON Condition 7c.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 7c	Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: A detailed and comprehensive document showing a five-year plan (the "plan") to generate and achieve efficiencies for L+M resulting from non-clinical shared services opportunities, L+M's integration with and adoption of YNHHSC information technology systems and platforms, YNHHSC's supply chain management services, integration of clinical and business practices across LMMG and NEMG, L+M's reduced cost of capital, and L+M's participation in YNHHSC population health initiatives. Subsequent to submission of the plan in its six month report, YNHHSC shall include a completed Balance Sheet, Statement of Operations, and Statement of Cash Flow for L+MH, L+M and LMMG (or of NEMG in the event of an NEMG-LMMG merger). For L+MH, the format shall be consistent with that which is in use at the time of reporting in OHCA's HRS Report 100 and Report 150 or successor reports; and	5/31/17 & 11/30/17	Refer to procedures for 15-32033-CON Condition #32f in the work plan above.	YNHHS submitted reporting to OHCA in accordance with Condition 32f on 5/31/17 and 11/30/17. The milestone dates for the six-month report are 5/31/17 and 11/30/17 for 15-32033-CON Condition 32f and 15-32032-CON Condition 7c.
5-32033-CON Condition 6	Within one hundred and eighty (180) days following the Closing Date, the Applicants shall file with OHCA the total price per "unit of service" for each of the top 25 most frequent MS-DRGs (inpatient) and top 25 most frequent CPT codes (outpatient) for L+MH services. The first filing shall be for the period October 1, 2015 – September 30, 2016. The Applicants shall provide the same information for three (3) full fiscal years thereafter, within sixty (60) days following the end of a fiscal year. OHCA shall provide the format for the filing. OHCA is imposing this condition to ensure that the proposed transfer of ownership does not adversely affect health care costs.	5/31/17 & 11/30/17	D&T will obtain YNHHSC's analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information. D&T will review work papers to confirm information and timely filing. * 1st filing is due within 180 days (March 2017); 2nd filing is due 60 days after the close of FY2017 which is 11/30/17 and the 3rd filing is due 60 dates after the close of FY2018 which is 11/30/18.	YNHHS submitted analysis of the top 25 most frequent MS-DRGs and CPT codes and related weighted average price information to OHCA in accordance with Condition 6 on 5/31/17 and 11/30/17. Modified semi-annual reporting for 5/31/17 was submitted to OHCA on 8/2/17.

15-32033-CON Condition 22	Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined below) for L+MH and LMMG (the "annual CMIR update"). YNHHSC shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section l 9a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 19a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut. c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section 19a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purposes of determining further conditions as necessary to correct	11/30/17	D&T will confirm that YNHHSC initiated this review within 90 days of closing by obtaining a copy of the relevant contract/engagement letter as evidence. D&T will also confirm that the analysis addresses the required elements. D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant.	The Independent Consultant (Milliman) submitted the CMIR to OHCA on 12/1/17. The Independent Monitor and Independent Consultant currently meet via conference call on a regular basis.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 22 (continued)	such condition and to create a performance improvement plan to address the conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall report to and take direction from the Commissioner. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do by law.			

15-32032-CON Condition 3	Within ninety days of the Date of Closing, YNHHSC shall initiate a cost and market impact review which shall comply with Connecticut General Statute Section 19a-639f, which such analysis shall include and shall be utilized to establish the baseline cost structure set forth below: a. Establishing a baseline cost structure and total price per unit of service (the "baseline CMIR") and establishing a cap on annual increases in total price per unit of service (as defined in d. below) for L+MH and LMMG (the "annual CMIR update"). Yale New Haven shall retain an independent consultant, subject to OHCA's approval, to conduct the baseline CMIR and the annual CMIR update and shall pay all costs associated with the cost and market review. To the extent that all data is not available to comply with the provisions of section 19a-639f the baseline CMIR shall be adjusted to reflect such information when it becomes available. b. In conducting the baseline CMIR and annual CMIR update, the cost and market impact review shall analyze the factors relative to L+MH and LMMG in accordance with subsection (d) of section 10a-639f of the general statutes and the Eastern Connecticut market more specifically: (a) L+MH and LMMG's size and market share within their primary and secondary service areas; (b) L+MH's and LMMG's prices for units of service, including its relative price compared to other providers for the same services in Eastern Connecticut; (c) L+MH and LMMG cost and cost trends in comparison to total healthcare expenditures statewide; (d) the availability and accessibility of services similar to those provided by L+MH and LMMG in their primary and secondary service areas; (e) the role of L+MH and LMMG in serving at-risk, underserved and government payer populations, including those with behavioral, substance use disorder and mental health conditions, within their primary and secondary service areas; (f) the role of L+MH and LMMG in providing low margin or negative margin services within their primary and secondary service areas; (g) general market conditions for hospitals and medical foundations in the state and in Eastern Connecticut in particular; and (h) and other conditions that the independent consultant determines to be relevant to ensuring that L+MH and LMMG prices do not exceed the market price for similar services in Eastern Connecticut. c. In recognition that the baseline CMIR pursuant to Connecticut General Statute Section l 9a-639f shall be conducted after the Date of Closing, in the event that the baseline CMIR finds a likelihood of materially increased prices as a result of the L+M affiliation with YNHHSC, notwithstanding these conditions, the Commissioner of Public Health (Commissioner) and YNHHSC shall meet and confer for the purpose of determining further conditions as necessary to correct such condition and to create a performance improvement plan to address the	11/30/17	Refer to procedures for 15-32033-CON Condition #22 above.	The Independent Consultant (Milliman) submitted the CMIR to OHCA on 12/1/17. The Independent Monitor and Independent Consultant currently meet via conference call on a regular basis.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 3 (continued)	conditions. The Commissioner shall determine whether YNHHSC is in compliance with such performance improvement plan. Prior to the end of each fiscal year, the independent consultant shall conduct the annual CMIR update and use the results of such annual CMIR update to establish a cap on any increase in the price per unit of service for the upcoming fiscal year. Nothing herein shall prohibit the independent consultant from considering and recommending any recommendations of the Certificate of Need Task Force on cost containment measures or a cap on annual cost or price increases. d. The independent consultant shall take direction from the Commissioner of the Department of Public Health. The independent consultant in establishing the cap shall take into consideration the cost reductions reflective of the efficiencies resulting from the affiliation and the annual cost of living of the primary service area or the Eastern Connecticut area. e. The independent consultant shall provide the baseline CMIR and the annual CMIR update to OHCA within thirty days of completion. OHCA shall keep confidential all nonpublic information and documents obtained as part of the baseline CMIR and the annual CMIR update and shall not disclose the information or documents to any person without the consent of YNHHSC and L+M, unless required to do so by law. The confidential information and documents shall not be public records and shall be exempt from disclosure under Connecticut General Statute Section 1-210.			

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 4	For purposes of determining the price per unit of service: a. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. b. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. c. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). d. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. e. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	11/30/17	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.	The Independent Consultant (Milliman) submitted the CMIR to OHCA on 12/1/17. The Independent Monitor and Independent Consultant currently meet via conference call on a regular basis.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 23	For purposes of determining the price per unit of service: f. A "unit of service" for inpatient hospital services shall be a case categorized by an ICD-9-DM/ICD-10-DM diagnosis code or a Diagnosis-Related Group (DRG) code and identified by the Connecticut Department of insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently occurring acute care hospital inpatient primary diagnoses, the fifty most frequently provided acute care hospital inpatient principal procedures, and the twenty-five most frequent inpatient surgical procedures. g. A "unit of service" for outpatient hospital services shall be a procedure or service categorized by a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding (HCPC) code and identified by the Connecticut Department of Insurance pursuant to P.A. 15-146 Section 2 as among the fifty most frequently provided outpatient procedures, the twenty-five most frequent outpatient surgical procedures and the twenty-five most frequent imaging procedures performed in the state. h. A "unit of service" for physician services shall be a work Relative Value Unit (wRVU). i. The baseline to be established as of the Date of Closing for L+M's total price per unit of service for physician services and inpatient and outpatient hospital services is inclusive of all administrative overhead, other ancillary fees including, but not limited to facility fees and the total price per unit shall reflect the total price of such service. j. All administrative costs for overhead, ancillary fees, facility fees or any other fees which are reflected in the total price per unit shall be determined by the independent consultant to be within any annual cap established.	11/30/17	D&T will obtain a copy of the CMIR performed by the Independent Consultant. D&T will meet annually with the Independent Consultant. D&T will not perform any additional procedures in the role of Monitor as it relates to 15-32033-CON Condition #23.	The Independent Consultant (Milliman) submitted the CMIR to OHCA on 12/1/17. The Independent Monitor and Independent Consultant currently meet via conference call on a regular basis.
15-32033-CON Condition 20 Paragraph 1	L+M and YNHHSC shall maintain the current L+MH and Lawrence + Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph.	5/31/17 & 11/30/17	D&T will evaluate and verify that contracts are maintained in accordance with this condition. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.	YNHHS submitted a Management Representation to OHCA in accordance with Condition 20 paragraph 1 on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 32c	Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of Conditions (20), (21) and (22) above.	5/31/17 & 11/30/17	For 15-32033-CON Condition 32c, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32c requirements have been met. We will meet with YNHHSC Management to read the contracts and confirm that this condition is met.	YNHHS submitted a Management Representation to OHCA in accordance with Condition 32c on 5/31/17 and 11/30/17.
15-32033-CON Condition 20 Paragraphs 2/3	Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation and in addition as set forth in paragraph 25 herein. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut. For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to cap determined through the process set forth below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	5/31/17 & 11/30/17	D&T will obtain the Independent Consultant/CMIR Report which should address/provide analysis to confirm paragraphs 2 and 3 of 15-32033-CON Condition #20. D&T as the Monitor will not independently perform additional/separate procedures related to paragraphs 2 and 3 of 15-32033-CON Condition #20.	YNHHS submitted the Independent Consultant/CMIR Report to OHCA in accordance with Condition 20 paragraphs 2/3 on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 1	Lawrence & Memorial Medical Group (LMMG) commercial health plan contracts in effect as of the Date of Closing for a period following the Date of Closing to December 31, 2017. Rates or scheduled increases in such previously negotiated rates that are in effect on the Date of Closing shall be maintained for a period ending December 31, 2017. Any L+M commercial health plan contracts that expire prior to December 31, 2017shall be extended to December 31, 2017 and any contracts without expiration dates shall be continued under their current previously negotiated terms for a period from the Date of Closing to December 31, 2017. No increase in negotiated rate schedules shall be negotiated during the periods set forth in this paragraph. Upon the expiration of any such L+M commercial health plan contracts after such period, L+M and YNHHSC shall negotiate new rates based on L+M's post-Closing cost structure, taking into account any cost or price reductions, i.e. efficiencies, achieved as a result of the affiliation. YNHHSC shall not impose a single System-wide rate and shall, for L+MH and LMMG, maintain a negotiated rate structure reflective of the market conditions applicable generally to hospitals and medical foundations in Eastern Connecticut. For a period of five years from the Date of Closing in the case of L+MH, and twenty-eight months from the Date of Closing in the case of LMMG, any annual increase in the total price per unit of service (as defined below) for L+MH and LMMG shall be subject to a cap determined through the process set forth in Paragraphs 3 and 4 below. It is the intent of the parties that such cap shall serve as a cap for the purpose of assuring patient affordability for services delivered by L+MH and LMMG.	5/31/17 & 11/30/17	Refer to procedures for 15-32033-CON Condition #20 outlined here and 1532033-CON Condition 20a, 20b and 20c.	YNHHS submitted Management Representations in accordance with Condition 20, referencing the requirements noted for Condition 1 on 5/31/17 and 11/30/17.
15-32032-CON Condition 7a	Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31) and April 1 through September 30 (due November 30) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: a. Affirmation that L+MH and LMMG commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of paragraphs (20), (21) and (22) above.	5/31/17 & 11/30/17	Refer to procedures for 15-32033-CON Condition #32c.	YNHHS submitted reporting to OHCA in accordance with Condition 7a on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 21a	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph 20 above, i.e. physicians providing services through NEMG to L + M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	5/31/17 & 11/30/17	D&T obtained YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21a.[1]	YNHHS submitted a Management Representation to OHCA in accordance with paragraph 20, satisfying the requirements of Condition 21a on 5/31/17 and 11/30/17.
15-32032-CON Condition 2a	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): a. LMMG and NEMG will integrate as of the Closing Date, and when NEMG is able to abide by the commitment set forth in paragraph I above, i.e. physicians providing services through NEMG to L+M patients, that were not providing services as of the Date of Closing, shall charge prices for services (site specific charges) based upon LMMG commercial health plan contracts and total price per unit of service, LMMG and NEMG shall implement the statutory merger contemplated in the Certificate of Need Application.	5/31/17 & 11/30/17	Refer to procedures for 15-32033-CON Condition #21a above.	YNHHS submitted a Management Representation to OHCA in accordance with paragraph 1, satisfying the requirements of Condition 2a on 5/31/17 and 11/30/17.

[1] D&T did not test payer submissions as commercial health plan contracts were frozen through 12/31/17. Separate procedures will be applied to assess compliance with the CMIR requirements and contracted rates.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 21b	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 20: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 20.	5/31/17 & 11/30/17	D&T will obtain YNHHSC's Management Representation submitted to OHCA relative to compliance with 15-32033-CON Condition #21b.	YNHHS submitted a Management Representation in accordance with paragraph 20, satisfying Condition 21b to OHCA on 5/31/17 and 11/30/17.
15-32032-CON Condition 2b	With respect to the proposed merger of LMMG and Northeast Medical Group (NEMG): b. Physicians who are hired, recruited or contracted by a YNHHSC affiliate to provide professional services (other than in a licensed hospital department) in the primary service area (which may from time to time change), currently the communities of East Lyme, Groton, Ledyard, Lyme, Montville, New London, North Stonington, Old Lyme, Preston, Salem, Stonington and Waterford, and in the following specialties shall be billed at the LMMG commercial health plan negotiated rates subject to the provisions of paragraph 1: family medicine; general medicine; internal medicine; obstetrics and gynecology; endocrinology; and psychiatry. Current LMMG physicians providing services in the primary service area as of the Date of Closing in any specialties shall be subject to the provisions of paragraph 1.	5/31/17 & 11/30/17	Refer to procedures for 15-32033-CON Condition #21b above.	YNHHS submitted a Management Representation in accordance with paragraph 1, satisfying Condition 2b to OHCA on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 16	The Independent Monitor will report to both OHCA and FLIS. The Independent Monitor shall conduct on-site visits of L+MH on no less than a semi-annual basis to assess adherence to DPH's Consent Order. The Independent Monitor shall furnish a written report of his or her assessment to OHCA and FLIS within thirty (30) days of the completion of each on-site review. YNHHSC will have the opportunity to review and provide written responses to the report. As OHCA deems necessary, the Independent Monitor shall meet with OHCA and FLIS personnel to discuss the written report and will perform additional periodic reviews. OHCA is imposing this Condition to ensure continued access to health care services for the patient population and to verify and monitor compliance with the Conditions set forth herein.	2 per year; report due 30 days after visit	D&T will plan, at a minimum, two site visits per year. The site visits will include meetings with Administration/Leadership and review of any documentation requested by D&T. D&T will provide a report that summarizes the activities from the prior six month period along with any recommendations or observations to YNHHSC, OHCA, and FLIS. Procedures associated with 15-32033-CON Condition #16 are expected to coincide/satisfy 15-32033-CON Conditions 33b and 33d as well.	The semi-annual site visits were completed on 3/1/17, 7/6/17, and 12/4/17. A brief report summarizing the site visit were submitted in accordance with Condition 16 on 3/23/17 and 12/4/17. D&T submitted report summarizing YNHHS activities to address Conditions from the prior six-month period on 04/07/17 and 12/11/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 8	In addition to the above, L+M and YNHHSC make the following commitment for a period of five years post-Closing: a. L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. a.L+M and YNHHSC shall appoint an independent monitor at their own cost (selected by YNHHSC and L+M and approved by OHCA) to serve as a post-transfer compliance monitor. b. Such monitor shall, at a minimum meet with representatives of the L+M community at six months after the Date of Closing and annually and shall report to OHCA in accordance with Section 19a-639(e) of the general statutes and specifically address: (i) L+M's compliance with the Certificate of Need Order; and (ii) the level of community benefits and uncompensated care provided by L+M during the prior period. c. L+M shall provide the monitor with reasonable access to its public filings and facilities and all other financial information necessary for the purposes of carrying out the monitor's duties. d. L+M shall hold a public forum in New London at six months after the Date of Closing and not less than annually thereafter during the monitoring period to provide for public review and comment on the monitor's reports and findings.	Ongoing	Refer to procedures for 15-32033-CON Condition #33 a through e above.	YNHHS submitted minutes from Community Meetings with "participation group" to OCHA on 1/27/17 and 3/1/17. D&T reviewed the public notice and attended the community meetings and public forums on 1/24/17, 3/1/17, 7/6/17, and 12/4/17 and submitted Public Forum minutes to OHCA on 3/23/17. Minutes for the 12/4/17 meeting were submitted on 12/7/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 8 (continued)	e. If the Independent Monitor determines that YNHHSC and L+M are substantially out of compliance with the conditions to the CON, the monitor shall notify YNHHSC and L+M in writing regarding the deficiency. Within two weeks of such notice, the monitor shall convene a meeting with representatives from YNHHSC and L+M for the purpose of determining compliance and any appropriate corrective action plan. If YNHHSC and L+M fail to implement a plan of correction satisfactory to the monitor within thirty days of such meeting, the monitor shall report such substantial noncompliance and its impact on health care costs and accessibility to OHCA. OHCA shall determine whether such non-compliance has had a material negative impact and what remedy is reasonably necessary to bring YNHHSC and L + M into compliance and shall have the right to enforce these conditions by all means and remedies available to it under law and equity, including but not limited to Conn. Gen. Stat. 19a-642 and the right to impose and collect a civil penalty under Conn. Gen. Stat. 19a-653 In addition, in the event OHCA determines YNHHSC and L+M are in material non-compliance, OHCA may order YNHHSC and L+M to provide additional community benefits as necessary to mitigate the impact of such noncompliance.	Ongoing	Refer to procedures for 15-32033-CON Condition #33 a through e above.	Per YNHHS submissions to OHCA, there are no noted instances of non-compliance with the requirements outlined in Condition 8.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 11	The Applicants shall maintain community benefit programs and community building activities for L+MH for three (3) years after the Closing Date consistent with L+MH's most recent Schedule H of IRS Form 990 or shall provide such other community benefit programs and community building activities that are at least as generous and benevolent to the community as L+MH's current programs, and the Applicants shall apply no less than a 1% increase per year for the next three (3) years toward the L+MH's community building activities in terms of dollars spent. In determining L+MH' s participation and investment in both community benefits and community building activities, the Applicants shall address the health needs identified by the applicable CHNA in effect at the time and the population health management objectives, including social determinants of health, contained in the related Implementation Strategy. a. On an annual basis, YNHHSC shall identify the amounts and uses related to community benefits and community building and shall discuss how such investments and support are being applied toward the health needs identified in the CHNA and population health management objectives. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing for three years and shall be posted on L+MH's website. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	11/30/17	D&T will obtain L+MH's most recent Schedule H of IRS Form 990 to act as a baseline. We will then compare on an annual basis the results of that year to the baseline in order to verify that the 1 percent increase requirement has been met. D&T will also obtain the YNHHSC report/summary on the amounts and uses related to community benefits and community building per the categories identified in the CHNA. D&T will evaluate these reports/summaries as compared to the CHNA and defined population health management objectives and will discuss any questions with YNHHSC Management. D&T will confirm that these documents are filed in a timely manner and posted to the L+MH website.	D&T obtained and reviewed Schedule H of 2016 IRS Form 990 and will review the 2017 990 when available. YNHHSC submitted an estimate analysis to OHCA in accordance with Condition 11 on 11/30/17.[2]

[2] YNHHS clarified their filing on 12/8/17 for Condition 11 and Condition 12 to correct FY16 Community Building and Community Benefit levels to match the FY16 990.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 31	L+M and YNHHSC have agreed to maintain at least the same level of community benefit consistent with L+M's most recent Schedule H of IRS Form 990 and its Community Health Needs Assessment (CHNA). L+M and YNHHSC agree to conduct an updated Community Health Needs Assessment by no later than December 31, 2016, and provide services in accordance with implementation plan adopted as part of the updated CHNA process and provide OHCA with its updated CHNA within thirty days of its approval.	11/30/17	After obtaining L+M's baseline Schedule H of IRS Form 990, D&T will obtain and confirm that L+M and YNHHSC have maintained at least the same level of community benefit. Cross-reference to 15-32033-CON Condition #11.	D&T obtained and reviewed Schedule H of 2016 IRS Form 990 and will review the 2017 990 when available. YNHHSC submitted an estimate analysis to OHCA in accordance with Condition 11 to address requirements of Condition 31 on 11/30/17.
15-32033-CON Condition 32h	A narrative description of L+M's community benefit commitments described herein, including without limitation the amounts spent and a description of such spending to support and invest in the communities that L+M serves.	11/30/17	Relative to 15-32033-CON Condition #32h, see procedures performed for 15-32033-CON Conditions #11 and #31.	D&T obtained and reviewed Schedule H of 2016 IRS Form 990 and will review the 2017 990 when available. YNHHSC submitted an estimate analysis to OHCA in accordance with Condition 11 on 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 12	The Applicants shall work toward making culturally and linguistically appropriate services available and integrated throughout L+MH's operations. Specifically, the Applicants shall ensure that L+MH shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities, in accordance with the implementing regulations of Section 1557 of the Patient Protection and Affordable Care Act. Additionally, the Applicants shall provide at L+MH, appropriate insurance navigator services for patients and, where appropriate, English as a second language and cultural competency training for employees. In complying with this Condition, the Applicants shall ensure that L+MH shall be guided by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care published by the U.S. Department of Health and Human Services' Office of Minority Health. For three (3) years following the Closing Date, YNHHSC shall submit a written report on its activities directed at meeting this Condition. Such reporting shall be filed within thirty (30) days of the anniversary date of the Closing and shall be posted on L+MH's website. OHCA is imposing this Condition so as to ensure continued access to health care services for the patient population.	11/30/17	D&T will obtain and review interpreter services policies and contracts as applicable. Additionally, our team will obtain the cultural competency plan, training and related policies. We will also obtain YNHHSC's report and supporting documents and confirm the timely filing of these materials.	YNHHS submitted documentation to OHCA in accordance with Condition 12 on 11/30/17.
15-32033-CON Condition 10	For three (3) years following the Closing Date, YNHHSC shall provide written notice to OHCA of any modification, amendment or revision to the charity care, indigent care and community volunteer services policies of L+MH within thirty (30) days of such change. The notice of these changes shall be accompanied by copies of any revised policies and the notice and revised policies shall be posted on the website of L+MH simultaneously with their submission to OHCA. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	11/30/17	After obtaining original L+MH policies on charity care, indigent care, and community volunteer services, D&T will read and assess these policies on an annual basis for changes. When changes are made to these policies, we will confirm OHCA is notified (as required) and revised policies are posted to the L+MH website.	YNHHS submitted notice of modifications to policies to OHCA in accordance with Condition 10 on 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 32e	Affirmation that L+M has adopted the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof, and that such Policies, if amended, provide assistance to patients that is at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect as of the date hereof.	5/31/17 & 11/30/17	For 15-32033-CON Condition 32 requirements a through e and g, D&T will obtain a copy of YNHHSC's Management Representation to OHCA that Condition 32 requirements a through e and g have been met.	YNHHS submitted documentation to OHCA in accordance with Condition 32e including financial assistance policies on 5/31/17 and 11/30/17. If future changes to policies are made, Independent Monitor will obtain YNHHS management representation that such policies are at least as generous as the YNHHSC Financial Assistance Program Policies currently in effect.
15-32033-CON Condition 27	L+M shall continue to recognize all collective bargaining units currently organized at an L+M affiliate, and honor the collective bargaining agreements currently in place.	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #27 has been met.	YNHHS submitted a Management Representation to OHCA in accordance with Condition 27 on 5/31/17 and 11/30/17.
15-32033-CON Condition 32g	Affirmation of the labor and employment commitments described herein, including but not limited to L+M' s service sites continued honoring of collective bargaining agreements in place as of the date hereof.	5/31/17 & 11/30/17	See others below	YNHHS submitted a Management Representation to OHCA in accordance with Condition 32g on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 28	Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.	YNHHS submitted a Management Representation to OHCA in accordance with Condition 28 on 5/31/17 and 11/30/17.
15-32032-CON Condition 6	Employees of any L+M affiliate shall not be required to reapply for their positions as a result of the affiliation. To the extent that any L+M employees leave their employment at L+M service sites within ninety days following the Closing Date and obtain employment with a YNHHSC affiliate, such employees' seniority shall be preserved (e.g., eligibility for benefits consistent with total years of service).	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #28 has been met.	YNHHS submitted a Management Representation to OCHA in accordance with Condition 6 on 5/31/17 and 11/30/17.
15-32033-CON Condition 29	L+MH shall maintain its current wage and salary structures for its non-bargaining or non-represented employees based on hospitals of similar scope, size and market conditions in Connecticut.	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #29 has been met.	YNHHS submitted a Management Representation to OCHA in accordance with Condition 29 on 5/31/17 and 11/30/17.
15-32033-CON Condition 30	L+M and YNHHSC shall use their best efforts to achieve efficiencies through the management of vacancies and attrition and to minimize the elimination of individuals' jobs.	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #30 has been met.	YNHHS submitted a Management Representation to OCHA in accordance with Condition 30 on 5/31/17 and 11/30/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32033-CON Condition 17	For three (3) years following the Closing Date, the Applicants shall hold a meeting of the YNHHSC Board and L+M Board ("Joint Board Meetings") at least twice annually. Such Joint Board Meetings shall be followed by a meeting to which the public is invited in advance and at which the public is informed of L+MH's activities and afforded an opportunity to ask questions and make comments. OHCA is imposing this Condition to ensure continued access to health care services for the patient population.	Twice a year	To confirm compliance with this provision, D&T will obtain minutes from these Joint Board Meetings and confirm notice of the public meetings is posted with proper notice. D&T will attend the public meetings as part of the Monitor role.	D&T reviewed materials[3] from the Joint Board Meetings of the YNHHSC Board and L+MH Board for meeting date 5/8/17 and 11/27/17, in accordance with Condition 17. The next Joint Board Meeting is scheduled for 2/26/18.
15-32033-CON Condition 24	L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.	YNHHS submitted a Management Representation to OCHA in accordance with Condition 24 on 5/31/17 and 11/30/17.
15-32033-CON Condition 32d	Affirmation that no L+M physician office has been converted to hospital-based status.	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #32d has been met.	YNHHS submitted a Management Representation to OCHA in accordance with Condition 32d on 5/31/17 and 11/30/17.
15-32032-CON Condition 5	L+M and YNHHSC shall not convert any L+M physician offices (including those that will be merged into NEMG) to hospital-based status.	5/31/17 & 11/30/17	D&T will obtain a copy of YNHHSC's Management Representation to OHCA that 15-32033-CON Condition #24 has been met.	YNHHS submitted a Management Representation to OCHA in accordance with Condition 5 on 5/31/17 and 11/30/17.

[3] No minutes were created for the 5/8/17 Joint Board Meeting – Deloitte reviewed an agenda write up of topics discussed and Cathy Zall, the Community Representative to the Board, provided an update during the July 6, 2017 Public Forum. Minutes from the 11/27/17 meeting were reviewed in draft and subject to edit by YNHHS until finalized at the next Joint Board Meeting on 2/26/17.

Condition Number	Condition Description	Milestone Date	D&T Procedure	Independent Monitor Observations
15-32032-CON Condition 7b	Every six months (the "six month reports") until September 30, 2018 and each year thereafter (each an "annual report"), YNHHSC shall submit notarized reports to OHCA for the periods of October 1 through March 31 (due May 31st) and April 1 through September 30 (due November 30th) certifying the achievement of each and every commitment described herein, including without limiting the foregoing the following specific detail: Affirmation that no L+M physician office has been converted to hospital-based status.	5/31/17 & 11/30/17	Refer to procedures for 15-32033-CON Condition #32f above.	YNHHS submitted reporting to OHCA in accordance with Condition 32f on 5/31/17 and 11/30/17. The milestone dates for the six-month report are 5/31/17 and 11/30/17 for 15-32033-CON Condition 32f, 15-32032-CON Condition 7c, 15-32032-CON Condition 7b.
15-32033-CON Condition 25	L+M shall attain cost savings as a result of the affiliation with YNHHSC as described in the CON application.	5/31/17 & 11/30/17	D&T will obtain and read YNHHSC's reporting created per 15-32033-CON condition #32f.	YNHHS provided reporting to OHCA in accordance with Condition 25 on 5/31/17 and 11/30/17.

User, OHCA

From: Cotto, Carmen
Sent: Monday, February 05, 2018 12:09 PM
To: User, OHCA
Cc: Roberts, Karen
Subject: FW: Yale/L&M Docket Numbers 15-32032 and 15-32033_Compliance Material Submission

From: Cotto, Carmen
Sent: Monday, February 5, 2018 11:59 AM
To: 'ksauders@deloitte.com' <ksauders@deloitte.com>
Cc: Capozzalo, Gayle (Gayle.Capozzalo@ynhh.org) <Gayle.Capozzalo@ynhh.org>; Roberts, Karen <Karen.Roberts@ct.gov>; Martone, Kim <Kimberly.Martone@ct.gov>
Subject: Yale/L&M Docket Numbers 15-32032 and 15-32033_Compliance Material Submission

Dear Kelly:

Please address the following in reference to Docket number 15-32032 and 15-32033:

1) OHCA is requesting that all compliance filings from the hospital staff, first go to you, as the Independent Monitor ("IM"), and then you file the material with OHCA. This will provide OHCA with verification that you have reviewed the material to determine compliance to the order prior to OHCA's review of the material. The submission of compliance documents by the hospitals' staff directly to OHCA and only copied to you does not allow OHCA to clearly identify the IM's involvement in the process of reviewing and submitting the documents.

Please continue to reference the CON docket number in the subject line of the email when transmitting and submit your responses via electronic mail by using the OHCA general email inbox which is OHCA@ct.gov.

You may contact me at (860) 418-7039 or Karen Roberts, Principal Health Analyst at (860) 418-7041, if you have any questions regarding this request.

Sincerely,
Carmen

Carmen Cotto, MBA
Associate Health Care Analyst
Office of Health Care Access
Connecticut Department of Public Health
410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, CT 06134

P: (860) 418-7039 |F: (860) 418-7053 |E: carmen.cotto@ct.gov

www.ct.gov/dph